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

September 2013
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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.


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 Health 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

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<td>Prerequisite Skills Review and Validation</td>
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<td><strong>Section 1:</strong> Basic Medication Administration Information/Terminology</td>
<td>30 minutes</td>
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<td><strong>Section 2</strong> Medication Orders</td>
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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

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
  o #1A – Abbreviations
  o #1B – Common Routes of Medication Administration
  o #1C – Common Dosage Forms of Medications
  o #1D – Six Rights of Medication Administration
  o #1E – Medication Errors
  o #1F – Residents’ Refusal to Take Medications
- Equipment and Supplies Used During Administration of Medications
  o 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 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

### 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

<table>
<thead>
<tr>
<th>Equipment and Supplies Used During Administration of Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medication cart</td>
</tr>
<tr>
<td>• MAR for each resident</td>
</tr>
<tr>
<td>• Soufflé cups for oral medications in pill or capsule form</td>
</tr>
<tr>
<td>• Calibrated plastic cups and oral syringes or droppers for oral liquid medications</td>
</tr>
<tr>
<td>• Alcohol wipes for use with injections</td>
</tr>
<tr>
<td>• Insulin syringes for use with insulin administration</td>
</tr>
<tr>
<td>• Sharps equipment</td>
</tr>
<tr>
<td>• Band-Aids for use with injections</td>
</tr>
<tr>
<td>• Lubricant for use with suppositories</td>
</tr>
<tr>
<td>• Blood pressure cuff, stethoscope, blood glucose meter as needed</td>
</tr>
<tr>
<td>• Gloves to use when coming into contact with mucus membranes (administering vaginal or rectal suppositories) and blood/body fluids (administering injections)</td>
</tr>
<tr>
<td>• Water cup and water for resident to drink when taking oral medications</td>
</tr>
<tr>
<td>• 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</td>
</tr>
<tr>
<td>• Food, such as applesauce or pudding to use when administering crushed medications</td>
</tr>
</tbody>
</table>

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

Medication Administration

5-Hour Training Course for Adult Care Homes
## 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 a 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 persons 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; are administered when resident “needs” the medication for a certain circumstance
- A discontinue order has to 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
  o #3A – Injection Safety Diabetes and Viral Hepatitis
  o #3B – Review of Measuring Devices
  o #3C – Always and Never Measuring Tips
  o #3D – Measuring Tips
  o #3E – Technique and Use of Meter Dose Inhalers
- Supplies for Hand Hygiene Activity
  o Alcohol – based hand rub product
  o 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

Medication Administration
5-Hour Training Course for Adult Care Homes
### 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.

#### 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: http://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

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*Medication Administration*  
*5-Hour Training Course for Adult Care Homes*
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.
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<table>
<thead>
<tr>
<th>TEACHING TIP: Ordering Medications</th>
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<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>• To avoid a medication error resulting from medication availability, there must be a system for insuring reordering and delivery of resident medications</td>
</tr>
<tr>
<td>• Medication supplies must be monitored regularly and reordered</td>
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<tr>
<td>• If a medication is not available, an effort to obtain the medication must be made and documented</td>
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<tr>
<td>• Notify the pharmacy, supervisor, physician and family, regarding any medication not being available, as needed and in accordance with facility policy</td>
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<tr>
<th>TEACHING TIP: Storage of Medications</th>
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<tr>
<td>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</td>
</tr>
</tbody>
</table>

**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

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**Medication Administration**

*5-Hour Training Course for Adult Care Homes*
Section 6

Handouts
# 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
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
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
**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
Medication Errors

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

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

• Medication aide’s role
  o Understands the facility’s medication error policy and procedure or knows where to locate it
  o Recognizes when a medication error is made
  o 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
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)
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.


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.
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)
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
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]
## Identification

<table>
<thead>
<tr>
<th>1. Patient's Last Name</th>
<th>First</th>
<th>Middle</th>
<th>2. Birthdate (M/D/Y)</th>
<th>3. Sex</th>
<th>4. Admission Date (Current Location)</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>5. County and Medicaid Number</th>
<th>6. Facility</th>
<th>7. Provider Number</th>
<th>8. Attending Physician Name and Address</th>
<th>9. Relative Name and Address</th>
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<thead>
<tr>
<th>12. Prior Approval Number</th>
<th>13. Date Approved/Denied</th>
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## Long Term Care Services

<table>
<thead>
<tr>
<th>15. Admitting Diagnoses – Primary, Secondary, Dates of Onset</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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<td>4.</td>
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## Patient Information

<table>
<thead>
<tr>
<th>Disoriented</th>
<th>Ambulatory Status</th>
<th>Bladder</th>
<th>Bowel</th>
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<tr>
<td>Constantly</td>
<td>Ambulatory</td>
<td>Continent</td>
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<tr>
<td>Intermittently</td>
<td>Semi-Ambulatory</td>
<td>Incontinent</td>
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<thead>
<tr>
<th>Inappropriate Behavior</th>
<th>Functional Limitations</th>
<th>Communication of Needs</th>
<th>Respiration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbally Abusive</td>
<td>Sight</td>
<td>Normal</td>
<td>Normal</td>
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<thead>
<tr>
<th>Personal Care Assistance</th>
<th>Skin</th>
<th>Nutrition Status</th>
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<tr>
<td>Bathing</td>
<td>Passive</td>
<td>Normal</td>
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<tr>
<td>Feeding</td>
<td>Active</td>
<td>Other</td>
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<tr>
<td>Dressing</td>
<td>Re-socialization</td>
<td>Supplemental</td>
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<tr>
<td>Total Care</td>
<td>Family Supportive</td>
<td>Parenteral</td>
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<th>Neurological</th>
<th>Intake and Output</th>
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<tr>
<td>30 Days</td>
<td>Convulsions/Seizures</td>
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<td>60 Days</td>
<td>Grand Mal</td>
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<tr>
<td>Over 180 Days</td>
<td>Dressings:</td>
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<th>Frequency</th>
<th>Special Care Factors</th>
<th>Frequency</th>
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<td>Blood Pressure</td>
<td>Bowel and Bladder Program</td>
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<td>Diabetic Urine Testing</td>
<td>Restorative Feeding Program</td>
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<td>PT (By Licensed PT)</td>
<td>Speech Therapy</td>
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<tr>
<td>Range of Motion Exercises</td>
<td>Restraints</td>
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## Medications / Name & Strengths, Dosage & Route

<table>
<thead>
<tr>
<th>Medications / Name &amp; Strengths, Dosage &amp; Route</th>
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<td>2.</td>
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<td>4.</td>
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<td>5.</td>
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19. X-Ray and Laboratory Findings / Date:

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<th>Additional Information:</th>
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<th>Physician's Signature</th>
<th>Date</th>
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<td>21.</td>
<td>22.</td>
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372-124 (12-92) 5-Hour Training Course for Adult Care Homes EDS – DMA COPY 6-9
# 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 |
|-------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|             |      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|             |      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|             |      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|             |      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|             |      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

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 #: ___________________________

5-Hour Training Course for Adult Care Homes 6-10
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

<table>
<thead>
<tr>
<th>NURSE’S MEDICATION NOTES</th>
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</thead>
<tbody>
<tr>
<td>1</td>
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<tr>
<td>Temperature</td>
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<tr>
<td>Respiration</td>
</tr>
<tr>
<td>Pulse</td>
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<tr>
<td>Blood Pressure</td>
</tr>
<tr>
<td>Initials</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Date/Hour</th>
<th>Medication/Dosage</th>
<th>Route</th>
<th>Reason</th>
<th>Initials</th>
<th>Results/Response</th>
<th>Initials</th>
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**NORTH CAROLINA MEDICAID PROGRAM**

**LONG TERM CARE SERVICES**

**FL-2 (86) HANDOUT #2D**

**NORTH CAROLINA MEDICAID PROGRAM**

**INSTRUCTIONS ON REVERSE SIDE**

**PRIOR APPROVAL**

**UTILIZATION REVIEW**

**ON-SITE REVIEW**

### IDENTIFICATION

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

<table>
<thead>
<tr>
<th>5. COUNTY AND MEDICAID NUMBER</th>
<th>6. FACILITY</th>
<th>ADDRESS</th>
<th>7. PROVIDER NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johnston 021-13-1415</td>
<td>Adult Care Assisted Living</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. ATTENDING PHYSICIAN NAME AND ADDRESS</th>
<th>9. RELATIVE NAME AND ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Bruton Adams Building, City, N.C.</td>
<td>Ben Clayton (brother)</td>
</tr>
</tbody>
</table>

### CURRENT LEVEL OF CARE

- HOME
- DOMICILY (REST HOME)
- SNF
- ICF
- HOSPITAL

### RECOMMENDED LEVEL OF CARE

- HOME
- DOMICILY (REST HOME)
- SNF
- ICF
- HOSPITAL

### PRIOR APPROVAL NUMBER

### DISCHARGE PLAN

### ADMITTING DIAGNOSES – PRIMARY, SECONDARY, DATES OF ONSET

1. **seizure disorder**
2. **hypertension**
3. **insulin-dependent diabetes (IDDM)**
4. **Asthma**

### PATIENT INFORMATION

<table>
<thead>
<tr>
<th>DISORED</th>
<th>AMBULATORY STATUS</th>
<th>BLADDER</th>
<th>BOWEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONSTANTLY</td>
<td>AMBULATORY</td>
<td>CONTINENT</td>
<td>CONTINENT</td>
</tr>
<tr>
<td>INTERMITTENTLY</td>
<td>NON-AMBULATORY</td>
<td>INCONTINENT</td>
<td>INCONTINENT</td>
</tr>
</tbody>
</table>

### PERSONAL CARE ASSISTANCE

- PASSIVE
- ACTIVE
- OTHER:

### FEEDING

- GROUP PARTICIPATION
- DECUBITI – DESCRIBE:
- PARENTERAL
- NASOGASTRIC
- GASTROSTOMY
- TOTAL CARE
- FAMILY SUPPORTIVE

### PHYSICIAN VISITS

- 30 DAYS
- 60 DAYS
- OVER 180 DAYS

### NEUROLOGICAL

- CONVULSIONS/SEIZURES
- GRAND MAL
- DRESSINGS:
- FORCE FLUIDS
- WEIGHT
- HEIGHT

### SPECIAL CARE FACTORS

- BLOOD PRESSURE
- DIABETIC URINE TESTING
- PT (BY LICENSED PT)

### MEDICATIONS / NAME & STRENGTHS, DOSAGE & ROUTE

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

### X-RAY AND LABORATORY FINDINGS / DATE:

- PPD 8/28/03 0mm
- PPD 2nd 9/15/03 0mm

**ADDITONAL INFORMATION:**

### PHYSICIAN'S SIGNATURE

**BRETON**

**DATE:** 9/04/2013
# Medication Administration Record Activity Answers

<table>
<thead>
<tr>
<th>Medications</th>
<th>HOUR</th>
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<tbody>
<tr>
<td>Dilantin 125mg/5ml 4ml by mouth every day</td>
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<tr>
<td>09/04/13</td>
<td>9PM</td>
</tr>
<tr>
<td>Furosemide 40mg for Lasix 40mg 1 tablet by mouth twice daily.</td>
<td></td>
</tr>
<tr>
<td>09/04/13</td>
<td>8 AM</td>
</tr>
<tr>
<td>4PM</td>
<td></td>
</tr>
<tr>
<td>Tylenol 325mg 2 tablets every 6 hours as needed for pain or T &gt; 100°F</td>
<td></td>
</tr>
<tr>
<td>09/04/13</td>
<td>P</td>
</tr>
<tr>
<td>R</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Humulin 70/30 insulin Inject 10 units subcutaneously before breakfast each day.</td>
<td></td>
</tr>
<tr>
<td>09/04/13</td>
<td>7 AM</td>
</tr>
<tr>
<td>Fingerstick blood sugars Check twice daily before breakfast and supper</td>
<td></td>
</tr>
<tr>
<td>09/04/13</td>
<td>7 AM</td>
</tr>
<tr>
<td>4PM</td>
<td></td>
</tr>
<tr>
<td>Zithromax 250 mg. 1 tablet once daily for 4 days</td>
<td></td>
</tr>
<tr>
<td>09/04/13</td>
<td>8 AM</td>
</tr>
<tr>
<td>Accupril 10 mg. 1 tablet by mouth once daily.</td>
<td></td>
</tr>
<tr>
<td>09/04/13</td>
<td>8 AM</td>
</tr>
<tr>
<td>Ambien 5mg tablets 1 tablet by mouth at bedtime.</td>
<td></td>
</tr>
<tr>
<td>09/04/13</td>
<td>9PM</td>
</tr>
</tbody>
</table>

Initials of individual(s) 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**

<table>
<thead>
<tr>
<th>Temp</th>
<th>Resp</th>
<th>Pulse</th>
<th>Blood Pressure</th>
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<table>
<thead>
<tr>
<th>Initials</th>
<th>Nurse’s Signature</th>
<th>Initials</th>
<th>Nurse’s Signature</th>
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**Charting Codes:**

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

<table>
<thead>
<tr>
<th>Date/Hour</th>
<th>Medication/Dosage</th>
<th>Route</th>
<th>Reason</th>
<th>Initials</th>
<th>Results/Response</th>
<th>Initials</th>
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</tr>
</tbody>
</table>

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5-Hour Training Course for Adult Care Homes

Back of page 6-12
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.

<table>
<thead>
<tr>
<th>Your Center Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>123 Brookshire Lane, Friendly, NC 27856</td>
</tr>
<tr>
<td>919-123-4567</td>
</tr>
<tr>
<td>DEA# AMB165664</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rx#</th>
<th>4003706</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Sullivan</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Jack C. Wallboard</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID# 123456</td>
</tr>
</tbody>
</table>

Give 1 tablet (5 MG) by mouth once daily at 6 PM.

<table>
<thead>
<tr>
<th>Coumadin 5 MG</th>
</tr>
</thead>
<tbody>
<tr>
<td>QTY: # 30</td>
</tr>
</tbody>
</table>

Used for Warfarin Sodium

<table>
<thead>
<tr>
<th>1/13/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Refills</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>1. FINGERSTICK DEVICES SHOULD NEVER BE USED FOR MORE THAN ONE PERSON</th>
<th>2. BLOOD GLUCOSE METERS SHOULD BE ASSIGNED TO ONLY ONE PERSON AND NOT SHARED</th>
<th>3. INJECTION EQUIPMENT SHOULD NEVER BE USED FOR MORE THAN ONE PERSON</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Restrict use of fingerstick devices to a single person. They should never be used for more than one person.</td>
<td>➢ Whenever possible, assign blood glucose meters to a single person.</td>
<td></td>
</tr>
<tr>
<td>➢ Select single-use lancets that permanently retract upon puncture. This adds an extra layer of safety for the patient and the provider.</td>
<td>➢ 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.</td>
<td></td>
</tr>
<tr>
<td>➢ Dispose of used lancets at the point of use in an approved sharps container. Never reuse lancets.</td>
<td>➢ If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared.</td>
<td>➢ Insulin pens should be assigned to only one person and labeled appropriately. They should never be used for more than one person.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>➢ Multiple-dose vials of insulin should be dedicated to a single person whenever possible.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>➢ Medication vials should always be entered with a new needle and new syringe. Never reuse needles or syringes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>➢ For information and materials about safe insulin pen use, visit <a href="http://www.ONEandONLYcampaign.org">www.ONEandONLYcampaign.org</a></td>
</tr>
</tbody>
</table>

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

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

---

*Medication Administration*
5-Hour Training Course for Adult Care Homes
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.

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

mg ≠ ml
MEASURING TIPS

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

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

Reminder: 1 cc = 1 ml
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.

If the strength of a medication is 20 mg/5 ml, this 15 ml cup contains 60 mg of medication.
If the strength of a medication is 40 mg/5 ml, this 15 ml cup contains 120 mg of medication.
YOU CAN'T TELL THE DIFFERENCE BY LOOKING

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

1 TSP. = 5 ml.

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

1 tbsp. = 3 tsp
3 tsp. = 15 ml

TIP: When measuring liquids, hold the cup at eye level.
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
How to handrub?
WITH ALCOHOL-BASED FORMULATION

1a Apply a palmful of the product in a cupped hand and cover all surfaces.

1b

2 Rub hands palm to palm

3 Right palm over left dorsum with interlaced fingers and vice versa

4 Palm to palm with fingers interlaced

5 Backs of fingers to opposing palms with fingers interlocked

6 Rotational rubbing of left thumb clasped in right palm and vice versa

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

8 Rinse hands with water

9 Dry thoroughly with a single use towel

10 Use towel to turn off faucet

11 ...and your hands are safe.

...once dry, your hands are safe.

How to handwash?
WITH SOAP AND WATER

0 Wet hands with water

1 Apply enough soap to cover all hand surfaces.

2

3

4

5

6

7

8

9

10

11

Wet hands with water

Apply enough soap to cover all hand 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

Rinse hands with water

Dry thoroughly with a single use towel

Use towel to turn off faucet

...and your hands are safe.

...once dry, 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.

October 2006, version 1.
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?
### 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 |
|-------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Take 1 tablet by mouth every 4 hours as needed for pain. | 2PM | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK |
| Discontinued 2/09/00 | 8PM | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK |
| LASIX 40mg. | 8AM | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK |
| Take 1 tablet by mouth once every day. | 2PM | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK |
| COUMADIN 5mg. | 8AM | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK |
| Take 1 tablet by mouth every other day. | 2PM | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK |
| Laxin 0.125 mg. | 8AM | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK |
| Take 1 tablet by mouth daily. Check pulse before giving and hold if pulse is less than 60 beats/min | 2PM | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK |
| AMOXICILLIN 250mg | 8AM | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK |
| Take 1 capsule by mouth 3 times daily for 10 days. | 2PM | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK |
| NITRO-DUR 0.4mg/hr PATCH ---- Apply 1 patch every morning and remove at bedtime | 8AM | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK |
| Take 1 tablet by mouth 3 times daily. | 2PM | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK |
| CAPOTEN 50mg | 8AM | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK |
| Take 1 tablet by mouth 3 times daily. (Give 2-25mg tablets) | 2PM | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK |
| LASIX 40mg | 8AM | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK |
| Take 1 tablet by mouth twice daily. | 2PM | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK | TK |

**Physician:** Dr. Moses  
**Telephone #:** 919-555-1212  
**Medical Record #:**

**Allergies:** NKA

**Diagnosis:** Congestive Heart Failure, Hypertension

**Resident:** Jo Burns  
**Date of Birth:** 10/17/30  
**Room / bed #:** 123-2
**NURSE’S MEDICATION NOTES**

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

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

**Injections/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

**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

**NURSE’S MEDICATION NOTES**

<table>
<thead>
<tr>
<th>Temperature</th>
<th>Respiration</th>
<th>Pulse</th>
<th>Blood Pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initials</th>
<th>Nurse’s Signature</th>
<th>Initials</th>
<th>Nurse’s Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>TK</td>
<td>Joel Kase</td>
<td>RB = Right side of back</td>
<td></td>
</tr>
<tr>
<td>CJ</td>
<td>El Jones</td>
<td>RC = Right side of chest</td>
<td></td>
</tr>
<tr>
<td>DB</td>
<td>Dennis Bar</td>
<td>LB = Left side of back</td>
<td></td>
</tr>
<tr>
<td>JU</td>
<td>Jeff Lee</td>
<td>LC = Left side of chest</td>
<td></td>
</tr>
</tbody>
</table>

**Table Definitions:**
- TK = Right side of back
- CJ = Right side of chest
- DB = Left side of back
- JU = 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** |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<td>1-3-13 10AM</td>
<td>Hydrocodone 10/325</td>
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<td>T</td>
</tr>
<tr>
<td>1-7-13 6PM</td>
<td>Coumadin 5mg</td>
<td>po</td>
<td>Not available</td>
<td>C</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pharmacy called</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1-9-13 10PM</td>
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<td>po</td>
<td>Pulse 54</td>
<td>J</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.]