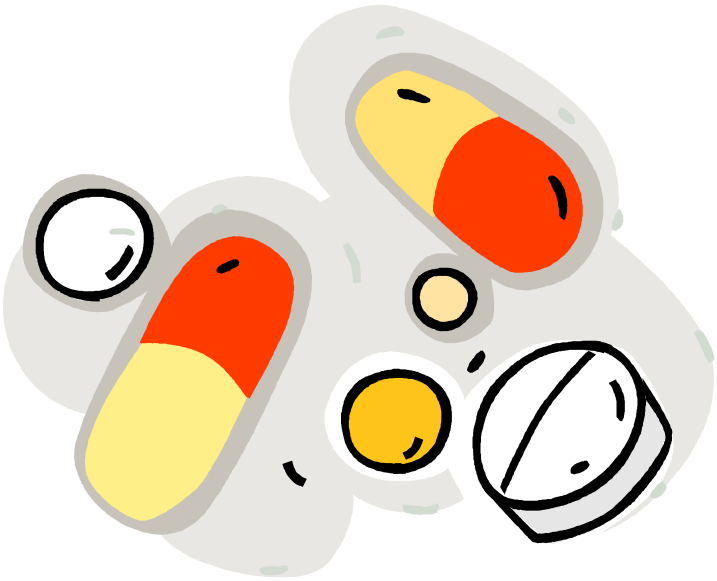
Medication Administration

5-Hour Training Course for Adult Care Homes

Instructor 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: 5-hour Training Course for Adult Care Homes*** was developed as a joint effort by the Center for Nurse Aide Education and Regulation and Adult Care Licensure Section of the Division of Health Service Regulation, N.C. Department of Health and Human Services.

The curriculum for the 5-hour training course was 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 a 5-hour, 10-hour and 15-hour standardized training course to assist qualified instructors to train unlicensed staff who will administer medications to residents in Adult Care Homes. Each training course includes an instructor manual, materials for a student manual and a certificate template required for participants who successfully complete the course(s).

Course Description

- The 5-hour training course was built around the current skills checklist required for medication staff in adult care homes. The majority of the 5-hour course schedule centers around time spent for instruction and validation of skills required for medication administration. Individuals are expected to pass the clinical skills tasks with 100% competency demonstrated. The design of the course was for a small class of employees or 1:1 training for a specific facility.

- 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 does include 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 was 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 was for a larger class than the 5-hour training course but limited 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.

Medication Aide Course Training Requirements and Directions for Instructor Manual

Minimum Requirements

This course has been prepared for instructors qualified to teach state-mandated content in medication administration to unlicensed staff employed in adult care homes.

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: 5-hour course for adult care homes:

- Prerequisite: Prerequisite Skills Review and Validation
- Section 1: Basic Medication Administration Information/Terminology
- Section 2: Medication Orders
- Section 3: Administration of Medication Theory (Including skills validation)
- Section 4: Ordering, Storage and Disposal of Medications
- Section 5: Medication Administration Skills Checklists

Classroom Instruction

Teaching Guide is at the beginning of each section and serves as a resource to prepare the instructor to teach the section. It lists the objectives to cover, handouts and activity sheets to duplicate, and supplies.

Blocks of content are included within the confines of borders or boxes and specify what is to be taught to the students during classroom instruction.

Teaching tips are included that complements the content and provides the instructor with ideas and suggestions to clarify information, involve students in discussion, and engage students with varied learning strategies. It is an expectation that the instructor will consistently incorporate teaching tips during the teaching of the content. Each teaching tip is preceded by a symbol, ☑ followed by a brief title of the teaching tip. Each instructor will incorporate the material with her/his presentation style but the content is to be covered throughout the course presentation.

Suggested activities promote student-centered learning and actively engage the students in the learning process. Activities provide the students with opportunities to practice what they have learned in class. The use of activities energizes the classroom, breaks-up the monotony of passive receipt of information through lecture and provides a deeper understanding of content by the students. Some activities involve the duplication of activity sheets.

Skills Requirements

The skills portion of the 5-hour and 15-hour training courses consist of skills critical to correct medication administration practice.

First, demonstration of skills must be performed by a qualified instructor. As the instructor demonstrates each skill, the students should have an unobstructed view of the process and have skill check sheets available to refer to and follow along as the instructor proceeds through the steps of the skill.

Guided student practice is a vital component of skill acquisition. Guided student practice is best done right after skills demonstration. During this type of student practice, the instructor observes the practice sessions and provides descriptive feedback. The instructor must be astute and correct errors during guided practice to prevent the repetition of errors. If a student continually practices a skill incorrectly, there is a great risk that the student will continue to perform the skill incorrectly during the skill check-off and while providing care to residents.

Skill check-offs are performed after demonstration and student practice have taken place. Skills check-offs for infection prevention and administration of oral, ophthalmic, otic, nasal, inhalant, transdermal and topical medications are considered basic medication administration skills to which the unlicensed person must demonstrate competency validation. Optional skills check-off for subcutaneous injections is included. A unlicensed person who will perform the "optional" task must be competency validated by a Registered Nurse.

Documentation

The adult care home must maintain documentation of successful completion of the medication administration training courses for each unlicensed staff that performs medication aide duties and successfully completes training. Documentation maintained in the employee's file includes the certificate of successful completion of required training courses and skills check offs for basic medication administration skills identified above. For 5-hour and 15-hour training courses performed specifically for staff of an adult care home, the skills check-offs completed during the training course may be used to meet the documentation of competency validation.

Requirements for Instructors

Instructors of the ***Medication Administration: 5-hour and 10/15-hour Aide Training Courses for Adult Care Homes*** should be a Registered Nurse or licensed pharmacist in good standing with their North Carolina occupational boards and knowledgeable in teaching current standards of practice of medication administration and infection prevention and regulations related to adult care homes. Skills for the basic medication administration skills listed above must be validated by the Registered Nurse or licensed pharmacist. Any other skills for routes of administration, including the "optional" administration routes listed above must be validated by a Registered Nurse.

Student Manual

A student manual may be created using the handout and activities. The student may benefit from review of the materials prior to the training. The student should receive a copy of the skills checklist. The information will help the student understand and perform the basic competencies required to safely administer medications by the following routes: oral, sublingual (under the tongue), otic (ear), ophthalmic (eye), nasal (nose), topical (on the skin), and inhalant (breathed into the lungs).

Course Objectives

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 1: Basic Medication Administration Information/Terminology

At the completion of this section, the student should:

1. Match common medical abbreviations with their meaning.
2. List and describe common dosage forms of medications.
3. List and describe common routes of medication administration.
4. List the six rights of medication administration.
5. Describe what constitutes a medication error and actions to take when a medication error is made or detected.
6. Describe resident's rights regarding medications – refusal, privacy, respect, and chemical restraint.
7. Define medication "allergy" and describe responsibility in relation to identified allergies and suspected side effects.
8. Demonstrate the use of medication resources or references.

Section 2 – Medication Orders

At the completion of this section, the student should:

1. List/recognize the components of a complete medication order.
2. 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.
3. Describe the responsibility of the Medication Aide in relation to admission orders, readmission orders, and FL-2 forms.
4. Identify required information on the medication label.

Section 3 – Medication Administration

At the completion of this section, the student should:

1. Demonstrate correct infection control concepts during medication administration.
2. Compare and contrast the documentation of routine medication administration and PRN medication administration.
3. List commonly used abbreviations and terminology related to medication administration.
4. Demonstrate proficiency in reading a medication label.
5. Use the Six Rights to administer oral, topical, eye, ear, inhalant, vaginal and rectal medications – right resident, right medication, right dose, right route, right time, and right documentation.
6. Demonstrate the use of the Medication Administration Record (MAR).
7. Identify proper action to take when special circumstances occur in relation to medication administration.

Section 4 – 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.

Course Schedule

Section	Estimated Allotted Time in Minutes
Prerequisite Skills Review and Validation	30 minutes
Section 1: Basic Medication Administration Information/Terminology	30 minutes
Section 2 Medication Orders	30 minutes
Section 3 Medication Administration (Includes Skills Checklists)	180 minutes
Section 4 Ordering, Storage and Disposal of Medications	30 minutes
Total	300 minutes

Prerequisite Skills Review and Validation

Prerequisite Skills Review and Validation

Objectives

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

Note: Medication Administration will require the Medication Aide to measure the vital signs of residents who are taking particular medications. The instructions should be a review since measuring vital signs is included in both the nurse aide training and the personal care aide training curricula.

Content

☑TEACHING TIP #1: Prerequisite Skills Review and Validation

Tell students:

- Before taking the 5-hour or 15-hour Medication Aide Course, you must be able to demonstrate how to obtain and record the following: temperature, pulse, respirations, and blood pressure.
- If the student already has competency validation for obtaining vital signs at the facility, the student is not required to demonstrate competency in measuring and recording vital signs. Documentation will be needed to reflect competency has already been demonstrated. Discuss devices for measuring vital signs that will vary. It is important students understand what measurements are within range and when to report the measurements.

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 heart rate, heart rate measured at the thumb side of the inner wrist
- For apical heart rate, 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

Prerequisite Skills Review and Validation
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
☑TEACHING TIP #2: Glucose Monitoring [ONLY REQUIRED IF MEDICATION AIDE WILL BE PERFORMING TASK] **Prerequisite Skills Review and Validation** Tell students: • Before taking the 5-hour and/or 15-hour Medication Aide Course, you must be knowledgeable about standard precautions with glucose monitoring. • If the student has NOT already completed the ***Infection Control Course*** for Adult Care Homes, the student should complete at least **Section 3: Bloodborne Pathogens** of the ***Infection Control Course***. Review procedures for the following activities related to glucose monitoring at the adult care home and teach/demonstrate: calibrating and cleaning the machine; range of glucose levels for the machine; interventions and policies when blood sugar values are too low or too high; and which machines are for single-resident use and which machines that are not.
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
Proceed to Section #1

Section 1

Basic Medication Administration Information/Terminology

Section 1 – Basic Medication Administration Information/Terminology

Objectives:

1. Match common medical abbreviations with their meaning.
2. List and describe common dosage forms of medications.
3. List and describe common routes of medication administration.
4. List the six rights of medication administration.
5. Describe what constitutes a medication error and actions to take when a medication error is made or detected.
6. Describe resident's rights regarding medications – refusal, privacy, respect, and chemical restraint.
7. Define medication "allergy" and describe responsibility in relation to identified allergies and suspected side effects.
8. Demonstrate the use of medication resources or references.

Advance Preparation – In General

- Review curriculum and presentation materials and activity
- Add examples or comments
- If no student manual used, prepare copies of handouts for section for each student

Supplies

- **Handouts**
  - #1A – Abbreviations
  - #1B – Common Routes of Medication Administration
  - #1C – Common Dosage Forms of Medications
  - #1D – Six Rights of Medication Administration
  - #1E – Medication Errors
  - #1F – Residents' Refusal to Take Medications
- Equipment and Supplies Used During Administration of Medications
  - Refer to page 1-3 for examples of supplies and equipment to show students
- Medication Resources or References used at adult care home
- Medication Policy and Procedure for adult care home

Advance Preparation – Medication Resources or References Activity

Refer to instructions on page 1-9 for activity

Section 1 – Basic Medication Administration Information/Terminology

Objectives

1. Match common medical abbreviations with their meaning.
2. List and describe common dosage forms of medications.
3. List and describe common routes of medication administration.
4. List the six rights of medication administration.
5. Describe what constitutes a medication error and actions to take when a medication error is made or detected.
6. Describe resident's rights regarding medications – refusal, privacy, respect, and chemical restraint.
7. Define medication "allergy" and describe responsibility in relation to identified allergies and suspected allergic reactions.
8. Demonstrate the use of medication resources or references.

Content

☑ TEACHING TIP: Infection Control Course

Determine whether students have had the Infection Control Course required for adult care home staff. If not, the student should complete the training as soon as possible. Information on infection control in this course is minimal

☑ TEACHING TIP: Abbreviations

If available, locate the approved abbreviation list at the adult care home and point out this to the students

Common Abbreviations

- Abbreviation – a shortened form of a word or phrases
- Often used in medical and residents' records, such as physician's orders
- Medication Aides must learn abbreviations for terms common to medication administration
- On the Medication Administration Record (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

☑ HANDOUT #1A: Abbreviations

Distribute a copy of the handout, *Abbreviations* to each student, or locate handout in Student Manual

Section 1 – Basic Medication Administration Information/Terminology

☑ TEACHING TIP: Abbreviations Handout

Tell students:

- These are abbreviations that you will see frequently when you give medications to your residents
- You should learn these abbreviations

☑ HANDOUT #1B: Common Routes of Medication Administration

Distribute a copy of the handout on Common Routes of Medication Administration to each student or locate handout in Student Manual

☑ TEACHING TIP: Common Routes of Medication Administration

Referring to the handout and the content below, discuss the common routes of medication administration. Use visual aids if available

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 #1C: Common Dosage Forms of Medications

Distribute a copy of the handout on Common Dosage Forms of Medications to each student or locate handout in Student Manual

☑ TEACHING TIP: Common Dosage Forms of Medications

Referring to the handout and the content below, discuss the common dosage forms of medication administration. Use visual aids if available

Section 1 – Basic Medication Administration Information/Terminology

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

☑ Teaching Tip: Introduction to Equipment and Supplies Used During Administration of Medication

Show examples of supplies and equipment used during medication administration

Section 1 – Basic Medication Administration Information/Terminology

Equipment and Supplies Used During Administration of Medication

- Medication cart
- MAR for each resident
- Soufflé cups for oral medications in pill or capsule form
- Calibrated plastic cups and oral syringes or droppers for oral liquid medications
- Alcohol wipes for use with injections
- Insulin syringes for use with insulin administration
- Sharps equipment
- Band-Aids for use with injections
- Lubricant for use with suppositories
- Blood pressure cuff, stethoscope, blood glucose meter as needed
- Gloves to use when coming into contact with mucus membranes (administering vaginal or rectal suppositories) and blood/body fluids (administering injections)
- Water cup and water for resident to drink when taking oral medications
- Soap/water/paper towels or alcohol-based hand rubs to use before preparing medications/before administration of medication to each resident/after administration of medication to each resident
- Food, such as applesauce or pudding to use when administering crushed medications

☑ **HANDOUT #1D: Six Rights of Medication Administration**

Distribute a copy of the handout on Six Rights to each student or locate handout in Student Manual

Referring to the handout and the content below, discuss the Six Rights of Medication Administration

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 and writing down if a medication ordered was not administered and the reason it was not administered

Section 1 – Basic Medication Administration Information/Terminology

☑ HANDOUT #1E: Medication Errors

Distribute a copy of the handout on Medication Errors to each student or locate handout in Student Manual

Referring to the handout and the content below, discuss the definition of medication errors, examples and the Medication Aide's role

Medication Errors

- Describe – occurs when the administration of a medication is not as prescribed by the doctor or prescribing practitioner; 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
- Medication Aide's role
  - Understand 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

Medication Administration and Resident's Rights – Importance and Examples

- Respect – how the resident is addressed
  - Do not interrupt 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
- 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

Section 1 – Basic Medication Administration Information/Terminology

- 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 restraint – means a drug that is used for discipline or convenience and not used to treat a medical symptom
  - Do not administer medications, especially psychotropics, for staff convenience

☑ **HANDOUT #1F: Resident's Refusal to Take Medications**

Distribute a copy of the handout on Reasons for Resident's Refusal to Take Medications to each student or locate handout in Student Manual

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

Recognizing and Reporting Side Effects

- 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 adult care home'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 when there is a change in the resident without contact with the resident's physician

Section 1 – Basic Medication Administration Information/Terminology

- 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 insure safe care, the Medication Aide must be taught how to observe and report changes in the resident 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

☑ TEACHING TIP: Medication Resources or References

Locate and demonstrate use of the following written materials housed at the adult care home: medication resources, reference books, manuals and/or pharmacy information sheets; and policy and procedure manuals, particularly the sections that address medication administration. Resources written for non-health professionals are recommended for use by Medication Aides instead of references written for health professionals, such as *The Physician's Desk Reference (PDR)*

Examples of Resources to use:

- The Pill Book Mass Market Paperback by Harold M. Silverman (Author)
- The PDR Pocket Guide to Prescription Drugs [Mass Market Paperback] PDR Staff (Author)
- Complete Guide to Prescription & Nonprescription Drugs Paperback – by H. Winter Griffith (Author)

☑ ACTIVITIES: Medication Resources or References

Require each student to

- Look up at least three unique medications commonly ordered for residents living in adult care homes in a medication resource/reference book, such as Lasix, Coumadin, and Synthroid
- View the table of contents in the policy and procedure manuals at the adult care home and look up and read about at least two policies/procedures regarding medication administration

Proceed to Section #2

Section 2

Medication Orders

Section 2 – Medication Orders

Objectives:

1. List/recognize the components of a complete medication order.
2. 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.
3. Describe the responsibility of the Medication Aide in relation to admission orders, readmission orders, and FL-2 forms.
4. Identify required information on the medication label.

Advance Preparation – In General

- Review curriculum and presentation materials and activity
- Add examples or comments
- If no student manual used, prepare copies of handouts for section for each student

Supplies

- **Handouts**
  - #2A – Medication Orders
  - #2B – FL-2 (Blank)
  - #2C – Medication Administration Record (Blank)
  - #2D – FL-2 for Garrett Clayton for Transcription Activity
    (Answer to activity is the MAR for Garrett Clayton Handout # 2E)
  - #2F – Medication Label

- MARs, Medication Labels or Physician Order Forms used at adult care home to use in activities or show students

Advance Preparation – Activities

- Refer to instructions on page 2-4 for Medication Order Activity
- Refer to instructions on page 2-6 for Medication Orders and Transcription Activity
- Refer to instructions on page 2-7 for Medication Label Activity

Section 2 – Medication Orders

Objectives

1. List/recognize the components of a complete medication order.
2. 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.
3. Describe the responsibility of the Medication Aide in relation to admission orders, readmission orders, and FL-2 forms.
4. Identify required information on the medication label.

Content

☑ **TEACHING TIP: Medication Orders Content**

Tell students:

- Because nurses are not required to be employed in adult care homes, Medication Aides may be responsible for receiving and transcribing orders.
- It is important that you understand required procedures as well as the limitations of your role in medication documentation.
- You will need to pay close attention to the material because you are required to demonstrate competency of handling medication orders.

Definition of an Order

- 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

- 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
- Orders for psychotropic medications prescribed for PRN administration must include
  - Symptoms that require the administration of the medication
  - Exact dosage
  - Exact time frame between dosages
  - Maximum dosage to be administered in 24-hour period

Section 2 – Medication Orders

- Example – Ativan 0.5 mg. by mouth every 4 hours PRN for pacing or agitation**;** physician must be contacted if more than four doses are needed in 24-hour period.

☑ HANDOUT #2A: Medication Orders

Distribute a copy of the handout, *Medications Orders* to each student, or locate handout in Student Manual.

☑ TEACHING TIP: Medication Orders

Refer to the Medication Orders handout and tell students

- An order is required to administer, change or discontinue any medication or treatment
- It is important to know the components of a medication order
- Contact the prescribing health care provider if the order is not legible - DON'T GUESS!
- If an order is not complete or clear on how to administer, the Medication Aide must contact supervisor or physician – DON'T GUESS!

Discuss the different types of medication orders, examples and the difference between a routine medication order and a PRN medication order

☑ ACTIVITY: Medication Orders Activity

Refer the students to the lower section of the Medication Orders handout and require them to complete the activity. Discuss answers with students upon completion.

Telephone or Verbal Orders

- Although regulations for adult care homes allow Medication Aides to accept telephone or verbal orders, the policy for the adult care home may only allow written orders from the prescribing practitioner. The pharmacy also may not accept a verbal order from a Medication Aide
- It is important the Medication Aide always repeat the order back to the prescribing practitioner
- Order is to be dated and signed by person receiving the order and signed by the prescribing practitioner within 15 days of when order is received
- A copy of an order, including a telephone order, is always kept in resident's record

☑ OPTIONAL HANDOUT #2B: FL-2

Distribute a copy of the handout, FL-2 to each student, or locate handout in Student Manual.

Section 2 – Medication Orders

☑ OPTIONAL HANDOUT #2C: Medication Administration Record (MAR)

Distribute a copy of the handout, Medication Administration Record (MAR) to each student, or locate handout in Student Manual.

☑ TEACHING TIP: Documentation

Locate examples of an FL-2, physician's order sheet and other forms of documentation used by the facility regarding orders and medication administration. Review these examples with the students.

Tell students

- Documentation is an important part of medication management.
- It is frequently referred to as the "6th Right" of medication administration.
- Forms used to document can be quite confusing to unlicensed people who are unfamiliar with the process.
- Medication Aides must know how to use the MAR and other forms to insure safe medication management.

Forms Commonly Used to Document Medication Orders – FL-2 Form

- FL-2 form is required for new admissions in adult care homes
- Important that all information on FL-2 is reviewed for accuracy
- If any clarification is needed, contact prescribing practitioner
- If FL-2 has not been signed within 24 hours of admission
  - Verify orders with prescribing practitioner by fax or telephone
  - 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

Forms 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 resident's record.

Form Commonly Used to Transcribe Medication Orders – Medication Administration Record (MAR)

- **Each resident has a medication administration record (MAR)**
- Form onto which medication and treatment orders are transferred
- Record of all medications and treatments to be administered
- Record of staff who administered medications
- Record of medication not administered and the reason
- Record of staff who administered medications

Section 2 – Medication Orders

Transcription of Orders Onto MAR

- Transcribe means to write down or to copy
  - 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
  - Initial or sign and date orders written on the MAR
  - Transcribe using proper abbreviations or written out completely; include all components of a medication order
  - 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; 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

☑ ACTIVITY: Medication Orders and Transcription Activity

Distribute the MAR (Handout # 2C) and FL2 for Clayton Garrett (Optional Handout #2D). Have the student enter the resident's personal identification onto the MAR. Then choose several drugs listed on the FL-2 (Handout #2D) and require students to transcribe orders onto the blank MAR. Discuss answers (Handout #2E) with students upon completion.

☑ TEACHING TIP: Medication Label

Locate a medication label or a copy of a medication label provided by the pharmacy provider for the facility and discuss the location of information below on the label.

Medication Labels

- Information required:
  - 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)

Section 2 – Medication Orders

- 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

HANDOUT #2F: Medication Label Handout

Distribute a copy of the handout, *Medication Label*, or locate handout in Student Manual

☑ TEACHING TIP: Medication Label

Refer to the Medication Label handout and tell students

- Directions on medication label from pharmacy are checked against the MAR.
- If there is a discrepancy between the information on the MAR and the medication label, check the order in the resident's record.

☑ ACTIVITY: Medication Label Activity

Refer the students to the lower section of the Medication Label Activity handout and require them to complete the activity. Discuss answers with students upon completion.

☑ TEACHING TIP: Discrepancies Between Medication Label and Order Entry on the MAR

Review the procedure for discrepancies between the medication label and order entry on the MAR and teach the procedure.

Proceed to Section #3

Section 3

Medication Administration

Section 3 - Medication Administration

Objectives:

1. Demonstrate correct infection control concepts during medication administration.
2. Compare and contrast the documentation of routine medication administration and PRN medication administration.
3. Recognize the need to document in the resident's record when necessary.
4. Describe correct documentation of medication.
5. List commonly used abbreviations and terminology related to medication administration.
6. Demonstrate proficiency in reading a medication label.
7. Use the Six Rights to administer oral, eye, ear, nasal, inhalant topical medications and subcutaneous injections – Right RESIDENT, Right MEDICATION, Right DOSE, Right ROUTE, Right TIME, and Right DOCUMENTATION.
8. Demonstrate the use of the Medication Administration Record (MAR).
9. Identify proper action to take when special circumstances occur in relation to medication administration.

Advance Preparation – In General

- Review curriculum and presentation materials and activity
- Add examples or comments
- If no student manual used, prepare copies of handouts for section for each student
- Copies of Skills sheets for each student

Supplies

- Handouts
  - #3A – Injection Safety Diabetes and Viral Hepatitis
  - #3B – Review of Measuring Devices
  - #3C – Always and Never Measuring Tips
  - #3D – Measuring Tips
  - #3E – Technique and Use of Meter Dose Inhalers
- Supplies for Hand Hygiene Activity
  - Alcohol – based hand rub product
  - Soap, Paper Towels and Accessibility to Sink
- Gloves (Different sizes) – for Optional Activity
- Equipment and Supplies needed for Skills Checklists
- Sharps Container, Syringes, Single use Lancets, Reusable Lancing Device, Glucose Monitoring Device and any agents for cleaning and/or disinfecting per manufacturer

Advance Preparation – Activities

Refer to instructions on page 3-4 (Hand Hygiene), 3-6 (Gloves) and 3-9 (MAR) Activities

Section 3 – Medication Administration

Objectives

1. Demonstrate correct infection control concepts during medication administration.
2. Compare and contrast the documentation of routine medication administration and PRN medication administration.
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7. Use the Six Rights to administer oral, eye, ear, nasal, inhalant topical medications and subcutaneous injections – Right RESIDENT, Right MEDICATION, Right DOSE, Right ROUTE, Right TIME, and Right DOCUMENTATION.
8. Demonstrate the use of the Medication Administration Record (MAR).
9. Identify proper action to take when special circumstances occur in relation to medication administration.

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

Section 3 – Medication Administration

- Do not administer medications from single-dose or single-use vials, ampules, bags or bottles to more than one resident
- 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

☑ TEACHING TIP: Alcohol-based Hand Rub

Locate alcohol-based hand rub product used in the adult care home. Read manufacturer's directions to determine amount of product needed. Show alcohol-based hand rub product to students, pointing out the amount of product required

ACTIVITY #1: Hand Positions During Hand Hygiene (Optional)

Distribute WHO's How to Hand Rub? How to Hand Wash? Activity Handout #1 to students

While referring to the WHO Hand Rub/Hand Wash Handout, talk through and demonstrate each hand motion during hand hygiene and notice to make sure the students are following along and copying what is being demonstrated:

- Rub hands, palm to palm
- Rub right palm over left back of hand with interlaced fingers; and then switch
- Rub palm to palm with interlaced fingers
- Rub backs of fingers to opposite palm with fingers interlocked
- In a rotational motion, rub left thumb while clasping in right palm; and then switch
- In a rotational backwards and forwards motion, rub left palm with clasped right fingers; and then switch
- Grasp right wrist with left hand; and then switch

Your Hands – Other Important Points

- There are other things you can do to prevent the spread of infection
- Fingernails
  - Keep nails short and clean
  - Do not wear fake nails, gel nails or nail extensions, because they can hide harmful germs
- Jewelry
  - Leave at home because harmful germs can stick to jewelry

The student will have to demonstrate competency with Hand Wash and Hand Rub

Section 3 – Medication Administration

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 care worker will or think will come into contact with blood or body fluids (urine, stool, spit, mucus coughed up)
- Wear gloves any time health care worker will or think will come into contact with non-intact skin (opened up skin, such as sores or cuts)
- Wear gloves any time health care worker will or think 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

Section 3 – Medication Administration

- 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
- 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

ACTIVITIES #2 and #3: Gloves (Optional)

Follow instructions for Activity #2: Glove Sizing
Follow Instructions for Activity #3: Gloves, Gloves, Gloves

The student will have to demonstrate competency with putting on and removing gloves

☑ TEACHING TIP: Handout # 3 A: Injection Safety Diabetes and Viral Hepatitis

Distribute the handout, Injection Safety, Diabetes and Viral Hepatitis, and review infection prevention for assisted glucose monitoring and insulin injections

☑ TEACHING TIP: Locating Equipment and Supplies

Locate and familiarize self with equipment used during medication administration in the adult care home, such as medication cart and medication cups

Gathering Appropriate Equipment and Supplies

- Equipment and supplies needed will depend on medications to be administered, but will need to include at least the following
  - Medication administration records (MAR)
  - Medication cups for oral medications
  - Sufficient fluids available to administer medications
  - Soap and water to wash hands (if not available, alcohol-based hand rub)
  - **Keep supplies and equipment used in administering medications clean and orderly, such as medication carts, trays and pill crusher**

Section 3 – Medication Administration

☑ **TEACHING TIP: Identifying Residents Before Administering Medications**

Review the procedure for identifying residents before administering medications at the adult care home and teach/demonstrate the procedure

After teaching/demonstrating the procedure used at the adult care home, tell the students the following

- Most common method used for identifying residents before administering medications is photographs of residents in the medication administration records
- Photos should be kept updated and photograph is to have the name of the resident on it

Relying on other staff to identify residents for medication administration is not appropriate

☑ **TEACHING TIP: Medication Administration Record (MAR) and Medication Label**

Review the facility's medication administration record and procedure for transcribing orders onto the medication administration record and standard times for administration of medications

Demonstrate how the medication administration record and medication label are compared to ensure safe and accurate administration

The MAR and the Medication Label

- The Medication Aide uses the MAR every time when preparing and administering medications
- **Do Not Ever Give Medications From Memory!!!**
- Compare the medication label to the MAR three times to make sure the medication is labeled for this resident and that it is the right medication, right dose, right route and right time
  - The **first** check happens when removing the medication container from where it is stored
  - The **second** check happens just before or after opening the medication and preparing it for the resident
  - The **third** check happens after pouring the medication and before the medication is given to the resident
- The MAR is designed to promote safe and accurate medication administration
- Information on the MAR must be clearly written and kept updated
- The information on the MAR and the medication label should match, unless there has been a change in directions
  - The Medication Aide must be familiar with the adult care home's policy on direction changes
  - A medication label should only be changed or altered by the dispensing practitioner

Section 3 – Medication Administration

Timing of Medication Administration

- Important to understand timing in relation to administering medications, i.e., insulin and medications ordered to be administered on an empty stomach or in relation to meals
- Timing of medications in relation to meals
  - Before meals – medication generally administered within 30 minutes prior to the resident eating meals
  - With meals – medication generally administered when the resident is eating meals or right after finishing meals
  - After meals – medication administered after the resident has finished eating meals up to 30 minutes afterwards
- Residents in the facility during the medication pass should receive their medications within a window of time one hour prior to and one hour after the scheduled administration time on the MAR, except in the case of medications prescribed for administration in relation to meals or medications such as insulin
- If unsure about giving a medication because it is outside the designated time frame
  - Contact a supervisor or a health care professional regarding administration of the resident's medications or to determine if prescribing practitioner should be contacted
  - The medication should not be omitted without contacting a supervisor or a health care professional or prescribing practitioner

☑ TEACHING TIP: Documentation of Medication Administration on the MAR

Review the policies and procedures for documentation of routine and PRN medications, refusal or omission of medications using the correct forms and process

Documentation of Medication Administration

- The MAR has a space where the Medication Aide is to initial that a dose is given under the correct day and time
- The MAR is signed or initialed immediately after the medications are administered and prior to the administration of the next resident's medications
- Sign or document on the MAR only after observing the resident take the medications
- Pre-charting is not permitted and this includes signing the MAR anytime prior to the medications being administered
- Document an equivalent signature to correspond with the initials used on the MAR
- Do not erase or cover errors. If an error is made in the documentation on the MAR, follow the facility's policy to correctly document medication errors

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

Section 3 – Medication Administration

- Document effectiveness of the medication when determined
- A different employee, depending on time of administration and shift schedules may record the effectiveness of the medication. 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 may not be administered more frequently than physician has ordered
- The need for medication may be based upon the 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

Documentation in Resident's Record

- Document any contact with the prescribing practitioner or health care provider regarding a resident in the resident's record
- The employee also must be knowledgeable of the facility's procedures for documenting information that needs to be communicated to other staff or health professionals. This may be in the resident's record or on some other document used to communicate with staff or health professionals

Review of Documentation

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

☑ ACTIVITY #4A, B, C: Medication Administration Record (MAR)

Duplicate copies of Jo Burns' MAR and the MAR Worksheet for each student. Require each student to answer questions on the worksheet and review answers with class upon completion of activity

It should be clear to the student 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), and how it is to be given (Right ROUTE) and lastly, after the medication is given/held/refused, how to document on the MAR (Right DOCUMENTATION)

Unique Situations to do Prior to Administration of Medications – Vital Signs

- When a vital sign is to be obtained before administering a medication, obtain the vital sign results before preparing the medication for administration
- Examples – pulse or blood pressure

Section 3 – Medication Administration

☑ TEACHING TIP: Unique Situations to do Prior to Administration of Medications – Crushing Medications and Mixing in Food

Locate the device used for crushing medications, review the policy for crushing medications and mixing medications in food at the adult care home, and inform the student of facility's policy on crushing medications

Demonstrate the crushing of a medication using the device used at the adult care home. If the device for crushing medication is used for more than one resident, demonstrate cleaning procedure and prevention of cross-contamination of residents' medications

☑ TEACHING TIP: Current List of Medication that Should not be Crushed

Locate the current list of medications that should not be crushed at the adult care home and share with the students. Show students where the list is located

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

Unique Situations to do Prior to Administration of Medications – Crushing Medications and Mixing in Food

- Do not crush medications until immediately before the medications are administered
- The devices used to crush medications may vary in facilities
  - The most common method – using a pill crusher and crushing the medications using two medication soufflé cups
  - If the medications are unit dose, the employee may crush the medication in the unit dose package and empty into a medication cup
  - A mortar and pestle may also be used; to avoid cross-contamination when crushing medications and the residue from the medication is present, the device must be cleaned thoroughly before crushing another resident's medications

☑ TEACHING TIP General Medication Administration

Refer to the skill sheets on General Medication Administration as you review the preparation steps and subsequent steps

General Medication Administration

- Prepare work area and cleanse hands
- Always use the resident's MAR when administering medications
- Check for allergies

Section 3 – Medication Administration

- Begin the **SIX RIGHTS** of Medication Administration
  - Select correct MAR for **Right Resident**
  - Select **Right MEDICATION, Right DOSE, Right TIME,** and **Right ROUTE,** comparing the MAR to the medication label while performing the 3 label checks.
  - Prepare **Right DOSE** for **Right ROUTE**
  - Identify **Right RESIDENT**
- Explain to the resident what you are going to do.
- Administer medication at the **Right TIME**
- Offer liquids and observe resident take medications
- Cleanse hands
- Initial the MAR immediately after the medication is administered and prior to the administration of medications to another resident **Right DOCUMENTATION**
- Correctly document any medications that are refused or not administered

☑ **TEACHING TIP: Administering Oral Medications**

Refer to the skill sheet on how to administer oral medications as you review the process of administering oral medications with the students

Oral Medications in Solid Form

- Appropriate positioning of resident, elevation of head
- Place capsules or tablets for resident in medication or soufflé cup for administration
- Administer powdered medications such as bulk laxatives with the amount of fluids indicated
- Offer resident sufficient fluids following the administration of oral medications even if the medication is administered in a food substance or the medication is a liquid
- Observe the resident taking the medication to assure the medication is swallowed before documenting the administration of the medications

Liquids

- Never approximate the amount of medication to be administered, such as liquids
  - The amount ordered is to be the amount administered
  - Use a calibrated syringe for measuring liquids in amounts less than 5 ml and unequal amounts

- Measure liquid medications in a calibrated medication cup/device; never use eating utensils or other household devices for administering medications
- When measuring liquids, place the medication cup on a flat surface and measured at eye level to ensure accuracy

Section 3 – Medication Administration

- For liquids, hold the medication container so that the medication flows from the side opposite the label so it doesn't run down the container and stain or obscure label
- Do not mix liquid medications together
- Certain medications have special measuring devices for administering the medication; these measuring devices have increments marked off in mgs; instead of mls and usually have the name of the medication on the measuring device
- Liquids may have administration requirements such as Shake Well and 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; some liquids, i.e., liquid Potassium, must be mixed with sufficient fluids to decrease side effects

☑ **HANDOUT #3B: Review of Measuring Devices**

Distribute a copy of the handout on Review of Measuring Devices to each student or locate handout in Student Manual

☑ **TEACHING TIP: Common Measuring Devices**

Referring to the handout, compare and contrast the different measuring devices used to administer oral, liquid medications. Pay special attention to ml versus mg. Use visual aids if available

☑ **HANDOUT #3C and # 3D: Always and Never and Measuring Tips**

Distribute a copy of the handouts to each student or locate handout in Student Manual

☑ **TEACHING TIP: Always and Never and Measuring Tips**

Referring to the handouts, discuss/demonstrate if applicable the concepts included

☑ **TEACHING TIP: Administering Sublingual Medications**

Refer to the skill sheet on how to administer a sublingual medication as you review the process of administering sublingual medications with the students

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

Section 3 – Medication Administration

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

☑ **HANDOUT #3E: Inhalers**

Distribute copies of the handout, Technique and Use of Meter Dose Inhalers. Review with students

☑ **TEACHING TIP: Administering Eye Drops and Ointment**

Refer to the skill sheet on how to administer eye drops and ointment as you review the process of administering eye drops and ointment with the students

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

☑ **TEACHING TIP: Administering Ear Drops**

Refer to the skill sheet on how to administer ear and ointment as you review the process of administering eye drops and ointment with the students

Ear Drops

- Wash hands before and after administration of medication
- Gloves are to be worn as indicated
- By gently pulling on the ear, straighten the ear canal
- Request the resident to remain in same position for 5 minutes to allow medication to penetrate
- Gently plug the ear with cotton to prevent excessive leakage if necessary

Section 3 – Medication Administration

☑ **TEACHING TIP: Administering Nose Drops and Nasal Sprays/Inhalants**

Refer to the skill sheet on how to administer nose drops and nasal sprays/inhalants as you review the process of administering nose drops and nasal sprays/inhalants with the students

Nose Drops and Nasal Sprays/Inhalers

- Wash hands before and after
- 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**

☑ **TEACHING TIP: Administering Inhalants**

Remind students to check manufacturer instructions before using inhalers because some require priming prior to administration

☑ **TEACHING TIP: Administering Medications Using Transdermal Products/Patches**

Refer to the skill sheet on how to administer medications using transdermal products/patches as you review the process of administering medications using transdermal products/patches with the students

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

Section 3 – Medication Administration

☑ **TEACHING TIP: Administering Topical Medications**

Refer to the skill sheet on how to administer topical medications as you review the process of administering topical medications with the students

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

STOP

☑ **TEACHING TIP: Administering Injections**

Demonstrate/allow for student practice/perform skill check-off **only if** injections will be administered by Medication Aides at the adult care home. If administering injections will be taught/practiced/checked-off during class, a Registered Nurse must validate skills competency of injections

Refer to the skill sheet on how to administer injections as you review the process of administering injections with the students

Injections

- Never recap syringes
- Disposed of syringes in appropriate sharps containers
- Wash hands before and after
- Wear gloves

Proceed to Section #4

Section 4

Ordering, Storage and Disposal of Medications

Section 4 – Ordering, Storage and Disposal of Medications

Objectives:

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.

Advance Preparation – In General

- Review curriculum and presentation materials and activity
- Add examples or comments

Supplies

- Controlled Substance Logs or Forms used at adult care home to keep accurate accountability of controlled substances
- Forms used for Destruction or Return of Medications
- Policies and Procedures for Ordering, Storage, Controlled Substances and Disposal

Section 4 – Ordering, Storage and Disposal of Medications

Objectives

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.

☑ TEACHING TIP: Ordering Medications

Review procedures for the following activities related to ordering medications at the adult care home and teach/demonstrate: simple refills; emergency pharmaceutical services; receiving medications when delivered from the pharmacy; accounting of medications administered by staff.

- To avoid a medication error resulting from medication availability, there must be a system for insuring 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, regarding any medication not being available, as needed and in accordance with facility policy

☑ TEACHING TIP: Storage of Medications

Review the policies and procedures for storage of non-refrigerated and refrigerated medications and show where each type is maintained or kept in the adult care home

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)

Section 4 – Ordering, Storage and Disposal of Medications

☑ TEACHING TIP: Controlled Substances

Review the procedures for storage of controlled substances, correctly signing out for controlled substances, and reporting of any discrepancies discovered and teach/demonstrate the procedures. If special packaging is provided by the pharmacy for controlled drugs, show packaging used

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"
  - 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

☑ TEACHING TIP: Disposal of Medications

Review the procedure for disposal of medications when opened and prepared, but not given and teach the procedure

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
- Discuss the facility's procedures with disposal of medications

Proceed to Section #5

Section 5

Medication Administration Skills Checklists

Medication Administration Skills Checklists

During the Medication Administration – 5-hour Training Course, you will be tested on skills listed below. You will be expected to do the skill 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 it 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.

SKILLS:

1. Hand Hygiene/Gloves
2. General Medication Administration
3. Oral Medication Administration
4. Sublingual Medication Administration
5. Eye Medication Administration
6. Ear Medication Administration
7. Inhalant Medication Administration
8. Nasal Medication Administration
9. Transdermal Medication Administration
10. Topical Medication Administration

Optional (if employee will perform skill)

11. Injections-Insulin Administration

Instructions for Completing the Medication Administration Skills Checklists

1. You will need to print a set of checklists for each student to use during the training session. Walk around and observe students and provide instruction for skill steps not performed at an acceptable level. The training session is to prepare the student for the skills check off.

2. All documentation on the checklist for the final check off is to be in ink.

3. The date, name of student, and name and credentials of the evaluator are to be written on each page of the checklist.

4. As the student performs the skills, place a check beside skills steps performed at an acceptable level (Yes) and an X by skill steps not performed at an acceptable level (No)

5. Indicate if the student Passes or needs to ReDo by checking the block provided.

6. **Instructor keeps all the checklists for your record, unless the skills validation of a student/employee is for a specific adult care home. The student will receive a certificate upon successful completion of the training course but the student does not receive the skills checklist.**

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

☐ **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.		
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 toward 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		

Continued 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 6

Handouts

HANDOUT # 1A

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 # 1B

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 # 1C

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 cannot 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

HANDOUT # 1D

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 completed 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 # 1E

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

- **Medication aide's role**
  - Understands the facility's medication error policy and procedure or knows 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 # 1F

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. Example is:
   - 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?

(continued next page)

HANDOUT #1F

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, 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 # 2A

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 or "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 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.

(continued next page)

HANDOUT # 2A

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 # 2AA

Medication Orders - Answers

Identify the information missing for each medication order below:

Risperdal 2 mg. Give 1 tablet by mouth

[specific direction on how often to give the Risperdal or frequency of administration]

Riopan Liquid 15 ml. by mouth every hours as needed

[specific direction on how often to give the Riopan or frequency of administration AND the reason for administration]

Aricept 1 tablet by mouth at bedtime

[Strength of Aricept to give]

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

[Strength of Tylenol to administer]

Ativan 0.5 mg. 1 tablet by mouth as needed

[specific direction on how often to give the Ativan or frequency of administration AND the specific reason for administration]

FL-2 (86)

INSTRUCTIONS ON REVERSE SIDE

NORTH CAROLINA MEDICAID PROGRAM
LONG TERM CARE SERVICES

HANDOUT # 2B

☐ 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 / 13. DATE APPROVED/DENIED	14. DISCHARGE PLAN
_____ HOME _____ DOMICILIARY (REST HOME) _____ SNF _____ OTHER _____ ICF _____ HOSPITAL _____	_____ HOME _____ DOMICILIARY (REST HOME) _____ SNF _____ OTHER _____ ICF _____		_____ 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 # 2C

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

FL-2 (86) HANDOUT #2D

INSTRUCTIONS ON REVERSE SIDE

NORTH CAROLINA MEDICAID PROGRAM
LONG TERM CARE SERVICES

☐ 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	×	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 NCS
×	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~~	FSBS ac breakfast & supper		RESTORATIVE FEEDING PROGRAM		
	PT (BY LICENSED PT)			SPEECH THERAPY		
	RANGE OF MOTION EXERCISES			RESTRAINTS		

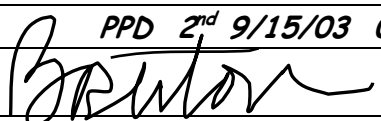
18. MEDICATIONS / NAME & STRENGTHS, DOSAGE & ROUTE

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

HANDOUT # 2E

MEDICATION ADMINISTRATION RECORD ACTIVITY ANSWERS

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
Dilantin 125mg/5ml 4ml by mouth every day 09/04/13	9PM	→																														
Furosemide 40mg for Lasix 40mg 1 tablet by mouth twice daily. 09/04/13	8 AM	→																														
	4PM	→																														
Tylenol 325mg 2 tablets every 6 hours as needed for pain or T > 100°F 09/04/13	P																															
	R																															
	N																															
Humulin 70/30 insulin Inject 10 units subcutaneously before breakfast each day. 09/04/13	7AM	→																														
	site																															
Fingerstick blood sugars Check twice daily before breakfast and supper 09/04/13	7AM	→																														
	4PM	→																														
Zithromax 250 mg. 1 tablet once daily for 4 days 09/04/13	8AM	→								*STOP only 4 doses*																						
Accupril 10 mg. 1 tablet by mouth once daily. 09/04/13	8AM	→																														
Ambien 5mg tablets 1 tablet by mouth at bedtime. 09/04/13	9PM	→																														
Initials of individual(s)l transcribing orders are also needed.																																

Charting for the month of: **09/04/13**	through **09/30/13**		
Physician: **Dr. Bruton**	Telephone # **919-555-1212**	Medical Record #:	
Alt. Physician:	Alt. Physician Telephone #:		
Allergies: **CODEINE**		Rehabilitation Potential:	
Diagnosis: **SEIZURE DISORDER, HTN, IDDM, ASTHMA, CHF**		Admission Date:	
Resident's Name: **Garrett Clayton**	Date of Birth: **10/17/50**	Room / bed #: **BW999**	

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

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

HANDOUT 2-F

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 # 3A

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

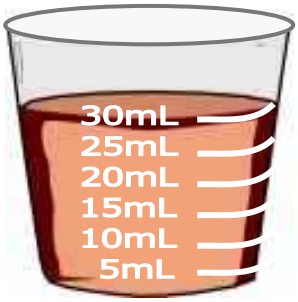
1. FINGERSTICK DEVICES SHOULD NEVER BE USED FOR MORE THAN ONE PERSON	**2. BLOOD GLUCOSE METERS SHOULD BE ASSIGNED TO ONLY ONE PERSON AND NOT SHARED**	**3. INJECTION EQUIPMENT SHOULD NEVER BE USED FOR MORE THAN ONE PERSON**
➢ Restrict use of fingerstick devices to a single person. They should never be 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.

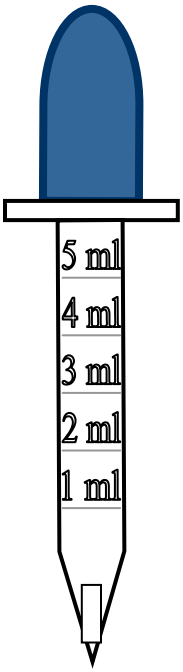
Adapted from the Diabetes and Viral Hepatitis Important Information on Safe Diabetic Care, N.C. DHHS Division of Public Health

HANDOUT # 3B

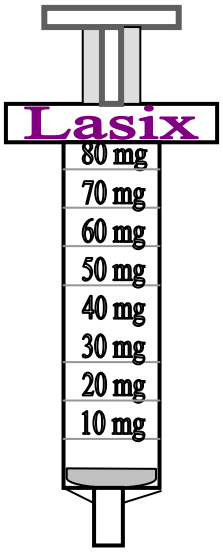
Review of Measuring Devices



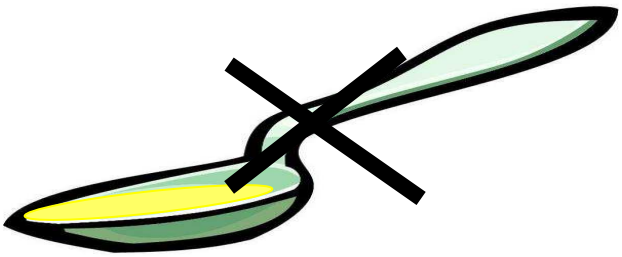
Medication Cup
Use on a level surface when measuring



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

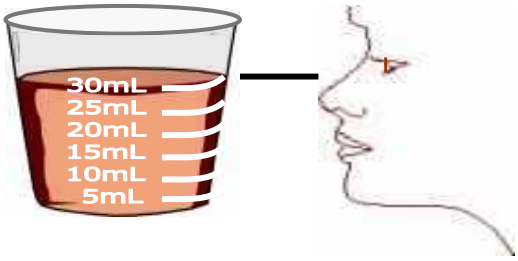
HANDOUT # 3C

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.**



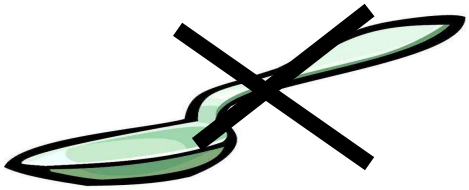
4. **If the label says to measure in mls, ALWAYS use a measuring device that is marked in mls.**

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 ! ! !

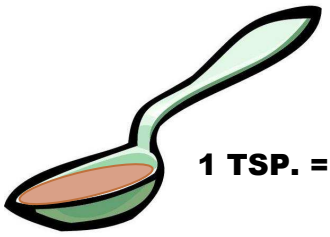
TIP: Always read the label carefully to be sure you are measuring the right thing.

←15ml→

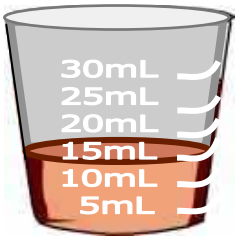
If the strength of a medication is 20mg/5ml, this 15ml cup contains 60*mg* of medication.

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

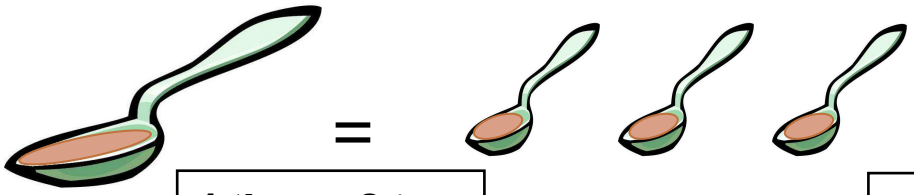


1 TSP. = 5ml.



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.

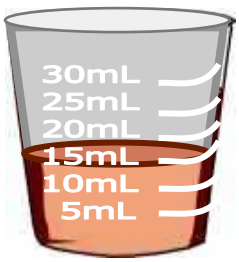


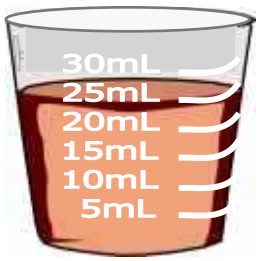
=

1 tbsp. = 3 tsp

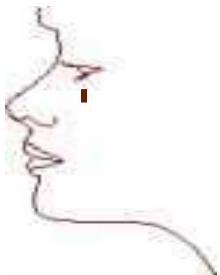
=

3 tsp. = 15ml





25 mL



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

HANDOUT # 3E

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.

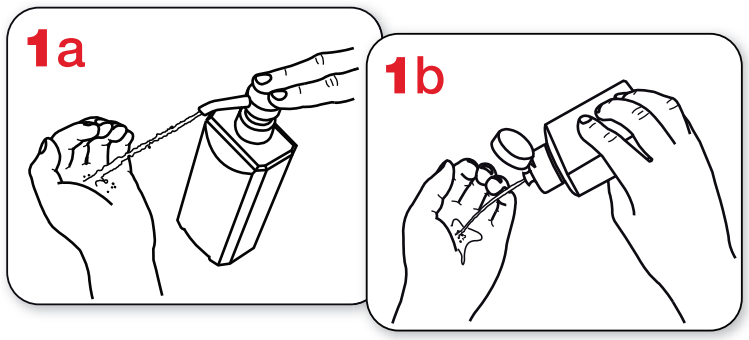
If a medication aide provides the resident with the inhalers to administer, the medication aide is responsible for instructing the resident of the proper technique and dose ordered.

Section 7

Activities

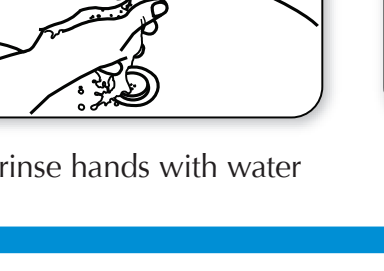
7-2

How to handrub?
WITH ALCOHOL-BASED FORMULATION



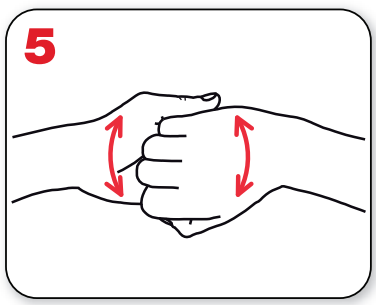
Apply a palmful of the product in a cupped hand and cover all surfaces.

Rub hands palm to palm

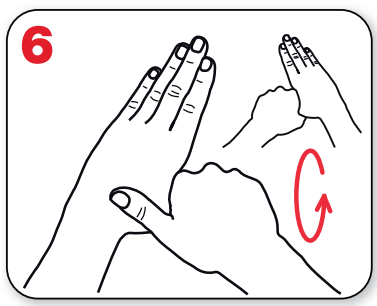


right palm over left dorsum with interlaced fingers and vice versa

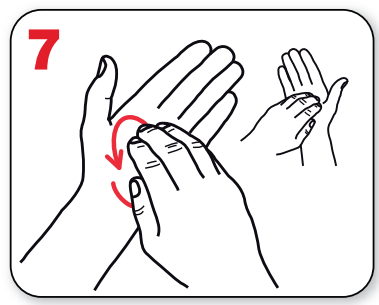
palm to palm with fingers interlaced



backs of fingers to opposing palms with fingers interlocked

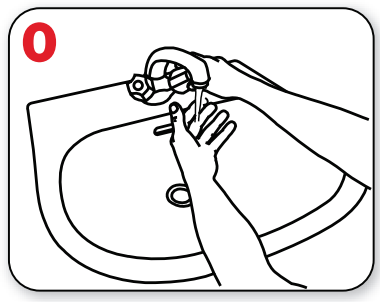


rotational rubbing of left thumb clasped in right palm and vice versa

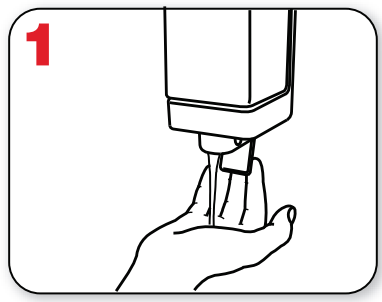


rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa

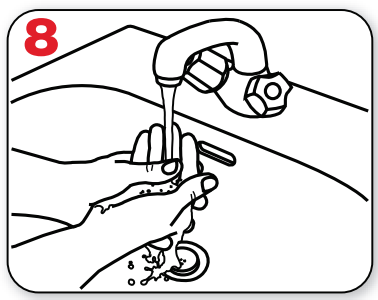
How to handwash?
WITH SOAP AND WATER



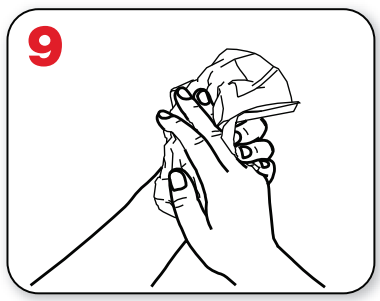
Wet hands with water



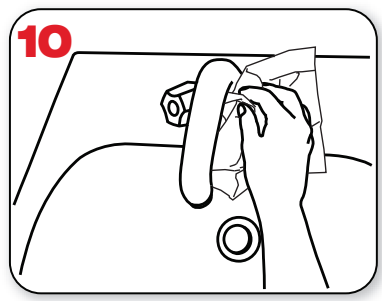
apply enough soap to cover all hand surfaces.



rinse hands with water

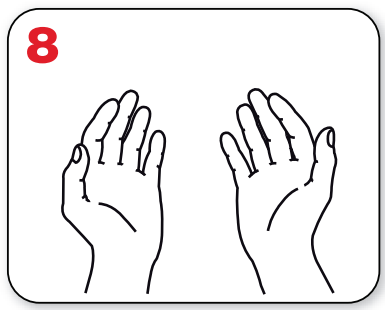


dry thoroughly with a single use towel



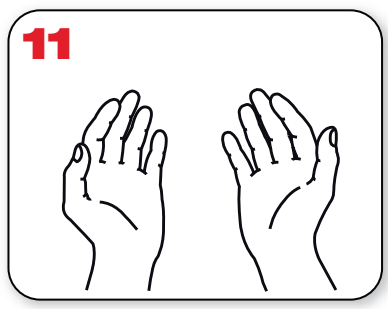
use towel to turn off faucet

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

ACTIVITY #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 Activity # 3 Gloves, Gloves, Gloves.

ACTIVITY #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?

ACTIVITY #4A
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 9. Mrs. Burns has asked for something for pain. Can Mrs. Burns receive something for pain?

12. Does Mrs. Burns have allergies?

ACTIVITY #4A - 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?

ACTIVITY #4B 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	Stop 10 days only JK																		
	2PM	→	→	TK	TK	JU	JU	JU	JU	JU	TK	TK	TK																			
	8PM	→		DB	DB	DB	CJ	CJ	CJ	CJ	CJ	DB	DB																			
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		

ACTIVITY #4C
Medication Administration Record (MAR) Worksheet Answers

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). [Check individual documentation]

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

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

4. Why did Mrs. Burns receive a dose of Hydrocodone 10/325 on the 3rd of January? [Mrs. Burns had pain in her right leg.]

5. Why didn't Mrs. Burns receive three doses of Amoxicillin on the 22nd of January? [She was only supposed to receive Amoxicillin for ten days and the ten days had passed; the Amoxicillin had been discontinued.]

6. What times did Mrs. Burns receive 25 mg of Capoten on January 2nd? [8 AM, 2 PM, and 8 PM]

7. Why was Mrs. Burns' Coumadin dose circled on January 7th? [The dose of Coumadin was not available to administer.]

8. Where was Mrs. Burns' Nitro-dur patch placed on January 10th? [On the left side of Mrs. Burns' chest.]

9. What time does Mrs. Burns have her Nitro-dur patch removed? [8 PM]

10. Who is Mrs. Burns' physician? [Dr. Moses]

11. It is 11 PM on January 9. Mrs. Burns has asked for something for pain. Can Mrs. Burns receive something for pain? [No, because Mrs. Burns had a dose of Hydrocodone 10/325 at 10 PM and can only have it every 4 hours.] If so, administer the appropriate medication and document on Mrs. Burns' MAR. [No documentation should occur.]

ACTIVITY #4C - Continued
Medication Administration Record (MAR) Worksheet Answers

12. Does Mrs. Burns have allergies? [No]

13. How much Lasix did Mrs. Burns receive at 4 PM on January 18th? [40 mg.]

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. [Check individual documentation]

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? [Yes] If so, administer the appropriate medication and document on Mrs. Burns' MAR. [Check individual documentation]

16. It is 8 AM and time for Mrs. Burns to receive her Lanoxin. What must you do prior to administering the Lanoxin? [Check Mrs. Burns' pulse rate.]

17. What are Mrs. Burns' diagnoses? [Congestive heart failure and hypertension]

18. What are the 6 Rights of medication administration?

    a. Right resident

    b. Right medication

    c. Right dose

    d. Right route

    e. Right time

    f. Right documentation]

19. How many days was Mrs. Burns supposed to receive Amoxicillin? [10]

20. Why is there a zero in front of the decimal on Lanoxin 0.125 mg? [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 Lanoxin 0.125 mg, the decimal might be missed and instead of giving 0.125 mg. of Lanoxin it might incorrectly be read as 125 mg of Lanoxin which would be deadly.]

Appendix

CERTIFICATE OF COMPLETION

Medication Administration: 5-Hour Training Course for Adult Care Homes

This is to certify that

_____

Name of Student

has successfully completed a North Carolina State-approved Medication Administration Training Program at

_____

Name of Training Location (school, facility, etc.)

on the _____ day of _____, 20____.

Certified by:

_____ _____

Print Name of Trainer | Employed by

_____ _____

Signature of Trainer (include licensing credentials) | Date

References

N.C. Department of Health and Human Services/N.C. Board of Nursing – Medication Administration: A Medication Aide Training Course. 2006

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5-Hour Medication Course
Test

Name _____

Facility _____

Part 1: Match the term or phrase on the right with the abbreviation or term on the left by placing the correct letter on the appropriate line.

_____	1. PRN	a.	milligram
_____	2. ac	b.	at bedtime
_____	3. stat	c.	Medication Administration Record
_____	4. SL	d.	over the counter
_____	5. MAR	e.	before meals
_____	6. mg	f.	tablespoonful
_____	7. pc	g.	placed and affixed to the skin
_____	8. OTC	h.	teaspoonful
_____	9. Subcutaneous	i.	milliliter
_____	10. po	j.	immediately
_____	11. qhs	k.	sublingual
_____	12. tbsp	l.	placed under the tongue
_____	13. transdermal	m.	after meals
_____	14. ml	n.	by mouth
_____	15. gm	o.	gram
_____	16. QOD	p.	as needed
_____	17. tsp	q.	every other day
_____	18. sublingual	r.	inject into the fat with a syringe

Part 2: Fill in the blank with the appropriate word or term. You may choose to use the word bank below.

19. A heart tablet taken by the mouth and swallowed is an example of a medication taken by the _____ route.

20. A medication that is inserted into the rectum is given using the _____ route.

21. A _____ medication is applied directly to the skin surface.

22. A suspension must be _____ before measuring and administering the medication.

23. A medication _____ is a reaction that occurs because of an unusual sensitivity to a medication or other substance.

24. A medication _____ occurs when a medication is not administered as prescribed by the doctor or practitioner.

25. A hard, compressed medication in a round, oval, or square shape is called a _____.

26. When placing an ear drop into the right ear, the medication aide should pull the external ear _____ and back.

27. Crushed medications may be placed in food such as applesauce or _____.

28. _____ must be worn when there is a chance of contact with mucus membranes.

29. A fine, ground form of medication that may be used on the skin for rashes is called _____.

30. A device that is placed and affixed to the skin is given by the _____ route.

Word Bank:

Powder	Gloves	Pudding	Shaken	Error	Restraint
Oral	Up	Tablet	Transdermal	A lemon	Rectal
Down	Capsule	Refuse	Allergy	Chemical	Topical

Part 3: Dr. Smith has ordered a STAT dose of oral liquid cough syrup for Mrs. Jackson. Circle each supply that the Medication Aide will need to have in order to administer the medication.

33. Soufflé cup

34. MAR for Mrs. Jackson

35. Alcohol wipe

36. Calibrated plastic cup

37. Gloves

38. Applesauce

39. Lubricant

Part 4: Dr. Majors has ordered a rectal suppository for Mr. Thompson. Circle each supply that the Medication Aide will need to have in order to administer the medication.

40. Soufflé cup

41. MAR for Mr. Thompson

42. Alcohol wipe

43. Calibrated plastic cup

44. Gloves

45. Applesauce

46. Lubricant

Part 5: List 4 of the 6 rights of medication administration.

47. _____

48. _____

49. _____

50. _____

5-Hour Medication Test
Answers

Name _____

Facility _____

Part 1: Match the term or phrase on the right with the abbreviation or term on the left by placing the correct letter on the appropriate line.

_____ 1.	PRN (p)	a. milligram
_____ 2.	ac (e)	b. at bedtime
_____ 3.	stat (j)	c. Medication Administration Record
_____ 4.	SL (k)	d. over the counter
_____ 5.	MAR (c)	e. before meals
_____ 6.	mg (a)	f. tablespoonful
_____ 7.	pc (m)	g. placed and affixed to the skin
_____ 8.	OTC (d)	h. teaspoonful
_____ 9.	Subcutaneous (r)	i. milliliter
_____ 10.	po (n)	j. immediately
_____ 11.	qhs (b)	k. sublingual
_____ 12.	tbsp (f)	l. placed under the tongue
_____ 13.	transdermal (g)	m. after meals
_____ 14.	ml (i)	n. by mouth
_____ 15.	gm (o)	o. gram
_____ 16.	QOD (q)	p. as needed
_____ 17.	tsp (h)	q. every other day
_____ 18.	sublingual (l)	r. inject into the fat with a syringe

Part 2: Fill in the blank with the appropriate word or term. You may choose to use the word bank below.

19. A heart tablet taken by mouth and swallowed is an example of a medication taken by the oral route.

20. A medication that is inserted into the rectum is given using the rectal route.

21. A topical medication is applied directly to the skin surface.

22. A suspension must be shaken before measuring and administering the medication.

23. A medication allergy is a reaction that occurs because of an unusual sensitivity to a medication or other substance.

24. A medication error occurs when a medication is not administered as prescribed by the doctor or practitioner.

25. A hard, compressed medication in a round, oval, or square shape is called a tablet.

26. When placing an ear drop into the right ear, the medication aide should pull the external ear up and back.

27. Crushed medications may be placed in food such as applesauce or pudding.

28. Gloves must be worn when there is a chance of contact with mucus membranes.

29. A fine, ground form of medication that may be used on the skin for rashes is called refuse.

30. A device that is placed and affixed to the skin is given by the transdermal route.

Word Bank:

Powder	Gloves	Pudding	Shaken	Error	Restraint
Oral	Up	Tablet	Transdermal	A lemon	Rectal
Down	Capsule	Refuse	Allergy	Chemical	Topical

Part 3: Dr. Smith has ordered a STAT dose of oral liquid cough syrup for Mrs. Jackson. Circle each supply that the Medication Aide will need to have in order to administer the medication.

33. Soufflé cup

34. MAR for Mrs. Jackson

35. Alcohol wipe

36. Calibrated plastic cup

37. Gloves

38. Applesauce

39. Lubricant

Part 4: Dr. Majors has ordered a rectal suppository for Mr. Thompson. Circle each supply that the Medication Aide will need to have in order to administer the medication.

40. Soufflé cup

41. MAR for Mr. Thompson

42. Alcohol wipe

43. Calibrated plastic cup

44. Gloves

45. Applesauce

46. Lubricant

Part 5: List 4 of the 6 rights of medication administration.

- Right resident
- Right medication
- Right dose
- Right route
- Right time
- Right documentation