RAAM Clinic Toolkit

CLINICAL AND ADMINISTRATIVE POLICIES

SECTION CONTENTS

INTRODUCTION

Each RAAM clinic must develop a compilation of administrative and clinical policies to ensure the clinic is functioning well and prioritizing staff and client safety. Within this section are a few key sample policies that are meant to illustrate the breadth of policies relevant to providing quality RAAM clinic care. Organizational policies must always supersede the sample policies provided.

RAAM CLINIC ADMINISTRATIVE POLICIES

Drop-in and Scheduled Hours

RAAM clinics may structure their schedules differently, depending on clinician/staff capacity and client volumes/demand.

1. *Drop-ins and booked appointments occur at different times*: Predetermined hours are blocked off exclusively to accommodate drop-ins, and booked appointments (referrals/follow-ups) occur outside of these windows.
2. *Booked appointments and drop-ins available during the same hours*: Booked appointments and drop-ins are offered during the same clinics/hours, and drop-ins are "fit in" between scheduled appointments.

3. *Different schedules based on clinical role*: Some sites may have some members of the team accommodating both booked and fit-in appointments during RAAM clinic hours and some team members exclusively serving drop-ins. For example, counsellors and peer support workers may keep their RAAM clinic hours open for drop-ins so that initial assessments can be offered quickly upon a new client's arrival, but physicians may wish to have some booked appointments during RAAM clinic hours to ensure they will have at least some fee-for-service income if the clinic is slow that day.
4. *Exclusively drop-in hours*: No booked appointments are available through the service. For follow-up appointments, clients are given a specific day or window of days when they should return to ensure proper medication continuity and support. They are not given a specific appointment time for that day but will be seen as soon as possible after arriving.
5. *Exclusively booked appointments*: No drop-in hours are offered. Clients must be referred or phone ahead to receive an appointment time.

META:PHI does not promote one model over another, in recognition that different clinics have different resources and staffing models. However, as motivation to attend treatment can fluctuate, providing service as immediately as possible is best. Ideally, RAAM clinic care is accessible within three days (including weekends) of a person desiring to attend the clinic.This translates to clinics being open for drop-in service at least three full or partial days each week. During drop-in hours, a prescriber is expected to be available either in person or virtually. It is also recommended that publicly listed drop-in hours end at least half an hour before the clinic ends to ensure that staff are not kept overtime or expected to work beyond their compensated hours.

Mechanisms For Service Delivery

Different service delivery mechanisms offer different advantages to clients.

1. *In-person service delivery*: Clients come to the RAAM clinic to see a health care provider who is also there in person. This option allows for a physical assessment of the client, maximizes opportunities to develop rapport, and does not rely on client access to technology.
2. *Online video*: Clients see a health care provider virtually from any location using a secure video conferencing application. This option eliminates the need for clients to travel to a specific location while still allowing the client and the care provider to speak to each other "face to face".
3. *Phone*: Clients speak to a health care provider by phone from any location. This option eliminates the need for clients to travel to a specific location and does not require clients to have a smartphone, laptop, tablet, or internet access. A telephone visit is not always appropriate for an initial assessment.
4. *Mobile clinic/providers*: Health care providers see clients in the community rather than at a fixed physical address. This option gives access to clients who might not otherwise seek RAAM clinic services.

RAAM clinics are encouraged to provide at least two different forms of service delivery in order to maximize the various advantages to clients that these different forms offer (see **RAAM Clinic Quality Targets**, Quality Target 3).

Missed Appointments

Missed initial appointments booked by referral are followed up by the medical secretary, who may offer an alternative appointment time or provide the client with drop-in hours. If the client is unable to make three booked appointments, they can be offered the drop-in hours for future visits.

Clients who have discontinued treatment should be encouraged through multiple avenues to reconnect with the clinic, be it through in-person visits, phone support, or virtual appointments. Peer support can play a key role in providing a non-judgmental avenue to re-engage clients with RAAM clinic services.

There are several potential reasons why a client might repeatedly miss appointments, including instability, difficulty functioning, or escalation of substance use. However, clients should not be discharged from the clinic due to missed appointments, as the known potential harms of discontinuing treatment, like escalation of substance use, loss of tolerance, and overdose, outweigh the potential harms of providing care to a client who follows up sporadically. The clinical team should work with the client to overcome the barriers to clinic attendance and prescribe medications in a way that encourages re-engagement and minimizes risk.

Age Restrictions

RAAM clinics should be welcoming to clients of all ages, including those under 18. RAAM clinic care providers can play an important role in assisting young people by (a) at minimum, connecting them to youth-oriented services (medical, social services, etc.), and (b) providing pharmacotherapy with consideration paid to the young person's capacity to consent to treatment. In supporting youth, the clinical team should be prepared to collaborate with family and friends in treatment planning discussions, so long as the client has provided consent to do so.

Managers should ensure that front-line staff are confident in the rules concerning age and capacity, and the clinical team should ensure that the young person understands the limits to confidentiality, including capacity to consent.

Lack of Health Card

RAAM clinics should provide service to clients who lack a provincial health card. A member of the RAAM clinic team should work with the client to help them complete the OHIP card **application**; clients who lack the necessary documentation to obtain a health card should be referred to a community service that provides identification support.

Many organizations in which RAAM clinics are located, such as hospitals, are able to provide codes that can be entered in place of an OHIP number to ensure fee-for-service physicians are still compensated for their time. Clinics should be familiar with these codes where available, while prioritizing assisting individuals in obtaining an OHIP card as quickly as possible.

Temporary Medication Coverage[1]

Engagement in treatment for substance use can be dramatically hindered if clients do not have immediate access to medications. For clients without coverage or means to pay, clinics should consider covering medications on a temporary basis whenever possible to facilitate treatment initiation. Depending on the situation, this may include medication coverage for up to one month. This process typically involves having an account with a local pharmacy. A member of the RAAM clinic team should work with the client to secure ongoing coverage for their medication (e.g., Trillium, ODSP, OW) as soon as possible.

Medications suggested for coverage include (but are not limited to) the following:

- Anti-craving medications for AUD (acamprosate, naltrexone)
- OAT (buprenorphine, methadone, slow-release oral morphine)
- Withdrawal management (diazepam, lorazepam, clonidine, gabapentin, pregabalin)
- Antibiotics
- Antidepressants/mood stabilizers (SSRIs, antipsychotics)

For support with smoking cessation, consider assisting clients with enrolling in the **STOP program**.

Chronic Pain Clients

Some individuals may present to the RAAM clinic seeking assistance for managing chronic pain. In general, RAAM clinics should avoid undertaking long-term prescribing of opioids (other than OAT) for chronic pain, as this is best undertaken in a primary care or pain clinic setting. However, RAAM clinic providers may provide support for chronic pain symptoms where substance use is also a concern. Support may include providing referrals to specialist care and providing the client's primary/pain care providers with an opinion on the client's underlying substance use and mental health diagnoses. The RAAM clinician may also provide suggestions regarding medications. This is especially important with regard to opioid medications.

If a patient presents with both chronic pain and an opioid use disorder, the RAAM clinician should offer opioid agonist treatment for the OUD, and adjust the medication to assist with the pain. There is evidence that clients with comorbid pain and OUD experience improvements in pain when they receive OAT.

Client Feedback Process[2]

RAAM clinics should routinely collect data on client experience to inform quality improvement work (see **RAAM Clinic Quality Targets**, Quality Target 12). This can be accomplished by administering tools such as the **Ontario Perception of Care Tool for Mental Health and Addiction** or another **client satisfaction survey** (see **Data Collection and Reporting**). The following process is recommended for collecting and responding to ad hoc client feedback (vs. anonymous survey feedback).

[1] Adapted from materials provided courtesy of the Northwestern Ontario Regional RAAM Steering Committee.
[2] Adapted from materials provided courtesy of the Northwestern Ontario Regional RAAM Steering Committee.

For concerns:

1. A RAAM clinic client raises a concern with clinic staff.
2. Staff gathers basic information from the client about their concern.
3. Staff forwards the information to the RAAM clinic manager.
4. The manager reviews the concern with the client, staff, and others as required and attempts to resolve the issue.
5. The manager communicates resolution to the client.
6. The resolution of the concern will be reported at the next management team meeting or via e-mail to relevant staff.
7. The clinic team and management will problem-solve to determine how the issue will be prevented going forward.

For praise:

1. A RAAM clinic client shares praise/appreciation with clinic staff.
2. The staff person forwards information to the RAAM clinic manager.
3. The manager shares the positive feedback with relevant individuals (broader team, director, identified individual who went above and beyond).
4. The positive feedback is documented for future consideration (team member review, review of clinic processes that are going well, etc.).

Information Sharing and Consent

To ensure consistent and seamless care across organizations serving a shared client, information about the client's RAAM clinic treatment may need to be shared with external agencies. Information sharing must only happen with client's written permission. Clinic staff should first explain the need to share information with external agencies, then obtain written consent from the client using the **Consent to Obtain and Release Information** form (see **Resources Specific to First Clinical Visit**).

In some instances, members of the care team may have an ethical or professional duty to report information such as risk of harming self or others (see information on mandatory reporting in **General Clinical Resources**). Clients should be made aware of this duty to report in the first visit.

Code White (Violence/Potential Violence)[3]

A **Code White** is initiated to provide the appropriate support in situations of unexpected violence. Most violent situations can be prevented. When a violent situation appears imminent, a **Code White** should be initiated.

The following situations may require initiation of a **Code White**:

- Aggressive/violent person (where initial attempts to defuse the situation have failed)
- Potential threat of injury (i.e., weapon)
- Hostage taking

[3] Adapted from materials provided courtesy of Brant, Haldimand, Norfolk RAAM Clinics.

Code White Procedure

1. Notify the clinic manager to announce a **Code White** over the PA system.
2. Secure the area by instructing everyone to leave the area immediately.
3. Communicate all pertinent information to the appropriate personnel.
4. Debriefing session will be held following the completion of **Code White**.

Individual responsibilities

Clinic manager:

When notified of a CODE WHITE situation, announce the following over the PA system:

Attention please, attention please
Code White – [specific area]
Code White – [specific area]
Code White – [specific area]

When directed, announce the following over the PA system:

Attention please, attention please
Code White all clear
Code White all clear
Code White all clear

Code White leader:

The most appropriate staff member available will assume the role of Code White leader, which includes the following responsibilities:

- Provides leadership through direction and guidance to staff during Code White.
- Works with care providers as appropriate for the management of the aggressive person.
- Contacts security/police if their assistance is required.
- Notifies the clinic manager or designate of the occurrence of the Code White and the outcome.
- Facilitates a debriefing session to evaluate the incident.

In the event of a Code White:

- Remain calm and avoid exhibiting any aggressive behaviour in order to reduce the level of agitation.
- Remain alert for opportunities to ensure safety of all occupants.
- Request assistance from other individuals who may be able to defuse the situation.

Incident investigation and review

A manager will ask a member of the Health and Safety team to immediately start an investigation of the incident, including obtaining witness reports.

All incidents of violent and/or threatening behaviour will be documented in a note in the client's chart. In specific circumstances, an alert may be placed in the front of the client's chart or on the client's computer profile (e.g., for clients who repeatedly exhibit violent and/or threatening behaviour).

Consideration should be paid to the cause of the incident, e.g. whether it was likely to have been a 'one-off" due to intoxication or crisis, or likely to be repeated, due to a chronic mental health issue such as paranoid psychosis. If the violent behaviour is deemed likely to be repeated, the clinic may consider referring the client to a service better equipped to manage such issues, such as a hospital-based mental health service.

The clinic manager will meet with the client's care providers (and the staff member immediately involved in the incident, if not the care provider) to establish a follow-up plan that ensures staff and client safety, e.g. two staff members will be present at the time of the client's appointment.

RAAM CLINICAL POLICIES

Medical Directives

Naloxone Administration Policy[4]

Effective (date): _____

Authorizing prescriber: _____

Contact person taking responsibility: _____

Recipients

Any individual seen at this clinic that meets the conditions for use of this medical directive.

Authorized implementers

Any RAAM clinic staff member with the knowledge, skill, and judgment to safely implement this medical directive who is not authorized through another college.

Order and/or procedure

This medical directive includes delegation of the controlled act of administering a substance by inhalation.

In the event of a suspected opioid overdose:

1. Call 911 immediately.
2. Administer 4 mg/0.1 mL naloxone nasal spray intranasally.
3. Repeat naloxone administration in alternate nostrils (if previously administered in left nostril, switch to right nostril) every 2–3 minutes as needed until Emergency Medical Services are present.
4. If the individual does not have a pulse or is not breathing, inform the 911 operator and follow their recommendations until Emergency Medical Services arrive.

Indications

Any individual with signs of an opioid overdose, including but not limited to the following:

1. The individual is minimally responsive or unresponsive.
2. The individual's breathing is very slow, abnormal, or has stopped (i.e., respiratory rate of less than 10 breaths per minute).
3. You hear deep snoring or gurgling sounds coming from the individual's upper airway (agonal respirations).
4. The individual's fingernails or lips are blue or purple.
5. The individual's body is very limp.
6. The individual's pupils are very small.

[4] Adapted from materials provided courtesy of Addiction Services Central Ontario.

Contraindications

The individual is known to be sensitive to naloxone or one of its ingredients.

Consent

Prior to implementing the medical directive, the employee must obtain consent if the individual is capable of providing it. In an emergency situation, if the individual is not capable of providing consent, the employee may administer treatment without consent if, in their opinion, all of the following are true:

- The individual is incapable of providing consent with respect to the treatment;
- The individual is experiencing severe suffering or is at risk if the treatment is not administered promptly of suffering serious bodily harm; and
- It is not reasonably possible to obtain a consent or refusal on the individual's behalf or the delay required to do so will prolong the suffering that the individual is experiencing or will put the individual at risk of suffering serious bodily harm.

Documentation and communication

In addition to standard documentation, the employee must document the following in the individual's clinical record:

- Route and dose administered
- The name of this medical directive
- The name of the implementer
- Legible signature of implementer including credentials
- Date and time (unless documenting electronically)

For example, 4 mg naloxone administered intranasal as per Naloxone Administration Medical Directive, John Smith, Addictions Counsellor.

Review and quality monitoring

If issues related to using this medical directive are identified at any time, notify the clinical director or supervisor.

Medical directives will be reviewed, edited as necessary, and renewed every year by the clinical director and/or supervisor. If new information becomes available between routine renewals, the directive will be reviewed and edited as necessary. The contact person taking responsibility and authorized implementers identified in this medical directives will be notified when changes are made.

It is the organization's responsibility to attain and house appropriate signatures and documentation to support the use of this medical directive and to ensure that authorized implementers have the training, knowledge, skill, and judgment necessary to use this directive.

Administrative approval

Executive Director, RAAM clinic	Signature	Date

Approving prescriber(s)

Name and designation	Signature	Date

List of authorized implementers

Name and Designation	Signature	Date

Point-of-care Urine Testing[5]

Effective (date): _____

Authorizing prescriber: _____

Contact person taking responsibility: _____

Recipients

Any client seen at the RAAM clinic that meets the conditions for use of this medical directive.

Authorized implementers

A registered practical nurse (RPN) or registered nurse (RN) employed by the RAAM clinic and currently in good standing with the College of Nurses of Ontario. The individual must possess the knowledge, skill, and judgment to safely implement this medical directive. Note: Some settings may permit roles outside of nursing to perform point-of-care testing with appropriate knowledge and training.

[5] Adapted from materials provided courtesy of Addiction Services Central Ontario.

Terms

- Urine testing: Point-of-care (POC) testing for urine drug screen and rapid ethyl glucuronide (EtG) via urine dipstick (opioids, benzodiazepines, benzoylecgonine, methamphetamine, EDDP, buprenorphine, alcohol, fentanyl) to manage substance use disorders; and/or urine beta hCG to expedite the diagnosis or confirmation of pregnancy.
- Breathalyzer: Point-of-care (POC) testing of current blood alcohol content from a breath sample to determine intoxication.

Indications

1. POC urine drug screen: Clients who present with substance use concerns and require ongoing monitoring for use, contraindications to medications, and/or monitoring the adherence of the treatment plan.
2. POC urine beta hCG by dipstick (pregnancy test): To screen individuals with symptoms of pregnancy, a missed menstrual period, or a clinical situation in which pregnancy status needs to be determined.
3. POC rapid urine ethyl glucuronide (EtG) test (alcohol test): This test will detect the presence of ethyl glucuronide, a breakdown product of ethanol. For clients who present with substance use concerns and require ongoing monitoring for alcohol use, contraindications to medications, and/or monitoring the adherence of the treatment plan.
4. POC breathalyzer: To screen for the presence of alcohol intoxication and ensure safety (for example: ability to operate a vehicle if a client drove to the clinic they presented at).

Documentation and communication

- All diagnostic tests being ordered, and their results, must be documented in the EMR as outlined in the CNO Standards of Practice in accordance with standard documentation.
- The results of the test and the required follow-up are the responsibility of the health care provider (NP, MD) who has provided care for the client in the clinic.
- Further collaboration may be necessary to initiate certain subsequent treatments and/or testing.
- Annual routine renewal will occur on the anniversary of the activation date and will involve collaboration between the authorizing provider and policy implementers (RPN, RN).

Review and quality monitoring

If issues related to using this medical directive are identified at any time, notify the clinical director or supervisor.

Medical directives will be reviewed, edited as necessary, and renewed every year by the clinical director and/or supervisor. If new information becomes available between routine renewals, particularly if this new information has implications for unexpected outcomes, the directive will be reviewed and edited as necessary. The contact person taking responsibility and authorized implementers identified in this medical directives will be notified when changes are made.

It is the organization's responsibility to attain and house appropriate signatures and documentation to support the use of this medical directive and to ensure that authorized implementers have the training, knowledge, skill, and judgment necessary to use this directive.

Administrative approval

Executive Director, RAAM clinic	Signature	Date

Approving prescriber(s)

Name and designation	Signature	Date

List of authorized implementers

Name and Designation	Signature	Date

Management of Alcohol Withdrawal

The purpose of this medical directive is to support RNs and RPNs in managing alcohol withdrawal in the RAAM clinic setting when prescribers (MDs/NPs) are unavailable.

Effective (date): _____

Authorizing prescriber: _____

Contact person taking responsibility: _____

Recipients

Any individual seen at this clinic presenting with symptoms of alcohol withdrawal.

Authorized implementers

Any RAAM clinic registered nurse (RN) or registered practical nurse (RPN) currently in good standing with the College of Nurses of Ontario (CNO). The individual must possess the knowledge, skill, and judgment to safely implement this medical directive and must have knowledge of the client's condition and medication profile. If the RN/RPN lacks any of these or feels that future consultation is required, they will contact the prescriber. This directive serves as an authorizing mechanism for registrations of the CNO. This directive does not preclude members of other colleges who may already have authorizing mechanisms in place from administering lorazepam for alcohol withdrawal.

Order and/or procedure

This medical directive includes delegation of the controlled act of administering an oral tablet. Diazepam is the preferred agent for most clients; lorazepam should be used if the client is older than 60, taking opioids or other sedating medications, has severe liver dysfunction (e.g., cirrhosis, severe hepatitis), low serum albumin, or respiratory failure or distress (COPD, pneumonia).

All clients will be assessed by a RAAM clinic nurse practitioner or physician prior to medication administration or initiation of the procedure. An order is required for this procedure. The RN/RPN must enter the order into the client's electronic medical record (EMR) prior to implementing the following protocol:

a. Complete vital signs and perform urine drug screen on admission to RAAM clinic.
b. Complete CIWA-Ar assessment (see General Clinical Resources).
c. Obtain order.

If CIWA-Ar score 20+ (severe withdrawal):

a. **Give diazepam** 20 mg PO x 1 dose STAT, if urine drug screen negative for benzodiazepines.
b. Send client to Emergency Department via ambulance.
c. If client condition worsens or additional support is required, initiate code blue procedure and don appropriate PPE.

a. **Give lorazepam** 4 mg PO/SL x 1 dose STAT, if urine drug screen negative for benzodiazepines.
b Send client to Emergency Department via ambulance.
c. If client condition worsens or additional support is required, initiate code blue procedure and don appropriate PPE.

If CIWA-Ar score 11–19 (moderate withdrawal):

a. CIWA-Ar hourly and before each dose of diazepam while client is on site.
b. Give diazepam 10 mg to 20 mg PO every 1 to 2 hours until CIWA-Ar is less than or equal to 10, or until a maximum of 3 doses are given.
c. If CIWA-Ar remains above 10 after 3 doses, contact physician or nurse practitioner.

a. CIWA-Ar hourly and before each dose of lorazepam while client is on site.
b Give lorazepam 2 mg PO/SL every 1 to 2 hours until CIWA-Ar is less than or equal to 10, or until a maximum of 3 doses are given.
c. If CIWA-Ar remains above 10 after 3 doses, contact physician or nurse practitioner

If CIWA-Ar 10 or below (mild withdrawal):

a. Continue to observe.
b. Repeat CIWA-Ar in 1 hour.

Once client's CIWA-Ar is 10 or below:

a. Give gabapentin 300 mg PO TID for seven days and thiamine 300 mg PO OD for three days, daily dispensed from local pharmacy.

b. Clients are to be reassessed the next day in person or by telephone by a RAAM clinic team member.

Contraindications

- Known allergy or hypersensitivity reaction to medication(s) named in this directive (consult physician/nurse practitioner)
- Any condition that prevents reliable implementation of CIWA-Ar (e.g., advanced neurocognitive deficits, extreme language barrier)
- Advanced liver disease
- Severe respiratory impairment
- Acute narrow-angle glaucoma

Possible adverse reactions

The most common reactions include drowsiness, unsteadiness, trembling, problems with muscle control or coordination, ataxia, hypertonia, irritability, and abdominal discomfort. Severe reactions could include respiratory depression/distress, extreme fatigue, coma, or death.

Review and quality monitoring

If issues related to using this medical directive are identified at any time, notify the clinical director or supervisor.

Medical directives will be reviewed, edited as necessary, and renewed every year by the clinical director and/or supervisor. If new information becomes available between routine renewals, the directive will be reviewed and edited as necessary. The contact person taking responsibility and authorized implementers identified in this medical directives will be notified when changes are made.

It is the organization's responsibility to attain and house appropriate signatures and documentation to support the use of this medical directive and to ensure that authorized implementers have the training, knowledge, skill, and judgment necessary to use this directive.

Administrative approval

Executive Director, RAAM clinic	Signature	Date

References

CNO Practice Standards Medication 2019- RN/ RPN
CNO Dispensing FAQ RN/ RPN
CNO Practice Standards for NPs
CPSO dispensing standards

Approving prescriber(s)

Name and designation	Signature	Date

List of authorized implementers

Name and Designation	Signature	Date

Medication Policy[6]

Purpose

The purpose of this policy is to establish comprehensive procedures for the handling, storage, administration, and documentation of medications within the RAAM clinic. This policy is designed to ensure the highest standards of medication safety, accuracy, and confidentiality, while adhering to regulatory requirements and best practices.

Scope

This policy applies to all RAAM clinic medical staff involved in the receipt, storage, administration, and documentation of medications within the RAAM clinic. It encompasses all aspects of medication management, including delivery, secure storage, administration practices, and reporting of adverse drug reactions. All regulated staff are advised to follow their respective college best practice guidelines. For the purpose of this document, staff eligible to handle, store, and administer medications includes physicians, nurse practitioners, registered nurses, and registered practical nurses employed at the RAAM clinic.

Not all RAAM clinics receive or hold medications; in situations where medications are accessed directly from a pharmacy (hospital or retail) and administered within the RAAM clinic, the same best practices for administration and documentation should be followed.

For clinics that do receive and hold medications, it is important to note that some clinics hold only medications prescribed for specific clients, while others maintain a stock of medications ordered "for clinic use" in order to have a small quantity of medications available for rapid access. As these are typically controlled substances, storage and medication audits are subject to strict regulations.

[6] Adapted from materials provided courtesy of Brant, Haldimand, Norfolk RAAM Clinics.

Policy statement

RAAM clinics are committed to providing safe and effective medication management through adherence to best practices in the following domains:

1. Delivery

1.1. Delivery process

Medication deliveries must be coordinated with designated staff and executed with strict adherence to confidentiality and security protocols. Documentation of receipt must be precise, including verification of medication orders and proper temperature checks for refrigerated items.

- **Scheduling:** Coordinate a specific delivery time with the pharmacy service provider to ensure the availability of designated staff and necessary resources.
- **Designated staff:** Identify and notify the designated staff responsible for receiving the medication delivery prior to the arrival of medications.
- **Confidentiality and security:** Ensure no client-specific information is visible on the outer packaging to maintain confidentiality. During delivery, adhere to strict confidentiality and security protocols to protect medication and client information.

1.2. Documentation

- **Receipt of medications:** Use paper or electronic methods to document the receipt of medications, including the name of the registered staff member receiving the medications and their identifying credentials.
- **Verification:** Confirm that the received medications match the delivery order.
- **Refrigerated items:** Verify refrigerated medications are maintained between 2 and 8 degrees Celsius upon receipt. Document the client name, provider name, medication instructions, quantity, date transferred from the pharmacy, and transfer of care sign-off, and update the inventory sheet.

2. Storage

All medications must be stored securely in a locked medication room with controlled access. Medications must be organized systematically in labelled cabinets, with refrigerated items stored between 2 and 8 degrees Celsius. Controlled substances must be stored in designated, locked cupboards to ensure safety and compliance with legal requirements

2.1. Medication room

- **Location and access:** Store all medications in the medication room, which must be locked at all times when not in use. Restrict access to the medication room to authorized medical staff only. Keys must be kept with a designated registered staff member.
- **Medication cabinets:** Store medications in a locked cabinet within the medication room. Cabinets must have labeled drawers for specific medication types to prevent cross-contamination and be clearly labeled to indicate medication categories (e.g., antibiotics, pain relievers).

2.2. Refrigerated medications

- **Storage requirements:** Maintain refrigerated medications between 2 and 8 degrees Celsius. Place each refrigerated item in a designated medication fridge with client name, provider name, medication instructions, quantity, date transferred from pharmacy, and transfer of care sign-off, and update inventory sheet.

2.3. Controlled medications

- **Storage:** Store controlled medications in a locked cupboard, separated by medication class. Narcotics must be stored in a distinct, locked cupboard separate from other controlled medications. Separate look-alike and sound-alike vials and drug names with different coloured vials or packaging to avoid errors.
- **Inventory recording:** Narcotic inventory should be counted at the beginning and end of shifts.

3. Audits

Regular audits of medication storage and destruction processes are required to ensure compliance with policy and to maintain safety standards. These audits include verifying inventory levels, checking expiration dates, and ensuring secure storage of medications awaiting destruction.

3.1. Medication room audit

- **Scheduled:** Conduct monthly audits.
- **Procedure:** Ensure cabinets contain no more than a one-month supply of medications with a current order on the MAR or profile. Remove expired or improperly stored items immediately. Ensure hazardous chemicals and cleaning products are not stored in the medication room.
- **Refrigerator:** Check and document refrigerator temperatures twice daily to ensure they are maintained between 2 and 8 degrees Celsius. Verify the refrigerator is connected to the emergency power system and ensure all refrigerated medications are clearly labeled and not expired.

3.2. Medication awaiting destruction

- **Scheduled:** Monthly audits are required.
- **Procedure:** Store non-controlled medications in a secure container in the medication room. Store controlled medications awaiting destruction in a secure, stationary container within a double-locked area, separate from active controlled medications. Ensure the container is sealed to prevent retrieval before pick-up by the waste management company.

4. Medication administration

Medications must be prepared and administered following the six rights of medication administration: Right Medication, Right Dose, Right Client, Right Route, Right Time, and Right Documentation.

4.1. Administration procedures

- **Narcotics**: Narcotics removed from the narcotics cupboard for administration must be double-counted, initialed by two staff members, and documented.
- **Controlled medications:** Two staff members are required to sign off on administration.
- **Injection documentation:** All injections must have the expiry date and lot numbers clearly marked.
- **Two client identifiers:** Use two client identifiers to confirm identity during medication administration. Ensure medication administration is discreet and away from the waiting room to protect client privacy.

5. Documentation

Accurate and timely documentation of medication administration, adverse drug reactions, and other relevant information is essential. All records must be maintained in electronic formats where applicable, with thorough reporting of adverse reactions to appropriate healthcare providers and regulatory bodies

- Record all medication administrations using the clinic system (electronic or paper) to ensure accurate tracking and reporting.
- For clients receiving medications dosed per the **CIWA-Ar** or **COWS**: Use the appropriate scale to determine dosage, and document the dose in milligrams, time and client response.
- Log all administered injections specifying dose, interval, route, lot number, and the next injection booking. An electronic record is preferred.

5.1. Adverse drug reactions

- **Notification:** Notify physicians and nurse practitioners immediately if an adverse drug reaction occurs. Submit a report to Ontario AEFI Reporting using the **Adverse Events Following Immunization Reporting Form** and send it to the local Public Health unit. Also report to MedEffect Canada and other relevant parties.
- **Reporting resources:** Refer to Public Health Ontario's **Fact Sheet on Adverse Events Following Immunization** and the **Reporting Form**. Report adverse reactions through **MedEffect Canada**.

5.2. Documentation of adverse reactions

- **Documentation:** Record the circumstances of any adverse reactions experienced by the client and the treatment administered or recommended.

Dispensing of medication samples

Medication samples (clinical evaluation packages) should only be distributed to clients by staff with prescribing authority (physician and NP). Medication samples may be dispensed in order to allow prescribers to evaluate the clinical performance of the medication outside of the context of post-marketing surveillance studies, to initiate therapy, or for a similar purpose. Any departure from this must be justifiable in terms of principles of ethical medical practice (for example, where the normal means of obtaining drugs or other medical products would result in an excessive financial burden or other hardship to the client). All samples provided to clients must be recorded in the client health record (CPSO Practice Standard – drug samples).