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1

Medication Administration Responsibilities

November 8, 2024
9AM-11AM

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2

Today's Presenters

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3

Training Objectives

- Review Medication Administration Certification responsibilities
- Define Medication Errors
- Define Unusual Incident Medication errors
- Define Medication Related MUIs
- Review the Steps of a Med Related MUI Investigation
- Address Patterns of Medication Errors
- Identify Causes and Contributing Factors and Prevention Plans
- Review the MAIS system and provider responsibilities

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4

Medication Administration Certification Responsibilities

- Medication Administration Certification authorizations
  - **Category 1** – administration of oral, topical, inhaled medications, oxygen and 13 health-related activities
  - **Category 2** – administration of medications through stable and labeled G/J tube
  - **Category 3** – administration of insulin and injectable treatments for metabolic glycemic disorders

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5

Medication Administration Certification Responsibilities

Authority of DD Personnel to Perform Services by Type - Medication Administration Reference Grid (ORC 5123.41-.47 and OAC 5123-6-03)

See yellow boxes for County Board responsibility for RN Quality Assessment reviews.

Applicable Setting	Certification 1 13-HRAs (Health-Related Activities) [illegible]	Certification 1 Medication Administration (Prescribed Oral, Topical, O2 and Inhalers)	Certification 2 G / J Tube Prescribed Medication Administration	Certification 3 Insulin by Sub-Q Injection & Pump and injectable treatments for metabolic glycemic disorders	Delegable Nursing Tasks Including 13 HRAs & Administration of Nutrition by G/J Tube
Adult Services Settings up to 16 people	Without nursing delegation	Without nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation
Family Support Services	Without nursing delegation	Without nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation
Certified Supported Living Services (1-4 individuals per living arrangements)	Without nursing delegation	Without nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation
Certified Home and Community Based Services (1-4 individuals per living arrangements)	Without nursing delegation	Without nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation
Residential Facilities : 1-5 Beds	Without nursing delegation	Without nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation
Early Intervention, Pre-School, School Age	With nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation
Adult Services Settings with 17 or more people	With nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation
Residential Facilities : 6 or more Beds	With nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation
Other Services by DD Boards or by Ohio Dept of DD	With nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation

*As per OBN's Administrative Code Chapter 4723-13, an RN may delegate specific NURSING TASKS to uncertified personnel (following all provisions in OAC 4723-13). Delegation of MEDICATION requires [illegible] Certification(s).

For Authority of DD Personnel to Perform Service by Type-Medication and other helpful resources, visit:

https://dodd.ohio.gov/home/med-admin

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6

Medication Administration Certification Responsibilities

- Personnel should know why they are administering each medication every time it is administered
- Personnel should have access to information on potential side effects
  - Pharmacy information sheet
  - Online resources
    - Drugs.com
  - Healthcare professional

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7

Medication Administration Certification Responsibilities

- Prepare and administer medications for only one person at a time
- Check the MAR to see when the last dose was given, and next dose is due
  - If a medication that should have been given has not been given, investigate, report as UI
- Never prepare medications before it is time to administer them
- Never administer medications that have been prepared by someone else

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8

Medication Administration Certification Responsibilities

- 6 Rights of Medication Administration
- I = Right **I**ndividual (person)
- M = Right **M**edication including strength
- D = Right **D**ose
- R = Right **R**oute
- T = Right **T**ime and date
- D = Right **D**ocumentation

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9

Medication Administration Certification Responsibilities

Follow specific Step-by-Step guidelines

1. Wash hands.
2. Start at the beginning of the medication administration record (MAR) and review, checking for the following:
   a. Individual's name
   b. All the medications ordered
   c. Medications to be given now
   d. Confirm that the previous dose was given
   e. Confirm the dose for this time and date has not yet been given
   f. Any allergies
   g. Special instructions for giving the medication
3. Read all the pages of the person's MAR to confirm ALL the medications you will need to prepare for administration. This includes the entire medication name (including strength), the dose (amount), and route of each medication you will be giving to the person at this time.
4. Get the medication from secure storage.

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10

Medication Administration Certification Responsibilities

5. Read the entire label carefully including the expiration date and special instructions. Make sure the packaging description of the medication matches the medication inside the container.
6. The **first check** of the MAR to the label:
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name – including strength, **D**ose, **R**oute, **T**ime and date)
7. The **second check** of the MAR to the label:
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name – including strength, **D**ose, **R**oute, **T**ime and date)
8. If they do not match, do not give the medication until there is clarification from a healthcare record or healthcare professional regarding the medication. If they do match go to the next step.

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11

Medication Administration Certification Responsibilities

9. Using a medication cup, place the medication in the cup without touching the medication with your fingers.
10. The **third check** (done for each medication after it is placed in the cup):
    a) Check the medication label against the MAR to confirm the 5 rights
    b) Check the amount of the medication in the cup to make sure it matches the label and the MAR.
    c) Use the options "dot system" at this step.
11. Using steps 5-10 put the next medication into the cup. Repeat until all scheduled oral medications have been prepared.
12. Secure the medication containers before leaving them to go administer medications that have been prepared to give. Never leave prepared medication unattended.
13. Identify the person to receive the medication. Take your time and make sure you are giving the prepared medication to the correct person. Confirm the person's identity with a picture or with another personnel who knows the person.

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12

Medication Administration Certification Responsibilities

14. Explain to the person the name and purpose of the medications(s) you are giving to them.
15. Be certain the medication is taken (swallowed). Check the person's mouth if uncertain.
16. Leave the person in a safe and comfortable manner.
17. Document that the medication was administered (this is the 6th Right of medication administration). Place your initials on the MAR in the space for the specific **I**ndividual's **M**edication(s), **D**ose, **R**oute, **T**ime/date, **D**ocumenting that you have given the medication (**I M DR TD**).
18. Document any complaints/concerns and action taken. If the medication is only used as needed, document the need and the response to treatment.
19. If the medication was missed, held, declined or given late, document by circling your initials and explain on the back of the MAR. Write and Unusual Incident Report.
20. Return the equipment to storage.
21. Make sure your initials, full name, and title are written in a space provided for signatures on the MAR or on a Master Signature Log.

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13

Medication/Treatment Errors

OAC 5123-6-01 Definitions of terms used in Chapter 5123-6 of the Ohio Administrative Code

(Z)(1) Wrong prescribed medication/treatment administered or performed

(2) Medication/treatment administered or performed at the wrong time

(3) Medication/treatment administered or performed by a route not prescribed or in the case of over-the-counter medication, not as indicated by the manufacturer

(4) Incorrect dose or amount of medication/treatment administered or performed

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14

Medication/Treatment Errors continued

(5) Expired medication/treatment administered or performed

(6) Contaminated medication/treatment administered or performed

(7) Improperly stored medication/treatment administered or performed

(8) Medication/treatment, other than over-the-counter medication authorized in ORC 5123.42, administered or performed without corresponding order from a licensed health professional authorized to prescribe drugs

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15

Medication/Treatment Errors continued

(9) Not performing or administering a prescribed medication/treatment during the prescribed time, including but not limited to, failure to ensure the medication/treatment equipment, or supplies needed to administer or perform the medication/treatment are available at the prescribed time or declination of a prescribed medication/treatment by an individual

(10) Not documenting a medication/treatment that was administered or performed

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16

Medication/Treatment Errors continued

(11) Administration or performance of prescribed medication/treatment by DDP without certification or whose certification has expired

(12) Administration of over-the-counter medication authorized in accordance with ORC 5123.42 by DDP without required training

(13) Administration or performance of medication/treatment without nursing delegation when nursing delegation is required

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17

Poll Question

Is an Incident Report required for every medication error

- Yes
- No

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18

OAC 5123-6-07 General provisions and compliance for performance of health-related activities and administration of prescribed medication

(D) Requirements for developmental disabilities personnel to report medication/treatment errors

- Any medication/treatment error … that results in physical harm to the individual will be immediately reported to an appropriate health care professional.
- … will be reported in accordance with rule 5123-17-02 … when the medication/treatment error meets the definition of major unusual incident or unusual incident.
- All medication/treatment errors will be documented in an unusual incident report ….

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19

Incident Report Requirements

When submitting incident reports for medication errors,

- List the name, dosage, frequency, and administration method of medication
- List the reason for which the medication is prescribed
- List the name of the staff person(s) involved
- Document the date and time of the MAIS entry
- Specifically list the immediate actions (call 9-1-1, doctor, or poison control)
- Specifically list any changes, or lack of, exhibited by the individual

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20

Unusual Incident Medication Errors

Medication errors without a likely risk to health and welfare

UI Examples :

- Personnel administered medications with expired certification
- Personnel without certification
- Individual returned home late from an appointment and received medication outside of scheduled time
- Medication not documented as administered

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Important Questions

- How do you determine if it was a MUI or UI?
- How do you determine risk?
- Does there have to be adverse outcome?

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Medication Error Related MUIs

- Neglect
- Unanticipated Hospitalization
- Misappropriation
- Unapproved Behavioral Supports

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MUI Investigation Breakdown

Many MUI medication errors meet the criteria for neglect:

"When there is a duty to do so, failing to provide an individual with medical care, personal care, or other support that consequently results in serious injury or places an individual or another person at risk of serious injury. Serious injury means an injury that results in treatment by a physician, physician assistant, or nurse practitioner."

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24

MUI Investigation Breakdown

"When there is a **duty to do so**, failing to provide an individual with medical care, personal care, or other support that consequently results in serious injury or places an individual or another person at risk of serious injury. Serious injury means an injury that results in treatment by a physician, physician assistant, or nurse practitioner."

Review the ISP; consider if the individual is able to self-administer or if the person receives support from staff. If supported by staff, what is the level and type of support?

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25

MUI Investigation Breakdown

"When there is a duty to do so, **failing to provide an individual with medical care, personal care, or other support** that consequently results in serious injury or places an individual or another person at risk of serious injury. Serious injury means an injury that results in treatment by a physician, physician assistant, or nurse practitioner."

What did the PPI fail to provide (medication not ordered or administered as prescribed – dosage, method, time)? Was the medication of another administered? Was the individual who can self-administer with assistance reminded? Was the medication expired? Had the medication been discontinued?

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26

MUI Investigation Breakdown

"When there is a duty to do so, failing to provide an individual with medical care, personal care, or other support that consequently results in **serious injury** or **places an individual or another person at risk of serious injury**. Serious injury means an injury that results in treatment by a physician, physician assistant, or nurse practitioner."

What was the medication (name, dosage, frequency, reason)? What was the serious injury or risk caused by the error (death, hospitalization, ER visit, seizure, behavior – could have a negative result for individual or another)?

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27

MUI Investigation Considerations

- Did the staff member follow the six rights of med administration? Right person, right medication, right dose, right route, right time, right documentation
- Was the staff person trained to support the individual's needs?
- Was the staff person distracted?
- Was the staff person rushed?
- Was the MAR correct?
- If the medication of another was administered, did each individual ultimately receive their correct medication?

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28

MUI Investigation Considerations

Medication errors due to missing medications may be the result of misappropriation

What was the medication, is it prone to abuse (narcotics, opiates / pain medications, many behavioral PRNs)?	Review the PPI's online criminal history for drug charges or charges that suggest a drug history, ask if the provider will have a drug test done.	Review the PPI's employment history for unexplained absences or tardiness.
Review the MAR for refused medications	What is disposal policy?	Review the UI / MUI history for escalation of behaviors normally controlled by medication.

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29

MUI Investigation Considerations

Over medication of PRN benzodiazepines (Ativan, Xanax, Klonopin) or depressants, including some OTC medications, may be a sign of Unapproved Behavioral Support (chemical restraint).

Review MAR history, compare staff schedule to look for patterns. Review incident reports on the individual's behavior before the PRN was given, did it warrant giving the medication? What was the individual's reaction after being given the medication? Was it given for staff convenience?

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30

Common Causes and Contributing Factors

- Staff being rushed.
- The person passing medications was distracted because they were taking a personal call at the time.
- Employee did not complete the "right person" check and gave the person their roommate's medications.
- Staff pre-set up medications in cups for convenience and administered improperly.
- A change in the prescribing doctor resulted in lapse of medication availability and no one contacted pharmacy/office for options.
- Medications were not secured.

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31

MUI Medication Error

Danielle was ordered medication to treat a psychiatric disorder. Her refill ran out and multiple staff documented that they could not give the medication because it was not available. Neither the pharmacy nor the doctor were contacted that Danielle was out of medication. Danielle went weeks without her medication that kept her healthy. As a result, she started to have some adverse effects which ultimately led to a psychiatric hospitalization.

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32

Tips and Tricks

Tips so the person doesn't run out of medication

- Don't assume someone else is going to get the medication! Take action to make sure the person has their medication, especially newly ordered medications.
- Check the bottle/label for refills. The prescription label should clearly state exactly how many refills your prescription has left. If you see "no refills" then make a plan. Don't wait, call the prescribing doctor about getting a new order. Sometimes you may need to take the person to see doctor before they will order refills.

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Tips and Tricks

Tips if you run out of medications-no refills available

- Ask the pharmacist to call the physician and obtain a new order immediately.
- Call your supervisor, Nurse, or the person's SSA to discuss how to get person needed medications.

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34

Tips and Tricks

Tips if the regular pharmacy does not have the ordered medication

- Ask the pharmacy to check if other pharmacies in the area have the medication in stock.
- Some pharmacies also are open 24 hours a day and that is an option if the medication is not available at regular pharmacy, or they are closed when medication is needed.
- Ask if they have any of the medications and can provide those until the full supply is available.

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35

Tips and Tricks

Tips if you run out of medications-no refills available

- Call the pharmacist and ask to provide an emergency supply (a week's dose) until the physician can be contacted regarding a refill order. They may ask for a small payment to cover the cost of the medicines, or they may give it to you as a 'loan' against your next prescription.
- Call the physician's office/after hours on-call physician, especially in cases of critical medications where missing one to several doses can be dangerous. For example, prolonged missed Seizure medications can result in increased seizures, hospitalizations and even death.

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36

Tips and Tricks

Tips so the person doesn't run out of medication

- Consult your pharmacist about pharmacy services like auto-refill, bubble packs and other helpful tools for managing medications and ensuring refills are available.
- Plan ahead…if you know a person is moving or switching physicians, ensure that there are enough medications to get the person through the transition.

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37

MUI Medication Error

Staff administering medication found tape on the back of Susan's Ativan bubble package, indicating tampering. Upon investigation, they discovered a different pill inside. Beth did not administer the medication and immediately informed her supervisor. A follow-up with the pharmacist revealed that the substituted medication could have significantly lowered Susan's blood sugar, potentially leading to hospitalization.

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38

How to Prevent

- Always inspect the medication packaging-report anything unusual
- Complete counts of controlled substances-don't just do math
- Confirm the identity of the pill with a healthcare professional or trusted website (Drugs.com) or pharmacy description

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39

MUI Medication Error

The program supervisor took Katie to a medical appointment several hours away. She was not given her morning medications, which included seizure medication. Katie had a seizure in the vehicle while on the way home late that afternoon. She was taken to the hospital. While waiting for test results, Katie had another seizure. Katie was taken to another hospital and while in the ambulance being transferred had a 3rd breakthrough seizure. She was hospitalized for two days and then discharged.

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40

How to Prevent

- Why were the medications not administered?
  - Was personnel currently certified?
  - Was personnel who ran the appointment aware that the medications were not administered?
  - Could the doctor have been contacted prior to the appointment to change the medication time?

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41

MUI Medication Error

Heather, a Direct Support Professional, informed Dwayne that his medications were ready. While assisting Jim with his blood sugar, Dwayne entered the office and mistakenly took the medications meant for Jim along with his own before Heather could intervene. Heather promptly notified the nurse, who instructed her to take Dwayne to the emergency department. Dwayne was evaluated and subsequently released.

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42

MUI Medication Error

A DSP prepared Daniel's medications in a medication cup and laid them on the desk, waiting for him to come get his medications. In the meantime, Henry entered the room and took his peer's medications and ingested them. Poison control was contacted and advised that Henry would be sleepy and to monitor him. Approximately 10 minutes later, Henry was observed to be drooling and was taken to the emergency room. At the hospital, he was given Narcan. Henry was subsequently hospitalized for 2 days and released home.

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43

How to Prevent

- Do not leave prepared medication unattended
  - What were personnel distracted by?
- Take medications to the individual
  - Do not take shortcuts-follow the step-by-step instructions
  - Supervisory personnel should not model shortcuts
    - Supervisory personnel should immediately intervene if they observe personnel not administering medications correctly.

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44

MUI Medication Error

Staff inadvertently administered Ahmed the wrong medications. Staff gave him his roommates medications instead, which included Chlorpromazine, Divalproex, Clonazepam, Propranolol, and Risperidone. His physician was notified and asked staff to take his vitals. They reported his blood pressure and heart rate were low. The doctor ordered that Ahmed be taken to hospital. He was admitted and given an IV to clear the medication out of his system. He went home after 3 days.

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MUI Medication Error

Sam was accidentally given his housemates medication. Poison control was contacted and advised that Sam would be sleepy and to monitor him. Approximately 10 minutes later, Sam was observed to be drooling, and it was determined to take him to the emergency room. At the hospital, he was given Narcan. Sam was subsequently hospitalized for 2 days based upon being placed on a ventilator at the emergency room.

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46

How to Prevent

- Prepare and administer medications for one person at a time
  - Are personnel aware of whose medications they have?
- Were personnel not aware of who the individuals were?
  - Is there a means to identify the individuals?
    - Picture on the MAR
    - Confirm with another person who knows the individual
- Were personnel explaining name and purpose of medications?
- Were personnel rushed when administering medications?

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47

MUI Medication Error

Amy's mother prepared medications and placed them in a medication dispenser for DSP to administer. Amy's mother prepared the medications incorrectly, however, the medications were all the same size, color, and shape, so they appeared to be correct.

Amy received the incorrect medication for five days which caused her to have a seizure which required hospitalization.

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48

How to Prevent

- Unlicensed personnel are not authorized to administer medications from a medication dispenser.
- Unlicensed personnel must follow the step-by-step directions for medication administration each time they administer medication.

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49

MUI Medication Error-Systems

During a review of January-March 2023 MARs for 62-year-old Maria, it was found that there were over 140 blanks on the MAR.

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50

How to Prevent

- What is the priority?
  - Personnel should be aware that documentation is required, why are they choosing to do something else?
  - Medication administration is not completed until documentation is done.
- Who is reviewing the MAR?
  - Next person administering medication should review MAR to ensure previous doses were administered
  - Is manager reviewing MAR?
  - What is employer oversight?

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51

Addressing Medication Error Trends

Early identification

Root cause analysis

Effective prevention planning

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52

Medication Related MUI Data

- About 33% of all neglects are for treatment, which includes medication errors.
- From Jan 1, 2024-September 30, 2024, there have been over 70 neglect MUIs due to medication errors.

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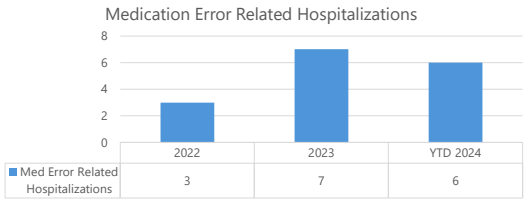
53

Medication Related MUI Data



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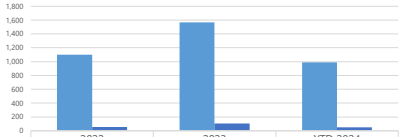
- Hospitalizations reflect unplanned stays over 24 hours or when person has been admitted.
- Approximately 102,000 people served

54

Medication Related MUI Data

Medication Related Misappropriations by Year



	2022	2023	YTD 2024
Total Misappropriations MUIs	1,098	1,567	990
Med Related Misappropriations	55	108	50

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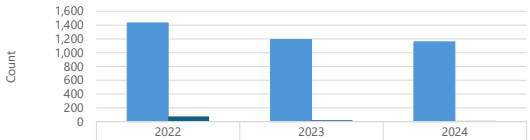
55

Medication Related MUI Data

Number of Unapproved Behavioral Supports -Chemical



	2022	2023	2024
Total UBS	1,431	1,188	1,155
Chemical UBS	76	19	12

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56

Poll Question

Which of these strategies will increase safe and accurate medication administration practices?

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57

Next steps: Strategies for increasing safe and accurate medication administration

- Continue to monitor
- Read and sign training packet
- Repeating the same training
- Review of medication errors months later
- Medication Error Analysis
- Focused Retraining
- Monitor Medication Supply

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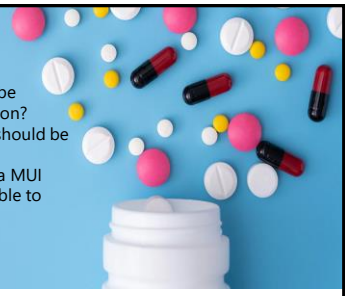
Poll Question

Should all medication errors be uploaded to MAIS as a notation?

- Yes, all medication errors should be noted
- No, only ones that rise to a MUI
- Would depend if attributable to the Med Passer's action



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59

OAC 5123-6-03 Authorization of developmental disabilities personnel to perform health-related activities and administer prescribed medication

(F)(6) If the employer of developmental disabilities personnel believes or is notified by the county board, the department, a delegating nurse, or the quality assessment registered nurse that developmental disabilities personnel have not safely performed or will not safely perform health-related activities, or have not safely administered or will not safely administer prescribed medication, the employer will:

(a) Prohibit the action from commencing or continuing;

(b) Immediately make other staffing arrangements so that performance of health-related activities or administration of prescribed medication are completed as prescribed, including compliance with the requirements of this chapter;

(c) If applicable, immediately notify the county board via the major unusual incident reporting system pursuant to rule 5123-17-02 of the Administrative Code; if applicable, the county board will notify the quality assessment registered nurse; and

(d) If applicable, immediately notify the delegating nurse.

(e) Enter a notation in the certification record of the developmental disabilities personnel in the medication administration information system database described in rule 5123-6-07 of the Administrative Code.

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60

OAC 5123-6-07 General provisions and compliance for performance of health-related activities and administration of prescribed medication

(F) Prohibition on performance of health-related activities and administration of prescribed medications by DDP

When the employer prohibits the action from continuing or commencing, the employer will notify

- DDP
- Department by notation in MAIS
- County Board
- Delegating nurse

The employer will ensure corrective action is taken

The employer will notify the department, CB and delegating nurse of corrective action and end of prohibition

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61

Notation Entry in MAIS – WHY?

Notification to DODD of medication errors via documentation of a notation in MAIS on the record of the certified developmental disabilities personnel responsible for the error.

- Health of safety of people we support
- Required in Rule (OAC)
- Identify patterns
- Track DSP even when change employers
- Multiple notations trigger DODD review prior to renewal of certification

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62

Notation Entry in MAIS

Entered by RNT or person with secretarial access and association with RNT

The notation needs to include the following information:

- Type of error
- Determination of the cause and contributing factors
- Prevention plan
- Training/retraining
- Corrective action

- If the medication error is not directly attributable to the certified personnel's action/inaction, no notation is needed in MAIS

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63

MAIS Notation Process

1. Go to DODD website (dodd.ohio.gov). Click on the log in icon to go to the OH|ID Log In page.
2. Enter Username and Password.
3. Click on Applications, Select Application MAIS.
4. Go to Certification & Registration, choose Search for a Person.
5. Choose DD Personnel. (Click on Search).
6. Enter last four digits of the social security number or DD Personnel Code. Click on Search.
7. A list of personnel with the same last four digits of the social security number will appear. Review the list for the personnel you are searching for. When the name appears, click on the four digits of the social security number in the first column, next to the person's name.
8. Click on Desired Action.

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64

MAIS Notation Process

Select Desired Action Below – Add/Update/View Notations

1. Click on Add/Update/View Notation to view or add notations.
2. Click on Add new Notation.
3. Enter Notation information (fill in all required fields).
4. To Upload notation. Click on Choose File. Another window will appear, reflecting your own documents; e.g., those which you have saved on your own computer. Click on the document you are trying to enter. Now click on Open. The document you have chosen will automatically appear in the field next to the words Choose File. Click on Upload. Please note - files to be uploaded cannot contain symbols in the name (. , / \ ; : ! # " *)

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65

Notations

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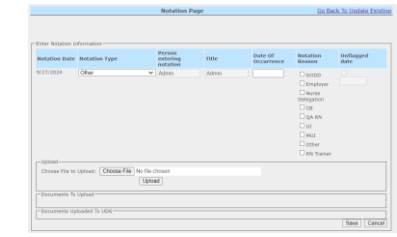
66

Notations



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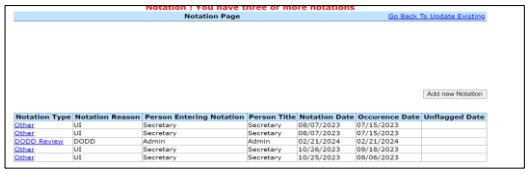
67

Notations



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68

What can I do as a Provider to Promote Safe Medication Administration

- Check staff in MAIS
- Enter notations when you don't have a nurse
- Help develop effective prevention plans
- Oversight/supervision – consistently follow the process
- Have a system for verification of certification; renewal of certification
- Be available to staff to address questions and concerns

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69

Multi-Tasking Safely

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70

Promoting Safe Medication Administration Tips

- Confirm employees have certification
- Provide oversight and supervision
- Protocols: establish clear guidelines on how and when staff should consult with RNs or physicians about medication administration.
- Mentorship: pair less experienced staff with seasoned professionals for guidance and support.
- Have clear expectations of staff and their responsibilities during their shift
- Have job descriptions: define roles and responsibilities clearly to prevent confusion.

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71

Promoting Safe Medication Administration Tips

- Be aware of laws and rules of medication administration- Stay Informed: Ensure all staff are familiar with local, state, and federal regulations regarding medication administration.
- Regular training: Hold periodic refresher courses to update staff on any changes in laws or protocols and offer support.
- Reinforce the 6 Rights
  - Document training sessions: conduct role-playing scenarios or quizzes to reinforce these principles.
  - Visual aids: create handouts summarizing the 6 Rights for easy reference.

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72

Promoting Safe Medication Administration Tips

- Ask Your RN Trainer or County Board Nurse for Assistance and Support.
- Open Communication: Encourage staff to seek guidance whenever they have questions.
- Schedule meetings with RNs or nursing supervisors to discuss challenges and provide feedback.
- Promote safe multitasking.
- Look at medication errors as opportunity to learn and improve safe medication administration for all.

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73

Thank you!

How to claim credits:

RN-LPN How to claim OBN CE credits – request and submit completed evaluation by close of business Tuesday, November 12, 2024. Request to be made to training.team@dodd.ohio.gov

Attendees will receive a certificate of attendance emailed to them within 30 days. The certificate will include approval for 2 hours DODD CPDs for IA, Superintendent, CB Member, SSA.

Webinar will be posted on the website with answers to questions. CEs and CPDs are not available for the recorded presentation, only for live viewing on November 8, 2024.

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74

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75

Resources

MAIS Search for current verification and verification history
https://mais.prodapps.dodd.ohio.gov/MAIS_PublicAccess.aspx

MAIS Email ma.database@dodd.ohio.gov

For Medication Info https://www.drugs.com/

You Are Your Brother's Keeper video
https://dodd.ohio.gov/home/med-admin

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76

QUESTIONS?

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77