Vancouver CoastalHealth
Promoting wellness. Ensuring care.

ATTENTION: _____

RE: PERSONAL ASSISTANCE GUIDELINES FOR: **MEDICATION MANAGEMENT**

Was the 'Decision to Delegate' tool used to determine if it is safe and suitable to delegate this task? □ *Yes* □ *No*

Is this Delegated Task a: □ New Task □ Change to Task □ Review

PARIS ID: _____

Client: _____ Phone #: _____ Physician: _____ Phone #: _____

Client is able to direct own care? □ Yes □ No

Family or Client's Key Caregiver: _____Relationship to Client: _____

Phone #: _____

This is to confirm home support has agreed to accept the task of MEDICATION MANAGEMENT:

□ Administration □ Other: _____

VCH Community staff will continue to monitor the client's condition. They should be contacted as soon as possible by Home Support staff if there are any concerns about the task(s) or a change in client's condition.
VCH Community Contact:

Name: _____ Phone:_____ Date:_____

Title: _____

TASK GUIDELINES:

LOCATION OF MEDICATIONS

Kitchen: _____ Bathroom: _____ Other: _____

ORAL MEDICATIONS

Give From:

Dosette: _____ Bubble Pack: _____ Other: _____

At the following times:

As designated on the container: _____ OR Other: _____

Medication is prepared by:

Home Care Nurse: _____ Pharmacy: _____

Family Member: _____ Other: _____

EYE DROPS

1. Drug: _____

Times to be given: _____

# of drops: _____ □ Right □ Left □ Both Eyes

2. Drug: _____

Times to be given: _____

# of drops: _____ □ Right □ Left □ Both Eyes

3. Drug: _____

Times to be given: _____

# of drops: _____ □ Right □ Left □ Both Eyes

CREAMS/OINTMENTS

1. Drug: _____ Directions: _____

2. Drug: _____ Directions: _____

3. Drug: _____ Directions: _____

4. Drug: _____ Directions: _____

MEDICATED PATCH

Drug: _____ Dose: _____

Apply to: _____ **Apply**: AM PM **Remove**: AM PM

Drug: _____ Dose: _____

Apply to: _____ **Apply**: AM PM **Remove**: AM PM

OTHER MEDICATIONS (suppository, nasal sprays, inhalers etc...)

ADDITIONAL INSTRUCTIONS:

TASK COMPETENCY: (Complete if applicable)

Persons Trained:	Name	Date	Competence Demonstrated (Y/N)
Agency Supervisor:			
Unregulated Care Provider(s):			

REFER TO THE DETAILED: (X All that apply)

- □ Written Instructions
- □ Diagrams
- □ Photographs
- □ Other

This is not a task that can be transferred to another UCP or client. If one of the above UCP's leaves or there is a change in the client's status it is the responsibility of the agency supervisor to contact the delegating HCP.

The referring HCP is available for ongoing consultation and /or teaching. The client's Home Care file will remain active in order to provide monitoring service for the above delegation. Community staff should be contacted as soon as possible if there are any concerns about the task(s) or a change in client's condition.

PAG AFTER HOURS BACK-UP PLAN

When the trained Unregulated Care Provider is not able to complete the task contact the home support Supervisor or the home support on call Supervisor;

Then Either: *(X 1 option)*

- □ The client family/contact will be required to do the task

  Designated Back-up contact: Name: _____ *Phone:* _____*; **or***

- ❑ Refer to Care Plan (***Include Detailed PAG After Hours Back-up Plan***); ***or***
- ❑ Other _____

Copied to: □ Client □ HCN □ PT □ OT □ CM □ Physician