AE-109

Medication Management Guide

How medications are stored, administered, documented, and reviewed at Aeternum.

Medication support at Aeternum is dependable and quiet — organized enough to be safe, gentle enough that it never feels clinical. This guide explains our practices, which follow Oregon requirements for medication administration in licensed residential settings, along with prescriber and pharmacy direction.

Who provides medication support

- Only staff who have completed medication administration training and a documented competency check provide medication support.
- Training covers the rights of medication administration, documentation, side effects, controlled substances, error reporting, and refusal.
- Competency is reassessed on a regular schedule and after any medication error.
- Licensed nursing consultation is available for review, delegation, and education.

Storage

- All medications are stored in a locked, temperature-appropriate medication room or cabinet — never loose in bedrooms unless an approved self-administration plan exists.
- Controlled substances are double-locked with a separate count record reconciled each shift.
- Refrigerated medications are kept in a dedicated locked refrigerator with daily temperature logs.
- Each resident's medications are stored separately in original, pharmacy-labeled containers.
- Expired, discontinued, and unused medications are documented and destroyed or returned through an approved disposal method.

Administration

Every medication pass follows the same verification, every time:

- Right person, right medication, right dose, right route, right time — verified against the current medication administration record.
- The label is checked against the order before and after preparation.

- The resident is told what they are taking and why, in plain language.
- Medication is observed as taken, then documented immediately — never in advance.
- As-needed medications include the reason given and a documented follow-up on whether it helped.

Self-administration

Independence with medication is a goal for many residents. When the prescriber and support team agree, a written self-administration plan is put in place with a secure personal lockbox, an agreed level of staff oversight, periodic accuracy checks, and a clear plan for what happens if the routine slips. Skills-building toward independent medication management is part of daily living support.

- Refusals are documented with the reason, the resident's stated concern, and prescriber notification when appropriate.
- Controlled substance counts are reconciled and signed each shift.
- Records are retained and available to the resident, their guardian, and authorized providers, consistent with privacy law.

Changes and new orders

1. Orders are accepted only from a licensed prescriber, in writing or with written confirmation of a verbal order.
2. The pharmacy is contacted to update labels and dispensing.
3. The medication record is updated before the next scheduled dose.
4. The resident is informed of the change, its purpose, and expected effects.
5. Family or guardian are notified per the release on file.
6. Discontinued medications are removed from active storage the same day.

Side effects and monitoring

- Staff monitor for and document side effects, changes in sleep, appetite, mood, and movement.
- Concerns are reported to the prescriber promptly, and urgently for any severe reaction.
- Vital signs, weight, and lab work are supported and tracked as ordered.
- Residents are encouraged to describe how a medication feels — their report is the most important data we have.

The right to refuse

Residents may refuse any medication. Staff respond by asking about the concern, offering to revisit it later, documenting the refusal, and notifying the prescriber when a pattern develops. A refusal is a conversation starter, never a discipline matter, and never grounds for retaliation.

Medication errors

If an error occurs, the resident's safety comes first: assess, contact the prescriber or poison control as indicated, and monitor. Every error is documented, reported to leadership and to the prescriber, disclosed to the resident and their designated contacts, reported to the state where required, and reviewed to prevent

Aeternum coordinates with each resident's own prescriber, primary care provider, and pharmacy. We do not prescribe. We schedule and support appointments, share monitoring information with consent, and make sure nothing falls through the gap between providers.

Over-the-counter items and supplements

Non-prescription medications, vitamins, and herbal supplements are reviewed with the prescriber before use because of interaction risks, and are stored and documented the same way as prescriptions.