



Policy & Procedure Manual

MEDICATION AND TREATMENT ADMINISTRATION – R-V-2

POLICY:

All medications and treatments shall be administered by authorized personnel only. Authorized personnel are those staff or students who have attended the full day medication and treatment in-service and/or specialized training in-services. Authorized trained personnel will also complete a Medication and Treatment Quiz every three years to ensure their knowledge of medication processes is up to date and accurate.

People supported will be educated about all medications they receive. If an individual is able to self-administer medications, they will be supported to do so with guidance and instruction from staff. It is the person's right to refuse any medication or treatment.

All administration of medications and treatments shall be in a manner consistent with recognized standards of pharmacology, and in accordance with Physician's orders.

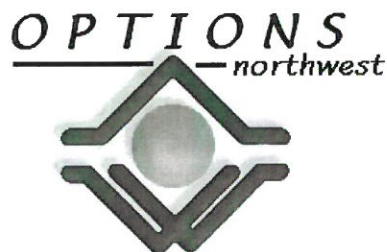
PURPOSE:

1. To ensure the safe administration of medications and treatments.

PROCEDURE:

Prior to Medication/Treatment Administration:

1. Staff must be familiar with the expected actions, side effects, contraindications and any special implications related to all medications/treatments administered to people supported.
2. Prior to the administration of all medications and treatments, staff must be familiar with the reason it was prescribed. It will be indicated on the Medication and Treatment Purpose form found at the front of the individual's section of the Medication Binder (see Appendix A). This information will be explained to the individual in a manner and language they can understand, and the date this was completed will be indicated on the form. Specific instructions for administering medications for each individual will be identified under the Medical Section of their Individual Support Plan (I.S.P.) and noted on the comment section top right of the MAR sheet.



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3. Any concerns about the order will be clarified with the Pharmacist prior to administering the medication/treatment.
4. Staff, with the involvement of the individual as appropriate, will use their discretion when holding a medication i.e. holding a sleeping pill when an individual is already sleeping; holding a laxative when an individual is experiencing diarrhea. Document a held medication/treatment according to Documentation of Medication and Treatment Administration Policy R-V-3. An Incident Report shall be completed according to, Medication and Treatment Incident Reporting Policy R-V-9.
5. Verify the MAR sheets with the Physician's orders for the correct medication, dosage, route, person and time. Check the allergy section on the top of the MAR sheet prior to administration. Any discrepancy must be clarified with the pharmacist.
6. Medications must be administered within 1 hour before or after the time indicated on the MAR sheet. In extenuating circumstances contact the pharmacist for direction and follow Medication and Treatment Incident Reporting Policy R-V-9.
7. Do not alter or re-label a medication/treatment container. **RE-LABELLING OF MEDICATION/TREATMENT MUST BE DONE BY JANZEN'S PHARMACY.** All medications and treatments must be individually labeled and only used by that individual unless it is non-prescription medication see Non-Prescription Medications Policy R-V-8.

Preparing Medications/Treatments:

1. Wash your hands and assemble the required equipment.
2. Avoid conversation and distraction.
3. Prepare medications/treatments for one individual at a time.
4. Use disposable gloves as necessary.
5. Visually inspect the medication/treatment and the container for any abnormal appearance, expiry date and any special instructions.

Steps in Administering Medications:

1. Identify Individual (using photo on Pouch Porter)
2. Refer to MAR – count the number of medications for that pass



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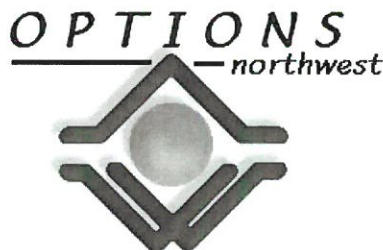
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3. Tear off the appropriate pouches for that pass time (ensure sequentially numbered pouches are torn off e.g. 1 of 2, 2 of 2)
4. Retrieve any non-packaged for that pass as indicated on the MAR.
5. Count all the medications in the pouches and compare information with the MAR.
6. If medications are to be crushed, they may be crushed inside the sealed pouch. Confirm with Janzen's Pharmacy whether the medications contained within the pouch are safe or appropriate to crush. If the pouch contains tablets and capsules, the tablets may be moved to one side of the pouch and crushed. The pouch may then be opened, the capsules removed, and the crushed tablets poured out and mixed with the appropriate delivery vehicle. The capsules may then be opened and mixed into the appropriate delivery vehicle as usual.
7. Tear the pouch(es) open and pour the medications into the med cup.
8. Prepare any non-packaged medications as indicated on the MAR.
9. Dispose of the plastic pouch in the appropriate confidential container.
10. If a capsule needs to be opened or a tablet needs to be crushed in order to facilitate the person's ability to swallow, or permit the administration of the medication by enteral tube, check Medication Information sheets or with the pharmacist to ensure the medication is crushable.
11. Pour a liquid medication/treatment from the side opposite the label and wipe the bottle and bottle rim after pouring.
12. Prepared Medications/treatments are never to be left unattended.
13. Medications/treatments shall be administered by the staff who prepared the medication/treatment.
14. Immediately prior to administering medications/treatments check the medication prepared with the MAR sheet. Ensure the medications in the medication cup coincide with the number of medications on the MAR sheet.

Administration of Medications/Treatments:

1. Ensure individual identification prior to medication/treatment administration using the individual's picture located in the Medication Record Book.



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2. Explain the procedure to the individual in a reassuring manner and in a language, they can understand. If an individual is able to self-administer medications/treatments, they will be supported to do so with guidance and instruction from staff.
3. Provide privacy as required.
4. If the individual refuses the medication/treatment, take the opportunity to explain the importance of taking the prescribed medications. Store the medication in the locked medication cupboard and offer the medication within the 1 hour timeframe. If the individual still refuses after the 1 hour timeframe, contact Janzen's Pharmacy for direction. Document the refusal in the progress notes and follow Medication and Treatment Incident Reporting Policy R-V-9. Make the Supervisor, Physician and, if applicable, the person acting on the individual's behalf aware of repeated refusals. If medication will be wasted, do so in accordance with Medication Wastage/Disposal Policy R-V-7.
5. If a dose is wasted, staff is to pull the pouches from the same pass time for the last day on the PacMed Roll. For example, if Janzen's Pharmacy supplies weekly meds from Tuesday to Monday and a dose is wasted in Tuesday's 1200 hr package, staff should unroll the pouch strip to use Monday's 1200 hr meds. Always use all of the pouches from the pass time to replace a dose. Inform the Pharmacy as soon as possible if you require replacement pouches by writing a request on a Re-Order Sheet. Include Individual's name, date to be replaced and time. Replacement pouches will be sent with a 'REPLACEMENT' sticker on them, for easy reference when receiving the order.

Following Medication/Treatment Administration:

1. Documentation of medications/treatments shall be done immediately following administration in accordance with Documentation of Medication and Treatment Administration Policy R-V-3. Any abnormal observations shall be noted in the individual's Personal Binder and Daily Log Book.
2. Use the pouch label to sign off the corresponding MAR sheet square and ensure the appropriate pouch is empty during the sign off.

A. DRAWING LIQUID MEDICATION INTO A SINGLE USE ORALSYRINGE

When administering liquid medication and the required dosage is not scored on a medication cup, Janzen's Pharmacy will supply a stopper in each medication bottle and the medication will be drawn up using a single use oral syringe. A separate syringe will be used for each liquid medication. Discard the syringe after each use.

a) Using a Stopper:

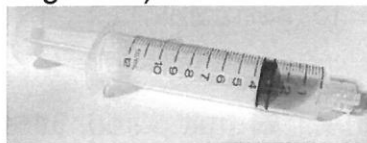
1. Insert the plunger of the syringe completely into the barrel
(See diagram 1)

Diagram 1:



2. Take the cap off the top of the stopper. Push the tip of the syringe into the hole of the stopper.
3. Turn the bottle upside down.
4. Pull the plunger of the syringe back so that the medication is drawn from the bottle into the syringe. Pull the plunger back to the point on the scale that corresponds to the dose prescribed. (See diagram 2).

Diagram 2:



5. Turn the bottle back up the right way and carefully remove the syringe from the stopper, and for stability and accuracy, hold it by the barrel rather than the plunger.
6. Gently push the plunger of the syringe down to release the prepared medication into a medication cup and follow the policy for the required route.

b) Stopper Not Available:

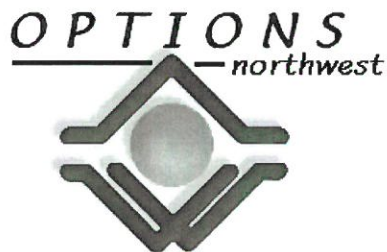
Note: If a bottle stopper is not available to draw up liquid medication, staff will notify Janzen's Pharmacy and ask them to send the stopper ASAP. Until stoppers arrive, staff will draw medication into an oral syringe in the following manner:

1. Pour a small amount of medication into a medication cup.
2. Insert the plunger of the syringe completely into the barrel. (See Diagram 1)

Diagram 1:



3. Place the tip of the syringe into the liquid in the medication cup.
4. Pull the plunger of the syringe back so that the medication is drawn from the medication cup into the syringe. Pull the plunger back to the point on the scale that corresponds to the dose prescribed. (See diagram 2 above)



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5. Any excess medication remaining in the cup should be poured back into the medication bottle.
6. Gently push the plunger of the syringe down to release the prepared medication into the medication cup and follow the policy for the required route.

B. ORAL MEDICATION ADMINISTRATION

1. Explain the procedure to the individual in a reassuring manner and in a language they can understand.
2. If the individual is in bed, ensure that their head is raised as close to 90 degrees as possible to prevent aspiration. The individual should remain elevated for 30 minutes following administration of medications unless otherwise indicated in their I.S.P. Binder.
3. If the individual is unable to self-administer, follow directions indicated in the individual's I.S.P. Binder.
4. Offer the person at least 60 ml. of fruit puree, juice, pudding and/or water with or following the medication and ensure the medication has been swallowed.

C. GASTROSTOMY TUBE MEDICATION ADMINISTRATION

NOTE: SPECIALIZED INSERVICE REQUIRED

Medication Administration by Feeding Tube

1. Explain the procedure to the individual in a reassuring manner and in a language they can understand.
2. Assist the person to an upright position, as close to 60 degrees as possible. If fed in bed, position them on their right side, if possible, to decrease the risk of reflux.
3. Pinch off the tube to prevent air from entering.
4. Remove the tube plug and connect the feeding syringe into the tube opening.
5. Pour a small amount (10 ml.), of room temperature water into the syringe barrel, unless otherwise directed by the Physician or the Dietician, and release the tube to ensure the free flowing patency of the tube. Pinch the tube.
6. Pills must be crushed and/or capsules opened and mixed with at least 5 ml. of warm water unless contraindicated by Medication Information Sheets or the Pharmacist.



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7. Pour one prepared medication into the feeding syringe barrel, release the tube and gently swirl the syringe in a circular motion until the medication reaches the neck of the syringe. Continue until all medications have been administered in the same manner.
8. If an obstruction of the tube occurs, a gentle milking action with your fingers on the tubing or gentle pushing of the obstruction using the syringe may relieve the obstruction. If the obstruction persists, a new tube will have to be inserted. Refer to Feeding Tube Replacement – Gastrostomy Policy – R-VI-3.
9. Following the medication administration, flush the tube with 30 to 50 ml. of room temperature water, unless otherwise directed by the Physician or the Dietician.
10. Pinch off the tube and remove the syringe.
11. Reinsert the tube plug and ensure the individual is clean and comfortable and remains in an upright position for 30 minutes to promote absorption of the medication.
12. Cleanse the feeding syringe with tap water and pat it dry. Return the syringe to the feeding tray.

D. MIC-KEY TUBE MEDICATION ADMINISTRATION

NOTE: SPECIALIZED INSERVICE REQUIRED

1. Explain the procedure to the individual in a reassuring manner and in a language they can understand.
2. Assist the individual to an upright position, as close to 60° as possible. If fed in bed, position them on their right side if possible to decrease the risk of reflux.
3. Make sure the tube is clamped off. Rotate the extension set clockwise approximately $\frac{3}{4}$ turn and pull gently to ensure tube is secure. Do not turn the connector past the stop point.
4. Uncap the Mic-key feeding port cover.
5. Insert the extension set into the feeding port by aligning the black lines on the extension set and feeding port.
6. Connect the feeding syringe into the tube opening.
7. Pour a small amount of room temperature water into the syringe barrel, unless otherwise directed by the Physician or the Dietician, unclamp the tube and ensure the free flowing patency of the extension set. Clamp the extension set off.



8. Pills must be crushed and/or capsules opened and mixed with at least 5 ml. warm water unless contraindicated by Medication Information Sheets or the Pharmacist.
9. Pour one prepared medication into the feeding syringe barrel, unclamp the extension tube and gently swirl the syringe in a circular motion until the medication reaches the neck of the syringe. Continue until all medications have been administered in the same manner.
10. If an obstruction of the extension set occurs, a gentle milking action with your fingers on the tubing or gentle pushing of the obstruction using the syringe may relieve the obstruction. If the obstruction persists, a new Mic-key will have to be inserted according to Feeding Tube Replacement – Gastrostomy Policy –R-VI-3.
11. Following the medication administration, flush the tube with 30 to 50 ml. of room temperature water, unless otherwise directed by the Physician or the Dietician. Clamp the extension set and remove the syringe.
12. Disconnect the extension set by rotating it counter clockwise until the black lines on the extension set and feeding port become aligned.
13. Gently detach the extension set and cap the Mic-key feeding tube securely with the attached feeding port cover. Ensure the individual is clean and comfortable and remains in an upright position for 30 minutes to promote absorption of the medication.
14. Cleanse the extension set with running tap water and pat dry. Return the extension set to the feeding tray.

E. EYE DROPS/OINTMENTS

1. All eye drops and ointments are individually labeled with the person's name and are to be used for that person only.
2. Explain the procedure to the individual in a reassuring manner and in a language they can understand.
3. Assess the external eye structure for any abnormalities and document the same in the individual's Personal Binder.
4. Position the person sitting with their head slightly back or lying on their back.
5. Gently wash away any crusts or drainage present along the eyelid margin or inner corner. Always wipe the eye from the inner corner outward. To prevent cross infection, use a separate clean cloth for each eye.



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Eye Drops

1. Explain the procedure to the individual in a reassuring manner and in a language they can understand.
2. With a gauze or Kleenex resting below the lower lid, gently press downward over the bony prominence of the cheek.
3. Gently instill the prescribed number of drops into the center of the lower lid without touching the tip of the dropper to the eyeball. Use a clean gauze or Kleenex for the other eye if applicable.
4. The person should close their eye to allow the medication to be distributed evenly over the eye.

Eye Ointment

1. Explain the procedure to the individual in a reassuring manner and in a language they can understand.
2. Follow the same instructions as for eye drops, but instead, gently squeeze a thin layer of the prescribed medication on the exposed inner surface of the lower eyelid, beginning at the inner corner outward.
3. Gently wipe any excess ointment from the outer eyelids, wiping from the inner corner outward.

F. VAGINAL CREAM OR SUPPOSITORY

1. Prepare the required dosage as directed.
2. Explain the procedure to the individual in a reassuring manner and in a language they can understand.
3. If possible, have the person void prior to inserting the medication. Position her on her back with her knees flexed. Drape with a blanket to ensure privacy.
4. Put on your gloves and spread the labia well apart, inspecting the external genitalia. Document any abnormalities. With a clean cloth, remove any discharge as needed.
5. Apply a water soluble lubricant (i.e. muko jelly) to the suppository or applicator.
6. Insert the applicator approximately 3-4 inches (8-10 cm) into the vagina in a gently rotating motion. Slowly depress the applicator plunger depositing the cream or

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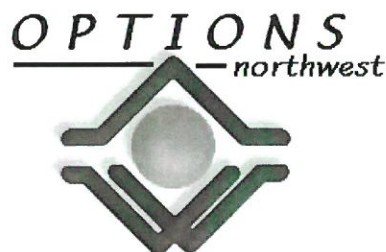
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suppository in to the vagina. Remove the applicator while keeping the plunger depressed.

7. If no applicator is supplied, gently insert the rounded end of the suppository approximately 3-4 inches (8-10 cm) along the posterior wall of the individual's vagina using your gloved index finger.
8. Ensure the person is left comfortable and encourage her to remain on her back for 5 to 10 minutes following the procedure.

G. TOPICAL MEDICATION AND TREATMENT

1. Explain the procedure to the individual in a reassuring manner and in a language they can understand.
2. Put on your gloves.
3. Assess the condition of the individual's skin and document any abnormality. Cleanse the area as prescribed by the Physician.
4. Pat the skin dry or allow it to air dry. If the skin is excessively dry or flaking, apply the topical agent while the skin is still damp.
5. Apply the topical agent.
 - a) **Cream, Ointment, Oil-based Lotion and Suspension-based Lotion:**
Apply as directed by Physician's orders, or by directions on the package.
 - b) **Aerosol Spray:**
If the neck or upper chest are to be sprayed, turn the person's face away or shield the face with a towel. Apply following Physician's orders, or by directions on the package.
 - c) **Powder:**
Be sure the skin surface is thoroughly dry. Fully spread apart any skin, such as between the toes or under the axilla. Dust the area with a fine, thin layer of powder.
5. Cover the area with a dressing, if ordered.

H. NASAL MEDICATION

1. Explain the procedure to the individual in a reassuring manner and in a language they can understand.



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2. Assess the external nose and chart any abnormal appearance and any discharge.
3. Clean the nasal passage of discharge as well as possible.
4. Position the person with their head tilted as directed by the Physician or package directions.

Nose Drops

- a) Instill the required number of drops into the nose. Avoid touching the inner surface of the nose with the dropper.
- b) Discard any medication remaining in the dropper.
- c) Encourage the person to remain in the required position for the prescribed/recommended amount of time as specified on the label.
- d) If both nostrils are to be treated, repeat the procedure for the other nostril.
- e) Wipe the person's face.

Nasal Spray

- a) Insert the tip a short distance (approx. 1 cm.) into the nostril. Squeeze the prescribed/recommended amount of medication into the nostril, allowing the person a breath between each application.
- b) Allow the person to remain in the required position for the prescribed/recommended amount of time.
- c) If both nostrils are to be treated, repeat the procedure for the other nostril.
- d) Wipe the person's face.

I. EAR DROPS

1. Explain the procedure to the individual in a reassuring manner and in a language they can understand.
2. Assess the external ear for any abnormalities.
3. Clean the outer ear.
4. Straighten the ear canal by grasping the top of the earlobe and gently pulling upward. If the person is a child, grasp the bottom of the earlobe and gently pull down and back. This straightens the ear canal to make instillation easier.
5. Hold the dropper directly over the ear canal and gently instill the prescribed/recommended number of drops into the ear.
6. Encourage the person to remain in the same position for the prescribed/recommended amount of time to allow the medication to flow to the full length of the ear canal.
7. Wipe the outer ear clean.



8. If both ears are to be treated, repeat the procedure for the other ear.

J. RECTAL SUPPOSITORY

Bowel Regulation:

1. For a regular suppository (one that is not a PRN), the suppository will be given as prescribed unless otherwise indicated by the Physician.
2. For a PRN suppository, check the Bowel Movement Chart (B.M. Chart) to determine the last recorded date the person had a B.M. According to the information on the chart, determine if a suppository is due.
3. To ensure accuracy, check the last recorded date of suppository administration on the MAR sheet and/or in the individual's progress notes.
4. Provide privacy and explain the procedure to the individual in a reassuring manner and in a language they understand.
5. Assist the person into a left side-lying position.
6. When administering the suppository, apply your gloves and remove the suppository from its wrap. Lubricate the rounded end of the suppository, separate the buttock and slip the suppository into the anus. With your index finger, guide it along the wall of the anus and rectum for approximately 3 inches (8 cm) or the length of your finger. If possible, have the person take a deep breath, as it relaxes the anal sphincter. Withdraw your finger and briefly hold the buttocks together to ensure the retention of the suppository.

NOTE: DO NOT INSERT THE SUPPOSITORY INTO THE FECAL MASS AS THIS PREVENTS ABSORPTION.

7. Discard equipment and wash your hands.
8. Document as per Documentation of Medication and Treatment Administration Policy R-V-3. Complete the B.M. Chart by placing an "S" in red ink in the appropriate area.

For PRN suppositories: In the individual's progress notes record the medication, dosage, route and time of administration.

For a regular suppository, document the administration on the MAR sheet.



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9. Record the person's response to the suppository, including the amount, colour, consistency of the result or the lack of a result. The suppository order should include direction should there be a poor or no result from the suppository.
10. Chart all B.M.'s on the B.M. Chart

Rectal Medication:

1. Provide privacy and explain the procedure to the individual in a reassuring manner and in a language they can understand.
2. Assist the person into a left side lying position.
3. Apply your gloves, remove the suppository from its wrap and lubricate the rounded end of the suppository. Separate the buttocks and slip the suppository into the anus. With your index finger, guide it along the wall of the anus and rectum for approximately 3 inches (8 cm) or the length of your finger. Withdraw your finger and briefly hold the buttocks together to ensure retention of the suppository. Discard equipment and wash your hands.

NOTE: DO NOT INSERT THE SUPPOSITORY INTO A FECAL MASS AS THIS PREVENTS ABSORPTION.

4. Document as per Documentation of Medication and Treatment Administration Policy R-V-3.

K. ENEMA

Bowel Regulation:

1. For a regular enema (one that is not a PRN) the enema will be given as prescribed unless otherwise indicated by the Physician.
2. For a PRN enema, check the Bowel Movement (B.M.) chart to determine the last recorded date the individual had a B.M. According to the information on the chart, determine if an enema is due.
3. To ensure accuracy, check the last recorded date of enema administration on the MAR sheet and/or in the individual's progress notes.
4. Provide privacy and explain the procedure to the individual in a reassuring manner and in a language they can understand.
5. Assist the individual into a left side lying position and apply your gloves.



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6. When administering the enema, remove the plastic cap from the enema container (the tip is pre-lubricated, but more lubricant may be applied). Separate the buttocks to expose the anus. Insert the tip of the container gently and slowly into the rectum 2 – 4 inches (5-10 cm).
7. Squeeze the container until the prescribed amount of fluid has entered into the rectum and colon. Withdraw the tip of the container gently and quickly and briefly hold the buttocks together to ensure retention.

NOTE: DO NOT INSERT THE TIP OF THE ENEMA INTO THE FECAL MASS AS THIS PREVENTS ABSORPTION.

8. Discard equipment and wash your hands.
9. Document as per Documentation of Medication and Treatment Administration Policy R-V-3. Complete the B.M. chart by placing an “E” in red ink in the appropriate area.

For PRN enemas: In the individual’s progress notes record the medication dosage, route and time of administration.

For a regular enema, document the administration on the MAR sheet.

10. Record the person’s response to the enema, including the amount, colour, consistency of the result or the lack of a result. The enema order should include direction should there be a poor or no result from the enema.
11. Chart all B.M.’s on the B.M. chart

L. MEDICATION BY INHALATION

1. Explain the procedure to the individual in a reassuring manner and in a language they can understand.
2. Assist the individual into a sitting position as close to 90 degrees as possible.

Using an Aerosol Inhaler with an Aerochamber and Mask:

- a) Shake the inhaler well. Remove the cap end.
- b) Prime the inhaler by fully depressing the container once into the air away from yourself.
- c) Insert the mouthpiece of the inverted inhaler into the aerochamber receptacle.
- d) Place the aerochamber mask over the person’s nose and mouth, forming a good seal against their face. Fully depress the container into the mouthpiece attachment, releasing one puff of medication.
- e) Hold the mask on the person’s face until they have had 2 (two) full respirations.



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- f) If a second puff is required, wait as directed by the Physician or package directions and repeat d) and e) above.
- g) Remove the face mask and aerochamber from the person's face. Remove the mask from the aerochamber and run warm water through the large opening in the rubber ring. Clean the mask with warm water also. Shake off the excess water and allow the aerochamber and mask to dry in a clean area.

Nebulizer with Aerosol Mask and Air Compressor:

NOTE: SPECIALIZED INSERVICE REQUIRED

- a) Plug the air compressor into the electrical outlet.
 - b) Remove the nebulizer cap and pour the prescribed medication into the reservoir.
 - c) Replace the nebulizer cap and insert the nebulizer outlet into the bottom of the face mask. Connect one end of the ¼" tubing into the bottom of the nebulizer.
 - d) Connect the other end of the ¼" tubing into the air compressor outlet.
 - e) A pulse is taken according to Pulse Policy R-VI-5as as a baseline prior to treatment to determine any adverse effects of the medication.
 - f) Place the mask comfortably over the person's nose and mouth, adjusting the elastic straps to hold the mask in place.
 - g) Turn on the air compressor (a light mist of medication should be observed in the mask). Attempt to keep the nebulizer vertical to foster the nebulization of the medication. Tap sides of the nebulizer frequently to ensure no medication adheres to the sides.
 - h) The procedure is complete when the misting in the mask ceases and no medication can be seen in the nebulizer. Turn the compressor off and remove the face mask.
 - i) If the person becomes increasingly agitated during the procedure and you are unable to complete the procedure, remove the face mask. Check their pulse and respiration and seek medical attention if the person continues to be in respiratory distress, and document in the individual's progress notes.
 - j) Wash the face mask and nebulizer with warm water and dry. Place the tubing, face mask and nebulizer in a plastic bag and seal the bag. Write the name of the person and the date of the first use on the sealed bag. This equipment can be reused for the same person as long as it remains in good condition.
 - k) If a nebulizer and face mask have been used frequently during an individual's acute respiratory infection, the equipment must be discarded once the infection is resolved.
3. Ensure the individual is clean and positioned comfortably.



RECOMMENDED BY: Director, Community Services

APPENDICES: 1

OPERATIONAL ACCOUNTABILITY: Administration, Community Services

ORIGINAL POLICY DATE: March 2002

AUTHORIZED BY: Executive Director

SIGNATURE:

- OPTIONS northwest -
MEDICATION/TREATMENT PURPOSE FORM

INDIVIDUAL'S NAME: Jane Pacmed

NAME OF MEDICATION/ TREATMENT	DATE STARTED	DATE COMPLETED	DATE EXPLAINED TO RECIPIENT	REASON MEDICATION/TREATMENT IS GIVEN
Furosemide	Mar 28/17	Apr 3/18	Mar 28/17	water retention
Paroxetine HCL	Mar 28/17		Mar 28/17	anti-depressant
Metformine HCL	Mar 28/17		Mar 28/17	control blood sugar level
Ferrous Gluconate	Mar 28/17		Mar 28/17	Iron Supplement
Atorvastatin	Mar 28/17		Mar 28/17	cholesterol
Acetaminophen	Mar 28/17		Mar 28/17	pain management
Docusate Sodium	Mar 28/17		Mar 28/17	stool softener
Risperidone	Mar 28/17		Mar 28/17	anti-psychotic
Phenobarb	Apr 3/18		Apr 3/18	anti-convulsant
Tylenol #3	Apr 3/18		Apr 3/18	pain management

