Medications Procedures

and safe food handling

For all Employees of Community Living St.Marys & Area
As part of our *COMPASS TRAINING*
updated Oct 2015

Did You Know?

- 50% of patients (including children) are not taking their prescription drugs correctly
- 30% of prescription drugs are being misused in a manner that poses a serious threat to the patient' health
- 60% of patients cannot identify their medications
- 40% of patients receive drugs prescribed by two or more doctors
- 10% of patients over 65 share prescription medicines with others
- 3-30% of hospital admissions are due to incorrect use of drugs by patients at home
- 1 of 10 people do not fill their prescriptions due to the cost
- One of every two patients with high blood pressure will stop taking the prescribed medications and never tell their physicians. Of the patients who continue taking medications, only two-thirds will take enough to control their blood pressure. The result can be life threatening medical complications such as heart attack, stroke or congestive heart failure

Medication Procedure Training Purpose & Rules

To support people to take their medications in a safe and responsible manner by identifying clear steps for medication administration.

General Responsibilities for Administering Meds.

1. Give only medications for which there is a Doctor's order and/or prescription. In consultation with the doctor, family, other health professionals, over the counter and supplements may be taken by the person.

2. Support and teach people to understand the importance of their medications and the responsibilities that go with it.

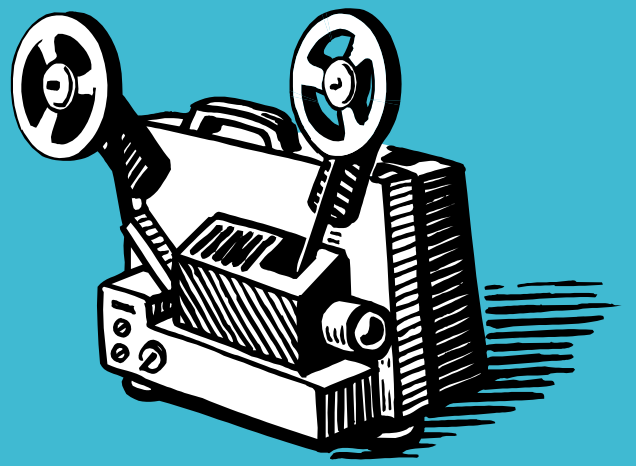
3. Know why the drug is given, expected action of the drug, the dose and the possible side and adverse effects. Use resources such as CPS, Drug Book Guide, Pharmacy, package inserts, Doctor, etc.

4. Follow safe procedures while preparing and administering medications. Know the Six Rights in Drug Administration (to follow)

5. Store medications in a safe area. As of late 2015, all medications we support people to take, will be kept in a locked box, and for anyone who has narcotics, they will be in a double locked box.

6. Check expiry dates of medications. Do not give if discoloured, chalking or unusual odour

7. Always wash your hands. Avoid handling medications



Proper hand washing technique (in 2 minutes)

As taken from https://www.youtube.com/watch?v=MIE0KbGIXjM

8. Do not crush or take apart capsules unless the Doctor gives the okay. Dispose as per procedure.

9. Do not give medications if the person is showing signs of toxicity, vomiting, very sedated or unconscious, showing signs of allergic reactions. Doctor may need to be called.

The Six Rights in Drug Administration

#1 Right Person

- Read the name of the blister pack, and Medication Administration Record (MAR) sheet
- Talk to the person and use their name
- Give medication to one person at a time

#2 Right Drug

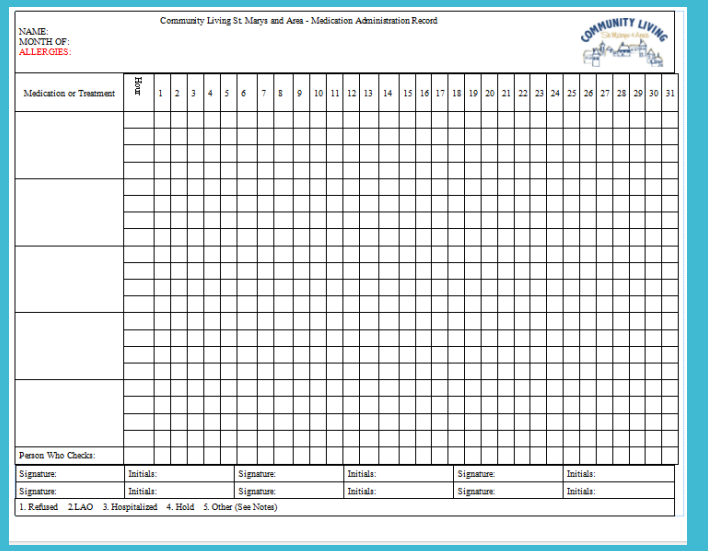
- Read the blister pack and the MAR sheet
- Research the drug actions, side effects and reason for giving
- Do three checks when pouring
- Know the generic and trade name for the medication

3 Right Dose

- Check the blister pack and the MAR sheet
- Look at the dose on the label
- Consider the dose amount, and, how you will formulate that prescription
- Measure accurately; know abbreviations, symbols and equivalents
- Make sure the person takes all the medication

#4 Right Time

- Read the MAR sheet and medication bottle
- Give the medication at the time ordered, leeway of 30 – 60 minutes
- For blood levels give at stated intervals, such as four to eight hours
- Know abbreviations for times – a.c., p.c., od, b.i.d., etc



Community Living St. Marys and Area - Medication Administration Record

NAME:
MONTH OF:
ALLERGIES:

Medication or Treatment	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Person Who Checks:																																

Signature:	Initials:	Signature:	Initials:	Signature:	Initials:
Signature:	Initials:	Signature:	Initials:	Signature:	Initials:

1. Refused 2.LAO 3. Hospitalized 4. Hold 5. Other (See Notes)

This is what our MAR sheet looks like

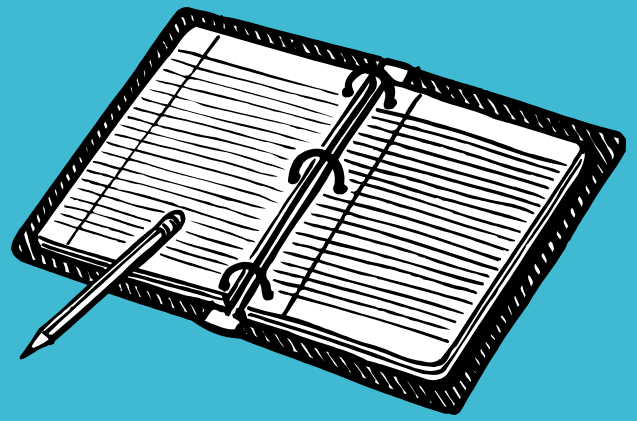
#5 Right Method

- Read Doctor's order, MAR sheet and blister pack.
- Give orally if no method is stated or indicated. Ask if unsure
- Give as indicated – with milk, on an empty stomach, with applesauce, etc
- Think and keep your mind on your work
- Pour pill into lid of container first. Pour liquid directly into measured cup or spoon.

#6 Right Documentation

- Every medication must be recorded on person's file – Dr.'s Order, MAR, along with dose, time, route.
- The person checking the blister pack and giving medications must record after doing so
- Any medication not administered must be recorded on MAR sheet, noted in log/communication books (indicating the reason)

What is included in a person's Med Book?

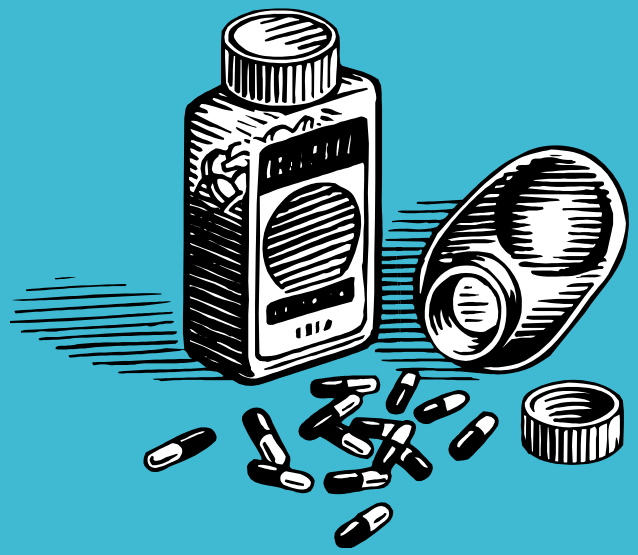


Each person receiving support from an agency employee to administer their medication and treatment must have a Med Book.

Contents of the Med Book

- Medication Administration Record (MAR)
- Physician's Orders
- Medication & Treatment Notes
- Medical/Consultation Appointment
- Related forms
- Information printouts of the person's meds (usually provided by pharmacy)

Who will pour Medication?



A person's pharmacy will pre-pour medications into a blister pack. A Support Worker giving medication must be eighteen years of age or older, and must be first oriented to medication procedures by Team Leader or trained designate. Liquid medication and/or PRN medication may be in original containers, and should be noted on the MAR sheet.

How to Administer Medication

- Wash and dry hands thoroughly
- Read (MAR) sheet and dispense only medication listed
- Select correct medication (1st check). Medication must be in the blister pack with original pharmacy label
- Check label against current MAR (2nd check)
- Dispense medication from the blister pack into med cup. Do not touch medication with your hands
- Check label on blister pack with MAR (3rd check)
- Administer as required by person (i.e. Do you need to use applesauce, do you hand it to the person or do you assist them to take it?)
- Sign MAR sheet to indicate you have administered medication
- When blister pack arrives, an employee will check the meds and initial 'person who checks' on the MAR sheet. Any mistakes should be taken back to pharmacy to be fixed.

Remember…

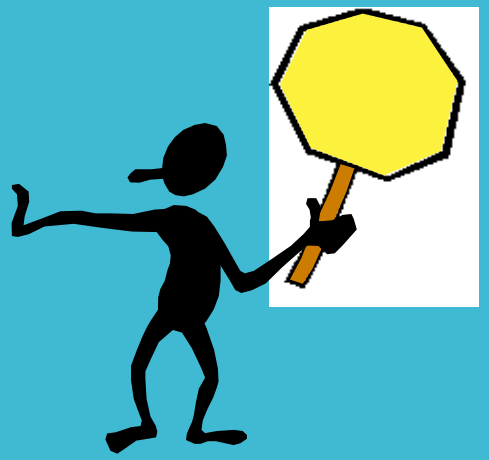
- Never change or re-label medication.
- Never remove label from blister pack.
- Never give medication from non-legible or unlabeled blister packs.
- Always follow special instructions on the label, such as "keep refrigerated"
- Always check that the name on the blister pack is exactly the same as the name written on the MAR. Check the dose on the MAR with the dose on the blister pack.
- Always read the label 3 times
- For meds not in the blister pack (i.e. liquids, infrequent meds), it must be noted on the MAR sheet where it is located

- ✘ Never sign the MAR sheet before administering medication
- ✘ Never administer any medication that is not authorized by a doctor
- ✘ Never give medication by mouth to a person who is vomiting, who can not swallow or is semi-conscious
- ✓ Always read the label 3 times
- ✓ Always observe the person until medication is swallowed
- ✓ Always give capsules and tablets first to be followed by any liquid medication
- ✓ Always dispose of any medication that has become contaminated (i.e. Fallen on the floor, etc)

How to Pour and Administer Liquid Medication

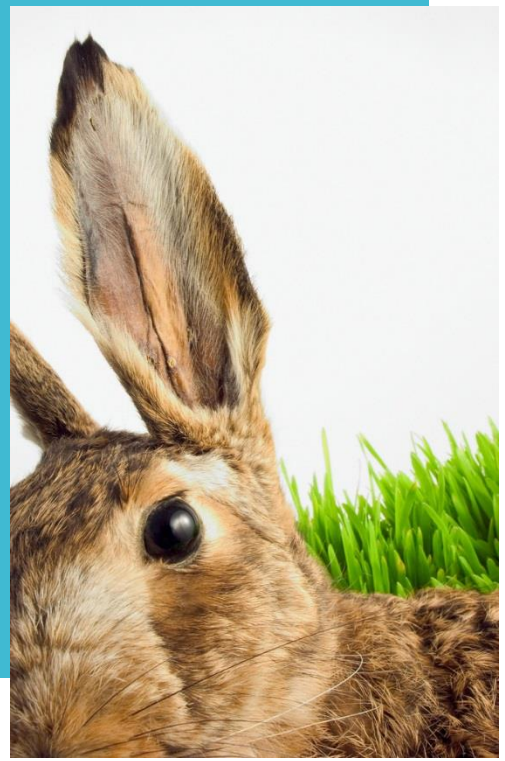
- Wash and dry hands thoroughly
- Read current MAR sheet to determine liquid medication to be given at that time
- Select correct medication (1st check)
- Check label on bottle against MAR (2nd Check)
- Shake bottle with lid on several times with your hand over the label (unless otherwise stated on the bottle)
- Pour away from the label into a measuring line of cup
- After pouring medication, wipe lip of bottle with a clean, dry cloth
- Check label on the bottle with MAR (3rd check)
- Immediately administer as required by person
- Sign MAR to indicate you have poured and administered liquid medication.

Remember…



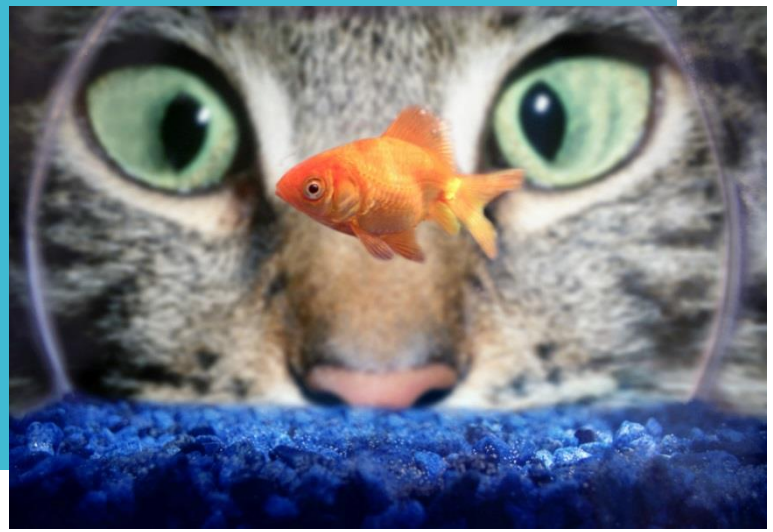
- Liquid medication will NOT be poured in advance
- Expectorants should NOT be followed by water

How to administer ear drops



- Wash hands before and after procedure
- Read current MAR sheet to determine medication to be given at that time
- Select correct medication (1st check)
- Check label on the med container against MAR (2nd check)
- Pour if appropriate and complete (3rd check)
- Have person lie on their side with affected ear up
- If an adult, gently pull their ear upward and back
- If a child, gently pull their ear downward and back
- Instill drops, being careful not to touch ear with dropper. Do not let the drop fall directly on the eardrum, allow it to slide into ear.
- Have the person remain lying on their side for a few minutes
- Immediately sign MAR to indicate you have administered the medication

How to Administer Eye Drops and Eye Ointments



- Was hands before and after procedure
- Read current MAR sheet to determine medication to be given at that time
- Select correct medication (1st check)
- Check label on med container against MAR (2nd check)
- Have the person lie down with head tilt backwards or sitting in a chair with head tilted backwards
- Cleanse eyelid and lash from inner corner to outer corner with moistened cotton swab, use a clean swab for each eye
- Draw medication into dropper, complete (3rd Check)
- Draw down lower lid, carefully steady hands on person's face, have the person look up, allow drop(s) to go into eye pocket between lower lid and eyeball, release eyelid. Have them keep their eye closed for a minutes, use a cotton swab to wipe eye
- Immediately sign MAR to indicate you have administered medication.

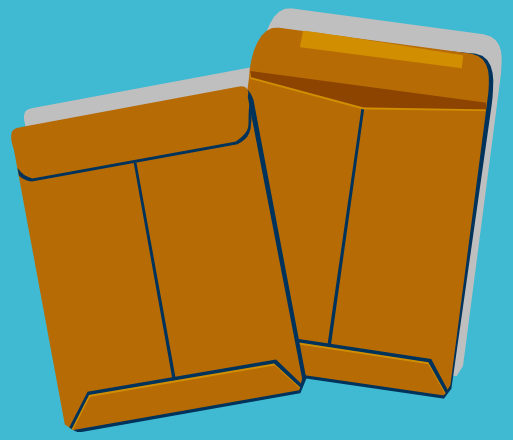
How to Administer Nose Drops

- Wash hands before and after procedure
- Read current MAR sheet to determine medication to be given at that time
- Select correct medication (1st check)
- Check label on the med container against MAR (2nd check)
- Have the person lie on their back, head turned to the side and slightly back
- Draw medication into a dropper, complete (3rd check)
- Instill prescribed number of drops into each nostril
- Have the person remain in that position for a few minutes
- Immediately sign MAR to indicate you have administered medication.

How to Administer Rectal Medication

- Wash hands before and after the procedure
- Read current MAR sheet to determine medication to be given at that time
- Select correct medication (1st check)
- Check label on med container against MAR (2nd check)
- Pour medication, complete 3rd check)
- Have person lie on their left side with their right knee at the right angle keeping the person covered as much as possible and their buttocks slightly elevated
- Put on a glove, lubricate index finger. Do not need to lubricate index finger for enema, pre-packaged fleet enemas are already lubricated. Air is displaced from the enema. Enema should be between room temperature and body temperature
- Insert solid medication. The enema is inserted into the rectum 2 – 3 inches. The fluid is allowed to flow. Once you have started to squeeze the fleet enema bottle do not release until it has been removed from the rectum
- Hold buttocks together for a few minutes to prevent expulsion
- Provide for discomfort – place on back and ask to retain suppository/enema for 15 – 20 minutes if possible
- Immediately sign MAR to indicate you have administered medication

Pouring Medication for Leaves of Absence



- Label the small medication envelope correctly (include person's name, drug name, number of tablets, dosage, time to be administered, date to be administered and initial of staff pouring)

Example:

Don Smith 0800hrs
Phenobarbital 100mg
2 capsules
July 2014 MM

- Transfer medication from the blister pack to envelope and seal.
- Write LOA on person's current MAR sheet instead of initials
- Record the date, time of administration on a Medication and treatment Note Sheet and also who is responsible for administration. Remember to put your own initials here
- Ensure that person who will be administering medication (family, friends etc) is aware of all necessary information

Notes

- When a person is away from home at times of medication administration, they may take their pill cases with them or take poured medication in small medication envelopes. The above information should be written on a dossette if a person takes it out of the home.
- For longer periods of absence (i.e. Going to the cottage for a week, etc) staff should take along the person's med box and current MAR sheet
- Medication in original containers may be required on some trips (i.e. visit to the USA, camp etc)

P.R.N. Medication

- This is a medication (prescription or non-prescription) that has doctor's orders to be "taken as required."
- All PRN medications are to be listed on MAR sheet
- Sign MAR sheet to indicate that you have given PRN Medication
- Record administration of any PRN medication on Medication and Treatment Notes sheet. Include date, Time, PRN med given, dosage, initials of worker who poured and administered, why PRN med given, and results. It should also be noted in a person's log/communication book-why it was needed and if it worked.

Notes

- People who self-administer their medications may not have PRN medications listed on the MAR sheet and may not record on Medication and Treatment Notes
- Note on PRN sheet why med given and result

Time Limited Medication

- This is a medication (prescription or non-prescription) that has doctor's orders to be taken for a certain number of days

Medication Errors

Medication errors include, but are not limited to the following:

- Wrong dose – any dose above or below the dose ordered by a physician
- Omission – any dose not given by the time the next dose is given
- Wrong person
- Wrong time – any medication given more than 60 minutes before or after prescribed time
- Failure to record properly
- Upon discovery of a med error, the person who discovers the error will do the following:

Step 1

Determine who/if you need to call: the pharmacy, Team Leader, Emergency, on all staff, family physician or support staff who made the error (if not you) as appropriate.

Medication Errors Continued

Step 2

Determine, with the information given from one of the previous mentioned resources what needs to be done as a result of the error (e.g.. If MAR sheet was not signed, was the medication taken and not signed for, or, was the medication, in fact, not taken, does it need to be given)

Step 3

Implement recommendation

Step 4

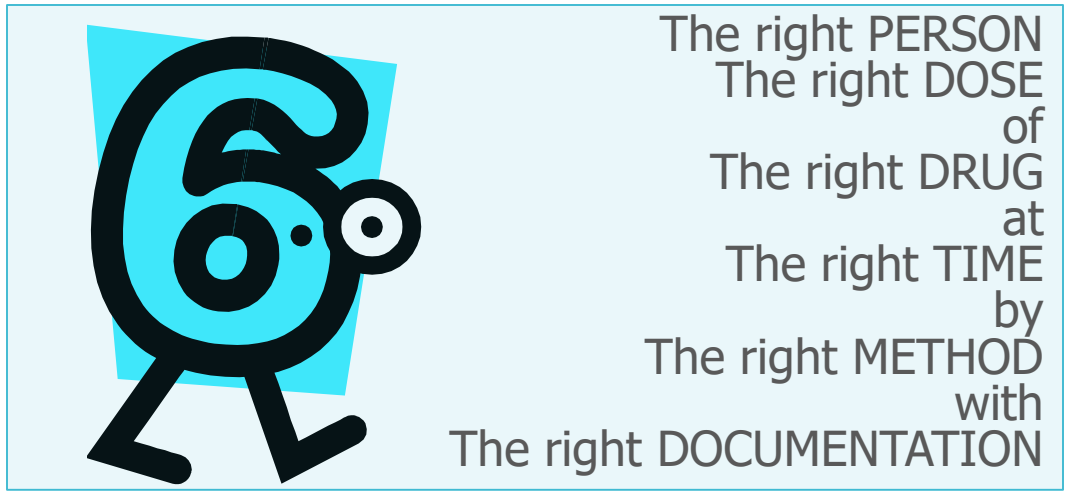
Complete Medication Error Report

Step 5

Medication Error Report needs to be forwarded to the Team Leader the next business day. Copy attached to Mar Sheet. Copies will be filed with the Team Leader, Individual's personal file and Support Worker Personnel File.

Rights

In giving medication, be sure to give:



N.B. Remember people have the Right to Refuse!
Document this if it occurs and alert the Team Leader.
This is not a med error.

Medication Changes

When a medication change occurs it is the Team Leader's responsibility or their designate to ensure adequate record changes are made immediately in the following places:

- Daily Log – in red
- Communication Book - in red ink
- MAR Sheet
- Physician's Orders
- Medication and Treatments History

Notes:

All recording must be in ink

Disposing of Medication

Medications may need to be destroyed for the following reasons:

- Contaminated
- *Refused
- Extra
- Expired
- Change in Prescription

Medications need to be taken to the pharmacy for destruction. Liquid medication must be taken to the pharmacy for disposal.

* Depending on refusal circumstances, medication should be taken back to pharmacy to possibly be re-packaged into a new blister pack

Information about Drugs

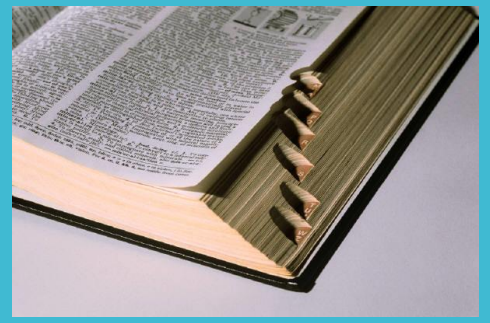
Information about Drugs

Information about all medications which a person takes will be included in their Medication book. Drug information will include: generic and trade names, drug group, dosage, contraindications, interactions, side effects and overdose effects, and picture. The Pharmacy is an excellent resource for information. The Team Leaders or designate are responsible for keeping the books up to date.

Please note:

Under the regulated Health Care Professionals Act, employees of Community Living St. Marys & Area as unregulated health care professionals may only assist or perform aspects of care traditionally provided by Registered Health Care Providers, if they are trained and it is part of the person's regular routine.

Terms Indicating Drug Actions



Indications

A list of conditions or diseases for which the drug is meant to be used.

Actions

A description of cellular changes that occur as a result of the drug. This information is very technical and is aimed at the doctor or pharmacist.

Contraindications

A list of conditions for which the drug should not be given (i.e. pregnancy).

Warning and Precautions

A list of condition or types of patients that warrant closer observation for specific side effects when given the drug (i.e. asthma, blood pressure, kidney problems).

Side Effects and Adverse Reactions

A list of possible unpleasant or dangerous secondary effects other than the desired effect (i.e. dizziness, nausea, constipation, drowsiness). The ones most likely to occur are usually in *italics* (CPS). You may need to use a medical dictionary to look up words used in the CPS.

Interactions

A list of other drugs or food which may alter the effect of the drug and usually should not be given during the course of treatment (i.e. some drugs can not be taken with milk)

Approved Standard Abbreviations used in Drug Prescriptions and Labels

Abbreviation	Meaning	Abbreviation	Meaning
@	At	L	Litre
Ad lib.	As desired	Mg.	Milligram
AM, a.m.	Morning	ml.	Millilitre
BID, b.i.d.	Twice a day	NPO	Nothing by mouth
c.	With	OD	Right eye
cc	Cubic centimetre	OS	Left eye
dc (disc)	Discontinue	OU	Both eyes
Gm.	Gram	Oz.	Ounce
Gt., or gtts	Drop or Drops	p.c.	After meals
H (hr.)	Hour	per	By means of
h.s.	At Bedtime (hour of sleep)	PO, p.o.	By mouth

Approved Standard Abbreviations used in Drug Prescriptions and Labels

Abbreviation	Meaning	Abbreviation	Meaning
PRN, p.r.n.	When required, as needed	s.	Without
Pt., or O	Pint	ss	One half
q.	Every	soln	Solution
q.d.	Every day	tab	Tablet
q.h.	Every hour	TID, t.i.d.	3 times per day
q. (2,3 etc) h.	Every (two, three…)	Tsp.	Teaspoon
GID, q.i.d.	4 times per day	T (tbsp.)	Tablespoon
q.o.d.	Every other day	Oint., ung.	Ointment

Conversions

24 Hour Clock System (may see prescriptions written this way)

12:01a.m. = 0001 hrs (1 min after midnight)

8:00a.m. = 0800 hrs

8:00p.m. = 2000 hrs

11:50p.m. = 2350 hrs

12:00 midnight = 2400 hrs

**Note we use am/pm on CLSMA MAR sheets*

Volume

1 c.c. (cubic cm) = 1ml = 1 mm

1 tsp = 5 ml

1 T. = 15 ml

Recording

Observations

PURPOSE

Observation is essential to assist in making a diagnosis, or in keeping track of a person's progress. It gives purpose and direction to a person's care. It aids others (doctors, therapists, social workers) in their work with a person and their family.

Developing Observation Skills

As with anything else, observation skills and judgment develop with practice, patience and the will to improve. There are five personal resources which are used when using observation skills:

Looking-Take particular note to detect the unusualness or usualness of facial expressions, skin, body posture, person's immediate surroundings (i.e. ventilation, temperature, nourishment) and their condition (i.e. if the diet was consumed or not).

Recording (continued…)

Listening-It is the most important half of the conversation. Purposeful listening during conversation is a means for gaining such information as coherence, disorientation, worries, fears, needs and interests of the person.

Smelling-Unusual odours are in index to circumstances and they capture the attention of an alert support worker. I.e.: the observation of a sweet odour in a person's breath might be valuation information to a physician.

Talking-It is important to show the person genuine acceptance. Keep in mind the *how* something is said or asked (tone of voice, language used, facial expressions, attention, etc) makes all the difference in the way a person responds.

Touching or Feeling-Taking the pulse is a good example of observing through touch. Placing the hand on the brow detects fever or perspiration. During both, the sense of touch may locate abnormalities of the skin or scalp.

The following are not necessarily numbered in order of importance, nor would all nine points apply to each recording. However, the time something was observed must accompany the remarks. The nature of what is recorded is determined by what is important for the physician or professional to know. Observations should be noted in individual log notes.

1. Time/when observed.
2. Location of abnormal sensation (exactness in so far as possible)
3. Duration (how long it lasted, i.e. chill)
4. Frequency/intensity (pain was constant or intermittent, severe, mild, throbbing, etc).
5. Relief obtained from nursing measures (whether or not it seemed to help)
6. General appearance of the person (if this has changed)
7. Amount, colour, character of discharge (urine, feces, vomit, sputum, drainage).
8. Exact words of the individual, when indicated
9. Complaints such as: to eating, sleeping, pain, etc.

Taking a Temperature

Purpose

To determine the temperature of the body heat as an observation.

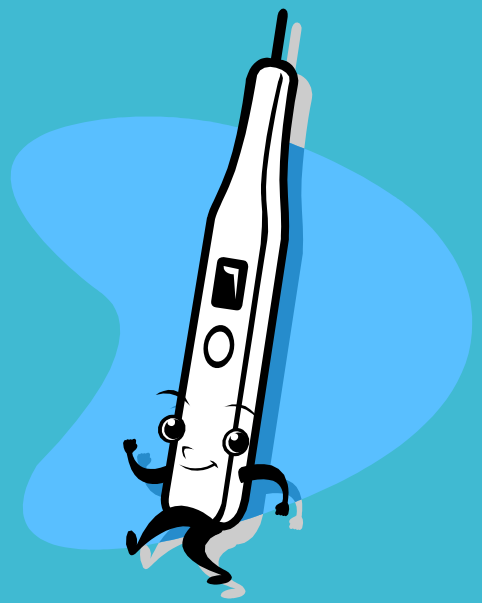
Equipment

Thermometer, other equipment as required.

Course of Action

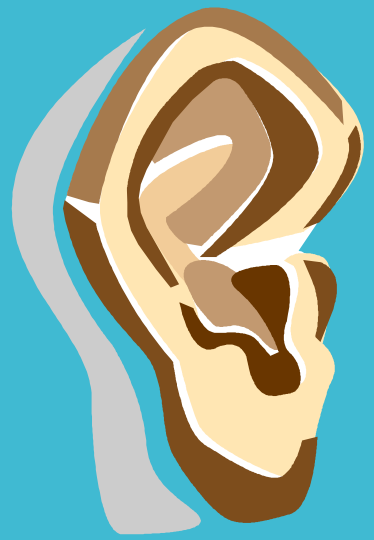
Ensure the digital thermometer is in good working order (i.e. batteries)

Oral Temperatures



1. Ensure that the person is in a comfortable position, either sitting or lying
2. Place end of the thermometer under the person's tongue, or as directed. Ask them to keep lips closed and see that they do not talk, bite or remove the thermometer
3. Leave the thermometer in place for time specified on digital thermometer instructions
4. Read and record thermometer reading. Clean used end as directed in instructions.

Ear Thermometer



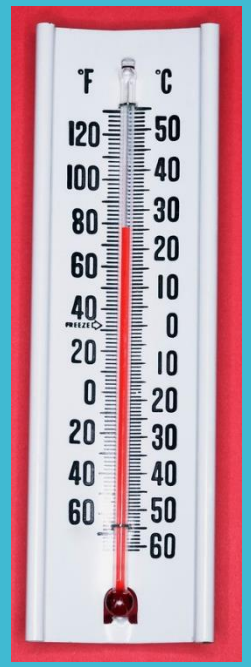
1. Ensure the person is in comfortable position, either sitting or lying
2. Verify new or clean and intact lens filter is attached.
3. Select proper mode and push “on”
4. Stabilize hand. Gently pull ear up and back. Insert thermometer gently in ear canal until snug
5. Depress activation button, hold one second or according to instructions
6. Read thermometer and record reading. Change or clean lens filter as directed

Other means of taking a temperature

Older methods of getting a temperature include rectal and auxiliary (under the armpit).

These are rarely used any more.

Normal Temperature Range



For **Oral**, **Ear**, or **Auxiliary**, the normal range is:
36.6°C (96.8°F) to 37.5°C (99.5°F)

For **Rectal**, the normal range is:
36.6°C (96.8°F) to 38.1°C (100.5°F)

Temperature will vary from one person to another and will fluctuate throughout the day.

Forms

Revised Oct 2013
Uploaded to Sharepoint ☐

Physician's Orders

Date: _____
Name: _____
Address: _____
Date of Birth: _____

Weight: _____
Drug Allergies: _____
Team Leader: _____

Orders

1. Folic Acid	5mg	1 tablet	1 x day	0800		
2. Dilantin	100mg	1 capsule	3 x day	0800	1400	2100
3. Tylenol	500mg	1 tablet up to 4 x day		PRN		
4. Tetracycline	200mg	1 capsule	4 x day until finished			

5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

_____M.D.
Signature of Physician

cc: Community Living St. Marys & Area

Forms

COMMUNITY LIVING
St. Marys & Area

Revised Oct 2013
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Medical/Consultation Appointment

Name:_____

Date:_____

Type of Consultation: _____

Physician/Consultant:_____

Diagnosis/Notes:

Treatment:

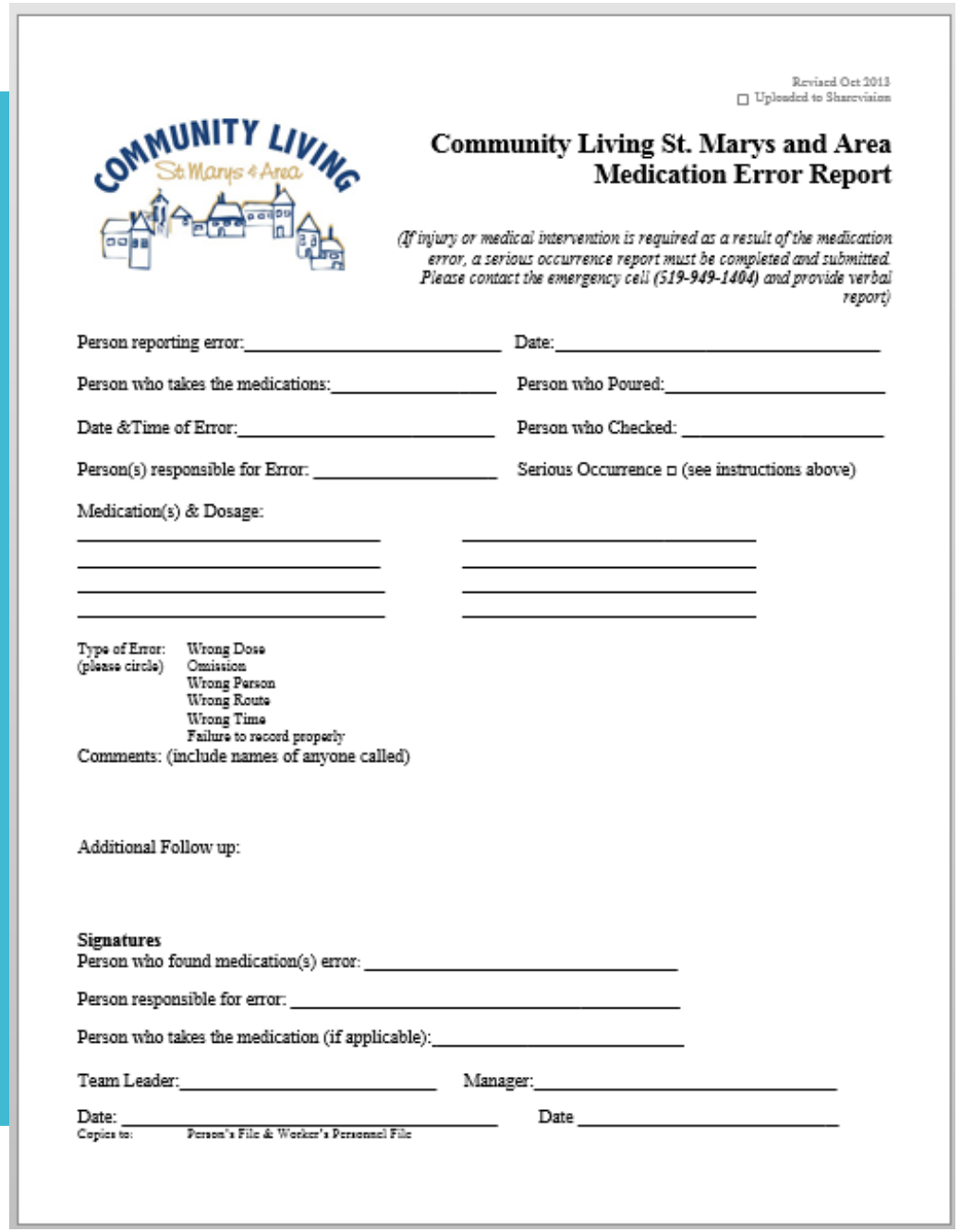
Follow Up:

_____
Signature of Physician/Consultant

cc: Community Living St. Marys & Area

Revised April 2005

Forms



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Community Living St. Marys and Area
Medication Error Report

(If injury or medical intervention is required as a result of the medication error, a serious occurrence report must be completed and submitted. Please contact the emergency cell (519-949-1404) and provide verbal report)

Person reporting error:_____ Date:_____

Person who takes the medications:_____ Person who Poured:_____

Date &Time of Error:_____ Person who Checked: _____

Person(s) responsible for Error: _____ Serious Occurrence ☐ (see instructions above)

Medication(s) & Dosage:

_____ _____
_____ _____
_____ _____
_____ _____

Type of Error: (please circle)
Wrong Dose
Omission
Wrong Person
Wrong Route
Wrong Time
Failure to record properly

Comments: (include names of anyone called)

Additional Follow up:

Signatures

Person who found medication(s) error: _____

Person responsible for error: _____

Person who takes the medication (if applicable):_____

Team Leader:_____ Manager:_____

Date: _____ Date _____

Copies to: Person's File & Worker's Personnel File

Forms

Community Living St. Marys and Area - Medication Administration Record

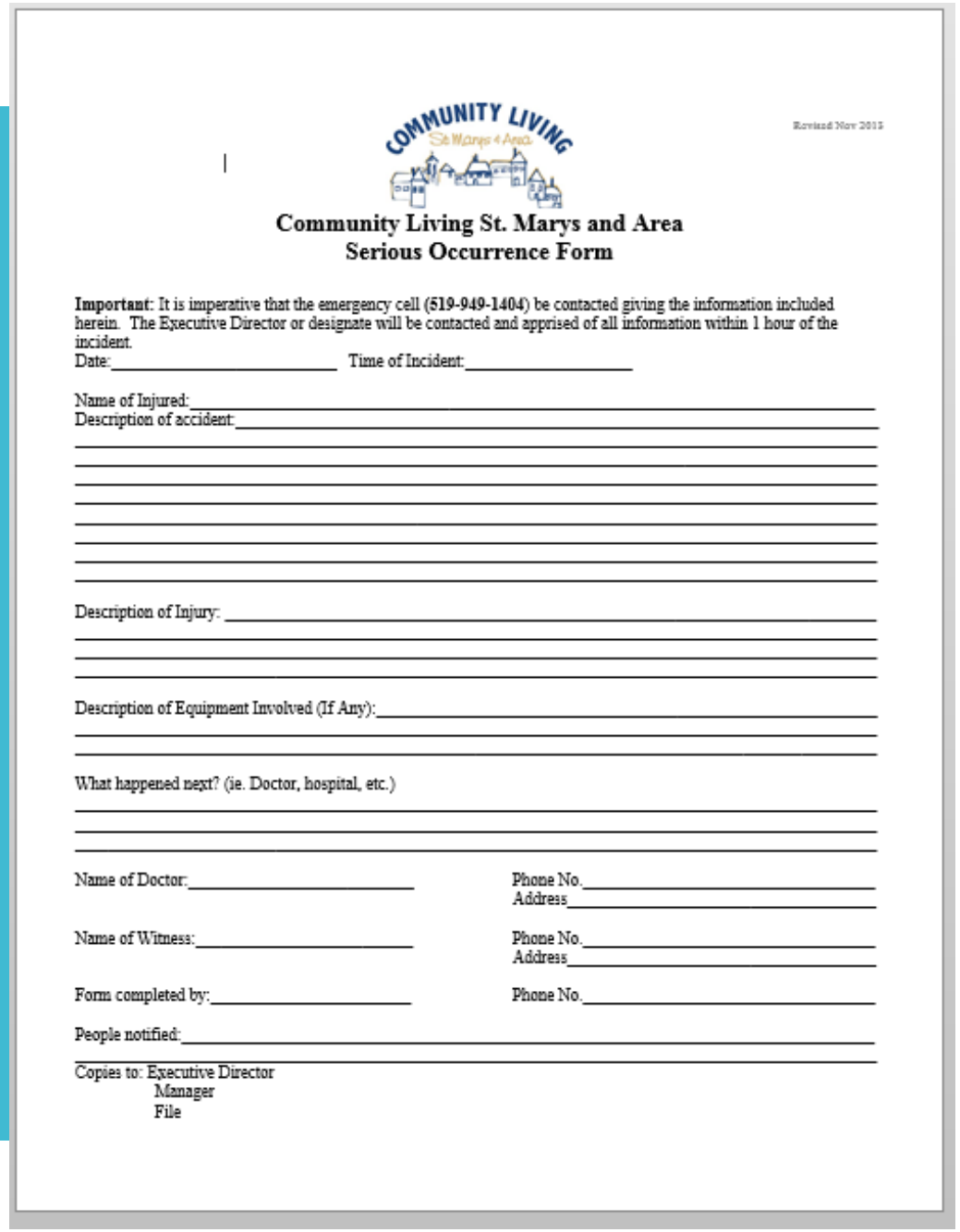
NAME:
MONTH OF:
ALLERGIES:

Medication or Treatment	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Person Who Checks:																																

Signature:	Initials:	Signature:	Initials:	Signature:	Initials:
Signature:	Initials:	Signature:	Initials:	Signature:	Initials:

1. Refused 2.LAO 3. Hospitalized 4. Hold 5. Other (See Notes)

Forms



Revised Nov 2015

Community Living St. Marys and Area
Serious Occurrence Form

Important: It is imperative that the emergency cell (**519-949-1404**) be contacted giving the information included herein. The Executive Director or designate will be contacted and apprised of all information within 1 hour of the incident.

Date:_____ Time of Incident:_____

Name of Injured:_____
Description of accident:_____
_____
_____
_____
_____
_____
_____
_____
_____

Description of Injury: _____
_____
_____
_____

Description of Equipment Involved (If Any):_____
_____
_____

What happened next? (ie. Doctor, hospital, etc.)
_____
_____
_____

Name of Doctor:_____ Phone No._____
Address_____

Name of Witness:_____ Phone No._____
Address_____

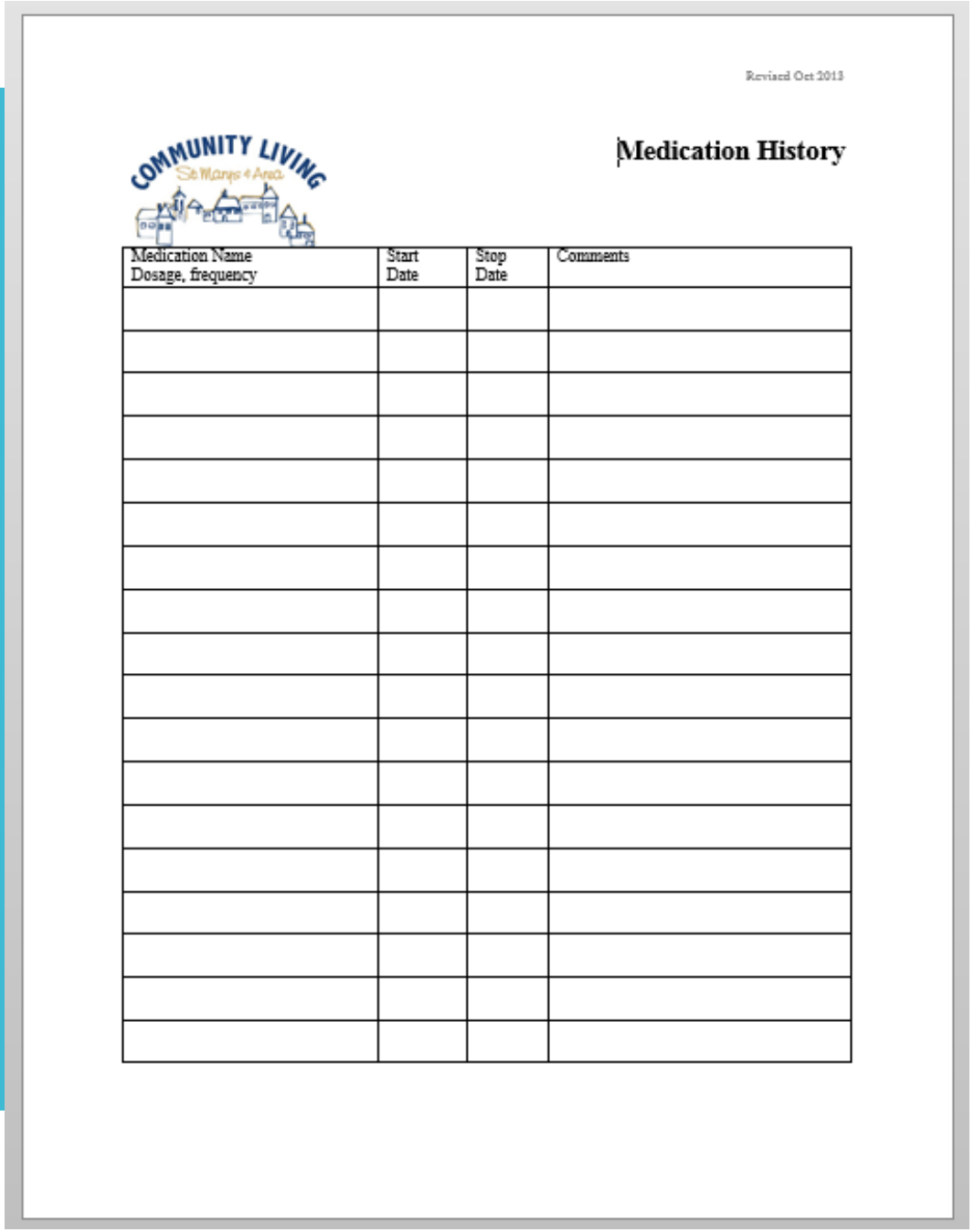
Form completed by:_____ Phone No._____

People notified:_____
_____

Copies to: Executive Director
Manager
File

Please refer to Policy #S13 in your Policies and Procedures binder for full definition of what is included under 'serious occurrence'

Forms



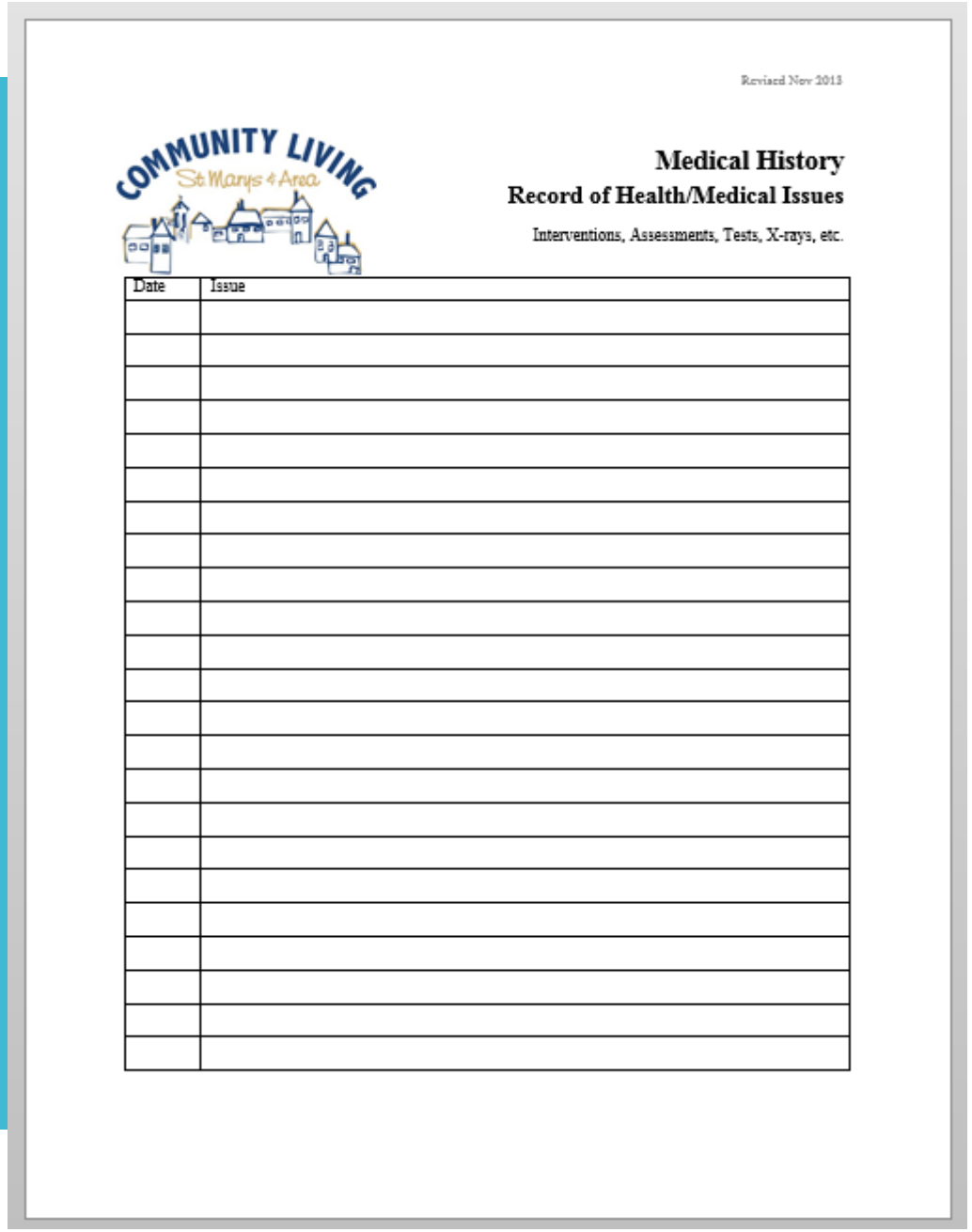
Revised Oct 2013

COMMUNITY LIVING
St Marys & Area

Medication History

Medication Name Dosage, frequency	Start Date	Stop Date	Comments

Forms



Revised Nov 2013

COMMUNITY LIVING
St Marys & Area

Medical History

Record of Health/Medical Issues

Interventions, Assessments, Tests, X-rays, etc.

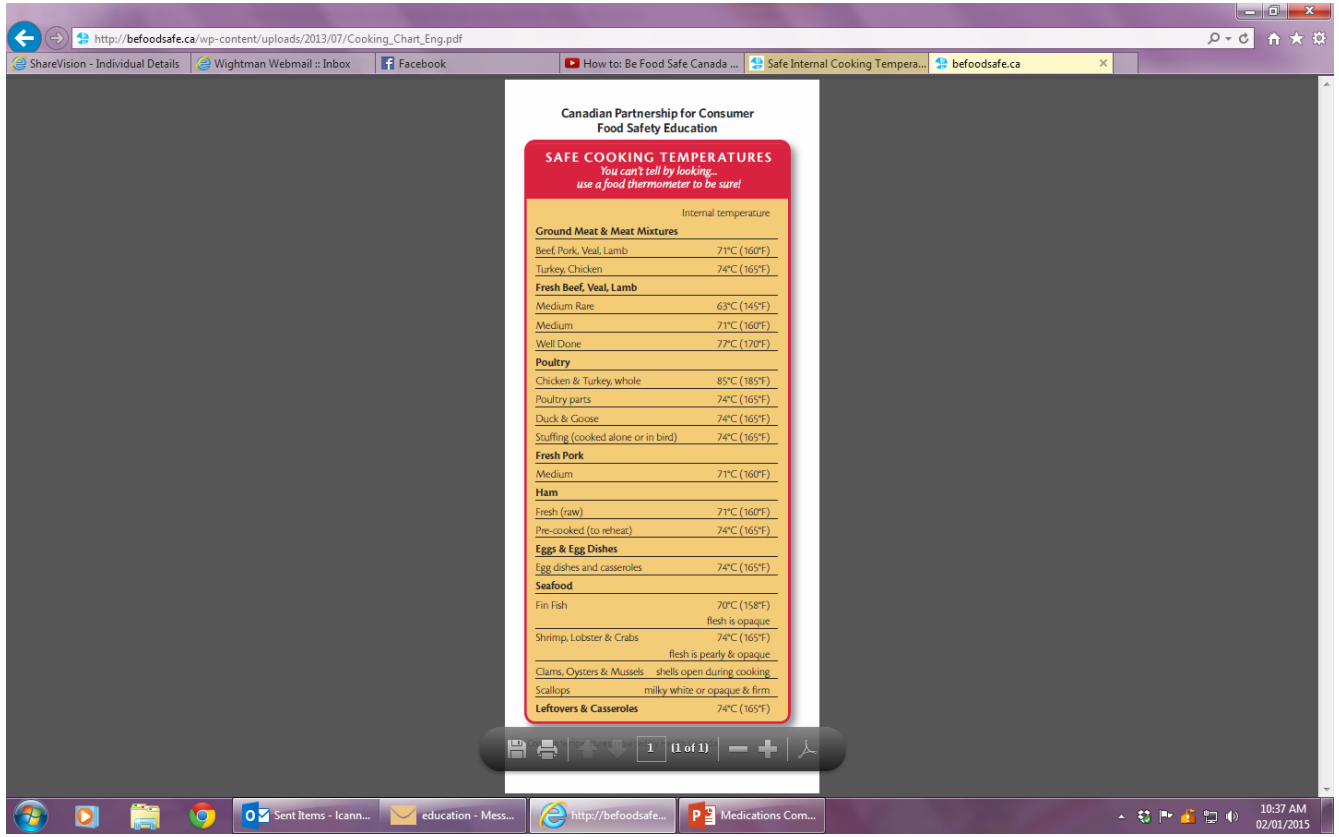
Date	Issue

Safe Food Handling

As taken from https://www.youtube.com/watch?v=sf7ic4Lhnv8

Safe Food Temperatures

Refer to the printed copy of the Safe Food Temperatures in your handouts (as taken from http://befoodsafe.ca/be-food-safe/cooking-charts/)



Canadian Partnership for Consumer Food Safety Education

SAFE COOKING TEMPERATURES

You can't tell by looking... use a food thermometer to be sure!

	Internal temperature
Ground Meat & Meat Mixtures	
Beef, Pork, Veal, Lamb	71°C (160°F)
Turkey, Chicken	74°C (165°F)
Fresh Beef, Veal, Lamb	
Medium Rare	63°C (145°F)
Medium	71°C (160°F)
Well Done	77°C (170°F)
Poultry	
Chicken & Turkey, whole	85°C (185°F)
Poultry parts	74°C (165°F)
Duck & Goose	74°C (165°F)
Stuffing (cooked alone or in bird)	74°C (165°F)
Fresh Pork	
Medium	71°C (160°F)
Ham	
Fresh (raw)	71°C (160°F)
Pre-cooked (to reheat)	74°C (165°F)
Eggs & Egg Dishes	
Egg dishes and casseroles	74°C (165°F)
Seafood	
Fin Fish	70°C (158°F) flesh is opaque
Shrimp, Lobster & Crabs	74°C (165°F) flesh is pearly & opaque
Clams, Oysters & Mussels	shells open during cooking
Scallops	milky white or opaque & firm
Leftovers & Casseroles	74°C (165°F)