Medication Administration

10/15-Hour Training Course for Adult Care Homes

Student Manual

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Center for Aide Regulation and Education
Adult Care Licensure Section

The Medication Administration: 10-Hour/15-Hour Training Course for Adult Care Homes was developed as a joint effort by the Center for Nurse Aide Education and Regulation and the Adult Care Licensure Section of the Division of Health Service Regulation, N.C. Department of Health and Human Services.

The curriculums for the 10-hour and 15-hour training courses were adapted from the ***Medication Administration: A Medication Aide Training Course*** developed by the North Carolina Department of Health and Human Services and the North Carolina Board of Nursing.

CURRICULUM DEVELOPMENT

Center of Aide Education and Regulation, Division of Health Service Regulation

Adult Care Licensure Section, Division of Health Service Regulation

North Carolina Department of Health and Human Services

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Medication Aide in Adult Care Homes

1. A Medication Aide in adult care homes is an individual who has successfully completed the required Medication Aide course(s) approved by the N.C. Department of Health and Human Services, passed the state written medication exam for unlicensed staff in adult care homes and has competency skills validation at the employing facility.

   Any individual employed as a Medication Aide **prior to 10/01/2013** must be able to verify employment as a medication aide within the previous 24 months and completed competency skills validation and passed the state written exam for Medication Aides in adult care homes.

   All Medication Aides in adult care homes must have competency validation at the employing facility and maintain the 6 hours of continuing education requirements annually.

2. The laws and regulations governing Medication Aides in adult care homes in N.C. include: GS § 131D-4.5, GS § 131D-4.5A, GS § 131D-4.5B, 10A NCAC 13F/G .0403; 10A NCAC 13F/G .0503; 10A NCAC 13F/G .0505; 10A NCAC 13F/G .0506, 10A NCAC 13F/G .0903 and 10A NCAC 13F/G .1000.

3. The routes of medication administration in this course include the following: oral, eye, ear, nasal, inhalant, transdermal and topical. General information and skills check off for subcutaneous injections, is included in the curriculum but is only required if the task will be performed by Medication Aide.

4. Allegations of fraud against a facility or resident, resident abuse or neglect, misappropriation of property belonging to a resident or facility, or diversion of medication belonging to a resident or facility by the Medication Aide must be reported to the N.C. Health Care Personnel Registry. Substantiated findings by the Heath Care Personnel Registry are posted on the Health Care Personnel Registry.

5. It is the responsibility of the Medication Aide to notify the Adult Care Licensure Section of name and address changes.

6. Information on registration for the state written exam for unlicensed staff in adult care homes may be obtained at www.ncdhhs.gov/dhsr/acls/medtech.html or via email to AdultCare.ctu@dhhs.nc.gov. Results or verification may be obtained via website at N.C. Adult Care Medication Testing.

Introduction

In 2011, the North Carolina Legislature mandated training in addition to competency evaluation requirements for adult care home medication aides. As a response to the legislation, the North Carolina Department of Health and Human Services, Division of Health Service Regulation, has developed the required 5-hour and 10-hour training courses that include instruction in the key principles of medication administration and infection prevention.

The department developed 5-hour, 10-hour and 15-hour standardized training courses to assist qualified instructors to train unlicensed staff who will administer medications to residents in adult care homes.

Course Description

- The 10-hour training course builds upon content in the initial 5-hour training course and developed as a refresher for the employee. The 10-hour training course includes random competency validation of skills required for medication administration. A prerequisite for the 10-hour training course is successful completion of the 5-hour training course. The design of the course is for a larger class than the 5-hour training course but still limited in size to allow for interactive activities and practice of safe medication administration skills.

- The 15-hour training course was developed as another option to meet the requirements of the 5-hour and 10-hour training mandated by legislation. The course provides 10 hours of classroom instruction and 5-hours of clinical skills validation. Successful completion of this course meets the requirements for the 5-hour and 10-hour training courses. Individuals are expected to pass the clinical skills tasks with 100% competency demonstrated. The design of the course is for a larger class than the 5-hour training course but limited in size to allow for lots of practice and integration of safe medication administration skills.

The 5-hour, 10-hour and 15-hour training courses were adapted from the "***Medication Administration: A Medication Aide Training Course***" curriculum developed in 2006 by the North Carolina Department of Health and Human Services and the North Carolina Board of Nursing.

The 5-hour, 10-hour, and 15-hour competency-based curriculums provide unlicensed staff with basic knowledge and skills needed to ensure that medication administration is performed in a safe and effective manner. Successful completion of the 5-hour plus 10-hour training courses **or** the 15-hour training courses will prepare individuals to take the state written medication exam for adult care home staff.

Pre-requisite for Students

- Must be able to understand, follow and communicate written English instructions.
- Successfully complete the Pre-requisite Skills Review and Validation of the course.

Course Content

Each course has been divided into sections. Each of the sections includes core content considered to be foundations of medication administration knowledge that medication aides must know to safely and correctly administer medications in adult care homes. Curriculum pages are provided in a portrait layout with instructional content.

Medication Administration: 10/15-hour course for adult care homes:

Section A: Prerequisite: Prerequisite Skills Review and Validation	**Section G:** Infection Control
Section B: Medication Aide in Adult Care Homes	**Section H:** Medication Administration Supplies
Section C: Legal and Ethical Responsibilities	**Section I:** Administering Medications
Section D: Overview of Medication Administration	**Section J:** Medication Administration Skills Checklists
Section E: Medication Orders and the Medication Administration Record(MAR)	**Section K:** Ordering, Storage and Disposal of Medications
Section F: Using the Medication Administration Record	

Course Objectives

Section A - Prerequisite Skills Review and Validation

At the completion of this section, the student should:

1. Demonstrate correct technique in obtaining and recording a blood pressure.
2. Demonstrate correct technique in obtaining and recording a radial and apical pulse.
3. Demonstrate correct technique in obtaining and recording a respiratory rate.
4. Demonstrate correct technique in obtaining a temperature.
5. Demonstrate correct technique with assisted glucose monitoring.

Section B - Medication Aide in Adult Care Homes

At the completion of this section, the student should:

1. Identify the general role of a Medication Aide.
2. Explain the expectations of the role of a Medication Aide.

Section C - Legal and Ethical Responsibilities

At the completion of this section, the student should:

1. Recognize legal implications of negligence, fraud and diversion.
2. Recognize issues around medication administration errors.
3. Explain the resident's rights to privacy, confidentiality and refusal.

Section D - Overview of Medication Administration

At the completion of this section, the student should:

1. Demonstrate proficiency and safety in preparation of medications.
2. Recognize commonly used abbreviations and terminology related to medication administration.
3. Demonstrate proficiency in reading a medication label.
4. Identify the Six Rights to administer medications.

Section E - Medication Orders & Medication Administration Record (MAR)

At the completion of this section, the student should:

1. Transcribe orders onto the Medication Administration Record (MAR) correctly – use proper abbreviations, calculate stop dates correctly, transcribe PRN orders appropriately, copy orders completely and legibly and/or check computer sheets against orders and apply to the MAR, and discontinue orders.
2. Describe the responsibility of the Medication Aide in relation to FL-2, physician's orders and medication administration record (MAR).

Section F - Using the Medication Administration Record (MAR)

At the completion of this section, the student should:

1. Compare and contrast the documentation of routine medication administration and PRN medication administration.
2. Demonstrate the use of the Medication Administration Record (MAR).
3. Identity the three checks between medication label and MAR when administering medications.
4. Describe the action to take when a medication is not administered due to refusal or omission.

Section G - Infection Control

At the completion of this section, the student should be able to:

1. Understand the importance of hand hygiene, demonstrate hand washing techniques, demonstrate alcohol-based hand rub technique, and demonstrate the proper way of putting on and taking off clean gloves.
2. If applicable, the student should be able to understand the importance of standard precautions for assisted glucose monitoring and administering injections.

Section H - Medication Administration Supplies

At the completion of this section, the student should be able to:

Demonstrate understanding in preparing a clean, well lit and well supplied work area from which to safely administer medications.

Section I – Administering Medications

At the completion of this section, the student should:

1. Use the Six Rights to administer oral, topical, eye, ear, inhalant, and nasal medications – right resident, right medication, right dose, right route, right time, and right documentation.
2. Identify proper action to take when crushing or cutting medications in relation to medication administration.

Section J - Skills Checklists

At the completion of this section, the student should:

1. Complete the Skills Checklists without comments or instructions from your instructor/evaluator.
2. Achieve the goal of "Pass" by demonstrating the skills as outline on the checklist and completing them in the time allowed.

Section K – Ordering, Storage and Disposal of Medications

At the completion of this section, the student should:

1. Describe procedures for reordering medications and ensuring medications ordered are available for administration.
2. Describe correct storage and securing of medications.
3. Maintain an accurate inventory of controlled substances.
4. Identify the procedures for disposal of medications.

Section L – Handouts

Course Schedule

Section	10-Hour* Estimated Allotted Time in Minutes	15-Hour Estimated Allotted Time in Minutes
Section A Prerequisite Skills Review and Validation	0 minutes	30 minutes
Section B Medication Aide in Adult Care Homes	30 minutes	30 minutes
Section C Legal/Ethical Responsibilities	60 minutes	60 minutes
Section D Overview of Medication Administration	60 minutes	75 minutes
Section E Medication Orders and Medication Administration Record (MAR)	45 minutes	60 minutes
Section F Using the Medication Administration Record (MAR)	45 minutes	60 minutes
Section G Infection Control	30 minutes	45 minutes

Section	10 Hour* Estimated Allotted Time in Minutes	15 Hour Estimated Allotted Time in Minutes
Section H Medication Administration Supplies	20 minutes	30 minutes
Section I Administering Medications	60 minutes	120 minutes
Section J Medication Administration Skills Checklist	175 minutes	285 minutes
Section K Ordering, Storage and Disposal of Medications	30 minutes	30 minutes
Additional time for breaks and additional questions or training time for sections	45 minutes	75 minutes
Total	600 minutes	900 minutes

*** 10-hour training course** – For a student to complete the 10-hour training course, successful completion of the 5-hour training course is required. Estimated time for the completion of sections in the 10-hour training program varies from the 15-hour, due to the information or validation in the 10-hour training course was included in the 5-hour training course. The time needed for discussion of handouts and activities should be less than the 15-hour training course, since these were included as a part of the 5-hour training course and will be a review.

Definitions

administer – to give or direct application of a medication to the resident' body whether by injection, inhalation, ingestion or any other means

administration route – how the medication is administered or given, i.e., orally, topically, subcutaneous injection, inhalation, nasal, rectally, vaginally, etc.

adult care home – an assisted living residence in which scheduled and unscheduled personal care services are provided to two or more residents; licensed under 131D; includes family care homes

aseptic – free of disease-causing organism

cognitive impairment – altered ability to think, to reason and/or remember which interferes with the ability to function normally

controlled substances – potentially dangerous or habit-forming medications whose sale and use are strictly regulated by law; retrievable records for the receipt, administration and disposition are required

disinfect – to render free from disease-causing organism

expiration date – date after which a medication should not be used

external medications – medications administered on the outside of the body such as creams, ointments or transdermal patches

facility – an adult care home, includes family care homes

frequency – how often a medication is administered, e.g., once daily, twice daily before meals, every four hours as needed for cough, etc.

generic medication – an often lesser expensive medication that may be deemed therapeutically equivalent by U.S. Food and Drug Administration to a trade name drug, because it has the same active ingredient(s) and identical in strength, dosage form and rout of administration

medication administration record (MAR) – a legal record of the medications administered to a resident; provides instructions on what, how, and when to administer medications to a resident based on orders written by the health professional responsible for prescribing medications; a document that provides a location to document the act of administering or not administering a medication or medications to a resident

medication error – when a medication is administered in any way other than how it was prescribed

medication order – written or oral directions that a physician or other prescribing practitioner provides about a resident's medication or medications; required to administer, change or discontinue any medication to a resident

ophthalmic – related to the eye, usually refers to eye drops or eye ointment with medication administration

otic – related to the ear, usually refers to the administration of eardrops

OSHA – abbreviations for Occupational Safety and Health Administration

over-the-counter medication – medication available without a prescription; common abbreviation is OTC; require an order for administration in an adult care home

prescribing practitioner – licensed health professional with the authority by law to diagnose and treat illnesses and prescribe medications

prescription medication – any medication required by federal law or regulation to be dispensed only pursuant to a prescription

PRN order – a medication order for a medication to be administered as needed within a particular time parameter prescribed by the physician or prescribing practitioner

Standard Precautions – established by OSHA to prevent contamination by blood borne pathogens; wearing gloves when handling body fluids, wearing protective equipment and disposing of biohazardous waste

routine order – medication order for a medication to be administered over a period of time until discontinued

trade name – licensed name under which a medication prepared by a specific manufacturer is sold; also known as proprietary or brand name

Section A

Prerequisite Skills Review and Validation

Section A: Prerequisite Skills Review and Validation

Content

Blood Pressure (B/P)

- For electronic machines, check device for accuracy according to manufacturer's recommendations
- Choose correct size of cuff; blood pressure cuffs that are too small or large for the resident's arm might result in an inaccurate reading
- Report high and low blood pressures based on facility's policy or physician's order

Pulse

- Count number of heartbeats in one full minute
- For radial pulse, heart rate measured at the thumb side of the inner wrist
- For apical pulse, heart rate measured directly over the heart using a stethoscope
- May be obtained by using an electronic device
- Normal range is 60 beats/minute to 100 beats/minute

Respirations

- Number of breaths a person takes per minute
- One full breath is counted after resident has inhaled and exhaled
- Most accurate rate is taken when resident is not aware that respirations are being monitored
- Normal range is 10 to 24 breaths per minute

Temperature

- Activity, food, beverages and smoking all affect body temperature
- Temperature is measured using either the Fahrenheit or Celsius scale
- Normal oral temperature is 36.5 – 37.5 degrees Celsius or 96.7 – 99.6 degrees Fahrenheit

Section A: Prerequisite Skills Review and Validation

Fingersticks/Glucose Monitoring [ONLY REQUIRED IF MEDICATION AIDE WILL BE PERFORMING TASK]

- Know correct procedures for using (including manufacturer's instructions on cleaning and disinfecting) glucose monitoring machine and know where to locate information, if needed
- Wearing gloves when performing fingersticks and when using the glucose monitoring machine
- Lancets and lancing devices are used for only one resident and never shared
- Correctly dispose of lancets in sharps container
- Proper storage and identification of residents' supplies for assisted glucose monitoring
- Glucose monitoring devices vary greatly in how to clean and/or disinfect. It is critical to follow the manufacturer's instructions
- For lancing devices that are NOT single use devices, the device is to be labeled with the resident's name and the device is NEVER shared with another individual.

Proceed to Section B

Section B

Medication Aide in Adult Care Homes

Section B – The Medication Aide in the Adult Care Homes
Content
Role of the Medication Aide • Based on the need to provide safe care to the public, statewide uniform standards were developed for the training and competency testing for all Medication Aides involved in medication administration in adult care home settings in North Carolina. • The training for administration of medications provided in this course will prepare you at the basic level of medication administration. If you have completed the 5-hour medication training course for adult care homes, the 10-hour training course will help strengthen your skills with medication administration. • Each adult care home has policies to follow and some may have broader and more stringent policies that must be followed. Licensed capacity for adult care homes range from 2 to over 200, therefore, the medication aide's responsibilities vary greatly.
Expectations of the Medication Aide • Administer medications to residents as ordered by their physician, under the direction of the facility supervisor and administrator • Administer medications in accordance with o Established medication administration standards o Policies, procedures, and practices of the facility, based on specific licensure o Requirements of the state of North Carolina • Respect resident's right to confidentiality and privacy regarding o Health status o Diagnosis of illness o Medications • Only shares protected health information (PHI) confidentially with health care team members who need information to provide care to a resident • Follow the facility's standards in hand hygiene and infection control o Hand hygiene is an important part of infection prevention and performed in order to prevent spread of germs o Understanding standard precautions with injections and blood glucose monitoring is important to prevent spread of blood borne diseases

Section B – The Medication Aide in the Adult Care Homes

- Must follow the **SIX Rights** of medication administration
  - Identify the **Right RESIDENT**
  - Select the **Right MEDICATION**
  - Give the **Right DOSE**
  - Give by the **Right ROUTE**
  - Give at the **Right TIME**
  - Perform the **Right DOCUMENTATION**

- Follow clear, complete, specific instructions about medication administration documented on the medication administration record (MAR)

- Seek advice from supervisor or licensed healthcare professional before giving medication to the resident anytime something unusual occurs
  - Example – if resident is too drowsy to take medications, is vomiting, or cannot swallow well

- After medications are administered, correctly document that medications were taken

- Maintain security of medication cabinet or cart at all times; keep the cabinet or cart locked at all times when not in use

- Whenever you leave the work area, lock the cabinet or cart

- Respect decisions of residents who are able to make informed decisions about medications

- Follow specific facility policies/procedures and regulations regarding handling, storage, and disposal of medications
  - If the resident did not take medications, document a clear explanation of why it was not administered
  - Recognize when a medication should not be given, such as when the medication is expired, is not labeled or the label is not readable
  - Recognize that the "unsafe conditions" described above must be reported to supervisor immediately

- **REMEMBER** –The Medication Aide is the **last checkpoint** before the resident takes the medication and is an important safeguard for the residents to whom they are administering medications.

Limitations of the Medication Aide

- Medication Aide must be able to identify exactly what tasks the facility allows them to perform and what tasks they are not allowed to do legally

Section B – The Medication Aide in the Adult Care Homes

- If the resident asks questions about the medication, it is best for the Medication Aide to refer the question to the supervisor, primary physician, registered nurse, or pharmacist

- If there is something different about the resident or the medications they are taking, talk to the supervisor or primary physician prior to giving the medication

- If the resident seems to be having difficulty because of a medication, alert supervisor or primary physician immediately

- Report any errors in the administration of medications immediately to their supervisor or primary physician

Consequences of Exceeding Tasks

- If a Medication Aide exceeds those tasks and/or specific job duties outlined in this course and specific facility policy, it may result in legal or disciplinary action taken by the facility and state regulatory agencies. The Medication Aide may lose eligibility to work in certain health care areas

Adult Care Home Responsibilities for the Medication Aide

- The adult care home will have a thorough understanding and specific policies and procedures regarding your role as a Medication Aide that you must follow. Responsibilities of Medication Aide vary in adult care homes.

- As a Medication Aide, you can expect
  - Validation of your skills by employing facility
  - Orientation to facility policies and procedures regarding medication management and medication administration

Roles of Other Health Care Providers

- A healthcare provider such as a physician or nurse practitioner will diagnose disease and decide on treatments, which may include prescribing medications according to the needs of the resident

- Registered Nurse (RN) is involved with assessment, development and coordination of a resident's plan of care. Registered nurses are licensed to administer medications by all routes

- Pharmacist will dispense the medications prescribed for the resident and is a resource for questions with medications such as mixing of medications, dosing precautions

Section B – The Medication Aide in the Adult Care Homes
Medication Aide should know whom to contact: • If a resident needs an assessment/evaluation prior to administering a medication • If any questions or concerns related to medication administration • If a resident refuses medications or medications not available for administration
Proceed to Section C

Section C

Legal and Ethical Responsibilities

Section C – Legal and Ethical
Content

Legal and Ethical Standards
 	
• Ethical standards are guides to moral behavior
  o An example would be every person deserves respect and every person has her/his own beliefs
 	
• Legal Standards are guides to legal behavior
  o An example is performing her/his job according to the facility policy and state regulations

Legal Implications
 	
Negligence
 	
• When a person does not provide the standard of care that a person trained in the same way would do in a certain situation
 	
• Example – failing to give medications that have been ordered and transcribed onto the MAR
 	
• Remember
  o We, as citizens of the United States, have certain rights
  o Additionally, there are resident rights, which include being free from neglect
 	
Fraud
 	
• When a person is dishonest or cheats the system
 	
• Misrepresentation of any aspect of the job
 	
• Possible disciplinary action by the facility and may involve legal charges
 	
• Example – if a medication is charted as having been administered, but was not administered
 	
Diversion
 	
• Knowingly giving a medication to someone other than the resident the medication was prescribed for, but documenting that the medication was given to the right resident
 	
• Stealing medications
 	
• Never give medications to people whom the medications are not intended for, even when it seems harmless

Section C – Legal and Ethical

- Subject to disciplinary action and may involve legal charges

- Examples
  - If the Medication Aide takes medication intended for a resident and uses it for any other reason
  - Giving a resident's pain medication to a co-worker who has shoulder pain

Refer to HANDOUT: C-1 Medication Errors

Medication Errors

- **Definition:** when a medication is administered in any way other than how it was prescribed

- When the Medication Aide does not transcribe a physician's orders correctly, does not compare the instructions on the medication administration record (MAR), and the directions on the bottle, or the approved ways to administer the medication an error may occur

- Medication errors often have serious outcomes

- Administering medications carries a great responsibility including a need for being extremely careful and methodical

- Mistakes in giving medications are one of the most common causes of harm to residents under the care of others

- Giving the medication to the wrong resident can be a dangerous error

- Potentially serious types of errors that can occur and cause harm to the resident or residents include
  - Giving a medication to the wrong resident
  - Giving a medication at the incorrect time
  - Omitting a dose
  - Giving the wrong dosage
  - Giving an extra dose
  - Giving a medication by the wrong route
  - Giving the wrong medication
  - Or giving an expired medication

- **Medication Aide is to report errors immediately to supervisor and/or resident's physician**

- **Medication Aide is to document medication errors after notifying supervisor of error**

Section C – Legal and Ethical

- Ways to prevent medication errors
  - Always use the **SIX Rights** of medication administration
  - If the you cannot read or understand any part of the instructions on the MAR or what needs to be done to give a medication, ask supervisor before giving the medication
  - Wait to give any medication that has raised any questions or concerns until talking with supervisor or health care professional or resident's physicians; it is better to be safe than sorry

- Remember that once medication is swallowed or administered, it is too late to get it back

REMEMBER if in DOUBT – DON'T

Borrowing Medications

- Do not borrow medication from unit stock or another resident's medication supply, unless an emergency and your supervisor and a health care professional have been notified and directed you to borrow a medication
  - For a new medication, it would bypass the checks and balances needed, such as having the pharmacist check a new medication against what the resident is already taking to see if the new medication reacts with the medications the resident is already taking, if the medication is in the right dosage form or if there are allergies; these checks are done prior to the ordered medication being placed in the resident's medication supply
  - Your efforts to speed up the process by borrowing a medication from another resident may indeed cause costly negative effects for the resident, the facility, and yourself
  - Additionally, the resident you borrow from may not have the medications they need at the time they need them
  -

Refer to HANDOUT: C-3 Resident's Refusal to Take Medications

Independence and Refusal

- Encourage all residents to be as independent and participate in their medication and treatment administration, as much as can safely be done

- Occasionally, a resident will not or cannot take a medication
  - If a medication is not administered as ordered, whether refused or not given, report to supervisor and follow facility's policy
  - If a resident chooses to refuse medications, Medication Aide documents the medication was not taken
  - There will be a place to document the missed dose – either on the back of the MAR or some other designated place
  - It is important that the Medication Aide documents why the medication was not administered as ordered

Section C – Legal and Ethical

- Some Medication Aides will be administering medications to residents who are mentally impaired
  - If a resident is mentally impaired, they may not understand the benefits of their medications and may refuse them
  - If a resident is not capable of making informed decisions about their medications and they refuse to take medications, seek advice from supervisor about strategies for encouraging the resident to take medications
  - Never do anything that would be considered forcing a resident to take medication
  - For residents who are not able to give consent for medication, such as an incompetent resident, the legal guardian will provide consent
  - For residents with cognitive impairment, it is important to involve the family or resident's designee when the resident refuses a medication

Medication Administration and Resident's Rights

- **Respect** – how the resident is addressed
  - Do not interrupt a resident while eating for the administration of medications, such as oral inhalers and eye drops
  - Do not awaken resident to administer a medication that could be scheduled or administered at other times
  - Inform resident about the procedure that is about to be performed
  - Answer resident's question about medication and refer to supervisor, nurse or other health care provider when you do not know

- **Refusal** – resident has the right to refuse medications
  - Never force a resident to take a medication
  - Follow the facility's policy and procedure when a resident refuses medications (policy and procedure ensures that physician is notified in a timely manner based on resident's physical and mental condition and the medication)

- **Privacy** – being away from the public
  - Knock on closed doors before entering
  - Do not administer medications when resident is receiving personal care or in bathroom
  - Do not administer an injection outside resident's room if the resident receiving the injection or other residents present are offended by this
  - Do not administer medications outside the resident's room that require privacy and removal of clothing, such as vaginal and rectal administrations, dressing changes and treatments

- **Chemical restraints** –means a drug that is used for discipline or convenience and not used to treat a medical symptom
  Do not administer medications for staff convenience

Proceed to Section D

Section D

Overview of Medication Administration

Section D: Overview of Medication Administration

Preparing to Administer Medications

- Often the words drug and medication are used interchangeably
- Medications more commonly is used when talking about drugs used for therapeutic or helpful effects
- In this course, the word medication will be used when talking about drugs or medications used to treat residents
- Administering medications is an important responsibility and must be taken with great care. It is never an easy task and thus cannot be undertaken when you are trying to do several things at once
- In order to prevent errors and possible harm to a resident taking the medications, you must focus on this task solely
  - Do not talk to others while you or they are preparing and giving medications
  - Do not stop this task unless there is an emergency
  - Stopping and starting can cause medication errors
- Give medication to one resident at a time
  - Focus on giving all the medications for one resident before moving to another resident
  - This will help prevent getting one resident's medications mixed up with another resident's medications
  - Before taking the medications to the resident's room, mark your place in the MAR
- Remember to pour a cup (8 oz.) of water for the resident to drink with their medications.
  - When all the medications have been swallowed, encourage the resident to drink another cup of water to make sure all the medications were swallowed and moved into the stomach
  - Encouraging the resident to drink water also helps them stay hydrated
  - Oftentimes residents do not drink enough water and encouraging drinking of water at the time of medication administration will assist them in getting the amount of water they need each day
  - Giving the resident a sip of water beforehand may make it easier to swallow the medication
- Some residents take multiple pills at once
  - Ask them how they like to take their pills, one at a time or several at a time
  - If they prefer only a few at a time, assist them to take 1-2 pills at a time

Section D: Overview of Medication Administration

- It may be helpful to give medications to residents who do not need assistance first, leaving those needing assistance last

- This allows you to take the time you need to help those who need extra assistance take their medications

- Before you begin administering medications, check for any specific information needed prior to giving certain medications, such as pulse, blood pressure (BP), or blood sugar readings
  - This information is needed prior to giving certain medications to some residents
  - It is important this information be gathered as close to the time the medication is to be given as possible

- Another factor to consider when administering oral medications is how the resident is presently feeling
  - If resident is vomiting or has a change in behavior, contact your supervisor or resident's physician before administering any medication

- Resident may have various side effects from taking certain medications

- Side effects include but are not limited to the following
  - Change in behavior
  - Change in alertness
  - Change in eating or swallowing
  - Change in mobility
  - Skin rashes

- When there is a change in the resident, follow the facility's policy on what to do and who to notify, which may include
  - Notifying the supervisor, health care professional and/or physician
  - NOT administering a medication without first having contact with the resident's physician

- Observation of the resident is an important step in the cycle of medication administration
  - Resident's physician and health care providers often depend on the observations of direct care staff when evaluating residents
  - Also depend on Medication Aides to observe residents for both desired and undesired effect of medication

- To ensure safe care, the Medication Aide must know how to observe and report changes in the resident's physical and/or mental status. The Medication Aide must know what to report, to whom it should be reported, and when and how to report observations

Section D: Overview of Medication Administration

Medication Allergy

- A reaction occurring as the result of an unusual sensitivity to a medication or other substance
  - May be mild or life-threatening situation
  - May include rashes, swelling, itching, significant discomfort or an undesirable change in mental status, which should be reported to physician
- Role of Medication Aide
  - Should understand that information on allergies should be reported to the pharmacy and physician and this information is recorded in the resident's record
  - Upon admission, important to document any known allergies or if there are no known allergies should also be documented
  - Provide immediate emergency care if severe rash or life-threatening breathing difficulties occur

Medication Orders

Definition:

- The written or oral directions that a physician or other prescribing practitioner provides about a resident's medication or medications

Components of a Complete Order

- Medication name
- Strength of medication (if required)
- Dosage of medication to be administered
- Route of administration
- Specific directions for use, including frequency of administration
- Reason for administration if the medication is ordered PRN or as needed

Refer to HANDOUT D-1: Medication Orders

REMEMBER:

- An order is required to administer, change or discontinue any medication or treatment
- Contact the prescribing health care provider if the order is not legible - **DON'T GUESS!**

Section D: Overview of Medication Administration

- If an order is not complete or clear on how to administer, the medication aide must contact the supervisor or physician – **DON'T GUESS!**

Types of Medication Orders

- Four types of medication orders – routine orders, PRN orders, one time orders, and STAT orders
- It should be clear on the MAR what type of order the Medication Aide is being asked to follow
- Type of order depends on the desired effect of the medication
- Medication Aide is allowed to accept verbal orders or orders over the telephone, but obtaining a written order from the prescribing practitioner is the best and safest practice to obtain an order
- The medication orders are transferred to the MAR from the document(s) with the written orders when the orders are received. It is important the order is transferred to the MAR when the order is received. Do not wait until that medication is received.

Medication Labels

- Information required on medication labels of medications dispensed by the pharmacy:
  - Medication name
  - Medication strength
  - Quantity dispensed
  - Dispensing date
  - Directions for use
  - Pharmacy that dispensed the medication
  - Prescription number
  - Expiration date
  - Equivalency statement (when the brand or medication name dispensed is different than the brand or medication name prescribed)
- Labeling requirements for over-the-counter (OTC) medications include
  - In the original manufacturer's bottle with the resident's name, **OR**
  - Labeled by the pharmacy

Refer to HANDOUT D-2: Medication Label

Section D: Overview of Medication Administration

Common Abbreviations

- Abbreviation – a shortened form of a word or phrases
- Abbreviations are being used less often for medication administration but you still may see abbreviations
- Medication Aides need to learn abbreviations for terms common to medication administration
- On the MAR, abbreviations should be spelled out
- Be aware that abbreviations can lead to mistakes if they are not legible
- Always check with the supervisor if you have questions about abbreviations

Refer to HANDOUT D-4: SIX RIGHTS of Medication Administration

SIX RIGHTS of Administering Medications

Importance

- Safety and accuracy are important to welfare of the resident
- During a normal workday, Medication Aide may give many medications to large number of residents
- Chance of making a mistake each time a medication is given
- Anyone giving medications needs to stay focused, be organized, and careful
- Follow each and every time when administering medications; never skip them or become careless during administration
- To safeguard the resident always ask self these six questions when administering medications, which are often called **SIX Rights** of medication administration

Questions to Ask Self

- Am I giving the medication to the **right resident**?

Section D: Overview of Medication Administration

- Am I giving the **right medication**?
- Am I giving the **right dose**?
- Is this the **right route** (method of administration)?
- Is this the **right time**?
- Have I done the **right documentation**?

Right RESIDENT?

- Each time Medication Aide gives medications, the resident must be identified
- Giving medications to the wrong resident can cause serious harm
- Identify the resident who is to receive the medication by using methods outlined by facility; some facilities require identifying resident two to three different ways
- While Medication Aide may know the resident, this part of routine allows for completion of three checks in a careful manner, so do not skip it
- This habit will prevent carelessness and possibility of making a mistake now and later
- Most adult care homes have the Medication Aide perform identifying steps
  - A photo of the resident on the MAR to determine the right resident is about to take the right medicine by matching the picture with the resident
  - Require that the resident states first and last name
  - Do not ask the resident, “Are you James Jackson?” because it is too easy for the resident to say “yes” when he may not be James Jackson; particularly if the resident is confused or hard of hearing
  - Some residents are not able to state their names because they cannot talk, they may be confused or having speech impairments due to illness. In those situations, individual responses may not be realistic or accurate
- Even when Medication Aide administers medications to the same resident every day, safety measures for identifying the residents have to be in place
- If the facility has residents who are receiving medications with similar names, be certain to have an alert on the MAR; date of birth could be a better identifier, such as Leigh Chan and Lee Chang
- Do not use room numbers as an identifier because

Section D: Overview of Medication Administration

- There may be more than one resident in the room
- A confused resident could have wandered into the wrong room and crawled in bed
- Administration may have moved resident into a different room
- Resident could have been discharged and Medication Aide not aware prior to administering medications

- Some people may answer yes to another resident's name trying to get additional medications or trying to jump ahead of other people; particularly true if residents do not understand that medications can be different for different people or if the residents are confused

- If Medication Aide prepares medications away from the resident taking them, it is important to keep the MAR with the medications until the medications are taken, so that the wrong medicines are not accidentally given to wrong resident

- Important that Medication Aide keeps identifying information with the medications from the point of preparation to the point of giving medication to the resident

Right MEDICATION?

- Medication Aide must always refer to MAR when giving medications; never give medications from memory

- Three medication checks should always be done when giving medications to make sure Medication Aide has the right medication

- During the three medication checks, Medication Aide will not only make sure a particular medication is labeled for a particular resident, but during process Medication Aide also makes sure that medication name, dose, time, and route on the medication label matches information on the MAR
  - Check the medication name, dose, time and route on the package against the MAR when container is removed from shelf, drawer, or other storage place
  - Check medication name, dose, time, and route on the actual drug package or unit dose label against the MAR as medication is poured, package is opened, or before the medication is placed in the medicine cup
  - Check the medication name, dose, time, and route on package when medication container is returned to the shelf, drawer or storage place, or before it is opened and place in the medicine cup, just prior to giving the medication to the resident

- May feel like you are overdoing the checking, but it is this careful practice that will prevent medication errors

Section D: Overview of Medication Administration

- Do not be lulled into poor and unsafe practices because medication administration is done day in and day out
- Many adult care homes use medication packaging that helps to reduce errors such as unit dose, punch cards of medications, etc.
- Be alert for similar sounding names for medications while making right medication choices
- Never give a medication that you cannot identify by a written medication label or that is found at the resident's beside
- Best and safe practice is to never give a medication prepared by someone else

Right DOSE?

- Medication Aide must make sure the right dose is about to be administered by comparing medication label to the MAR; MAR will state exactly how much medication is to be given
  - For example, if digoxin 0.25 mg is to be given and the supply is digoxin 0.125 mg., two tablets must be given to equal the right dose
  - It is best for the MAR to state to give two tablets of digoxin 0.125 mg (0.125 mg + 0.125 mg = 0.25mg)
  - If instructions are not clear, ask for them to be made as clear and complete as possible to help prevent medication errors
- To help prevent medication dosing errors, a zero (0) should always precede a decimal but should not follow a decimal
  - For example, if the 0 is not present in the example above, the decimal might be missed and instead of giving 0.125 mg. of digoxin it might incorrectly be read as 125 mg of digoxin which would be deadly
  - If the dose of medication ordered is 1 mg and the order is written on the MAR as giving 1.0 mg, the decimal might again be overlooked and the MAR might read to give 10 mg of the medication, which would mean that the resident would be getting 10 times the dose ordered
- Another common right dose error is for people to mix up the abbreviations of ml (or mL) for milliliter and the abbreviation of mg for milligram
  - For example, a 1 ml dose does not equal 1 mg
  - Mixing up those abbreviations can result in dosage error

Refer to HANDOUT D-5 Decimal Point and Zeros

Refer to HANDOUTS: D-6 Common Routes of Medication Administration, D-7 Common Dosage Forms

Section D: Overview of Medication Administration

Right ROUTE?

- Right method of administration, such as whether a medication is given by mouth, in the ear, or eye, or if it is to be applied to the skin

- The route of medication administration will be noted on the MAR; if it is not, stop and ask supervisor

- Do not make assumptions about how to give a medication

- **Oral Routes**
  - Referred to as oral or PO – meaning by mouth
  - Medication is placed in mouth and swallowed
  - Certain people cannot take oral medications; people who cannot swallow well, such as, residents who do not have a gag reflex and choke easily, are confused, refuse to take medications by mouth, or are not to have anything by mouth
  - NPO - meaning nothing by mouth

- **Sublingual**
  - Placed under the tongue and allowed to dissolve and be absorbed under the tongue
  - Dissolves quickly and gets into blood stream quickly
  - Resident not to swallow tablet, nor to smoke, drink or eat while this tablet is under tongue

- **Topical Route**
  - Delivers medication directly to the area needing treatment or may allow medication to be absorbed to affect the entire body
  - These medications can be a variety of preparations including drops or ointment into the eye, drops into the ear, sprays in the nose or throat, suppositories in the rectum or vagina, and creams or ointment on the skin
  - Areas for topical medications are skin, eyes, ears, nose, throat, vagina, and rectum
  - Some topical medications affect the entire body, such as patches applied to the skin

- **Inhalation Route**
  - Delivers medication to lungs through an inhaler or aerosol
  - One way this medication is taken in is with an inhaler and a tube that is called a “spacer” or a disc device that allows the powder form of the medication to be pushed toward the back of the mouth and inhaled
  - Many different types of devices for inhalants
  - Become familiar with device before assisting someone with their inhaled medications

- **Subcutaneous**
  - Delivers medication to the subcutaneous (fat) layer of the body using a syringe and needle

Section D: Overview of Medication Administration

Right TIME?

- Make sure you give the medication at the **Right TIME**
- The time to give a medication is stated on the MAR
- Individual adult care homes will have set standard times for administration of medications
  - If a medication is to be given BID, meaning twice a day, then the facility may set those times to be 10 am and 10 pm
  - When a medication is ordered before (a.c.) or after (p.c.) meals, it should be given 30 min. before or after meals
- Medications that are given once a day should be given at the same time each day to keep the right amount of medicine in the resident's system
- Set times within a facility helps to prevent missed or doubled doses, which can be harmful to the resident receiving the medications
- The Medication Aide should not give the medication too early because it could be too much medication in the resident's system at one time
- Medication needs to be given within a set amount of time to provide the resident with the correct dose of medication at the right time that allows the medication to work as it should
  - For example, if a medication is fighting an infection and doses are given at time spans between doses too far apart, the infection may get worse, making it harder to treat
- The window of time for the medication to be given is one hour before or one hour after the time stated on the MAR; medications should be administered within this designated time frame
- If Medication Aide is unsure about giving the medication because it is outside the designated time frame, i.e., a medication was missed, a medication just arrived from pharmacy or a resident has returned to the facility after medications were administered, always check with supervisor, nurse, pharmacist or the resident's physician to determine if the medication should be administered or not administered; never omit a medication without contacting your supervisor, nurse, pharmacist or resident's physician because a resident was out of the facility when medications were administered

Section D: Overview of Medication Administration

- Timing of medications in relation to meals
  - Before meals – medication administered about 30 minutes prior to the resident eating meals
  - With meals – medication administered while the resident is eating meals
  - After meals – medication administered directly after the resident has finished eating meals up to 30 minutes afterwards

- Always check the time the last dose of a PRN medication was given before giving the new dose; if ordered time has passed since the last dose, the medication can be given

Right DOCUMENTATION?

- May have heard people say, "If it is not documented, it is not done."

- Documentation is important
  - If documentation is not completed there is no way to know that a medication has been given
  - Without correct documentation, there is a danger the resident will get the medication twice, possibly causing them great harm to miss receiving an ordered medication

- Medication Aide must document medications *immediately* on the MAR after each resident's medications are administered and prior to administering another resident's medications

- Do not chart or document medication before the resident actually takes it (called pre-charting)
  - Many things can happen between the time preparation area is left and when the resident actually swallows the medication
  - Always chart or document after the resident takes the medication

- After administering a PRN medication to a resident, the Medication Aide must document the date and time the medication was given on the MAR

- Immediate, clear, and accurate documentation shows that the **Right DOSE** of the **Right MEDICATION** was given to the **Right RESIDENT** at the **Right TIME on the Right DATE** by the **Right ROUTE**

Proceed to Section E

Section E

Medication Orders and Medication Administration Record (MAR)

Section E Medication Orders and the Medication Administration Record (MAR)
Content
Review the definition of a medication order • The written or oral directions that a physician or other prescribing practitioner provides about a resident's medication or medications
Refer to HANDOUTS E-1: FL-2 and E-2: Medication Administration Record (MAR)
Forms Commonly Used to Document Medication Orders • Forms commonly used to document medication orders and medication administration can be confusing to unlicensed people who are unfamiliar with the process • Examples of main forms used in most adult care homes o FL-2 o Physician's Order Forms • Medication Aides must know how to use these forms to ensure safe medication management and compliance with laws and regulations
Forms Commonly Used to Document Medication Orders– FL-2 • FL-2 form is required for new admissions in adult care homes • Important: all information on FL-2, and any admission documents with orders is reviewed for accuracy • If any clarification is needed, contact prescribing practitioner • If FL-2 has not been signed within 24 hours of admission o Verify orders with prescribing practitioner by fax or telephone o Document verification in resident's record, for example a note in the progress notes or orders may be rewritten as telephone orders and signed by prescribing practitioner; orders could also be faxed to prescribing practitioner for review, signature and date
Form Commonly Used to Document Medication Orders – Physician's Order Forms • Used to record prescribed medication and treatment orders • Any form used for physician's orders and medication orders must be retained in the

Section E Medication Orders and the Medication Administration Record (MAR)
resident's record.
Forms Commonly Used to Document Medication Orders and Medication Administration – Medication Administration Record (MAR) • Form onto which medication and treatment orders are transferred • Record of all medications and treatments ordered to be administered • Record of staff who administered medications • Record of medication not administered and the reason
Medication Orders and the MAR • A licensed person prescribes or writes a medication order in the resident's record or medical record • The medication order is then copied or transcribed onto the MAR. The MAR provides the instructions to the Medication Aide for administering medications
Transcription of Orders Onto MAR • Transcribe means to write down or to copy o In medication administration it means to copy medication or treatment orders onto the MAR • Orders are copied onto the MAR when the order is obtained or written o Initial or sign and date orders written on the MAR o Transcribe using proper abbreviations or written out completely; include all components of a medication order o Count number of dosages to be administered instead of number of days when calculating stop dates for medication orders that have been prescribed for a specific time period, such as antibiotics o Do not schedule PRN orders for administration at specific times; they are administered when resident "needs" the medication for a certain circumstance • A discontinue order must be obtained for an order to be discontinued, unless prescribing practitioner has specified the number of days or dosages to be administered or indicates that dosage is to be changed
Information on the MAR • All the information needed for medication administration must be clearly written on the MAR

Section E Medication Orders and the Medication Administration Record (MAR)

- MARs should include:
  - Resident's name (right resident)
  - Room or bed number (if applicable)
  - Facility number (if applicable)
  - Medication name (right medication)
  - Strength of dose or amount of medications to give (right dose)
  - Date and time to be given (right time)
  - Route to be given (right route)
  - Date the order was written
  - Date the order expires
  - Resident's allergies (if they have any)
  - Special instructions
  - Reason why PRN medication is being given (for example PRN medication for headache)
  - Initials of the personnel transcribing the physician's order to the MAR

- The MAR is kept current and accurate

Electronic MAR

Some adult care homes may use an electronic MAR (eMAR) that requires staff to document information and administer medication administration on the computerized MAR. The information on an eMAR for administration is the same information that would be found on a paper MAR.

The MAR and the SIX Rights of Medication Administration

- It should be clear to the Medication Aide from the MAR
  - What is to be given **(Right Medication)**
  - How much is to be given **(Right Dose)**
  - Who is to get the medication **(Right Resident)**
  - When it is to be given **(Right Time)**
  - How it is to be given **(Right Route)**
  - After administering the medication(s) where to document on the MAR that the medication was given **(Right Documentation)**

Proceed to Section F

Section F

Using the Medication Administration Record

Section F – Using the MAR During Medication Administration
Content
The MAR and Medication Administration • Always refer to the MAR when administering medications to make sure the right medication is given to the right resident at the right time • **Do NOT Ever Give Medications From Memory!!!** • **The medication aide uses the MAR when preparing and administering medications. Compare the label on the medication container to the order on the MAR three times** o The **first** check is when selecting or removing the medication from the storage area o The **second** check is before or after opening the medication and pouring the medication o The **third** check is after pouring the medication and before returning the medication container to the storage area or before you give the medications to the resident • Always double check that the medication prepared is the one that should be given at the designated time as listed on the MAR • The MAR is designed to promote safe and accurate medication administration. • The Medication Aide should always ask the supervisor about anything on the MAR that is not clear, to keep from making medication errors • **Remember, If in doubt, ASK** • Whenever medications are given, the Medication Aide will need to initial the MAR under the **Right TIME and DATE**, which is known as **Right DOCUMENTATION**
The MAR and Special Instructions • Many medications have special instructions in addition to the dose, time and route • These instructions are listed on the medication label and may also be on the MAR • If the instructions are unclear, ask supervisor prior to preparing the resident's medications

Section F – Using the MAR During Medication Administration

- Plan accordingly if there are certain things that need to be done before or during medication administration
  - Shake the medication well
  - Keep the medication refrigerated
  - Have the resident drink a full glass of water with this medication
  - Have the resident take the medication on an empty stomach or before eating
  - Have the resident take the medication with food
  - Have the resident take the medication after eating
  - Do not take the medication after eating
  - Do not take the medication with certain foods
  - Instruct the resident not to eat or drink 30 minutes after taking the medication
  - Have the resident sit up for ½ hour (30 minutes) after taking the medication
  - Crush the medication and mix it with a food product, such as applesauce or pudding

- Some labels include auxiliary stickers that include instructions such as do not crush

General Information for Documenting Administration of Medication on the MAR

- Sign the MAR only after observing the resident take the medications
  - Pre-charting is not permitted and this includes signing the MAR any time prior to the medications being administered
  - The MAR is signed immediately after observing the resident take the medication and prior to the administration of another resident's medication

- The MAR has a space where the Medication Aide initials that a dose is given under the correct day and time
  - Place your initials in the box that corresponds with the date and time for the medication given
  - If the medication is given more than once daily, initial in the appropriate box each time

- Resident's refusals and any omission of a medication must be documented on the MAR
  - Documentation on the MAR is to include the date and time the medication was to be administered, the reason the medication was refused or omitted and the initials of the Medication Aide
  - Often, initials are placed and circled in the appropriate box that corresponds with the date and time for the medication and the other information is provided on the back of the MAR
  - Remember to always follow-up with the supervisor for any refusals or omissions

- Each entry must be clearly recorded accurately and completely

- Use the ink color approved by the facility

Section F – Using the MAR During Medication Administration

- Do not erase or cover errors
- If an error is made in the recording that a medication has been given, follow facility's policy to correct documentation
- The facility will have a policy for documentation on the MAR, including for refusals and omissions

Documentation of PRN Medications

- Depending upon the adult care home, PRN medications may be recorded on the same MAR or a separate MAR
- A reason must be documented when a PRN medication is administered
  - Record symptoms that resident reports and signs that are seen, such as temperature 101^{o} F
  - For example, write 101^{o} F if Tylenol is given for an elevated temperature
- Follow the facility's policy regarding documentation of PRN medications
  - Include the amount administered, the time of administration and the reason for administration
  - The reason a PRN medication is to be administered is to be indicated in the order
- Document the effectiveness of the medication when determined
  - The resident will need to be checked on after the PRN is administered to determine the effectiveness of a PRN medication
  - If the PRN medication is reported as not effective, the Medication Aide will need to notify the supervisor and information documented
- If a resident is requesting or requiring administration of a PRN medication on a frequent or routine basis, report this to the supervisor or the physician
- Administer PRN medications when resident needs the medication but they may not be administered more frequently than the physician has ordered
- The need for medication may be based upon resident's request for the medication or observation by staff, i.e., resident exhibiting pain but does not request medications or may not be able to request the medication

Section F – Using the MAR During Medication Administration

Initials and Signatures

- Always initial and sign the signature sheet or the part of the MAR sheets on which initials are to be identified
  - This signature associates the Medication Aide's name to the initials used on the MAR
  - Allows for clear tracking of who gave what medications
  - Important that the Medication Aide initials each sheet of the MAR and writes name on the MAR in the space provided

- Location of the initial/signature is different on different forms, but signature blocks are usually located at the top or bottom of the MAR
  - Some facilities have a signature sheet that is kept in a special place such as the front of the MAR notebook

- **Key point** here is that all adult care homes will have some form for documentation of medications administered and a place for the Medication Aide to identify initials

- The Medication Aide must sign the designated page with initials on it once per sheet, per month, depending upon facility policy
  - For example, if Medication Aide is giving medications to the same set of residents day in and day out and has already signed the MAR, does not have to sign the sheet again
  - When a new sheet is put in the MAR and the Medication Aide is giving medications from it, it must be signed and initialed

Recheck MAR

- When the medication pass is complete, recheck the MAR to make sure all medications have been administered and documented appropriately

Proceed to Section G

Section G

Infection Control

Section G – Infection Prevention Practices
Content
Important Infection Control Concepts During Administration of Medication • Use sanitary technique when pouring or preparing medications into appropriate container • Do not touch or handle medications, but pour medication from the original medication container into a new, appropriate medication container; give the new container to resident • Never use your own hands to administer medications and never require resident to have to use his/her own hands to receive medications
Standard Precautions • Observe Standard Precautions • Wear gloves when there may be exposure to bodily fluids or mucus membranes, such as the vagina, rectum, inside of the nose, and the eyes • Wash hands with soap and water; or with an alcohol-based hand rub if hands are not visibly soiled or if there has been no contact with bodily fluids • Wash hands before and after removal of gloves • Wash hands before and after using shared medical equipment • Gloves should be worn and hand hygiene must be performed when transdermal products, i.e., Nitroglycerin or Durgesic patches, are applied or removed **Syringes, Needles and Vials** • Cleanse the tops of medication vials with 70% alcohol before inserting a needle into the vial • Never administer medications from the same syringe to multiple patients, even if the needle is changed • Do not reuse a syringe to enter a medication vial or solution • Do not administer medications from single-dose or single-use vials, ampules, bags or bottles to more than one resident

Section G – Infection Prevention Practices

- Multi-dose vials should be used for a single resident, whenever possible
- Dispose of used syringes and needles at the point of use in a sharps container that is closable, puncture-resistant, and leak-proof
- Never recap, bend or break needles

Gloves

- Most common type of Personal Protective Equipment worn with medication administration
- Description
  - Non-sterile (clean) gloves made using different materials, such as vinyl or latex; if allergic to latex, wear non-latex gloves
  - Come in different sizes

Gloves – Rules

- Should be worn once and then thrown away
- When wearing gloves, always work from (or touch) a clean area, before touching contaminated (or dirty) area
- Change gloves if hands are going to move from a body part that is contaminated (dirty) to a body part that is not contaminated (clean)
- Change gloves right away if dirty or torn
- Take gloves off carefully and do not touch skin or clothes with dirty sides of gloves
- Do not touch anything with dirty gloves that anyone may touch without gloves, like a doorknob
- Should be comfortable – not too loose or not too tight

Gloves – When to Wear

- Wear gloves any time you will or think you will come into contact with blood or body fluids (urine, stool, spit, mucus coughed up)
- Wear gloves any time you will or think you will come into contact with non-intact skin

Section G – Infection Prevention Practices

(opened up skin, such as sores or cuts)

- Wear gloves any time you will or think you will come into contact with mucus membranes (linings of natural body openings)
  - Inside or outside of the rectum
  - Inside of the mouth
  - Inside of the nose

- **Examples of when to always wear gloves:**
  - When you might touch blood, body fluids, non-intact skin, or mucus membranes
  - Providing or assisting with mouth care
  - Wiping a nose that is draining
  - Providing perineal care (the genitals and the buttocks)
  - Caring for a resident with cuts and sores
  - Performing a finger-stick blood sugar
  - Touching a surface or equipment that is contaminated or may be contaminated
  - If staff has open sores or cuts on own hands

Gloves – How to Put On (Don)

- Select correct size and type
- Insert hands into gloves
- Interlace fingers and smooth out folds creating a comfortable fit; and
- Carefully look for tears, holes, or discolored spots
- Special notice: when gloves and gown must be worn, ensure that each glove is extended over the gown cuff

Gloves – How to Remove

- Grasp outside edge of one glove near wrist
- Peel glove away from hand turning glove inside-out, with contaminated side on the inside
- Discard
- Wash hands

Section G – Infection Prevention Practices
• Being careful not to touch outside of the glove, peel off second glove from inside, creating a bag for both gloves • Hold the removed glove in the opposite gloved hand • With ungloved hand, slide one or two fingers under the wrist of the other glove
Proceed to Section H

Section H

Medication Administration Supplies

Section H: Medication Administration Supplies
Content
Prepare and maintain the work area for medication administration • Prior to beginning to give medications, you must prepare the work area whether that is a medication cart, medication room or medication counter • Gather all the supplies you will need • Supplies vary from facility to facility • Start with a clean area or cart • Giving medication requires clean technique • Wash your hands • Make sure the area is as well lit as possible
Medication Administration Supplies **The medication cart or work area should be stocked with supplies, such as:** • Alcohol wipes – little squares of material saturated with alcohol that come in handy for cleaning off skin before performing an injection, the mouthpiece of inhalers, stethoscopes, and other small areas • Alcohol-based hand rub or hand wipes – to cleanse hands and to protect you and resident from transferring germs • Clean Gloves in your size – to use when needed and to protect you and the resident from transferring germs • Surgilube – lubrication that is used for administration of vaginal or rectal medications • Band-Aids – small covering for puncture sites after performing an injection or used on other small areas of the skin and held in place with adhesive • Tape and gauze – small squares of fabric used to cover topical medications and held in place with surgical tape • Pill cutter – device used to cut a pill

Section H: Medication Administration Supplies

- Pill crusher or Mortar and pestle – device used to crush a pill
- Tissues – thin squares of paper used for dabbing or wiping off topical medication
- Tongue blades – thin wooden structures used to apply topical medication to sterile gauze
- Spoons – plastic device used to stir medications or scoop out food products and never used to measure medication
- Disposable drinking cups – used for drinking water and also for mixing powder medications
- Straws – thin tubes used by some residents to assist with drinking water or other fluids after taking medications by mouth

- Soufflé cups – small paper disposable medication cup with pleated sides and often used to hold tablets or capsules after removal from containers
- Metered or measured plastic cup – small plastic disposable medication cup used for liquids or pills
- Other devices for measuring liquid medications such as oral syringes or metered/measured medication droppers or spoons (used for amounts less than 5 ml or when dispensed with a liquid medication)
- Medication Administration Record (MAR) – review prior to starting and used during medication administration for accurate medication administration and documentation
- Medication cart/cabinet – centralized location of medications in a facility
- Water pitcher filled with fresh water
- Juices and any food products used in giving medications

Security of Medication Storage Areas

- While you are working as a Medication Aide, you are responsible for all the medications
- You must keep the medication storage area or cart locked at all times when you are not using it
- You will keep the keys with you for your entire work period, unlocking and locking each and every time you step away from the area or cart

Section H: Medication Administration Supplies

- If you are called away in an emergency, remember to lock the cart or area prior to leaving it
- Do not give the medication keys to residents or other facility personnel
- Follow your facility's policy regarding maintaining security of medications

Key Points

- When in doubt – **ASK!**
- Whenever you leave the work area, lock the cart or area
- Do not leave medications unattended on top of the cart or counter! Keeping the medication storage area locked prevents unauthorized access to medications by residents or other staff
- Throw away trash according to your agency's policy. Keeping your work area free from trash will help to prevent the spread of germs
- Cleanse hands often
- Keep all medication keys issued to you on your person at all times

Proceed to Section I

Section I

Administering Medications

Section I – Administering Medications
Content

Administering Oral (Solid) Medications
 	
Overview and Concepts
 	
• Some residents take multiple oral medications at once
  o Ask them how they like to take their pills, one at a time or several at a time
  o If they prefer only a few at a time, assist them to take 1-2 pills at a time
 	
• Remember to pour a cup (8 oz.) of water for the resident to drink with medications
  o When all the medications have been swallowed, encourage resident to drink another cup of water to make sure all the medications were swallowed and moved into the stomach
  o Encouraging the resident to drink water also helps them stay hydrated
  o Oftentimes residents do not drink enough water and encouraging resident to drink water at the time of medication administration will assist them in getting the amount of water they need each day
  o Giving the resident a sip of water beforehand may make it easier to swallow the medication

Types of Oral (Solid) Medications
 	
• **Tablet**
  o Hard, compressed medication in round, oval, or square shape
  o Some have enteric coating or other types of coatings, which delay release of the drug and cannot be crushed or chewed
 	
• **Capsule**
  o In a gelatin container that may be hard or soft
  o Dissolves quickly in stomach

Absorption Rates • When administering oral medications, it is important to administer at the time prescribed or scheduled • Oral medications are absorbed (used by the body) at different rates depending on various factors such as the content of the resident's stomach (empty or full)

Section I – Administering Medications

Cutting Medications

- Sometimes medications have to be cut in half to get the correct dose
- This should be clear on the MAR
- Use a pill cutter to divide a pill into half for the dose
- If the pill cuts unevenly, then the pill is to be thrown away and a new pill is cut (a replacement pill will need to be ordered)
- Always clean the pill cutter with an alcohol wipe after using it so that the next Medication Aide using it will not be mixing medications
- Be careful not to cut self on the razor sharp blade
- Discuss with supervisor if medication needs to halved
- When the prescribed dose is for only half a pill
- Follow the facility's policy on disposal of the other half of medication

A DO NOT CRUSH list is available from the Institute for Safe Medication Practice at: www.ismp.org/tools/DoNotCrush.pdf.

Crushing Medications

- Medication may need to be crushed if no liquid form of a medication is available and resident cannot swallow an oral solid medication
- MAR should state if a medication is to be crushed; Medication Aide will not make the decision whether to crush a tablet or not
- If it is not clear on the MAR, ask supervisor to provide clear instructions
- Several methods to crush a pill
  - Mortar and pestle or a pill-crushing device
  - Crushed in its package if only one pill is in the package
  - Placed between two clean small paper medication soufflé cups and crushed with a pestle or other crushing device

Section I – Administering Medications

- After crushing medication, clean tools that come in contact with the medication with alcohol or soap and water, being sure to dry them before returning them to storage

- When a medication is crushed it will taste bitter and is common to mix medication with small amount of food to help the resident tolerate the taste as they take the now bitter medication
  - Example, applesauce or pudding
  - Mix the crushed medication with as little applesauce or pudding as possible because if too much applesauce or pudding is used, the resident may not be able to eat it all or refuse to eat it all and thus not get all the medication
  - Never leave medication in food unattended, because another resident may come by and eat the food, accidentally taking the medication, which will be a medication error and can be very dangerous

- Offer resident sufficient fluids following the administration of oral medications even if the medication is administered in a food substance

- Observe the resident taking the medication to assure the medication is swallowed before documenting the administration of the medications
- Not all medications can be cut or crushed; do not ever cut or crush a pill that has an enteric (hard shell) coating, a capsule, or a pill that is sustained release or time released
  - Enteric-coated pill has a protective hard shell coating that allows it to pass through the stomach, without dissolving, to be absorbed in the small intestines
  - Enteric-coated medications designed to be swallowed whole and if cut or crushed, could burn a hole in the esophagus, stain the teeth, or not be absorbed because the stomach destroys the medication before it begins working
  - Capsules and sustained release medications are made to be absorbed over time and if cut open, lose that feature.
  - Cutting or crushing time-released medications can result in the resident getting an overdose of the medication because it is absorbed all at once instead of being released over a longer period of time
  - There is an extensive list of medications that cannot be crushed; however, Medication Aides are not to have to make a decision about cutting or crushing a medication because instructions should be clear on the MAR

Administering Liquid Medications

Overview and Concepts

- A common way to administer medications

- Come in many forms – solutions, suspensions, syrups and elixirs

Section I – Administering Medications

- Need to be aware extra care needs to be taken when measuring liquids and that Medication Aide should plan on taking more time
- Liquids may have administration requirements such as Shake Well or Requires Dilution prior to administration
  - Examples of these liquids are Dilantin Suspension, which must be shaken thoroughly because the medication settles and gives inconsistent dosing; liquid Potassium and bulk laxatives must be mixed with sufficient fluids to decrease side effects

Types of Liquid Medications

- Solution – a liquid containing dissolved medication
- Suspension – a liquid holding un-dissolved particles of medication and must be shaken before measuring and administering to resident
- Syrup – a liquid medication dissolved in a sugar water to disguise its taste
- Elixir – a sweet alcohol based solution in which medications are dissolved

Refer to HANDOUTS I-1: Review of Measuring Devices; I-2 Always and Never; I-3 Measuring Tips

Administering Liquid Medication Using a Medication Cup

- Do not mix liquid medications together
- Never approximate the amount of medication to be administered, such as liquids
  - Always use the correct measuring device when measuring liquid medications
  - Never use household measurements or spoons such as a teaspoon or tablespoon to measure medication doses because of inaccuracy
  - To administer liquid medications, use a small, clear, graduated medicine cup with measurements on the side
  - Use a calibrated syringe for measuring liquids in amounts less than 5 mL and unequal amounts
- Measure liquid medications on a flat, level surface at eye level to make sure that amount is correct
- When pouring liquid medications, hold the label under the hand so that the medication flows from the side opposite the label preventing the liquid from running down the container and stain or obscure label
- Liquids are prepared in separate cups from pills and tablets

Section I – Administering Medications

- To prevent contaminating the remaining medication, never pour excess medication back into the bottle
- Dispose of the excess medication per facility policy
- Ensure resident is sitting upright before administering liquid medication to a resident

Administering Liquid Medication Using a Medication Dropper

- Some medications come packaged with a medication dropper with measurements on the side
- If a medication comes with a special dropper, use that dropper only when giving that medication
- Keep dropper with the medication
- Some manufacturers have you replace the cap with the dropper/cap so that it is always ready for use to prepare the correct dose of medication.
- Liquid medications may have a oral dropper/syringe specifically for measurement of dose; the name of the medication and the strength of the medication will be printed on the dropper / syringe and should be used to only measure the medication identified on the dropper/syringe
- Be careful and note measurements on dropper are in mg or ml and prepare resident's dose appropriately
- Increase chances of making a dosing error if a different measuring device is used
- When using a special dropper to administer liquid medicine
  - Draw up the accurate dose of medication and put it into a medication cup to deliver it to the resident
  - Do not use the dropper to give the resident the oral medication because that will contaminate the dropper and in turn contaminate the remaining liquid medication

Section I – Administering Medications

Sublingual Medications

- Place the medication under the resident's tongue
- Instruct resident not to chew or swallow the medication
- Do not follow with liquid, which might cause the tablet to be swallowed

Oral Inhalers

- Spacing and proper sequence of the different inhalers is important for maximal drug effectiveness
- The prescribing practitioner may specifically order the sequence of administration if multiple inhalers are prescribed or the pharmacy may provide instruction on the medication label or MAR
- Wait at least one minute between puffs for multiple inhalations

Refer to HANDOUT 3-E: Oral Inhalers

Eye Drops and Ointments

- Wash hands prior to and after administration of eye drops and ointments
- Follow standard precautions
- Wear gloves as indicated
- Always wear gloves when there is redness, drainage or possibility of infection
- Wait a 3- to 5- minute period between medication when two or more different eye drops must be administered at the same time
- Do not touch eyes with dropper or medication container

Nose Drops and Nasal Sprays/Inhalers

- Wash hands before and after

Section I – Administering Medications

- Gloves are to be worn as indicated

- **For drops**
  - Resident should lie down on his/her back with head tilted
  - Request the resident to remain in the position for about 2 minutes to allow sufficient contact of medication with nasal tissue

- **For Sprays**
  - Hold head erect and spray quickly and forcefully while resident "sniffs" quickly
  - Have the resident tilt head back to aid penetration of the medication into the nasal cavity, if necessary

- Wipe dropper or sprayer with a tissue before replacing the cap

Transdermal Products/Patches

- Rotate application sites for transdermal patches to prevent irritation

- Document application sites on the MAR

- If the patch is ordered to be worn for less than 24 hours, document on the medication administration record that the patch was removed and the time it was removed

- Wear gloves and wash hands after patch is applied or removed

- When a patch is removed, clean the area to remove residual medication on the skin

Topical Medications

- Wear gloves and use tongue blade, gauze or cotton tipped applicator to apply medication

- Use a new applicator each time medication is removed from container to prevent contamination

- Provide privacy.

- Place the lid or cap of the container to prevent contamination of the inside surface

- Do not discard gloves and supplies in areas accessible to residents

Section I – Administering Medications
Injections • Never recap syringes • Dispose of syringes in appropriate sharps containers • Wash hands before and after • Wear gloves
Proceed to Section J

Section J

Medication Administration Skills Checklists

Medication Administration Skills Checklists

During the Medication Administration – 10/15-hour Training Course, you will be tested on skills listed below. You will be expected to do the skills without comments or instruction from your instructor/evaluator.

The goal is achieve a "Pass" by demonstrating the skill as outlined on the checklist and completing the skills in the time allowed. Errors that affect the safety of the resident receiving the medication or the Medication Aide will require a Redo. An example of such an error is not performing the SIX RIGHTS of Medication Administration.

SKILL SETS:

1. Handwashing
2. Alcohol-based Hand Rub
3. Putting On and Removing Gloves

4a. General Medication Administration Preparation Step

4b. General Medication Administration Subsequent Steps

5. Oral Medication Administration
6. Sublingual Medication Administration
7. Oral Inhalant Medication Administration
8. Eye Medication Administration
9. Ear Medication Administration
10. Nasal Medication Administration
11. Transdermal Medication Administration
12. Topical Medication Administration

Optional (if employee will perform skill)

13. & 14. Injections-Insulin Administration

Skill #1: Handwashing

Student Name _____

Steps	Performed Correctly?	
	Yes	**No**
1. Either remove watch or push it up higher on your arm		
2. Do not lean against the sink and do not touch the inside of the sink with your hands or wrists during the hand wash		
3. Wet hands with warm water, pointing your fingertips down		
4. Apply about a teaspoon of hand soap to the palm of your hand		
5. Wash all surfaces of the hands and wrists, using friction, for a minimum of 20 seconds, including: • Palms • Backs of hands • Wrists • Fingers, thumbs, and under nails		
6. Rinse hands with water, pointing your fingertips down, without touching the sink		
7. Use one dry paper towel to dry hands		
8. Use a new paper towel to turn off water and open door		
9. Throw paper towels in trash		

☐ **Pass** ☐ **Redo**

Comments:

_____ _____

Evaluator Name/Credentials **Date**

Skill #2: Alcohol-based Hand Rub

Student Name _____

Steps	Performed Correctly?	
	Yes	**No**
1. Apply alcohol-based hand rub to a cupped hand		
2. Rub all surfaces of the hands and wrists, using friction, until dry (at least 15 seconds), including: • Palms • Backs of hands • Wrists • Fingers, thumbs, and under nails		

☐ **Pass** ☐ **Redo**

Comments:

_____ _____

Evaluator Name/Credentials **Date**

Skill #3: Putting On (Donning) and Removing Gloves Check-off

Student Name _____

Putting on (Donning) Gloves

Steps	Performed Correctly?	
	Yes	No
1. Select correct size and type of gloves		
2. Insert hands into gloves		
3. Interlace fingers and smooth out folds creating a comfortable fit		
4. Carefully look for tears, holes, or discolored spots in each glove		

Removing Gloves

Steps	Performed Correctly?	
	Yes	No
1. Grasp outside edge of one glove near wrist		
2. Peel glove away from hand turning glove inside-out, with contaminated side on the inside		
3. Hold the removed glove in the opposite gloved hand		
4. With your ungloved hand, slide one or two fingers under the wrist of the remaining glove		
5. Being careful not to touch the outside of the glove, pull down, turning the glove inside out and over the first glove as you remove it		
6. Create a bag for both gloves		
7. Discard gloves		
8. Cleanse hands		

☐ **Pass** ☐ **Redo**

Comments:

_____ _____

Evaluator Name/Credentials **Date**

Skill #4A: General Medication Administration
Preparation Steps

Student Name _____

Skills Performance Objectives/Steps	Performed Correctly?	
	Yes	**No**
1. Gather appropriate materials		
2. Cleanse hands		
3. Prepare work area to be well lit, well stocked, and clean		
4 Check the MAR for medication allergies		
5. Check for special information if needed prior to giving the medication, such as pulse or BP		
6. Begin the SIX RIGHTS of medication administration a. Select correct MAR for **Right RESIDENT** b. Select **Right MEDICATION**, **Right DOSE**, **Right TIME** and **Right ROUTE** comparing the MAR to the label while performing the three label checks • When selecting the medication from the storage area • Before pouring the medication • After pouring and before returning the medication to the storage area		
7. Use clean technique when pouring or preparing medications into the appropriate container, without touching medication		
8. Prepare **Right DOSE** for **Right ROUTE**		
9. Identify the **Right RESIDENT** using multiple ID checks		
10. Explain to the resident what you are going to do. If there are special things you need them to do, tell them now		
11. Administer medication at **Right TIME**		
12. Assist resident with medication administration if needed		
13. Oral Medications • Offer adequate fluids with medications • Observe resident taking the medications; being sure all oral medications have been swallowed		
14. Cleanse hands		

Continue to Subsequent Steps (15-22)

☐ **Pass** ☐ **Redo**

Comments:

_____ _____

Evaluator Name/Credentials **Date**

Skill #4B: General Medication Administration
Subsequent Steps (15–22)

Student Name _____

Skills Performance Objectives/Steps	Performed Correctly?	
	Yes	**No**
15. Initial the MAR immediately after the medication is administered and prior to the administration of medication to another resident		
16. Document initials with signature. **Right DOCUMENTATION**		
17. Correctly document medications given		
18. Correctly document medications that are refused, held or not administered		
19. Dispose of contaminated or refused medications per policy		
20. Administer and document PRN medications and controlled medications appropriately, if applicable		
21. Recheck medication administration records to make sure all medications are administered and documented		
22. Maintain security of medications during medication administration – ensuring medication room/cart is locked when Medication Aide steps away from it		

☐ **Pass** ☐ **Redo**

Comments:

_____ _____

Evaluator Name/Credentials **Date**

Skill #5: Oral Medication Administration

Student Name _____

Skills Performance Objectives/steps	Performed Correctly?	
	Yes	No
1. Perform skills in Skill #4A: General Medication Administration Preparation Steps		
2. Assist residents as needed to appropriate position, to take medication		
3. Use appropriate measuring, cutting or crushing devices as needed for medication as listed on the MAR		
4. Pills can be mixed, put in the same cup, but may need to assist the residents to take one at a time if they prefer		
5. Mix powdered medications as instructed		
6. Pour liquid medications holding the label under hand and turned away from pouring side		
7. Liquids are shaken or diluted as directed on the label		
8. Measure liquid medications at eye level to the desired amount		
9. Liquids are shaken or diluted as directed on the label		
10. Liquids placed in separate cups		
11. Assist resident to take medications if needed		
12. Offer adequate fluids with medications, if appropriate		
13. Observe resident taking the medication; being sure all medications have been swallowed		
14. Cleanse Hands		
15. Perform skills in Skill #4B: General Medication Administration Subsequent Steps		

☐ **Pass** ☐ **Redo**

Comments:

_____ _____

Evaluator Name/Credentials **Date**

Skill #6: Sublingual Medication Administration

Student Name _____

Skills Performance Objectives/steps	Performed Correctly?	
	Yes	No
1. Perform skills in Skill #4A: General Medication Administration Preparation Steps		
2. Put on gloves		
3. Assist clients to place sublingual pill under tongue		
4. Instruct client to not swallow the pill. They are not to eat, drink or smoke until the medication is dissolved		
5. Remove gloves		
6. Cleanse hands		

☐ **Pass** ☐ **Redo**

Comments:

_____ _____

Evaluator Name/Credentials **Date**

Skill #7: Oral Inhalant Medication Administration

Student Name _____

Steps Skills Performance Objectives/Steps	Performed Correctly?	
	Yes	**No**
1. Perform skills in Skill #4A: General Medication Administration Preparation Steps		
2. Check the MAR for the time to wait between puffs or medications		
3. Put on gloves if administering inhalant and if indicated		
4. Give resident inhalers or administer inhalers in order listed on MAR		
5. Assist residents with proper technique of meter dose inhaler, or disc		
6. If spacer used, moved cap of inhaler and place mouthpiece end into slot of spacer. Remove cap of spacer and shake well. Give to residents to depress inhaler and inhale; or hold and instruct resident		
7. Clean mouthpiece with alcohol wipe, recap and store correctly		
8. Remove gloves if gloves worn		
9. Cleanse hands		
10. Perform skills in Skill #4B: General Medication Administration Subsequent Steps		

☐ **Pass** ☐ **Redo**

Comments:

_____ _____

Evaluator Name/Credentials **Date**

Skill #8: Eye Medication Administration

Student Name _____

Skills Performance Objectives/Steps	Performed Correctly?	
	Yes	No
1. Perform skills in Skill #4A: General Medication Administration Preparation Steps		
2. Check MAR for order and timing of drops or ointment, if there is more than one to be given. Give medications in correct order and at correct time intervals		
3. Get help to assist with eye medication administration to a confused resident		
4. Assist resident to a comfortable sitting position or to lie down		
5. Give the resident a tissue to wipe away medication that might run down cheek		
6. Put on clean gloves as indicated		
7. Select the correct eye		
8. Instruct resident to gently tilt head backwards and look up and away		
9. Gently pull lower lid down to create a "pocket" for medication		
10. **Drops**		
• Drop exact number of drops into eye "pocket" without touching dropper to the resident's eye or eyelid or your hands or fingers		
• Gently press the corner of the eye at the bridge of the nose for one minute		

Continued on next page

Skill #8: Eye Medication Administration
Continued from previous page

Student Name _____

Skills Performance Objectives/Steps	Performed Correctly?	
	Yes	**No**
11. **Ointment** • Run a thin line of ointment onto the lower lid without touching the tube tip to the resident's eye or eyelid or your hands or fingers • Instruct resident to stay put for 10 minutes after the ointment administration because their vision may be blurred		
12. Ask resident to gently close their eyes but not to squeeze them shut for about 2-3 seconds, rolling their eyes around behind their closed lid to distribute the medication		
13. Replace and tighten cap		
14. Store per agency policy		
15. Remove gloves if applicable		
16. Cleanse hands		
17. Perform skills in Skill #4B: General Medication Administration Subsequent Steps		

☐ **Pass** ☐ **Redo**

Comments:

_____ _____

Evaluator Name/Credentials **Date**

Skill #9: Ear Medication Administration

Student Name _____

Skills Performance Objectives/Steps	Performed Correctly?	
	Yes	No
1. Perform skills in Skill #4A: General Medication Administration Preparation Steps		
2. Get help to assist with ear medication administration to a confused resident		
3. Select the correct ear		
4. Assist resident to a comfortable sitting position with head tilted towards the side that does not need drops. Can have resident lie down with ear needing medication pointing up		
5. Warm ear drops in hands before giving		
6. Put on clean gloves		
7. Instruct resident to hold head still while you drop in drops		
8. Administer eardrops. Straighten the ear canal Gently pull the ear up and back		
9. Drop exact number of drops into ear without touching the resident's ear, hair or your hands or fingers with the dropper		
10. Gently press the ear closed for a few seconds, to keep drops from running out		
11. Ask resident to remain lying on their side for 5 minutes .		
12. Replace and tighten cap on eardrop bottle		
13. If stated on MAR, place a small piece of cotton loosely in ear after putting in drops. Leave in place for 15-20 minutes		
14. Remove gloves		
15. Cleanse hands		
16. Perform skills in Skill #4B: General Medication Administration Subsequent Steps		

☐ **Pass** ☐ **Redo**

Comments:

_____ _____

Evaluator Name/Credentials **Date**

Skill #10: Nasal Medication Administration

Student Name _____

Skills Performance Objectives/Steps	Performed Correctly?	
	Yes	No
1. Perform skills in Skill #4A: General Medication Administration Preparation Steps		
2. Position resident correctly • **Drops:** Assist resident to sit or lie down with head tilted back • **Sprays/Inhalants:** Have resident sit upright, then tip head back when the nose spray is inserted and squeezed		
3. Put on clean gloves		
4. Administer correct amount of medications: • **Drops:** Put in ordered number of drops • Instruct resident to stay put for a few minutes • **Sprays:** Spray quickly and forcefully while resident "sniffs"		
5. Wipe dropper or spray nozzle with a tissue		
6. Replace and tighten cap		
7. Store according to agency policy		
8. Remove gloves		
9. Cleanse hands		
10. Perform skills in Skill #4B: General Medication Administration Subsequent Steps		

☐ **Pass** ☐ **Redo**

Comments:

_____ _____

Evaluator Name/Credentials **Date**

Skill #11: Transdermal Medication Administration

Student Name _____

Skills Performance Objectives/Steps	Performed Correctly?	
	Yes	**No**
1. Perform skills in Skill #4A: General Medication Administration Preparation Steps		
2. Check MAR for directions as to where to put the patch or disc and how long to leave it on		
3. Provide privacy if needed		
4. Put on clean gloves		
5. Remove old patch/disc		
6. If patch/disc leaves a residue, wipe off excess and clean skin with soap and water if needed		
7. Initial and date new patch. Apply patch to skin, trying not to touch medicated side		
8. Put the patch at a new location		
9. Put on patch, one-half at a time to allow ease of application		
10. Remove gloves		
11. Cleanse hands		
12. Perform skills in Skill #4B: General Medication Administration Subsequent Steps		
13. On the MAR, document when patch was removed or changed, including where it was placed		

☐ **Pass** ☐ **Redo**

Comments:

_____ _____

Evaluator Name/Credentials **Date**

Skill #12: Topical Medication Administration

Student Name _____

Skills Performance Objectives/Steps	Performed Correctly?	
	Yes	**No**
1. Perform skills in Skill #4A: General Medication Administration Preparation Steps		
2. Provide privacy if needed		
3. Put on clean gloves		
4. When opening the container, place the lid with the inside up to keep from contaminating the inside of the lid		
5. Use gauze or cotton tipped applicator to apply cream or ointment as listed on the MAR		
6. Use a new gauze or cotton tipped applicator each time medication is removed from the container to prevent contaminating the medication left in the container. Apply to affect area		
7. When finished, replace and tighten cap		
8. Store medication container per agency policy		
9. Remove and throw away gloves and supplies used in application		
10. Cleanse hands		
11. Perform skills in Skill #4B: General Medication Administration Subsequent Steps		

☐ **Pass** ☐ **Redo**

Comments:

_____ _____

Evaluator Name/Credentials **Date**

Skill #13: Drawing and Injecting One Insulin

Student Name _____

Steps Skills Performance Objectives/Steps	**Performed Correctly?**	
	Yes	**No**
1. **Perform skills in Skill #4A: General Medication Administration Preparation Steps**		
2. Provide privacy		
3. Get help to assist with administration to a confused resident		
4. Assist resident if needed to prepare for injection		
5. Get supplies • Examine insulin for lumps, discoloration or crystals; signs the insulin should be discarded • New bottle, write the date of opening on bottle • Select appropriate syringe to measure units ordered		
6. Follow Standard Precaution procedures. Wear gloves		
7. Roll bottle if needed		
8. Wipe the top of the bottle with alcohol swab		
9. Pull plunger down to fill syringe with air volume equal to the amount of insulin to be injected		

Continue on next page

Skill #13: Drawing and Injecting One Insulin
Continued from previous page

Student Name _____

Steps Skills Performance Objectives/Steps	Performed Correctly? Yes	Performed Correctly? Yes
10. Holding syringe straight, stick the needle into the center of the rubber stopper in insulin bottle. Push plunger down injecting air into vial		
11. Turn insulin bottle upside down with needle still inside and gently draw the correct units of insulin in the syringe by pulling down on plunger		
12. Gently tap the side of syringe to allow any bubbles to float to top. Push any bubbles out of syringe and then draw insulin back in syringe to get the correct dose		
13. Remove the needle from insulin vial. Check to see if insulin and dose is correct		
14. Choose an injection site. Wipe with alcohol swab		
15. Pinch up skin and push needle into skin. Use the correct angle (45 to 90 degrees) for injection		
16. Inject the insulin slowly into resident. Pull needle out of skin with a quick smooth motion		
17. Discard the syringe/needle unit immediately into a sharps container		
18. Remove gloves		
19. Cleanse hands		
20. Perform skills in Skill #4B: General Medication Administration Subsequent Steps		

☐ **Pass** ☐ **Redo**

Comments:

_____ _____
Evaluator Name/Credentials **Date**

Preparing and Injecting with an Insulin Pen
(Skill #14)

Insulin pens are not all the same so it is critical to read and completely understand the operating instructions for the pen that the resident has. The insulin pen user manual provides information about proper use and storage of the device.

Two types of insulin pens:

Disposable pens which come pre-filled with insulin and the pen is discarded when the insulin is used.

Reusable pens which are loaded with a new insulin cartridge when the old cartridge is used. This pen is **ONLY** used for the specific resident it is ordered for. **Never share an insulin pen.**

Basic steps that are common to most models and types of pens are listed below.

- Remove the pen cap.
- Check the insulin (type, amount and appearance).
- Attach the pen needle and remove caps.
- Follow the pen manufacturer's directions to prepare or prime your particular pen.
- Dial the dose and inject.
- Remove the needle from the pen and dispose of properly.
- Replace the pen cover.

Remember to follow Standard Precautions.

Skill #14: Preparing and Injecting with an Insulin Pen

Student Name _____

Basic Skills Objectives/Steps May vary depending on type of insulin pen!	Performed Correctly?	
	Yes	**No**
1. Perform skills in Skill #4A: General Medication Administration Preparation Steps		
2. Provide privacy		
3. Get help to assist with administration to a confused resident		
4. Assist resident if needed to prepare for injection		
5. Get supplies		
6. Put on clean gloves		
7a. **Disposable Pen** • Remove the pen cap. • Wipe stopper with alcohol swab		
7b. **Reusable Pen** • Remove the cartridge holder from the pen body. • Insert the insulin cartridge into the cartridge holder. • Reattach the holder to the pen body. Wipe stopper with alcohol swab		
8. Take out new pen needle		
9. Position the needle along the axis of the pen		
10. Pierce the center of the cartridge		
11. Screw on the needle		
12. Pull off the outer and inner shield		
13. Follow the pen manufacturer's directions to prepare or prime your particular pen		
14. Wipe injection site with alcohol swab. Select insulin dose		
15. Perform the injection using the recommended technique		
16. Discard the needle and any supplies immediately and appropriately, i.e. into a sharps container		
17. Remove gloves		
18. Cleanse hands		
19. Perform skills in Skill #4B: General Medication Administration Subsequent Steps		

☐ **Pass** ☐ **Redo**

Comments:

_____ _____

Evaluator Name/Credentials **Date**

Section K

Ordering, Storage and Disposal of Medications

Section K – Ordering, Storage and Disposal of Medications

- Each adult care home will provide orientation to medication aide on how to order and obtain medications for residents
- To avoid a medication error resulting from medication availability, there must be a system for ensuring reordering and delivery of resident medications
- Medication supplies must be monitored regularly and reordered
- If a medication is not available, an effort to obtain the medication must be made and documented
- Notify the pharmacy, supervisor, physician and family as needed and in accordance with facility policy

Storage of Medications

- Medication storage areas, i.e., medication cart and medication room, need to be orderly so medication may be found easily
- Store medications in a locked area, unless medications are under the direct supervision of staff; direct supervision means the cart is in sight and the staff person can get to the cart quickly, if necessary
- Lock medication room/cart/cabinet when not in use. Unless the medication storage area is under the direct supervision of staff lock the medication area including carts
- Store external and internal medications in separate designated areas
- Store refrigerated medications in the medication refrigerator or locked container if stored in refrigerator accessible to other staff
- Store medications requiring refrigeration at 36 degrees F to 46 degrees F (2 degrees C to 8 degrees C)

Controlled Substances

- Controlled substances or controlled medications are medications that are kept locked most often in a special location or drawer in the medication cart or medication room
  - Medication Aide must make sure the number or amount of medication listed on the controlled substance log or form is correct before removing any medications for the resident. This is called the “count”

Section K – Ordering, Storage and Disposal of Medications

- When a controlled medication is removed, the amount removed must be documented and the number of remaining medications must be counted and that number recorded
- The facility must have a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances

- For each controlled substance there is a facility system in place to track
  - How much was delivered from pharmacy
  - How much was on hand when shift started
  - How much was used (given to the resident)
  - Who (resident) it was given to
  - Who gave the medication
  - How much was left
  - Reason a resident received a PRN controlled medication, such as pain

- Some facilities have a sheet for each drug, other facilities have a notebook for controlled substances

- Periodically, the controlled substances are counted, usually by two people at shift change, and Medication Aide may be held responsible for missing medications on shift

- Controlled substances may be stored in one location in the medication cart or medication room
  - When Schedule II medications are stored in one location together or with other controlled substances, the controlled substances are to be under double lock
  - When controlled substances, including Schedule II, are stored with the resident's other medications, only a single lock is required
  - There must be a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances

Disposal of Medications

- Reasons for disposal of medications include
  - Resident refused after medication was prepared
  - Medication was dropped on the floor or contaminated
  - Medication has expired
  - Medication has been discontinued by the resident's physician or prescribing practitioner

- Dispose of dosages of medication that have been opened and prepared for administration and not administered for any reason promptly

- Medications discontinued or expired are destroyed or return to pharmacy in accordance with facility policy

Section K – Ordering, Storage and Disposal of Medications

- Regulations require records be maintained for medications destroyed or returned to pharmacy
- Regulations and procedures for destruction or disposal of controlled substances will be different from other medications
- If training is facility specific, discuss the facility's procedures for disposal of medications

The END

Section L

Handouts

HANDOUT C-1

Medication Errors

Medication Error - when a medication is administered in any way other than how it was prescribed

- **Examples**
  - Omissions
  - Administration of a medication not prescribed by the prescribing practitioner
  - Wrong dosage, wrong time, or wrong route
  - Crushing a medication that shouldn't be crushed
  - Documentation errors

- **Role of the Medication Aide**
  - Understands the facility's medication error policy and procedure or know where to locate it
  - Recognizes when a medication error is made
  - Understands importance of acting quickly to report and correct medication errors to help prevent more serious problems

- The quicker the error is noted and reported, the better for the resident

- Reporting all the details around the error can help facility identify issues that may have contributed to the error and the facility may be able to make changes based on the information provided that can help to decrease medication errors in the future

HANDOUT C-2

Be Careful to Develop Good Medication Administration Practice Habits!

- Always read the medication labels and compare the label to the medication administration record (MAR).
- Perform the **SIX Rights** each and every time you give medications for each medication, for each resident. Sometimes it is tempting to think the **SIX Rights** are so basic and simple that you do not need to follow them anymore. Do **NOT** skip these important checks; they help you to avoid medication errors.
- Be sure to question unusual orders, for example, if more than 3 tablets or capsules are needed for one dose of a medication, there is a good chance that you are preparing to give too much medication.
- A "red flag" should be raised in your mind if the resident says they do not normally take this medication, such as a "blue tablet" Don't give the medication until you have re-checked to be sure you have the:

Right RESIDENT

Right MEDICATION

Right DOSE

Right ROUTE and the

Right TIME!

It is possible you have the correct medication and the pharmacy supplier has changed. However it is more likely that there is a medication error getting ready to happen. So you need to carefully recheck the MAR prior to giving the medications. If you continue to have doubts, contact your supervisor for clarification prior to giving the medication.

Remember if in DOUBT – DON'T!

HANDOUT C-3

Resident's Refusal to Take Medications

A. When the resident refuses medication:

1. The resident always has the right to refuse medications.
2. Residents refuse to take medications for many reasons. Some of the reasons are:
   a. The effects and/or side effects are unpleasant or unwanted.
   b. The medication tastes bad.
   c. The resident has difficulty swallowing.
   d. Religious, cultural, or ethnic beliefs.
   e. Depression or loss of will to live.
   f. Delusional belief that staff is intending to harm ("poison") him/her.

B. Types of refusal

1. Actual refusal is when a person directly refuses to take the medication.
2. Passive refusal is less direct and requires closer observation. Examples are:

   The resident takes the medication but later spits the medication out; he/she may or may not attempt to hide the medication.

C. Questions to ask to try to determine the reason for refusal:

1. Does the resident experience any unpleasant effect from the medication?
2. Does the resident have difficulty swallowing?
3. Is the resident afraid for some reason?
4. Is the resident refusing other medical treatment?

HANDOUT C-3

D. Examples of Strategies for dealing with resident's refusal:

1. If the resident refuses and gives no reason, wait a few minutes and then offer the medication again. If the resident refuses again, try again in another few minutes before considering a final refusal. This is particularly important with residents who have a diagnosis of dementia.

NOTE For residents with cognitive impairment such as dementia, it is important to know when the resident designee, such as responsible party or guardian, wants to be notified if the resident refuses medication. The resident designee may be able to encourage the resident to take the medication.

2. Notify the prescribing practitioner or supervisor when a resident refuses medication.

3. Document refusal.

4. Observe the resident and report any effect which may result from refusal.

5. If there is swallowing difficulty, report to your supervisor and/or resident's physician.

6. Consider changing the time of administration if taking the drug interferes with an activity or with sleep. (Example: diuretics may limit a resident's ability to participate in an outing because of the need to go to the bathroom frequently.)

7. If there is a suspicion of passive refusal such as "cheeking" medication or vomiting after administration, follow the recommendations for action on the resident's Individualized Care Plan.

8. If the refusals continue, explore other options with the resident's physician.

NOTE: Passive refusal is not uncommon in residents with diagnoses of mental illness. It is important that the resident or resident designee, facility staff, nurse, pharmacist and physician collaborate to develop and follow a plan to assist the resident with adherence to his/her drug regimen.

HANDOUT D-1

Medication Orders

Components of a Complete Order

- Medication name
- Strength of medication (if required)
- Dosage of medication to be administered
- Route of administration
- Specific directions for use, including frequency of administration
- Reason for administration if the medication is ordered PRN (as needed)

Examples:

Lasix 40 mg. – 1 tablet by mouth once a day in the morning
Tylenol 325 mg. 1 tablet by mouth every 4 hours as needed for pain

- Do not accept medication orders that state "continue previous medications" or "same medications" because they are not complete medication orders

Types of Medication Orders

There are four types of medication orders

- Routine orders
- PRN orders
- One time orders
- STAT orders

Routine Medication Orders

- Detailed order for a medication given on a routine or regularly scheduled basis such as every morning at 10 AM
- The reason the medication is being administered is usually in the resident's history and physical information or the prescribing practitioner's progress or notes

PRN Medication (as needed) Orders

- PRN means as needed or necessary
- A medication which is ordered to be given "when necessary" or "as needed" within a designated number of hours
- Are for medications that are needed periodically, such as pain medications, cough syrup, or laxatives
- Time interval will be listed on the MAR
    - A medication that is to be given every 4 hours (q4h) as needed cannot be given unless 4 hours have passed since the last time the resident has taken the medication
    - For example, a medication is listed on the MAR for pain to be given by mouth every 4 hours PRN
    - The Medication Aide is giving the resident their medications and the resident asks for a pain medication
    - Medication Aide looks at the last time the medication was given and it was only 3 hours ago
    - Medication Aide cannot give the medication because enough time has not passed since the last medication
    - Medication Aide can return and give the medication in 1 hour if it is still needed
    - Medication Aide should report the pain to supervisor to be evaluated further to see if a different medication or dosing time is needed

HANDOUT D-1

Medication Orders

One Time Orders

- Some medications to be given only once and are ordered to be given at a specific time and then discontinued.

STAT Orders

- These medications need to be given immediately or NOW. The STAT orders must be clearly written on the MAR that tell you the resident, medication, dose, route, and time. Do not give medications that do not have clear written instructions.

Activity:

Identify the information missing for each medication order below:

Risperdal 2 mg. Give 1 tablet by mouth

Riopan Liquid 15 ml. by mouth every hours as needed

Aricept 1 tablet by mouth at bedtime

Tylenol 2 tablets by mouth every 4 hours as needed for shoulder pain

Ativan 0.5 mg. 1 tablet by mouth as needed

HANDOUT D-2

Medication Label

Individually labeled medication bottles have the following information on the label:

- Resident's full name **(Right RESIDENT)**
- Name of Medication **(Right MEDICATION)**
- Strength of medication and amount to be given **(Right DOSE)**
- Directions on how to take the medication **(Right ROUTE)**
- Direction about when to take the medication, including how often to take the medication **(Right TIME)**
- Name of person who prescribed the medication **(usually a physician)**
- Issue **(dispensed)** date
- Expiration or discard date
- Pharmacy prescription serial number
- Name, address and phone number of issuing pharmacy
- Name of person who dispensed the medication (**usually a pharmacist**)
- Quantity of medication dispensed
- Auxiliary labels may provide important information such as "shake well"
- Warning Labels
- Equivalency statement when the name of the medication dispensed differs from the name of the medication ordered

ACTIVITY: Find each of the above components of a label on the label below.

Your Center Pharmacy		
123 Brookshire Lane, Friendly, NC 27856	919-123-4567	DEA# AMB165664
Rx# 4003706		Dr. Sullivan
Jack C. Wallboard	ID# 123456	
Give 1 tablet (5 MG) by mouth once daily at 6 PM.		
Coumadin 5 MG	QTY: # 30	
Used for Warfarin Sodium		
1/13/2015 0 Refills	DISCARD: 1/12/2016	
Dispensed By Marie O'Wow, RPh		

HANDOUT D-3

ABBREVIATIONS

DOSES

gm	= gram
mg	= milligram
mcg	= microgram
cc	= cubic centimeter
ml	= milliliter
tsp	= teaspoonful
tbsp	= tablespoonful
gtt	= drop
oz	= ounce
mEq	= milliequivalent

ROUTES OF ADMINISTRATION

po	= by mouth
pr	= per rectum
OD	= right eye
OS	= left eye
OU	= both eyes
AD	= right ear
AS	= left ear
AU	= both ears
SL	= sublingual(under the tongue)
SQ	= subcutaneous (under the skin)
per GT	= through gastrostomy tube

TIMES

QD	= every day
BID	= twice a day
TID	= three times a day
QID	= four times a day
q_h	= every __ hours
qhs	= at bedtime
ac	= before meals
pc	= after meals
PRN	= as needed
QOD	= every other day
ac/hs	= before meals and at bedtime
pc/hs	= after meals and at bedtime
STAT	= immediately

OTHER

MAR	= medication administration record
OTC	= over the counter

HANDOUT D-4

Six Rights of Medication Administration

- A method used during medication administration to safeguard the residents; before administering the medication the Medication Aide must ask self six questions – ***Am I giving the medication to the right resident? Am I giving the right medication? Am I giving the right dose? Is this the right route? Is this the right time? Have I done the right documentation?***

  - **Right RESIDENT** – identify resident to assure you are giving the medication to the resident who is supposed to receive the medication and using procedure required by the facility, such as photo on the MAR, asking a resident his/her name, etc.

  - **Right MEDICATION** – the name of the medication ordered by the physician; always use the three checks

  - **Right DOSE –** the amount of medication ordered

  - **Right ROUTE –** the method of medication administration

  - **Right TIME –** when the resident is ordered to receive the medication

  - **Right DOCUMENTATION** – the process of writing down that a medication was administered to the resident on the MAR **OR** if a medication was not administered and the reason it was omitted

HANDOUT D-5

Decimal Points and Zeros

Draw a line to match the following dose with the correct statement about the use of decimals and zeros:

Dose	Statement
.45 mg	Zero not needed, makes dose confusing
0.45 mg	ZERO needed in front of decimal
04.5 mg	Zero not needed, could be confused with higher dose if decimal overlooked
8.0 mg	Correct use of decimal and zero

HANDOUT D-6

Common Routes of Medication Administration

- **Oral** – taken by the mouth and swallowed
- **Buccal** – placed between cheek and gum
- **Sublingual** – placed under the tongue
- **Eye** – placed in the pocket of the eye created when the lower eyelid is gently pulled down
- **Ear** – placed in the ear canal created when the external ear is pulled up and back
- **Nasal** – placed in the nostril
- **Inhalant** – inhaled into the lungs
- **Transdermal** – placed and affixed to the skin
- **Topical** – applied to the skin or hair
- **Vaginal** – inserted into the vagina
- **Rectal** – inserted into the rectum
- **Subcutaneous**– injected into the fat with a syringe

HANDOUT D-7

Common Dosage Forms of Medications

- **Tablet**
  - Hard, compressed medication in round, oval, or square shape
  - Some have enteric coating or other types of coatings, which delay release of the drug and can not be crushed or chewed
- **Capsule**
  - In a gelatin container that may be hard or soft
  - Dissolves quickly in stomach
- **Liquid** – different types of liquid medications
  - Solution – a liquid containing dissolved medication
  - Suspension – a liquid holding undissolved particles of medication that must be shaken before measuring and administering to resident
  - Syrup – a liquid medication dissolved in a sugar water to disguise its taste
  - Elixir – a sweet alcohol based solution in which medications are dissolved
- **Suppository**
  - Small solid medicated substance, usually cone-shaped
  - Melts at body temperature
  - May be administered by rectum or vagina
  - Refrigerate as directed by manufacturer
- **Inhalant**
  - Medication carried into the respiratory tract using air, oxygen or steam
  - Inhalants may be used orally or nasally
- **Topical** – applied directly to the skin surface. Topical medications include the following:
  - Ointment – a semisolid substance for application of medication to the skin or eye
  - Lotion – a medication dissolved in liquid for applying to the skin
  - Paste – a semisolid substance thicker and stiffer than an ointment containing medications
  - Cream – semisolid preparation holding medication so it can be applied to skin
  - Shampoo – liquid containing medication that is applied to the scalp and hair
  - Patches (transdermal) – medication encased in a round, square, or oval disc that is affixed to the skin
  - Powder – fine, ground form of medication that may be used to be swallowed, or may be used as on the skin for rashes
  - Aerosol sprays – solution that holds the medication suspended until it is dispensed in the form of a mist to spray on the skin

FL-2 (86)

INSTRUCTIONS ON REVERSE SIDE

NORTH CAROLINA MEDICAID PROGRAM
LONG TERM CARE SERVICES

HANDOUT E-1

☐ PRIOR APPROVAL ☐ UTILIZATION REVIEW ☐ ON-SITE REVIEW

IDENTIFICATION

1. PATIENT'S LAST NAME FIRST MIDDLE	2. BIRTHDATE (M/D/Y)	3. SEX	4. ADMISSION DATE (CURRENT LOCATION)

5. COUNTY AND MEDICAID NUMBER	6. FACILITY ADDRESS	7. PROVIDER NUMBER

8. ATTENDING PHYSICIAN NAME AND ADDRESS	9. RELATIVE NAME AND ADDRESS

10. CURRENT LEVEL OF CARE	11. RECOMMENDED LEVEL OF CARE	12. PRIOR APPROVAL NUMBER	14. DISCHARGE PLAN
_____ HOME _____ DOMICILIARY (REST HOME) _____ SNF _____ ICF _____ OTHER _____ HOSPITAL _____	_____ HOME _____ DOMICILIARY (REST HOME) _____ SNF _____ ICF _____ OTHER _____	13. DATE APPROVED/DENIED	_____ SNF _____ HOME _____ ICF _____ DOMICILIARY (REST HOME) _____ OTHER _____

15. ADMITTING DIAGNOSES – PRIMARY, SECONDARY, DATES OF ONSET

1.	5.
2.	6.
3.	7.
4.	8.

16. PATIENT INFORMATION

DISORIENTED	AMBULATORY STATUS	BLADDER	BOWEL
☐ CONSTANTLY	☐ AMBULATORY	☐ CONTINENT	☐ CONTINENT
☐ INTERMITTENTLY	☐ SEMI-AMBULATORY	☐ INCONTINENT	☐ INCONTINENT
INAPPROPRIATE BEHAVIOR	☐ NON-AMBULATORY	☐ INDWELLING CATHETER	☐ COLOSTOMY
☐ WANDERER	**FUNCTIONAL LIMITATIONS**	☐ EXTERNAL CATHETER	**RESPIRATION**
☐ VERBALLY ABUSIVE	☐ SIGHT	**COMMUNICATION OF NEEDS**	☐ NORMAL
☐ INJURIOUS TO SELF	☐ HEARING	☐ VERBALLY	☐ TRACHEOSTOMY
☐ INJURIOUS TO OTHERS	☐ SPEECH	☐ NON-VERBALLY	☐ OTHER:
☐ INJURIOUS TO PROPERTY	☐ CONTRACTURES	☐ DOES NOT COMMUNICATE	☐ O2 PRN CONT.
☐ OTHER:	**ACTIVITIES/SOCIAL**	**SKIN**	**NUTRITION STATUS**
PERSONAL CARE ASSISTANCE	☐ PASSIVE	☐ NORMAL	☐ DIET
☐ BATHING	☐ ACTIVE	☐ OTHER:	☐ SUPPLEMENTAL
☐ FEEDING	☐ GROUP PARTICIPATION	☐ DECUBITI – DESCRIBE:	☐ SPOON
☐ DRESSING	☐ RE-SOCIALIZATION		☐ PARENTERAL
☐ TOTAL CARE	☐ FAMILY SUPPORTIVE		☐ NASOGASTRIC
PHYSICIAN VISITS	**NEUROLOGICAL**		☐ GASTROSTOMY
☐ 30 DAYS	☐ CONVULSIONS/SEIZURES		☐ INTAKE AND OUTPUT
☐ 60 DAYS	☐ GRAND MAL	☐ **DRESSINGS:**	☐ FORCE FLUIDS
☐ OVER 180 DAYS	☐ PETIT MAL		☐ WEIGHT
☐	☐ FREQUENCY		☐ HEIGHT

17. SPECIAL CARE FACTORS	FREQUENCY	SPECIAL CARE FACTORS	FREQUENCY
☐ BLOOD PRESSURE		☐ BOWEL AND BLADDER PROGRAM	
☐ DIABETIC URINE TESTING		☐ RESTORATIVE FEEDING PROGRAM	
☐ PT (BY LICENSED PT)		☐ SPEECH THERAPY	
☐ RANGE OF MOTION EXERCISES		☐ RESTRAINTS	

18. MEDICATIONS / NAME & STRENGTHS, DOSAGE & ROUTE

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

19. X-RAY AND LABORATORY FINDINGS / DATE:

20. ADDITIONAL INFORMATION:

21. PHYSICIAN'S SIGNATURE	22. DATE

HANDOUT E-2

MEDICATION ADMINISTRATION RECORD

Medications	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
		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
		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
		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
		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
		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
		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
		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
		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

Charting for the month of:	through	
Physician:	Telephone #	Medical Record #:
Alt. Physician:	Alt. Physician Telephone #:	
Allergies:	Rehabilitation Potential:	
Diagnosis:	Admission Date:	
Resident's Name:	Room and bed #:	

Instructions:
A. Put initials in appropriate box when medication given.
B. Circle initials when medication refused.
C. State reason for refusal on Nurse's Notes.
D. PRN medication: Reason given should be noted on Nurse's Notes.
E. Indicate injection site(code).

Result Codes:
1. Effective
2. Ineffective
3. Slightly Effective
4. No Effect Observed

Injection/Patch Site Codes:
1-Right dorsal gluteus
2-Left dorsal gluteus
3-Right upper chest
4-Left upper chest
5-Right lateral thigh
6-Left lateral thigh
7-Right deltoid
8-Left deltoid
9-Right upper arm
10-Left upper arm
11-Upper back left
12-Upper back right

NURSE'S MEDICATION NOTES

	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
Temperature																															
Respiration																															
Pulse																															
Blood Pressure																															

Initials	Nurse's Signature	Initials	Nurse's Signature

Charting Codes: **A**. chart error **B**. drug unavailable **C**. resident refused **D**. drug held **E**. dose contaminated **F**. out of facility **G**. see notes **H**. drug holiday

Date/Hour	Medication/Dosage	Route	Reason	Initials	Results/Response	Initials

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INSTRUCTIONS ON REVERSE SIDE

NORTH CAROLINA MEDICAID PROGRAM
LONG TERM CARE SERVICES

HANDOUT E-3

☐ PRIOR APPROVAL ☐ UTILIZATION REVIEW ☐ ON-SITE REVIEW

IDENTIFICATION

1. PATIENT'S LAST NAME	FIRST	MIDDLE	2. BIRTHDATE (M/D/Y)	3. SEX	4. ADMISSION DATE (CURRENT LOCATION)
Clayton	Garrett		10-17-50	M	09/04/13

5. COUNTY AND MEDICAID NUMBER	6. FACILITY ADDRESS	7. PROVIDER NUMBER
Johnston 021-13-1415	Adult Care Assisted Living	

8. ATTENDING PHYSICIAN NAME AND ADDRESS	9. RELATIVE NAME AND ADDRESS
Dr. Bruton Adams Building City, N.C.	Ben Clayton (brother)

10. CURRENT LEVEL OF CARE	11. RECOMMENDED LEVEL OF CARE	12. PRIOR APPROVAL NUMBER / 13. DATE APPROVED/DENIED	14. DISCHARGE PLAN
____ HOME ____ DOMICILIARY (REST HOME) ____ SNF ____ ICF ____ OTHER __X__ HOSPITAL	____ HOME ____ DOMICILIARY (REST HOME) ____ SNF ____ ICF ____ OTHER		____ SNF ____ HOME ____ ICF ____ DOMICILIARY (REST HOME) ____ OTHER

15. ADMITTING DIAGNOSES – PRIMARY, SECONDARY, DATES OF ONSET

1. seizure disorder	5. CHF
2. hypertension	6.
3. insulin-dependent diabetes (IDDM)	7.
4. Asthma	8.

16. PATIENT INFORMATION

DISORIENTED		AMBULATORY STATUS		BLADDER		BOWEL	
	CONSTANTLY	x	AMBULATORY	x	CONTINENT	x	CONTINENT
	INTERMITTENTLY		SEMI-AMBULATORY		INCONTINENT		INCONTINENT
INAPPROPRIATE BEHAVIOR			NON-AMBULATORY		INDWELLING CATHETER		COLOSTOMY
	WANDERER	**FUNCTIONAL LIMITATIONS**			EXTERNAL CATHETER	**RESPIRATION**	
	VERBALLY ABUSIVE		SIGHT	**COMMUNICATION OF NEEDS**			NORMAL
	INJURIOUS TO SELF		HEARING	x	VERBALLY		TRACHEOSTOMY
	INJURIOUS TO OTHERS		SPEECH		NON-VERBALLY		OTHER:
	INJURIOUS TO PROPERTY		CONTRACTURES		DOES NOT COMMUNICATE		O2 PRN CONT.
	OTHER:	**ACTIVITIES/SOCIAL**		**SKIN**		**NUTRITION STATUS**	
PERSONAL CARE ASSISTANCE			PASSIVE	x	NORMAL	x	DIET NCS
x	BATHING	x	ACTIVE		OTHER:		SUPPLEMENTAL
	FEEDING		GROUP PARTICIPATION		DECUBITI – DESCRIBE:		SPOON
x	DRESSING		RE-SOCIALIZATION				PARENTERAL
	TOTAL CARE		FAMILY SUPPORTIVE				NASOGASTRIC
PHYSICIAN VISITS		**NEUROLOGICAL**					GASTROSTOMY
	30 DAYS		CONVULSIONS/SEIZURES				INTAKE AND OUTPUT
x	60 DAYS		GRAND MAL		**DRESSINGS:**		FORCE FLUIDS
	OVER 180 DAYS		PETIT MAL				WEIGHT
			FREQUENCY				HEIGHT

17. SPECIAL CARE FACTORS		FREQUENCY		SPECIAL CARE FACTORS		FREQUENCY
	BLOOD PRESSURE			BOWEL AND BLADDER PROGRAM		
	~~DIABETIC URINE TESTING~~	FSBS ac breakfast & supper		RESTORATIVE FEEDING PROGRAM		
	PT (BY LICENSED PT)			SPEECH THERAPY		
	RANGE OF MOTION EXERCISES			RESTRAINTS		

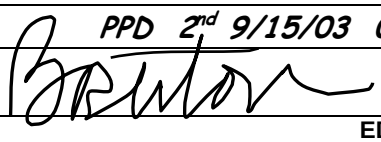
18. MEDICATIONS / NAME & STRENGTHS, DOSAGE & ROUTE

1. Dilantin 125mg/5ml - 4ml po every day	7. Accupril 10 mg. 1 tablet once daily
2. Lasix 40mg po twice daily	8. Zithromax 250 mg. 1 daily X 4 days
3. Tylenol 325mg 2 tabs po q6hr prn pain	9.
4. or temp greater than 100°F	10.
5. Humulin 70/30 – 10 units sq. ac breakfast	11.
6.	12.

19. X-RAY AND LABORATORY FINDINGS / DATE:

20. ADDITIONAL INFORMATION: PPD 8/28/03 0mm

PPD 2nd 9/15/03 0mm * allergies - codeine

21. PHYSICIAN'S SIGNATURE  22. DATE 9/04/2013

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EDS – DMA COPY

HANDOUT F-1 MEDICATION ADMINISTRATION RECORD

Medications	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
Hydrocodone 10/325 Take 1 tablet by mouth every 4 hours as needed for pain.	P																															
	R			TK						CJ																						
	N																															
LASIX 40mg. Take 1 tablet by mouth once every day.	8AM	TK	TK	TK	TK	TK	JU	JU	JU	JU	Discontinued 2-9-00 order changed, see below JU																					
COUMADIN 5mg. Take 1 tablet by mouth every other day. 2/08/00	6PM	→	→	→	→	→	→	(CJ)	X	CJ	X	DB	X	DB	X	DB	X	CJ	X	CJ	X	DB	X	DB	X	DB	X	CJ	X			
Lanoxin 0.125 mg. Take 1 tablet by mouth daily. Check pulse before giving and hold if pulse is less than 60 beats/min	8AM	TK	TK	TK	TK	TK	JU	JU	JU	JU	JU	TK	TK	TK	TK	TK	JU	JU	JU	JU	JU	TK	TK	TK	TK	TK	JU	JU	JU	JU	(H)	
	Pulse	64	68	72	74	80	84	80	64	60	66	64	72	83	83	88	72	80	80	72	76	60	64	66	68	68	72	80	82	84	54	
AMOXICILLIN 250mg Take 1 capsule by mouth 3 times daily for 10 days. 2/03/00	8AM	→	→	→	TK	TK	JU	JU	JU	JU	JU	TK	TK	TK																		
	2PM	→	→	→	TK	TK	JU	JU	JU	JU	JU	TK	TK	TK																		
	8PM	→			DB	DB	DB	CJ	CJ	CJ	CJ	CJ	DB	DB																		
															Stop 10 days only JK																
NITRO-DUR 0.4mg/hr PATCH ----Apply 1 patch every morning and remove at bedtime	8AM	TK	TK	TK	TK	TK	JU	JU	JU	JU	JU	TK	TK	TK	TK	TK	JU	JU	JU	JU	JU	TK	TK	TK	TK	TK	JU	JU	JU	JU		
	Site	RC	LC	RB	LB	RC	LC	RB	LB	RC	LC	RB	LB	RC	LC	RB	LB	RC	LC	RB	LB	RC	LC	RB	LB	RC	LC	RB	LB	RC		
	Remove																															
	8PM	DB	DB	DB	DB	DB	CJ	CJ	CJ	CJ	CJ	DB	DB	DB	DB	DB	CJ	CJ	CJ	CJ	CJ	DB	DB	DB	DB	DB	CJ	CJ	CJ	CJ		
CAPOTEN 25mg Take 1 tablet by mouth 3 times daily.	8AM	TK	TK	TK	TK	TK	JU	JU	JU																							
	2PM	TK	TK	TK	TK	TK	JU	JU	JU																							
	8PM	DB	DB	DB	DB	DB	CJ	CJ																								
											order changed see below 2-8-00 JU																					
CAPOTEN 50mg Take 1 tablet by mouth 3 times daily . (Give 2-25mg tablets) 2/08/00	8AM	→	→	→	→	→	→	→	→	JU	JU	TK	TK	TK	TK	TK	JU	JU	JU	JU	JU	TK	TK	TK	TK	TK	JU	JU	JU	JU		
	2PM	→	→	→	→	→	→	→	→	JU	JU	TK	TK	TK	TK	TK	JU	JU	JU	JU	JU	TK	TK	TK	TK	TK	JU	JU	JU	JU		
	8PM	→	→	→	→	→	→	→	→	CJ	CJ	CJ	DB	DB	DB	DB	DB	CJ	CJ	CJ	CJ	CJ	DB	DB	DB	DB	DB	CJ	CJ	CJ	CJ		
LASIX 40mg Take 1 tablet by mouth twice daily. 2/09/00	8AM	→	→	→	→	→	→	→	→	JU	TK	TK	TK	TK	TK	JU	JU	JU	JU	JU	TK	TK	TK	TK	TK	JU	JU	JU	JU			
	4PM	→	→	→	→	→	→	→	→	CJ	CJ	DB	DB	DB	DB	DB	CJ	CJ	CJ	CJ	CJ	DB	DB	DB	DB	DB	CJ	CJ	CJ	CJ		

Charting for the month of: **1/1/13** through **1/31/13**

Physician: **Dr. Moses**	Telephone # **919-555-1212**	Medical Record #:
Alt. Physician:	Alt. Physician Telephone #:	
Allergies: **NKA**		Rehabilitation Potential:
Diagnosis: **Congestive Heart Failure, Hypertension**		Admission Date: **5/03/09**
Resident: **Jo Burns**	Date of Birth: **10/17/30**	Room / bed #: **123-2**

Instructions:

A. Put initials in appropriate box when medication given.
B. Circle initials when medication refused.
C. State reason for refusal on Nurse's Notes.
D. PRN medication: Reason given should be noted on Nurse's Notes.
E. Indicate injection site (code).

Result Codes:

1. Effective
2. Ineffective
3. Slightly Effective
4. No Effect Observed

Injection/Patch Site Codes:

1-Right dorsal gluteus
2-Left dorsal gluteus
3-Right upper chest
4-Left upper chest
5-Right lateral thigh
6-Left lateral thigh
7-Right deltoid
8-Left deltoid
9-Right upper arm
10-Left upper arm
11-Upper back left
12-Upper back right

NURSE'S MEDICATION NOTES

	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
Temperature																															
Respiration																															
Pulse																															
Blood Pressure																															

Initials	Nurse's Signature	Initials	Nurse's Signature
TK	Todd Kase		RB = Right side of back
CJ	Cece Jones		RC = Right side of chest
DB	Dennis Barr		LB = Left side of back
JU	Jeff Ups		LC = Left side of chest

Charting Codes: ***A****. chart error* ***B****. drug unavailable* ***C****. resident refused* ***D****. drug held* ***E****. dose contaminated* ***F****. out of facility* ***G****. see notes*

Date/Hour	Medication/Dosage	Route	Reason	Initials	Results/Response	Initials
1-3-13 10AM	Hydrocodone 10/325 1 tablet	po	Pain in right leg	T	Effective at 12pm	T
1-7-13 6PM	Coumadin 5mg	po	Not available -	C		C
			Pharmacy called			
1-9-13 10PM	Hydrocodone 10/325 1 tablet	po	Pain in right leg	C	Effective as of 11pm	C
1-30-13 8 AM	Lanoxin 0.125 mg 1 tablet	po	Pulse 54	J		

HANDOUT F-2

Medication Administration Record (MAR) Worksheet

1. Turn to page 2 or back of MAR and print your initial to your first name and initial to your last name on page 2 of the Medication Administration Record (MAR).

2. On page 2 of the MAR write your first and last name in the blank block in the Nurse's Signature area.

3. Mrs. Burns' MAR includes medications administered during what month?

4. Why did Mrs. Burns receive a dose of Hydrocodone 10/325 on the 3rd of January?

5. Why didn't Mrs. Burns receive three doses of Amoxicillin on the 22nd of January?

6. What times did Mrs. Burns receive 25 mg of Capoten on January 2nd?

7. Why was Mrs. Burns' Coumadin dose circled on January 7th?

8. Where was Mrs. Burns' Nitro-dur patch placed on January 10th?

9. What time does Mrs. Burns have her Nitro-dur patch removed?

10. Who is Mrs. Burns' physician?

11. It is 11 PM on January 9th. Mrs. Burns has asked for something for pain. Can Mrs. Burns receive something for pain?

12. Does Mrs. Burns have allergies?

(continued)

Handout F-2 Continued
Medication Administration Record (MAR) Worksheet

13. How much Lasix did Mrs. Burns receive at 4 PM on January 18th?

14. It is 8 AM on January 30th. You have just administered one tablet of Lasix 40 mg to Mrs. Burns. Document that you gave the Lasix on Mrs. Burns' MAR.

15. It is 4 PM on January 31st. Mrs. Burns would like something for pain in her right leg. Can Mrs. Burns receive something for pain? If so, administer the appropriate medication and document on Mrs. Burns' MAR. [

16. It is 8 AM and time for Mrs. Burns to receive her Lanoxin. What must you do prior to administering the Lanoxin?

17. What are Mrs. Burns' diagnoses?

18. What are the 6 Rights of medication administration?

    a.

    b.

    c.

    d.

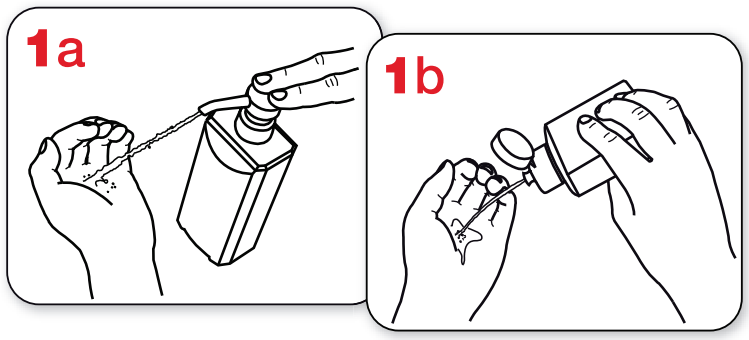
    e.

    f.

19. How many days was Mrs. Burns supposed to receive Amoxicillin?

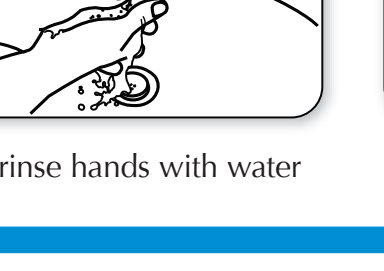
20. Why is there a zero in front of the decimal on Lanoxin 0.125 mg?

How to handrub?
WITH ALCOHOL-BASED FORMULATION



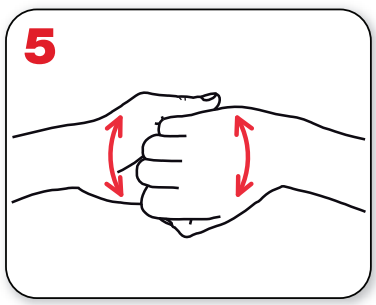
Apply a palmful of the product in a cupped hand and cover all surfaces.

Rub hands palm to palm

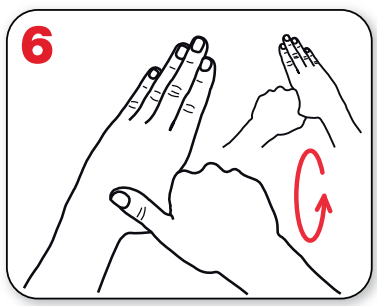


right palm over left dorsum with interlaced fingers and vice versa

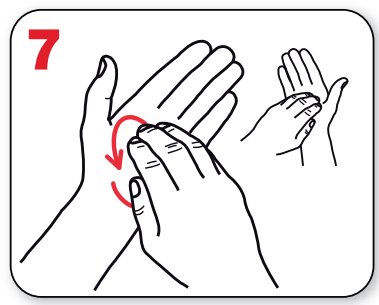
palm to palm with fingers interlaced



backs of fingers to opposing palms with fingers interlocked

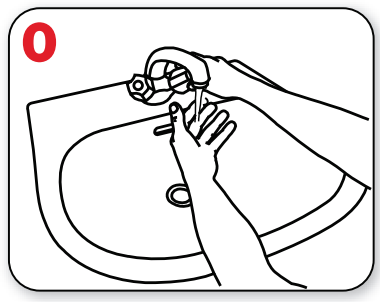


rotational rubbing of left thumb clasped in right palm and vice versa

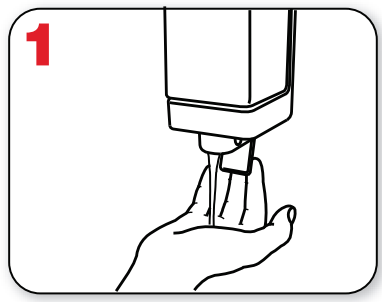


rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa

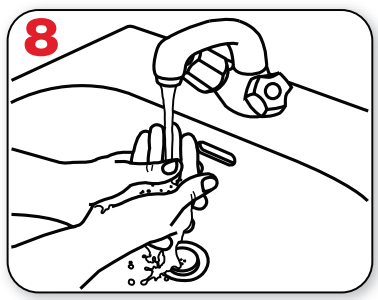
How to handwash?
WITH SOAP AND WATER



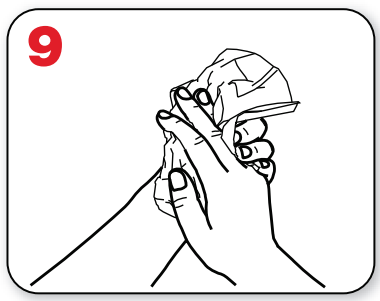
Wet hands with water



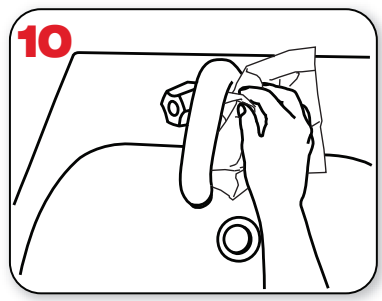
apply enough soap to cover all hand surfaces.



rinse hands with water

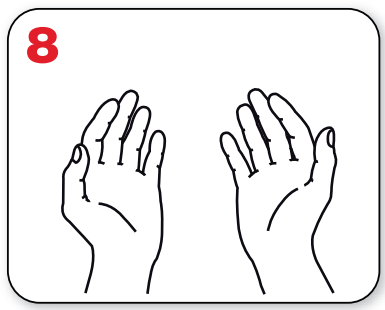


dry thoroughly with a single use towel



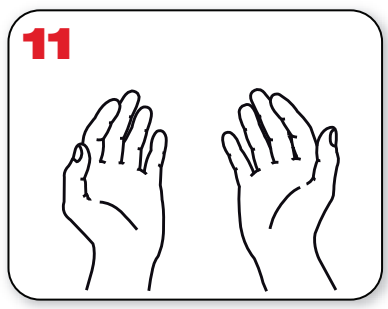
use towel to turn off faucet

20-30 sec



…once dry, your hands are safe.

40-60 sec



…and your hands are safe.

WHO acknowledges the Hôpitaux Universitaires de Genève (HUG),
in particular the members of the Infection Control Programme, for their active participation in developing this material.

World Health Organization

October 2006, version 1.

Design: mondofragilis network

HANDOUT G-2

Instructions for Glove Sizing

Preparation

Before class, get three pairs of gloves – small ones, average ones, large ones. Notice the size of your students' hands. Choose three students – one with large hands, one with tiny hands, and one with average hands. Ask the students if they will be willing to participate in an activity.

Tell Students

"We are going to do a fun demonstration. I have asked a few students to assist me with this activity."

Explanation of Activity

Ask the three students to come to the front of the room. Have the remaining students observe the demonstrations. First, have the student with large hands put on small gloves. Second, have the student with tiny hands put on large gloves. Third, have an average student put on the right size of gloves.

Wrap-up

Ask students to explain about the importance of choosing the correct size of gloves when caring for residents. Proceed to the next activity, Gloves, Gloves, Gloves.

HANDOUT G-3

Instructions for Gloves, Gloves, Gloves

Preparation

Before class begins, gather boxes of sizes of gloves.

Instructions to Students

"Now that you understand the importance of choosing gloves that are the correct size, I would like for each of you to choose the correct size of gloves that you would wear and put them on."

Explanation of Activity

Ask students to determine which size gloves they need. Ask each student to put on a pair of gloves in the appropriate size. After they have put on their gloves, drop a dollop of chocolate pudding on one glove of each student with a small plastic spoon.

Instructions to Students

"Rub your gloved hands together so you can spread pudding on both gloves – top and bottom. The pudding represents stool. Now, I want you to remove the gloves without getting the stool on your skin or clothes and throw away in the trashcan."

Wrap-up

Ask everyone if they can explain the importance of proper removal of dirty gloves. Ask if anyone got the fake stool on their hands and if so, how did they feel?

HANDOUT I-4

TECHNIQUE AND USE OF METER DOSE INHALERS

All Meter Dose Inhalers must be shaken!

Ask the resident to tilt the head back slightly and breathe out.

Position the inhaler in one of the following ways:

- Open mouth with inhaler one to two inches away.
- Use spacer with inhaler; place spacer in mouth (Spacers are particularly beneficial for older adults).
- Position inhaler in mouth, close lips around inhaler.

Press down on inhaler to release medication as the resident starts to breathe in slowly.

Encourage the resident to breathe in slowly (over 3 to 5 seconds).

Ask the resident to hold breath for 10 seconds to allow medication to reach deeply into the lungs.

If a resident is prescribed multiple inhalers, the physician may order a certain sequence to administer the inhalers or special instructions may be on the MAR.

Proper spacing of puffs and different inhalers is important for the maximal effectiveness of the medication.

- Wait one minute between “puffs” for multiple inhalations of the same medication.
- Wait a few minutes between administering another type of inhaler.

If a medication aide provides the resident with the inhalers to administer, the medication aide is responsible for instructing the resident of the proper technique and dose ordered.

HANDOUT G-4

Diabetes and Viral Hepatitis: Important Information on Safe Diabetes Care

Blood glucose testing and insulin administration can expose people to bloodborne viruses (hepatitis B virus, hepatitis C virus, and HIV) when supplies are shared between people.

Outbreaks of hepatitis B virus infection associated with unsafe diabetes care have been identified with increasing regularity particularly in long-term care settings such as nursing homes and assisted living facilities where residents often require assistance with monitoring of blood glucose levels or insulin administration.

In order to prevent infections, the North Carolina Division of Public Health urges all health care providers to follow these simple rules for safe diabetes care:

Three Simple Rules for Assisted Blood Glucose Monitoring and Insulin Administration

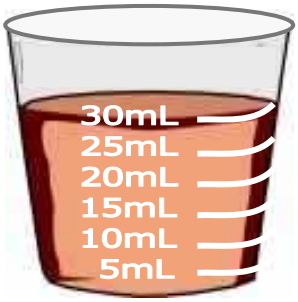
1. FINGERSTICK DEVICES SHOULD NEVER BE USED FOR MORE THAN ONE PERSON	**2. BLOOD GLUCOSE METERS SHOULD BE ASSIGNED TO ONLY ONE PERSON AND NOT SHARED**	**3. INJECTION EQUIPMENT SHOULD NEVER BE USED FOR MORE THAN ONE PERSON**
➢ Restrict use of fingerstick devices to a single person. They should never be used for more than one person. ➢ Select single-use lancets that permanently retract upon puncture. This adds an extra layer of safety for the patient and the provider. ➢ Dispose of used lancets at the point of use in an approved sharps container. Never reuse lancets.	➢ Whenever possible, assign blood glucose meters to a single person. ➢ If blood glucose meters must be shared, they should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. ➢ If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared.	➢ Insulin pens should be assigned to only one person and labeled appropriately. They should never be used for more than one person. ➢ Multiple-dose vials of insulin should be dedicated to a single person whenever possible. ➢ Medication vials should always be entered with a new needle and new syringe. Never reuse needles or syringes. ➢ For information and materials about safe insulin pen use, visit www.ONEandONLY campaign.org

Always practice proper hand hygiene and change gloves between each person.

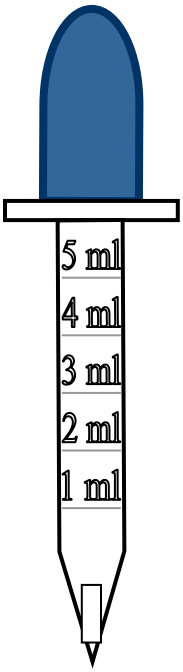
Adapted from the Diabetes and Viral Hepatitis Important Information on Safe Diabetic Care, N.C. DHHS Division of Public Health

HANDOUT I-1

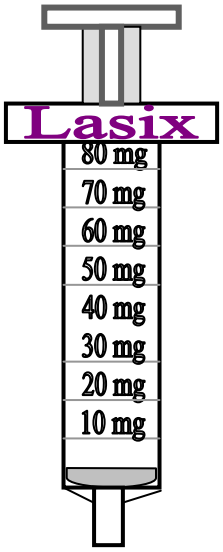
Review of Measuring Devices



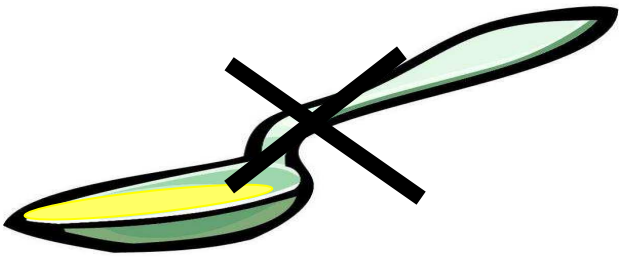
Medication Cup
Use on a level surface when measuring



Oral Dropper/Syringe
Use when measuring amounts less than 5 ml.



Special Oral Measuring Device
This measuring device has measurements of **mg instead of ml**. The oral syringe above would be used for measuring Lasix Solution.



Household Utensil
Do **NOT** use for measuring medications

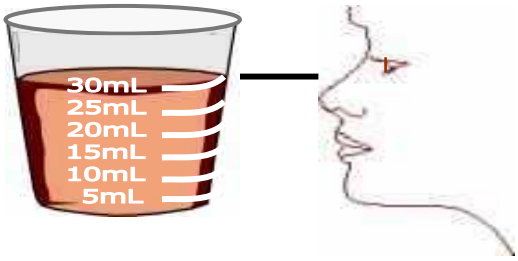
HANDOUT I-2

ALWAYS

1. **ALWAYS measure using the metric system.**

2. **ALWAYS use an oral measuring syringe for small amounts of liquid medication.**

3. **ALWAYS hold cups at eye level when measuring.**



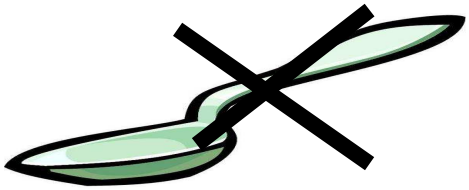
4. **If the label says to measure in mls, ALWAYS use a measuring device that is marked in mls.**

5. **If the label says to measure in mgs, ALWAYS use a measuring device that is marked in mgs for that medication.**

6. **ALWAYS consult your pharmacist when you have a question about measuring.**

NEVER

1. **NEVER use household spoons.**



2. **NEVER use cups that are not marked with the amount they hold.**

3. **NEVER switch the special droppers that come with some liquid medications.**

4. **NEVER measure mls with a measuring device that is marked in mgs.**

5. **NEVER measure mgs with measuring devices that are marked in mls.**

mg ≠ ml

6. **NEVER leave air bubbles mixed with the liquid in an oral measuring syringe.**

MEASURING TIPS

10cc = 10ml
20cc = 20ml
30cc = 30ml

TIP: use an oral syringe for amounts less than 5ml

Reminder: 1cc = 1ml
A cubic centimeter is the same as a milliliter.

mg. ≠ ml.

A mg is NOT the same as a ml ! ! !

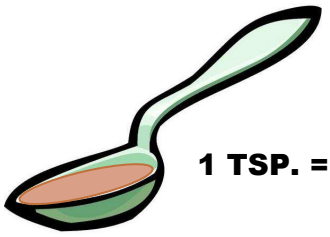
TIP: Always read the label carefully to be sure you are measuring the right thing.

←15ml→

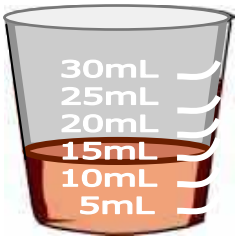
If the strength of a medication is 20mg/5ml, this 15ml cup contains 60*mg* of medication.

If the strength of a medication is 40mg/5ml, this 15ml cup contains 120*mg* of medication.

YOU CAN'T TELL THE DIFFERENCE BY LOOKING

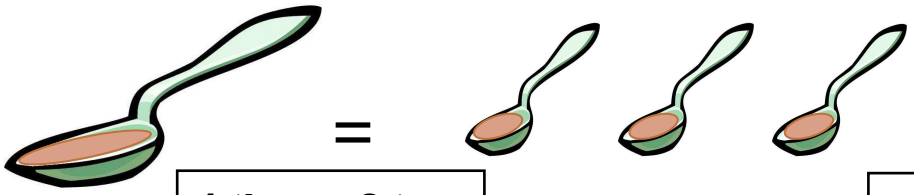


1 TSP. = 5ml.



TIP: Don't use household teaspoons. They are not accurate!

TIP: To be accurate, use the correct measuring tool. Ask your pharmacist. Some liquid medicines have special measuring tools.

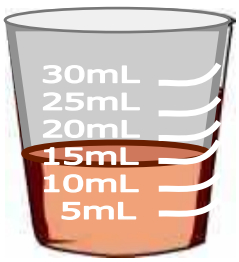


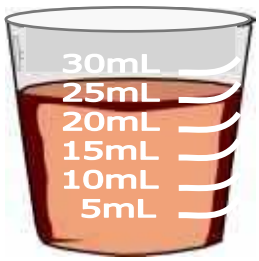
=

1 tbsp. = 3 tsp

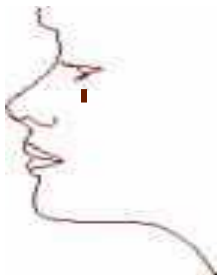
=

3 tsp. = 15ml





25 mL



TIP: When measuring liquids, hold the cup at eye level.

HANDOUT – Additional Resources

10 Tips for Administering Medication to the Cognitively Impaired Resident

INTRODUCTION: Accurate, safe medication administration means giving the *right drug* to the *right resident* in the *right dose* by the *right route* and at the *right time*, and documenting correctly. Achieving these goals can be a challenge with the cognitively impaired resident. Because they have difficulty with thinking, reasoning and remembering, these residents may, at times, be resistant, suspicious, or even aggressive. These problems may be compounded if the resident has difficulty chewing or swallowing. Caregivers must fine-tune skills to meet these unique challenges. The following will help caregivers to achieve medication administration:

1. Respect A diagnosis of cognitive impairment is no different than any other diagnosis when it comes to respect. Knock before entering the resident's room. A cheery "good morning" and a pleasant "please" and "thank you" may be the deciding factors as to whether the resident chooses to take the medication or not. Regardless of the resident's response, show respect in every aspect of your behavior.

2. Explain But keep it simple. Remember that the resident has the right to be informed and to be involved in his/her treatment. Some residents may understand single words only. Mirroring is a good technique to use to indicate what you want the resident to do. The simple action of placing an empty medication cup in your lips might be sufficient to get the resident to do the same.

3. Encourage Compliance Residents frequently refuse to take medications. Encourage, but be gentle. A non-confrontational approach and a gentle manner go a long way when it comes to persuasion. Be persistent. Residents who refuse medications one minute will often accept the next. Remember, the resident ultimately has the right to refuse. Force is *never* acceptable.

4. Make Eye Contact We speak volumes with our eyes. Cognitively impaired residents often have difficulty with verbal communication. Making eye contact when speaking helps the resident understand what you are saying. Teach your eyes to say, "I want you to take this medication because I care about you".

5, Adequate Fluids Offer fluids before giving the medication. A drink of juice or some pleasant-tasting beverage not only moistens the mouth, but evokes positive feelings as well. This will aid swallowing and help to prevent the medication from sticking inside the cheek or to the tongue. Don't forget to give plenty of fluids after the medication has been swallowed. The general rule is 8 oz unless fluid restriction is ordered.

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HANDOUT– Additional Resources

6. Crush Medications Crushing medications may be done in accordance with facility's policy and procedures. A physician's order is needed to crush medications. There are some medications that should not be crushed, e.g., enteric coated and delay release, and if there is no alternative for the medication, there has to be a physician's order specifically for the medication to be crushed. When in doubt on whether a medication can be crushed, contact your supervisor and/or pharmacist.

7. Be Patient Rushing not only agitates. Rushing may also cause choking and errors.

8. Observe & Report Be aware of any changes with a resident. The length of time that a resident takes a drug may alter the effectiveness of the drug, or have unwanted effects. Psychoactive drugs, those that affect the brain have long-term negative effects in the elderly. Report your observations promptly to the health care provider.

9. Document Record the date and time of every medication that you administer, if a drug is not given, record the reason why. Record the reason for administering, and effectiveness of all PRN (as needed) drugs.

10. Communicate Opening communication with residents, family and health care providers is a must. Frequent reviews of the resident's drug regiment should be done to reduce dosages or eliminate unnecessary drugs.

Good medication administration procedures combined with individualized care-giving strategy equals ***mission accomplished!***

Adapted from National **Gerontological** *Nurses Association. 2000 Horizons Christine A. Stacy, MS, RN, BC*

HANDOUT – Additional Resources

General Guidelines for Transcribing Orders onto the MAR

- **Transcribe** - means to write down or to copy from one place to another.
    - With medication administration, transcribing orders is when the information from the order is transferred or copied to the MAR.
    - When an order is received from the prescribing practitioner, the information from the order is transcribed to the current MAR.
    - With medication transcription, it is important to follow certain guidelines to ensure accuracy and compliance.

- If you are responsible to transcribe an order to the MAR, the following are basic guidelines to follow:
    - Transcribe the information from the order onto the MAR only if you are able to read all the information on the order.
    - Transcribe the information on the MAR only if the order is complete for administering the medication.
    - Transcribe all the information onto the MAR as it is written on the order.

Other guidelines for transcription onto MARs:

- Do not use abbreviations

- Record each medication ordered from the order form to include:
    - Name and strength of the medication
    - Dose, Route and Time(s) the medication is to be given
    - Date the medication is to be started
    - Date the medication is to be stopped (if provided)
    - The date and name of person who transcribed the order should be documented

- Mark out days the medication is not to be given **IF** the medication is not prescribed every day.

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- For new orders, include the date and indicate the time to start.
- Count number of dosages to be administered instead of number of days when calculating stop dates for medication orders that have been prescribed for a specific time period, such as antibiotics
- Do not schedule PRN orders for administration at specific times; are administered when resident "needs" the medication for a certain circumstance
- If a medication order is discontinued (stopped or changed) by the prescriber, Discontinue or D/C (abbreviation for discontinued) should be noted for the medication. The date discontinued and your initials should be included.
- If the medication is not discontinued BUT the dose is reduced or changed, this should be transcribed as a NEW medication order. The old order would be discontinued on the MAR. The new order with the revised dosage would be transcribed onto the MAR exactly as a new order would be.

NOTE: It is important to follow the facility policy regarding how a discontinued medication is indicated on the MAR as procedures may vary. When a new medication is ordered, changed or discontinued, be sure to notify the resident of changes.

Appendix

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