

This Inspection Guide provides *guidance* to the inspector during the initial planning of an inspection. Not all sections will be applicable in every situation and the inspector may need to adjust the inspection based on information collected.

PROFILE FOR RESIDENT

- Name, room number, home area
- Date of birth, date of admission, date of discharge (if applicable)
- Diagnoses
- Other resident information, as applicable: Physician, SDM, Advanced Directives, Activities of Daily Living, and RAI-MDS Outcome Scores, e.g., CPS

CLINICAL RECORD REVIEW (ELECTRONIC AND HARD COPY)

ASSESSMENTS

- RAI-MDS - Section O (Medications), Section U (Medication List)
- Three-month medication review, pharmacy review, pain scales (if applicable)

PLAN OF CARE

- Plan of Care based on assessments
- Interventions implemented as per plan of care
- Focus related to medications

MEDICATION ADMINISTRATION RECORD (MAR)

- Medications administered as ordered

TREATMENT ADMINISTRATION RECORD (TAR)

- Treatments administered as ordered

PROGRESS NOTES

- Effectiveness, monitoring, reassessments, communication with physician/pharmacy, external consults, specialty treatments

OBSERVATIONS

- Resident observation, e.g., self-administering medications if applicable
- Medication cart, secured when not in use
- Administration of medications/treatments, e.g., time, route etc.
- Drug storage areas
- Controlled substances
- Review drug destruction process (if applicable)

INTERVIEWS

RESIDENT/SDM

- Discuss if resident/SDM is aware of medications and benefits/risks, are they informed of any incidents.

DIRECT CARE STAFF

PSW and others as applicable

- Discuss administering topicals; have they received training
- Discuss monitoring of effectiveness of medications/treatments

REGISTERED STAFF AND MEDICAL PERSONNEL

- Discuss assessment/reassessment
- Discuss monitoring of effectiveness of medications/treatments
- Explore the ways in which other members of the care team are involved in medication management, e.g., physician, pharmacy, or other specialized resources
- Confirm process for medication incidents and adverse drug reactions, including documentation and records

MANAGEMENT

Director of Care, Administrator/Delegate

- Discuss process for handling medication incidents and adverse drug reactions, including analysis and corrective actions to prevent recurrence
- Medication incidents and adverse drug reactions are reported as required
- Follow up on any concerns noted from record review, observations, and other staff interviews

OTHER RECORD REVIEW

- Video or other visual or audio recordings
- Medication Incident Reports
- Policies and program relevant to medication management
 - Procedures are in place for safe medication administration
 - There is a monitored dosage system for drug administration
 - There is a record of drug ordering and receiving
 - Policy and procedure for medication incidents and drug reactions
 - Process for drug destruction and disposal
- Training records

FOR FURTHER GUIDANCE

Please refer to policies, guidance documents, and job aids available in the eInspectors' Handbook.