

# AMAP Training Guide

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BOOK 2

Office of Health Facility Licensure and Certification  
EFFECTIVE | MARCH 17, 2016

## Trainee Handout 1.1      **AMAP Scope and Limitations**

1. All medications administered by qualified personnel must be administered in accordance with prescribed orders, facility policy, and all applicable Federal and State laws and regulations. Administration of medications may be delegated to non-licensed staff in approved facilities.
  - **Medication Administration** *is assisting a person in the ingestion, application or inhalation of medications, including both prescription and non-prescription drugs or using universal precautions for rectal or vaginal insertion of medication according to the printed directions by a physician or other authorized health care practitioner.*
  - **Delegation** *is the handing over of a task to another person, usually a subordinate. It is the assignment of authority and responsibility to another person to carry out specific activities or functions.*
  
2. Facilities/entities approved for inclusion in this program:
  - ICF/MR (intermediate care facility for people with mental retardation)
  - Assisted Living Residences (ALR) formerly called Personal Care or Residential Board and Care Homes
  - Behavioral Health Group Homes
  - Private residence in which health care services are provided under the supervision of a registered nurse (RN)
  
3. There are various routes by which an Approved Medication assistive Personnel (AMAP) is permitted by law to administer medications. The proper route for administration must be specified in the physicians order. If the AMAP is administering medications and the route is not specified on the Medication Administration Record (MAR) or order, she should immediately notify the RN. The RN is responsible for clarification of the physician order and correct transcription onto the medication record.
  - Oral: swallowed by mouth
  - Sublingual: dissolved under the tongue
  - Buccal: related to the cheek or mouth
  - Topical: applied to the skin
  - Eye (ophthalmic): drops or ointments inserted/applied to the eye
  - Ear (otic): drops placed in the ear
  - Nasal: placed in the nose/nostril
  - Rectal: inserted into the rectum
  - Vaginal: inserted into the vagina
  - Inhalant: taken in through the mouth or nose by breathing in or inhaling
  - Trans-dermal: absorbed through the skin through application of a patch

4. **The following may NOT be delegated to an AMAP:**
  - **Injections**
  - **Any parenteral (instilled into body tissue) medications**
  - **Irrigations or debriding agents used in the treatment of skin conditions or minor abrasions**
  - **Wound care**
  - **An AMAP cannot transcribe a new physician order on the MAR.**
  
5. To be eligible for training and testing to become an AMAP and to administer medications in a facility, you must:
  - have a high school diploma or GED
  - not be listed on the State Nurse Aide Abuse Registry
  - have not been convicted of crimes against persons or drug related crimes as evidenced by a criminal background check
  - be able to read, write and understand English
  - be certified in CPR and First Aide (and maintain certification)
  - participate in the training program approved by the state and provided by a RN who has completed the department approved RN orientation course
  - pass the competency exam after the training program
  - be monitored and supervised by a registered nurse
  - participate in a retraining program from an RN every two years
  
6. The AMAP approved RN is responsible for monitoring all AMAPs authorized to administer medications. The RN must be available to the AMAP twenty-four (24) hours a day and respond to questions or concerns. The RN must ensure that a file is maintained on each AMAP verifying that they have met all eligibility requirements. The file must include a copy of their certificate for passing the test. It must also include all quarterly observations and two (2) year retraining documentation. Medication error reports and any additional training should be made part of the AMAP file. The RN is responsible for this documentation.

**Note:**

**The registered nurse may withdraw authorization for an AMAP if the nurse determines that you are not performing medication administration in accordance with the training and written instructions or if the RN finds that you have falsified information to become an AMAP.**

## Trainee Task 1.1 Worksheet

1. "Medication administration" means:
  - a. assisting a person in the ingestion, application, or inhalation of medications including prescription and non-prescription drugs
  - b. assisting a person in the ingestion of special foods
  - c. assisting a person in the ingestion illegal drugs
  - d. all of the above
  
2. "Delegation" means:
  - a. handing over a task
  - b. the assignment of authority and responsibility to another person
  - c. representing a licensed nurse
  - d. a and b
  - e. all of the above

3. List the required qualifications to become an Approved Medication Assistive Personnel.

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4. Give an example of a situation where you would not administer medications: \_\_\_\_\_

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5. Who may withdraw AMAP privileges? \_\_\_\_\_

6. Briefly describe the following routes of medication administration that are permitted under the code/rule:

A. oral \_\_\_\_\_

B. ophthalmic \_\_\_\_\_

C. otic \_\_\_\_\_

D. inhalant/nebulizer \_\_\_\_\_

E. nasal \_\_\_\_\_

F. rectal \_\_\_\_\_

G. vaginal \_\_\_\_\_

H. topical/trans-dermal \_\_\_\_\_

I. sublingual \_\_\_\_\_

## TASK 1.1 Evaluations

### AMAP Scope and Limitations

### INSTRUCTOR'S RATING SHEET

Rate Each Trainee Individually

Trainee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Instructor Name: \_\_\_\_\_

THE TRAINEE	COMMENTS	RATING	
Able to verbalize clear understanding of definitions			
Identified type of facilities where AMAPs can administer medications			
Verbalizes eligibility requirements for individual to participate in AMAP program			
Identifies routes that AMAP may administer medications			
Identifies limitations and verbalizes what AMAP cannot do			
<b>RATING DESIGNATION: A = ACCEPTABLE U = UNACCEPTABLE</b>			

## Trainee Handout 1.2 Medication Terms and Abbreviations

To safely administer medications, you must be able to clearly identify and interpret several medical abbreviations. This list contains many of the more common abbreviations used in ordering medications for administration and treatments, and charting/documentation.

- **ac** : before meals
- **bid**: twice a day
- **BP**: blood pressure
- **cap**: capsule
- **ĉ**: with
- **DNR**: Do not resuscitate. This is a specific order not to revive a patient artificially if they succumb to illness. If a patient is given a DNR order, they are not resuscitated if they are near death and no code blue is called.
- **ec**: enteric coated
- **elix**: elixir
- **fl**: fluid
- **gtt**: Drop
- **HTN**: hypertension (high blood pressure)
- **L**: liter
- **MAR**: medication administration record
- **ml**: milliliters
- **npo**: Nothing by mouth. For example, if a patient was about to undergo a surgical procedure requiring general anesthesia, they may be required to avoid food or beverage several hours prior to the procedure.
- **O2**: oxygen
- **oz**: ounce
- **P**: Pulse, Recorded as part of the physical examination. It is one of the “vital signs” and reflects the number of heart beats per minute.
- **pc**: after meals
- **po**: by mouth
- **Post** : after
- **Pre** : before
- **prn**: as needed
- **q**: every
- **q am**: every morning
- **q.d.**: every day
- **q2h**: every 2 hours
- **q3h**: every 3 hours
- **q4h**: every 4 hours
- **qid**: four times daily
- **qpm**: each evening
- **R**: respirations
- **Š**: without
- **SL** : sublingual
- **Supp**: suppository

- **T:** temperature. It is one of the “vital signs.”
- **tab:** tablet
- **tid:** three times a day
- **TPR:** temperature /pulse /respiration
- **tsp:** teaspoon
- **tbsp:** tablespoon
- **UA or u/a:** urinalysis
- **VS:** vital signs (Temperature, pulse, respirations, blood pressure)
- **Wt:** weight

These are just a few of the many abbreviations used in the healthcare industry. The RN must approve the use of any other abbreviation not identified on the list for use in the facility. You must know how to use each abbreviation. Contact the RN anytime you do not clearly understand an abbreviation.

## Trainee Task 1.2 Worksheet

### Identifying Medication Terms and Abbreviations

The RN instructor can add to this evaluation as desired.

Circle the correct answer.

1. The abbreviation “tid” means:
  - a. trends
  - b. 2 times a day
  - c. 3 times a day
  - d. time intake of drug
  
2. The abbreviation “supp” means:
  - a. sensory
  - b. suppository
  - c. bring it down
  - d. side of bed
  
3. The abbreviation “TPR” means:
  - a. temperature/pulse/respiration
  - b. two per
  - c. trooper
  - d. blood pressure
  
4. The abbreviation “bid” means:
  - a. twice a day
  - b. immediately
  - c. three times a day
  - d. standards
  
5. The abbreviation “cap” means:
  - a. capsule
  - b. control oxygen
  - c. complains of
  - d. common obstruction
  
6. The abbreviation “sl” means:
  - a. sublingual
  - b. signs and lesions
  - c. alert
  - d. slightly legal

7. The abbreviation that means fluids is:
- fl
  - flx
  - H<sub>2</sub>O
  - fsx
8. The abbreviation “po” means:
- posterior object
  - by mouth
  - purchase order
  - positive
9. The abbreviation “qh” means:
- every hour
  - every day
  - quarter
  - none of the above
10. The abbreviation “ac” means:
- after meals
  - air condition only
  - before meals
  - after cause
11. In healthcare, the abbreviation “MAR” means:
- means area range
  - Medication Administration Record
  - mess up
  - deface
12. The abbreviation “BP” in healthcare means:
- barometric pressure
  - basal pressure
  - blood pressure
  - base pulse
13. The abbreviation for capsule is:
- cap
  - c
  - cp
  - CPS

14. The abbreviation that means “with” is:

- a. w
- b. s
- c. ĉ
- d. wi

15. The abbreviation “prn” means:

- a. as needed
- b. practice range
- c. per RN
- d. diagnosis match

## TASK 1.2 Evaluation

### Medication terminology and abbreviations

#### INSTRUCTOR'S RATING SHEET

Rate Each Trainee Individually

Trainee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Instructor Name: \_\_\_\_\_

THE TRAINEE	COMMENTS	RATING	
Able to accurately identify common abbreviations			
Verbalized meaning of common abbreviations			
Utilized abbreviations correctly			
<b>RATING DESIGNATION: A = ACCEPTABLE U = UNACCEPTABLE</b>			

## 1.3 Trainee Handout

### Medications

#### Prescription drugs and non-prescription/over the counter (OTC) drugs

All Prescription drugs are designated as:

##### 1. Controlled or Schedule I - V Drugs

There are five (5) categories or schedules of drugs based on their potential to cause psychological and/or physical dependency as well as their potential for abuse. They range from Schedule I for substances with a high abuse potential and no current approval for medical use (e.g. heroin, marijuana, LSD, etc.) to Schedule V for substances containing limited amounts of certain narcotic drugs (cough medicines and diarrhea medicines).

**Narcotic:** central nervous system depressant agent containing opioids or drug that has morphine-like actions.

- a. Designated as a controlled substance
- b. Have a high potential for abuse
- c. Require special storage, usage reporting procedures and destruction
- d. Cannot be dispensed without a doctor's prescription
- e. Can only be administered by the AMAP when the medication order is written with specific parameters that preclude independent judgement

Administration of schedule drugs must be accurately documented and all medications must be accounted for at all times. Review facility policy for proof of use documentation, medication security for control drugs, accessibility, and requirements for counting control drugs and destruction policy.

2. Non-controlled Drugs: All other prescription drugs not on the Board of Pharmacy controlled substance list.

#### Non-prescription/over the counter drugs (OTC):

- a. Can be purchased by the consumer without a prescription
- b. Physician order needed for use in the facility
- c. Can be administered by the AMAP
- d. Can produce unwanted effects
- e. May interact with prescription drugs or foods

f. Must have facility specific policies in place for administration

### **Effects of Medication:**

The human body does not always function perfectly. Sometimes a person will take medication to help the body do its job better. There are four (4) outcomes that may occur when a drug is taken:

1. Desired effect
2. Unwanted effect (sometimes called side effects or adverse drug reactions)
3. Drug interactions
4. No apparent effect

#### **1. Desired Effects:**

Medications are given or prescribed for many reasons. Some examples include:

- Promote health: example - nutritional supplement
- Eliminate illness: example - antibiotics
- Control a disease: example - oral hypoglycemic
- Reduce symptoms: related to illness: example-cough suppressant, aspirin
- Alter behavior: example - anti-anxiety, anti-depressant, anti-psychotic

When the prescribed drug is working correctly, we say the medication is producing the desired effect. The desired effect is the beneficial effect we want the drug to accomplish.

#### **2. Unwanted Effects:**

When a drug is taken, there is always the possibility that the resident may not have the response to the drug that was expected to occur. Some of the outcomes can be life threatening such as a serious reaction to penicillin.

There is always the possibility that unwanted effects will also occur. Sometimes the unwanted effects are predictable. Often they are called side effects or adverse effects.

An example of an unwanted effect is drowsiness produced by sedating cold medications. Drowsiness may not occur in every person for whom the drug was prescribed, but happens frequently. Constipation is an unwanted effect that may occur when taking iron preparations.

Unwanted effects may be unexpected and unpredictable. Many elderly people become confused when starting on a new drug. Some people are very allergic to a drug such as penicillin and have a reaction that could be fatal.

### **Looking for Unwanted (side) Effects of Drugs:**

Unwanted effects show up in either physical or behavioral change. Any change occurring in the first few days of a new drug is important because it may have been caused by the drug. You can encourage the resident to report any changes and be observant for complaints. Any behavioral or physical changes which may be drug related should be reported to the RN.

Examples of unwanted effects:

1. Rashes
2. Diarrhea
3. Vomiting
4. Fainting
5. Lightheadedness
6. Blurred vision
7. Confusion
8. Irritability
9. Agitation
10. Lethargy

### **3. Drug Interactions:**

When a person is taking two or more drugs at one time, the drugs may interact with each other. The greater number of drugs taken, the greater chance for interaction.

Drug interactions may:

- Increase the effects of one of the drugs - called potentiation
- Decrease the effects of one or more of the drugs - called antagonism
- Produce a new and different unwanted (side) effect
- May react with certain foods

**THE GREATER THE NUMBER OF DRUGS TAKEN AT ONE TIME,  
THE GREATER THE POSSIBILITY OF A DRUG INTERACTION.**

### **4. No Apparent Desired Effect:**

Different drugs require different amounts of time before their effects are observable. For this reason, the nurse will tell you how long it may take before the expected action can be seen. If the time expected has gone by,

and no apparent desired effect from taking the medication can be seen, the AMAP **should notify the RN**. For example, if acetaminophen was ordered and given and the fever remains unchanged, there is no apparent desired effect.

### 1.3 Trainee Handout

#### USING DRUG INFORMATION

Using the Pharmacy drug information sheet review the information on Ibuprofen. You can use any other recognized drug information resource.

1. Read the section that identifies purpose and intended effects of the drug.
2. Read the section on side effects. List the side effects on a piece of paper. Think about any resident you know who may be taking Ibuprofen (Nuprin, Advil, Motrin IB) and decide if you can identify any of her/his behaviors or physical complaints that may be related to Ibuprofen side effects.

Recommended Reference:

1. Nursing Drug Reference Book
2. Pharmacy patient information inserts

Use drug reference materials and look up medications you have seen used frequently for your residents. Review listed drug purpose and side effects. Additional drug information is available from the pharmacist and pharmaceutical manufacturers. The inserts obtained from the pharmacy are a good reference.

**When a new medication is ordered for a resident/client that has not been included in the training and/or curriculum, the AMAP must check with the RN for information on this drug and check facility resources.** Before administering a medication, you should know the name of the medication, its purpose, and common side effects for the new medication.

Medication information resources:

- facility books
- drug information inserts
- pharmacy print outs
- on-line web sites (where available)

**This important number should be posted in the facility.**

<p><b>Poison Control Hotline 1- 800-222-1222</b> <b>Provides Information on Poisons and Drug Identification</b></p>
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Review the attached chart which is for reference only. You must understand the purpose and effects of medications used in your work setting.

*Not all side effects are included in this list.*

<b>Drug Type</b>	<b>Name of Drug</b>	<b>Purpose</b>	<b>Side Effects</b>
<b>Anti-infective</b>	Omnipen (Ampicillin)	Infection	Gastritis, fatigue, diarrhea
	Augmentin (Amoxicillin)	Bacterial Infection	Rash, diarrhea, allergic reaction
	Keflex (Cephalexin)	Infection	Gastritis, fatigue, diarrhea
	E-mycin (Erythromycin)	Infection	Diarrhea, nausea, vomiting
<b>Respiratory tract drugs</b>	Albuterol (Ventolin, Proventil) Metaproterenol (Alupent, Metaprel)	Bronchodilator	Tremor, nausea, tachycardia, palpitations, Nervousness, increased BP, dizziness, headache, irritated throat, epistaxis
	Atrovent (Ipratropium bromide)	Bronchospasm	Dizziness, nervousness, palpitations, nausea, dry mouth
	Maxair (Piruterol acetate)	Bronchodilator	Arrhythmia, hypotension, hyperactivity, diarrhea, dry mouth, anorexia, bad taste, abdominal pain, rash, edema
	Corticosteroids (Prednisone, Prednisolone)	Anti-inflammatory	Dry mouth, tremors, vomiting, diarrhea, nervousness, insomnia, headache, increased heart rate
	<b>Antihistamines:</b> Dimetane, Chlor-Trimton, Dimetapp, Dramamine, Benadryl, Claritin, Zyrtec	Allergic reactions, Rhinitis, motion sickness	Drowsiness, confusion, fatigue, dry mouth, nervousness

<b>Drug Type</b>	<b>Name of Drug</b>	<b>Purpose</b>	<b>Side Effects</b>
<b>Central Nervous System</b>	<b><u>Anti-psychotic:</u></b> Clozaril	Schizophrenia	Drowsiness, sedation, rigidity, akathisia, blood pressure changes, leucopenia, granulocytosis
	Geodon	Schizophrenia	somnolence, akathisia, dystonia, hypotension, nausea, constipation
	Risperdal	Schizophrenia	extra pyramidal reactions, agitation, tardive dyskinesia (TD), constipation, hypotension
	Seroquel	Management of psychosis	dizziness, somnolence, seizures, hypotension, leukopenia
	Zyprexa	Schizophrenia and short term treatment of acute mania	parkinsonism, dizziness, TD, blood pressure changes, dry mouth, increased appetite, leucopenia
<b>Central Nervous System</b>	<b><u>Anxiolytics:</u></b> Xanax	Anxiety, panic disorders	Drowsiness, headache, dizziness
	Tranxene, BuSpar, Valium, Ativan	Anxiety	
	<b><u>Narcotic/opiod analgesics:</u></b> Darvocet N, Darvon N, Endocet, Fiorcet, Fiorinal, Lortab, Percodan, Vicodin, Tylenol with Codeine	Pain	Sedation, dizziness, physical dependence

Drug Type	Name of Drug	Purpose	Side Effects
<p><b>Central Nervous System</b></p> <p>Anti-convulsant drugs do not cure seizures they only control them. Some drugs work by making over-active brain cells less excitable and other work by decreasing the brain cells' ability to transmit abnormal impulses to each other causing a seizure.</p>	<p><b><u>Non-narcotic analgesic:</u></b></p> <p>Tylenol, Aspirin Motrin, Advil</p> <p>Celebrex</p>	<p>Pain, arthritis, fever</p> <p>Arthritis</p>	<p>Headache, dizziness, gastric distress</p> <p>Dizziness, headache</p>
	<p><b><u>Anti-convulsants:</u></b></p> <p>Dilantin</p> <p>Phenobarbital</p> <p>Mysoline, Primidone</p> <p>Topamax</p> <p>Depakene, Depakote</p> <p>Trileptal</p> <p>Neurontin and Tegretol</p>	<p>Prevent and control seizures</p> <p>Epilepsy</p> <p>Seizures</p> <p>Adjunctive therapy for seizures</p> <p>Seizures, treatment of mania, prevention of migraines</p> <p>Seizures</p> <p>Seizures, neuralgia</p>	<p>Dizziness, headache, constipation, agranulocytosis</p> <p>Dizziness, hypotension</p> <p>Drowsiness, fatigue, vertigo</p> <p>Confusion, agitation, dry mouth, leukopenia</p> <p>Sedation, depression, increased appetite, hyperactivity</p> <p>Fatigue, headache, dizziness</p> <p>Fatigue, dizziness</p>

<b>Drug Type</b>	<b>Name of Drug</b>	<b>Purpose</b>	<b>Side Effects</b>
<p><b>Central Nervous System</b></p> <p>Antidepressants are used primarily to treat symptoms of depression such as appetite loss, difficulty sleeping, low energy, and low or depressed mood. These medications are also used to treat anxiety and obsessive-compulsive symptoms.</p>	<p><b><u>Antidepressants:</u></b></p> <p>Elavil</p> <p>Wellbutrin, Wellbutrin SR</p> <p>Celexa</p> <p>Sinequan</p> <p>Lexapro</p> <p>Prozac</p> <p>Serzone</p> <p>Paxil</p> <p>Zoloft</p> <p>Effexor</p>	<p>Depression</p> <p>Depression</p> <p>Depression</p> <p>Depression</p> <p>Depression</p> <p>Depression, bulimia, panic disorder</p> <p>Depression</p> <p>Depression, OCD, panic disorder, PTSD</p> <p>Depression, OCD, panic disorder, PTSD</p> <p>Depression, anxiety</p>	<p>Tremor, anxiety, headache</p> <p>Headache, anxiety, hyper/hypotension</p> <p>Dizziness, fatigue, tremor, tachycardia</p> <p>Dizziness, weakness, dry mouth</p> <p>Dizziness, tremor, hypertension</p> <p>Fatigue, headache, dizziness</p> <p>Headache, dizziness, hypotension</p> <p>Dizziness, tremor, dry mouth, anxiety</p> <p>Headache, tremor, dizziness, anxiety, dry mouth</p> <p>Headache, tremor, dizziness, anxiety, dry mouth</p>

<b>Drug Type</b>	<b>Name of Drug</b>	<b>Purpose</b>	<b>Side Effects</b>
<b>Cardiovascular system drugs:</b>  Agents that affect the rate or intensity of cardiac contraction, blood vessel diameter or blood volume	Lanoxin	Heart failure, atrial fib	Fatigue, muscle weakness, Headache, dizziness
	Calan	Angina, atrial fib	Headache, dizziness Hypotension
	Cardizem	Angina, atrial fib, hypertension	Headache, dizziness Hypotension
	Corgard	Angina, hypertension	dizziness Hypotension
	Nitro-Dur, Nitro Bid, Nitrogard	Angina	weakness, Headache, dizziness
	Isordil	Angina	weakness, Headache, dizziness
	Inderal, Propranolol	Angina, arrhythmias, hypertension	Fatigue, hypotension, bradycardia
	Procardia	Angina, hypertension	Hypotension, Headache, dizziness
	Prinivil, Zestril	Hypertension	Hypotension, Headache, dizziness
	Norvasc	Angina, hypertension	Headache, fatigue, palpitations
	Vasotec	Hypertension	Headache, dizziness, fatigue
	Catapres, Clonidine	Hypertension	dizziness, fatigue, hypotension
	Capoten	Hypertension	dizziness, fatigue, hypotension

<b>Drug Type</b>	<b>Name of Drug</b>	<b>Purpose</b>	<b>Side Effects</b>
<p><b>Diuretics:</b> Diuretics are used to treat the buildup of excess fluid in the body that occurs with some medical conditions such as congestive heart failure, liver disease, and kidney disease. Some diuretics are also prescribed to treat high blood pressure. Most of these drugs act on the kidneys to increase urine output. This reduces the amount of fluid in the bloodstream, which in turn lowers blood pressure.</p>	Lasix	Edema, pulmonary edema, hypertension	Headache, dizziness, hypotension
	Maxide, Diazide, Bumex	Edema caused by heart failure	Drowsiness, weakness, nausea
	HCTZ	Edema, Hypertension	Headache, weakness, hypotension
	Aldactone	Edema, Hypertension	Headache, drowsiness, gastritis
<p><b>Hormonal drugs</b></p>	<p><b>Antidiabetics:</b> Glipizide, Glucotrol</p>	Lower glucose level in Type II Diabetes and replace insulin therapy	Dizziness, headache, nausea, constipation
	Glyburide, DiaBeta, Micronase		Nausea, heartburn, leukopenia
	Avandia	Improve glycemic control	Fatigue, headache, diarrhea
	Starlix, Amaryl	Lower glucose level in Type II diabetes	Dizziness
	<p><b>Thyroid Hormones:</b> Synthroid, Levoxine</p>	Thyroid replacement hormone	Nervousness, headache, tachycardia, diarrhea, weight loss
	<p><b>Estrogen:</b> Estrace, Premarin</p>	Osteoporosis, menopausal symptoms	Headache, dizziness, hypertension

<b>Drug Type</b>	<b>Name of Drug</b>	<b>Purpose</b>	<b>Side Effects</b>
<b>Gastrointestinal tract drugs</b>	<b>Anti-ulcer:</b> Zantac, Tagamet, Nexium, Pepcid, Prilosec, Prevacid, Protonix, Carafate	Gastric ulcer, reflux, heartburn	Dizziness, headache
	<b>Antacids:</b> Tums, Maalox, Rolaids, Mylanta	Antacid	Headache, irritability
	<b>Laxatives:</b> Fiberall, Surfak, Enulose, Mg Citrate, Citrucel, Metamucil, Senokot, Milk of Mag	Constipation	Cramping, diarrhea
<b>Ophthalmic Drugs</b>	Tobrex	Ocular infections	Burning, itching, swelling
	Pilocarpine, Alphagen, Xalatan, Timoptic, Travatan	Glaucoma	Dizziness, eye irritation headache
	Visine	Eye irritation	Headache, blurred vision
<b>Otic Drugs</b>	Chloromycetin Otic	Ear infection	Itching, burning
	Cerumenex	Impacted cerumen	itching
<b>Nasal Drugs</b>	Beconase, Rhinocort, Flonase	Rhinitis, seasonal allergies	Headache
	Neo-synephrine, Afrin	Nasal Congestion	Headache, dizziness

This chart is for reference use only.

## Trainee Task 1.3 Worksheet

### Identifying Types of Medications

Circle letter of the correct answer

1. Amoxicillin is an example of which type medication?
  - a. Hormone
  - b. Anti-infective
  - c. Cardiovascular drug
  
2. Estrace is an example of which type of medication?
  - a. Mental health drug
  - b. Antibiotic
  - c. Hormone
  
3. Xanax is an example of which type of medication?
  - a. Respiratory drug
  - b. Drug that affects the central nervous system
  - c. Gastrointestinal tract drug
  
4. Which drug is an example of a cardiovascular system drug?
  - a. Methotrexate
  - b. Lanoxin
  - c. Dilantin
  
5. Which drug is an example of a respiratory tract drug?
  - a. Ventolin Inhaler
  - b. Tagamet
  - c. Amoxicillin
  
6. Norvasc is an example of:
  - a. Cancer drug
  - b. Gastrointestinal tract drug
  - c. Antihypertensive drug

7. Which is NOT an example of a topical medication?
- Cream
  - Capsule
  - Ointment
8. The various classes of medication fall into the categories of prescription drugs and over-the-counter drugs. Which of the following statements about prescription drugs is **not** true?
- The RN must delegate their administration by the AMAP.
  - You must be an authorized AMAP in order to administer.
  - They may be administered without a doctor's order.
9. Which of the following statements about over-the-counter drugs is **not** true?
- They must only be administered with a Physician order
  - They may be administered without a Physician order
  - They can produce unwanted effects
10. Which of the following statements accurately describe a drug on the controlled substance list?
- Can be administered without a doctor's prescription or patient's signature
  - Will not produce unwanted effects
  - May require special storage, usage reporting procedures and destruction
11. Which of the following drugs is an “over-the-counter” drug:
- Geodon
  - Paxil
  - Tylenol
  - Lasix
12. Which of the following is an appropriate reference for drug information:
- the encyclopedia
  - Webster Dictionary
  - Nursing Drug Handbook
  - Redbook

13. A narcotic is a:

- a. central nervous system stimulant
- b. central nervous system depressant
- c. bronchodilator
- d. antidepressant

14. Which of the following statements is not true:

- a. all drugs have potential side effects or unwanted effects
- b. two or more drugs may interact with each other
- c. different drugs require different amounts of time before their effects are observable
- d. the greater the number of drugs taken, the less possibility of a drug interaction

15. Which of the following drugs is not an inhalant medication?

- a. Visine
- b. Flonase
- c. Afrin
- d. Rhinocort

### **1.3 Recognizing Purpose and Effects of Medications**

#### **Case and Questions:**

Jerome Bender is a resident at the facility where you work as an AMAP. He is a responsible person capable of making decisions about his medication. He received a prescription for Dilantin to control his recent onset of seizures. He is reluctant to take the medication because he is not sure what the medication is for and is worried about unwanted effects.

Mr. Bender has some specific questions about unwanted effects of Dilantin. Tell him which licensed health care professional(s) can provide him with specific information about unwanted effects of Dilantin. Describe the process of notifying the RN of his concern.

If Mr. Bender's seizures are not affected by the Dilantin after five days, is this an unwanted effect or no apparent desired effect?

Mr. Bender takes the Dilantin for several days with no unwanted effects; however, he reports extreme drowsiness after taking a sedating cold medication within an hour of his regular dose of Dilantin. What type of unwanted effect might be occurring?

## 1.4 Trainee Handout

### THE SIX RIGHTS OF MEDICATION ADMINISTRATION

**EACH TIME YOU ADMINISTER OR ASSIST WITH THE ADMINISTRATION OF A MEDICATION YOU SHOULD BE SURE YOU HAVE FOLLOWED THE SIX RIGHTS:**

- **RIGHT RESIDENT**
- **RIGHT DRUG**
- **RIGHT DOSAGE**
- **RIGHT TIME**
- **RIGHT ROUTE**
- **RIGHT RECORD**

Nurses have long referred to these factors as the "six rights" of medication administration. Each time a drug is given, you should use a system to follow the six rights. **Check all six rights every time you administer a drug.** You should never try to administer medications from "memory".

#### **Right Resident -**

1. Know the residents
2. Check with other staff if you are not familiar with resident
3. Check resident identification source per facility policy i.e.: picture or armband.
4. Check for drug and latex allergies on each resident.

#### **Right Drug -**

To make sure you give the right drug, use the following process:

1. Compare information on the Medication Administration Record and the pharmacy label.
2. Make sure they agree.
3. If they do not agree, recheck to find out what is different. Contact the RN immediately for further instructions.

## Right Dosage –

Compare the MAR with the pharmacy label to make sure they agree.

## Right Time –

The pharmacy label and MAR will tell you how often the drug should be taken. Your facility should have a time schedule for administering drugs. The RN must fill in the time schedule on the MAR. It is best to administer medications no earlier than one (1) hour before the scheduled time and no later than one (1) hour after the scheduled time. If you are unable to administer the medication within an hour of the assigned time, contact the RN for further instructions.

### Your Facility's Time Schedule for Administering Drugs:

Daily: \_\_\_\_\_

Twice a day (bid): \_\_\_\_\_

Three times a day (tid): \_\_\_\_\_

Four times a day (qid): \_\_\_\_\_

Every six hours (q6h): \_\_\_\_\_

Every eight hours (q8h): \_\_\_\_\_

Every morning (q AM): \_\_\_\_\_

Nightly: \_\_\_\_\_

**Some drugs must be given at a specific time:** for example, before meals, one hour after meals, and at bedtime. These drugs should be given as prescribed. The RN must indicate any special instructions for administration on the MAR including the time the medications are to be administered.

**PRN Drugs -** These drugs are ordered to be given “as needed.” Many pain relievers, laxatives and “sleeping” pills fall in this category. When the resident has difficulty communicating, it may be hard to determine the need for these drugs. **The PRN order must be written with specific guidelines that include dose, frequency and purpose.** For example: Give Motrin 200 mg, two tablets daily by mouth for pain, when needed. The RN is responsible for ensuring that each prn medication has specific guidelines.

## Right Route –

Each medication is prescribed to be taken in a certain form and by a certain route. The oral route (by mouth) is the most common method of medication administration, but there are a number of other routes.

In some cases, the same medication can be given in several different forms (liquid, capsule and suppository) by several different routes (oral, topical, rectal). It is important for the Medication Assistive Personnel to know the dosage form and route of administration for each medication. The MAR and pharmacy label will tell you which route to use for administration.

<u>ROUTE</u>	<u>DOSAGE FORMS</u>	
Oral (by Mouth)	Capsule Liquid Lozenge	Tablet Spray Inhaler
Sublingual Buccal	Tablet Tablet	Liquid (spray) Liquid
Topical (on the Skin)	Cream Liquid Spray Patch (Trans-dermal)	Ointment Powder Gel
Ophthalmic (in the Eyes)	Liquid (Drops)	Ointment
Otic (in the Ears)	Liquid (Drops)	Ointment
Nasal (in the Nose)	Spray Ointment	Liquid (Drops) Nebulizer
Rectal* (in the Rectum)	Suppository Cream	Ointment Liquid (enemas)
Vaginal* (in the Vagina)	Aerosol Foam Cream Jelly Suppository	Ointment Liquid (Douche) Gel

*\*An AMAP may only administer suppositories, or apply medication externally to these areas.*  
**Right record - documentation**

The resident's medical record is a legal document. There are legal aspects to the healthcare facilities documentation. Careful charting is important for the following reasons:

- It is the only way to guarantee clear and complete communication between all members of the health care team.
- It is the legal record of the resident's treatment. Medical charts can be used in court as legal evidence.
- Documentation may protect the healthcare member and the facility from liability proving what the healthcare staff did or did not do.
- Documentation gives an up-to-date record of the status and care of each resident.

### **Guidelines for Documentation**

- Chart administration of medication after you give it, never before.
- When documenting the reason for administering a PRN medication, the record should reflect direct observations or resident specific complaint. For example, the AMAP cannot see a headache. The PRN medication reason would be charted as "Complains of a headache."
- Chart facts, not opinions
- Write neat
- If you make a mistake, follow facility policy for charting errors
- Never erase something that has already been charted
- Never use white out
- Make sure you date an entry with the correct date
- Always sign your chart entry

**Always remember if you did not chart it, you did not do it.**

Make sure that identified resident, prescription medication and MAR match and document initials as required for each medication administered at the correct time.

**REMEMBER, ONLY WHEN YOU ARE SURE OF THE SIX RIGHTS DO YOU ADMINISTER THE DRUG.**

- **Right Resident**
- **Right Drug**
- **Right Dosage**
- **Right Time**
- **Right Route**
- **Right Record**

**TASK 1.4 Evaluation**

**Demonstration of the Six Rights of Medication Administration**

**INSTRUCTOR’S RATING SHEET**

**Rate Each Trainee Individually**

**Trainee Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Instructor Name:** \_\_\_\_\_

<b>THE TRAINEE</b>	<b>COMMENTS</b>	<b>RATING</b>
Demonstrated all six rights in each medication administration observed by the instructor		
Check for latex and drug allergies on each resident prior to administering medications		
Identified the resident to be sure the medication was given to the right person		
Administered the right medication		
Administered the right dosage according to the prescription label and MAR		
Administered the medication at the right time		
Administered the medication by the right route according to doctor’s order and MAR instructions		
Made appropriate documentation on the right record for the resident		
Followed facility policy and procedures regarding the “six rights” of medication administration		

**RATING DESIGNATION: A = ACCEPTABLE U = UNACCEPTABLE**

**1.5 Sample Pharmacy label:**

J. Jones, RPh Pharmacist-in Charge	Community Pharmacy 50 Main Street Charleston WV 25302	304-344-1717 DEA AJ 1234567
Rx540125		11-29-20XX JRJ
Johnson, John		
Two (2) puffs four times daily Shake well before using. Separate puffs by one minute. Consult patient pkg. insert. (Take bronchodilators before steroids)		
Qty: 17 gms Dr. J. Adams Ventolin Inhaler		Refills: 2 Exp: 11-29-20XX Allen & Hanburys

Look closely at the pharmacy label. Find each component 1-9 on the pharmacy label.

R. Kubacki, RPh Pharmacist-in-Charge	Golden Crest Pharmacy 40 Olden Avenue Charleston, WV 25302	304-343-7725 DEA Ak 1234567
Rx 660660		6-14-20XX
Elinor Fritz		
Cognex 40 mg	Take one capsule four times daily.	
Qty: 100 Dr. Alzheimer		Refills: 6 Exp: 6/14/20XX

**Locate the following information:**

1. Resident name
2. Name, telephone number, and complete address of the dispensing Pharmacy
3. Either brand name or generic name of the medication. If the generic name is used, the manufacturer or distributor's name shall also appear
4. Strength of the prescribed medication
5. The quantity dispensed
6. The date of dispensing
7. The identifying number under which the prescription is recorded in the pharmacy's files
8. The prescriber's name
9. Directions for use

If there is any question or confusion about the pharmacy label, contact the RN.

## 1.5 Use of Medication Administration Record (MAR)

Instructions:

Give each trainee a simulated resident's MAR and a new pharmacy-delivered medication. Have the trainee perform the following exercises.

Medication Administration Record:

Identify where each of the following elements of the Medication Administration Record is located:

1. Name of the resident
2. Name and strength of drug
3. Amount of the drug ordered
4. Time(s) to be administered
5. Route of administration
6. Special instructions for storage or administration
7. Place for signature/initials of person administering the drug
8. Place for noting reason medication not administered with date and time

## 1.5 Trainee Handout

### How to use the Medication Administration Record (MAR) to document medication administration

#### When You Give a Medication:

Each time you administer medication to a resident, you must immediately document the following on the resident's Medication Administration Record (MAR):

1. Your initials in the correct location that indicates the medication, dose, date and time.

All staff administering medications must be sure they document their full signature on the MAR in the correct location with their corresponding initials. The corresponding initials must match the documented initials used on the MAR for verification of administration of medications.

2. If medication is a one time dose, or PRN document:
  - the time
  - the date
  - dosage
  - your initials
  - outcome: whether the medication was effective
3. If a medication is not given, circle date, initial and write in "missed" on the back of the MAR and explain why the dose was missed. Follow instructions on MAR or facility policy on this process.

#### When a new medication (or change in a medication's dosage, frequency, or route of administration) is prescribed:

1. In some cases, the nurse may alert the AMAP that a new medication has been ordered, or that the dosage, frequency, or route of administration has been changed on a resident's medication administration record.
2. The RN must receive the new order, review and transcribe the order on the MAR. When the new medication or new dosage of a current medication is delivered from the pharmacy, compare the medication pharmacy label to the MAR. The MAR and pharmacy label should be identical. If it is not, notify the RN.

## TASK 1.5 Evaluation

### Demonstration of the Proper Use of the Medication Administration Record

#### INSTRUCTOR'S RATING SHEET

Rate Each Trainee Individually

Trainee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Instructor Name: \_\_\_\_\_

THE TRAINEE	COMMENTS	RATING	
Identified the required elements of information on a resident medication administration record			
Documented the appropriate information after administering medications			
Documented the appropriate information when a medication is omitted			
Demonstrated the ability to indicate when a medication has been discontinued			
<b>RATING DESIGNATION:    A=ACCEPTABLE    U=UNACCEPTABLE</b>			

## 1.6 Trainee Handout

### **Infection Control - Using Medical Asepsis & Universal Precautions**

Health care workers must be responsible for protecting the residents and themselves from infection. This can be achieved by utilizing good infection control practices.

Infections occur under the following circumstances:

1. An infectious pathogen (microorganism that causes infection) is present
2. There is a reservoir (place) in which the pathogen can grow (i.e. human tissue)
3. There is a way that the pathogen can leave its reservoir (portal of exit) i.e. blood, break in skin, respiratory, gastrointestinal, urinary and reproductive tracts
4. There is a way the pathogen is transmitted (i.e. through the air, direct contact, contact with contaminated equipment, water, food)
5. There is a place for the pathogen to enter (portal of entry) i.e. break in the skin, through the respiratory system.
6. A new reservoir (host) that is susceptible to the pathogen (i.e. the elderly at times cannot fight infection as well as others)

Using medical asepsis (keeping free of disease - producing microorganisms) and the Blood borne Pathogen Standard issued by the Centers for Disease Control helps to prevent the spread of infection. The Standard requires health care workers to consider the body fluids of all patients (residents) potentially contaminated with communicable blood borne organisms.

Universal Precautions is an approach to infection control. According to the concept of Universal Precautions, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other blood borne pathogens.

There are many common aseptic practices that should be practiced in all settings at work and outside work. Examples of these would be:

- Always washing your hands after urination, bowel movements and changing of sanitary products
- Washing hands when there is any contact with a body fluid or substance (i.e. blood, urine, feces, vomit, saliva, respiratory secretions, any other body fluid or drainage)
- Washing hands before preparing or eating food
- Covering the mouth and nose when coughing or sneezing
- Practicing good daily hygiene

One of the most important ways (and one of the easiest) to prevent infection is hand washing. Hands are one of the most common transmitters of pathogens from one person or item to

either yourself or another person. Your hands should be washed BEFORE and AFTER providing any type of care.

### **Hand Washing Procedure**

1. Make sure that soap, paper towels, and a wastebasket are available.
2. Move watch and sleeves (if applicable) up arms approximately 5 inches.
3. Turn the faucet on using a paper towel and adjust water temperature for comfort.
4. Toss paper towel into wastebasket.
5. Wet wrist and hands thoroughly, keeping them below elbow level to keep microorganisms from being moved up your arms.
6. Dispense soap.
7. Lather hands and wrists by rubbing palms together for at least 20 seconds.
8. Wash each hand and wrist and between the fingers, for one (1) to two (2) minutes. Underneath the fingernails can be cleaned by rubbing the fingertips against the palm of the opposite hand.
9. The fingernails should be cleaned with the first hand washing of the day and if the hands become very soiled.
10. Rinse wrists and hands, maintaining them at a lower level than the elbows.
11. Repeat steps 6, 7, 8, and 10 if required.
12. Pat dry with a paper towel starting at the wrist and moving down to fingertips of each hand.
13. Discard the paper towel.
14. Use a dry clean paper towel to turn off each faucet.
15. Discard paper towels in wastebasket.

## **Use of Hand Sanitizers**

The facility must establish a policy on when to use hand sanitizers and how frequently they can be used before the caregiver must wash hands with soap and water.

## **Other Procedures for Maintaining Asepsis Including Universal Precautions**

1. Use disposable items (i.e. medication cups, drinking cups, thermometer sheaths) once per resident and dispose of per facility policy.
2. Wear gloves ANY TIME there may be contact with blood, any body fluids, and mucous membranes. (i.e. urine, feces, vomit, vaginal secretions, respiratory secretions).
3. Wear gloves any time there is contact with items soiled by anything mentioned in #2 (i.e. soiled lines, equipment).
4. Wear gloves if you have any openings in your skin.
5. Change your gloves after contact with each resident.
6. Never wash your gloves. Dispose of them after each use.
7. Wash your hands after removing the gloves.
8. Place any linen that have been soiled with blood or any body substances in leak-resistant bags. Carry dirty linens away from your body.
9. Follow facility policy for disposal of any contaminated waste.
10. If you should have any direct contact with blood or body fluids, wash your hands and/or other place where your skin is exposed.
11. If you have any open skin conditions, discuss this with the RN.
12. If you would have any direct exposure to blood or body fluids, notify the RN.

## TASK 1.6 Evaluation

### Using Medical Asepsis and Universal Precautions for Infection Control

#### INSTRUCTOR'S RATING SHEET

Rate Each Trainee Individually

Trainee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Instructor Name: \_\_\_\_\_

THE TRAINEE	COMMENTS	RATING	
Explained accurately the need for infection control			
Described how infections are transmitted			
Identified when hands should be washed and demonstrated correct procedure			
Identified when gloves should be worn and demonstrated correct use			
Described proper disposal of contaminated equipment and/or linens			
Described your facility's Infection Control Plan or policies			
<b>RATING DESIGNATION: A = ACCEPTABLE U = UNACCEPTABLE</b>			

## **Area 1.7 Trainee Handout**

### **Organize to administer medications**

#### A. General procedure to follow:

1. At beginning of work shift, review all residents' MARS
2. Plan your time schedule for administering medications to residents
3. Identify where residents' medications are stored:
  - a. In residents' apartments/rooms
  - b. In a central medication storage area

#### B. Medication administration procedure

1. Wash your hands
2. For each resident who needs medication according to the MAR, prepare medications using the six rights
  - a. Check drug and latex allergies on each resident prior to administering medications
  - b. Do not open/prepare medication until resident is ready to accept it
  - c. Keep medication within sight (unless it is locked up) until it is administered
3. Administer the medication as prescribed
  - a. If medication is dropped or contaminated, follow facility policy for destruction and documentation
  - b. Administer a replacement dose to resident
  - c. Notify the RN of use of an additional dose.
  - d. Follow policy procedure.
4. Document medication administration on the MAR.

C. Procedure after medication administration is complete.

1. Medications that are centrally stored must be kept locked.
2. Follow facility procedure for securing medications that are kept in residents' apartments/rooms

### **ORGANIZING TO ADMINISTER MEDICATIONS PRACTICE EXERCISE**

1. Collect Medication Administration Records for five to ten residents at your facility. (Prepare sample MAR'S if needed)
2. Using your facility's policies of medication administration, describe the process and procedures you would follow to administer medications to these residents at your facility today.
3. Write the planned time for administering medications. It is best to administer medications no more than one hour before or one hour after the scheduled medication administration time. If you are unable to administer medication within the assigned hour, contact the RN for further instructions.
4. Where are the residents' medications stored at your facility?
5. Identify two important steps you must perform before actually giving a resident his/her medications.
6. If you drop a resident's pill on the floor, what should you do?
7. What should you do after you have finished giving medications?

## TASK 1.7 EVALUATION

### Organizing to Administer Medications

#### INSTRUCTOR'S RATING SHEET

Rate Each Trainee Individually

Trainee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Instructor Name: \_\_\_\_\_

THE TRAINEE	COMMENTS	RATING	
Reviewed resident MAR's			
Planned time for administering medications			
Identify where medications are stored			
Wash hands before administering medications			
For each resident requiring medication, review "six rights" of medication administration			
Check for drug allergies			
Avoided opening/preparing medication until resident was ready to accept it			
Kept medication within sight (unless it is locked up) until it was administered			
Gave medication as prescribed			
Described proper procedure for destroying medication if dropped or contaminated per facility policy			
Documented medication administration on the MAR			
Demonstrates proper storage of medications/secures med cart/room			
<b>Rating Designation    A= Acceptable    U=Unacceptable</b>			

## 1.8.a Trainee Handout

### Documentation

Documentation must be legible, timely, complete, free of destruction or tampering, and objective. Objective documentation is FACTUAL. Only abbreviations approved by the RN can be used in facility documentation. Use common sense when documenting and document each step accurately. Legibility communicates information clearly and helps paint the picture. Failing to document facts accurately and timely can create many problems.

#### Terms to avoid:

“Pt. doing better”

“Voided several times”

“Confused and disoriented”

“Incident report filled out”

“As usual Dr. did not call back”

“No change”

When a resident is admitted to a facility, the RN is responsible for making sure that medication orders are transcribed correctly from the physician ordered prescription onto the MAR before you administer the medication to the resident. The pharmacy may generate a MAR or the RN may transcribe the information onto a facility MAR. Whichever method is used, it is the RN's responsibility to assure that the medications are correctly entered onto the MAR and reviewed before the AMAP staff administers the medication.

Any time there is a change in a medication order, the RN must be notified. Follow the facility procedure. You must assure that the RN is able to review the physician order and to transcribe and/or review the new order on the MAR.

In some cases, the resident may return from a physician's office with a written prescription stating that a medication should be discontinued. If a medication is discontinued, the RN is also responsible for discontinuing the medication on the MAR. You must notify the RN of the order change. If a medication is discontinued, the RN may call to inform the AMAP that the medication has been discontinued. The AMAP should follow the RN's instructions, not administer the medication, and appropriately document that the medication was not given. See “Discontinuing an ordered medication.”

If the dosage of a resident's medication is changed, it may be necessary to return the current medication to the pharmacy. In all instances, you should follow facility policy regarding any discontinued or unused medication. If there is a discrepancy between the MAR and the prescription, notify the RN.

You cannot take a telephone or verbal physician's order and you cannot transcribe any new order onto the MAR.

If the RN is not at the facility and a new order comes in for a resident/client, the order may be faxed to the RN. The RN must provide a signed copy of the MAR to the facility prior to

administration of the medication.

When administering medications, the AMAP must initial the MAR to verify that the medication has been given. The initials must be appropriately placed in the area specified on the MAR for documentation. There should also be a full signature with initials on the MAR for all persons administering medications in the facility.

### **Discontinuing an ordered medication**

Only the RN may receive an order from the physician to discontinue a medication. The RN may communicate this discontinuation order to the AMAP by telephone via a nursing instruction. Upon receipt of the nursing instruction, the AMAP will record the nursing instruction on the designated area on the back of the MAR or as per facility policy, logging the date and time received, and stops administering the discontinued medication. The RN must then record the discontinuation order onto the MAR prior to the start of the next scheduled shift.

### **When Re-fill Medication Arrives (Including Over-The-Counter Drugs):**

1. Compare the pharmacy label to the resident's Medication Administration Record. The information on the MAR and prescription label should be identical. If it is not, notify the nurse.
2. Some facilities have a special form for "logging in" medications from the pharmacy. In other facilities, the person who receives the medication from the pharmacy initials and dates the receipt to indicate that it has been reviewed and is correct. If you have any questions, call the registered nurse. Do not give the drug until your questions are answered by the registered nurse.
3. If the drug is a generic drug, its color and shape may be different from what you have seen before. ALWAYS check with the registered nurse if you have any questions, then document the response from the nurse for other staff who may be giving medications later. This documentation should be done according to facility policy. The facility is responsible for establishing the appropriate place to maintain this documentation.
4. Explain any differences to the resident when the drug first comes from the pharmacy. This will help the resident understand why the medication "looks different." You may want to have the registered nurse explain the change to the resident.
5. Explain to the resident that the medication has been discontinued. The medication must be disposed of according to facility policy.

## 1.8.b Trainee Handout

### Reporting and Documenting a Resident's Refusal to Take Medication

Fill in the information that describes your facility's procedure for reporting and documenting a resident's refusal to take prescribed medication.

The name of the delegating nurse or nurses to whom I should report a resident's refusal to take prescribed medication is/are:

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According to facility procedure, the following information must be included when providing written documentation for a resident's refusal to take medication:

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The steps in the facility's procedure for providing written documentation of a resident's refusal to take medication are as follows: (if a special form is used for this purpose, you may want to attach a copy of this form for reference)

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**TASK 1.8.b Evaluation**

**Reporting and Documenting a Client/Resident  
Refusal to Take Medication**

**INSTRUCTOR'S RATING SHEET**

**Rate Each Trainee Individually**

**Trainee Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Instructor Name:** \_\_\_\_\_

<b>THE TRAINEE</b>	<b>COMMENTS</b>	<b>RATING</b>	
Explained to resident the importance of taking medication as prescribed			
Tactfully and matter-of-factly encouraged resident to take medication			
Did not force resident			
Contacted appropriate RN in a timely Manner			
Followed RN's instructions			
If the medication seal has been broken, discard medication according to facility policy.			
Completed appropriate written documentation explaining how the situation was handled and what was done with the used medication.			

**RATING DESIGNATION: A = ACCEPTABLE U = UNACCEPTABLE**

## **TASK 1.8.c Trainee Handout**

### **Documenting Medication Errors**

Discuss examples of errors in administering medication:

1. Wrong medication is given to a resident
2. Wrong resident is given a medication
3. Wrong dosage of a prescribed medication is given
4. Medication is given at wrong time or not given at all (excluding medication refusal)
5. Wrong route of administration is used
6. Medication is not available
7. Wrong form of medication is administered. (i.e. liquid for a tablet, extended release for regular release)
8. Medication is administered but record indicates resident is allergic.

Review facility procedure for documenting medication errors.

### **Recognizing Medication Errors:**

The following are examples of medications errors:

1. The wrong medication is administered to a client/resident  
Example: Mrs. Kent is given Amoxicillin instead of Tetracycline
2. The wrong client/resident is given medication  
Example: Kay Blevins is given Benadryl 50 mg. that should have been given to Sally Turner.
3. The wrong dosage is given  
Example: Mr. Sams is given 500 mg of Tetracycline, but the doctor's order calls for 250 mg of Tetracycline
4. Medication is given to client/resident at the wrong time or not given at all  
Example: Mrs. Tyson was supposed to receive 50 mg of Macrochantin with her lunch, but it was not administered until 2:00 p.m., two (2) hours after her meal

5. Wrong route of administration

Example: Doctor's order states that Ms. Tussing is to receive one Levsin tablet sublingually (under her tongue), but the tablet is swallowed with fruit juice

6. Medication is not available

Example: Mr. Bohrer was supposed to receive Haldol 2 mg. at 9 a.m. The medication was not sent by the pharmacy

7. Wrong form of medication is administered

Example: Wellbutrin **ER** 200 mg. (extended release) once daily is ordered for Mr. Anderson. Wellbutrin 200 mg. was administered.

**TASK 1.8.c. Evaluation**

**Identifying and Reporting  
Medication Errors**

**INSTRUCTOR'S RATING SHEET**

**Rate Each Trainee Individually**

**Trainee Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Instructor Name:** \_\_\_\_\_

<b>THE TRAINEE</b>	<b>COMMENTS</b>	<b>RATING</b>	
Identified conditions, which constitute medication errors			
Identified steps taken when a medication error occurs			
Demonstrated knowledge and ability to document errors according to facility policy			
Describe how to handle or dispose of unused medications according to facility policy			

**RATING DESIGNATION:    A = ACCEPTABLE    U = UNACCEPTABLE**

## TASK 1.9 Trainee Handout

### Disposing of Medications

- A. Discuss facility policy for disposal of medications.
- B. Discontinued medications or expired medications should be handled according to facility policy.
- C. Never give one resident's discontinued drugs to another resident.
- D. Never give an expired medication to any resident.
- E. If a dose of a controlled substance becomes contaminated, it should be destroyed following the facility policy. (These drugs cannot be destroyed by an AMAP)
- F. Over-the-counter drugs (OTC) should be disposed of according to facility policy.

When a prescription expires, is discontinued or is left after a resident's death, certain procedures must be followed in disposing of the unused drugs.

1. Learn the policies and procedures for your facility relating to destruction of medication. **AMAP'S are not to dispose of certain medications and this will need to be addressed in the facility policy.**
2. ALL drugs must be destroyed beyond the possibility that they could ever be used again.
3. If a drug prescribed for a resident is discontinued or left after a resident's death, NEVER give to another resident.
4. Pharmacist may give credit for unopened unit dose packages or sealed containers, according to Board of Pharmacy Rules. Always return unused medications for credit when possible. Document according to facility policy the disposition of these drugs.
5. If a drug of any kind becomes contaminated, notify the RN. Facility policy will then be implemented.

## TASK 1.9 Evaluation

### Disposing of Medications

#### INSTRUCTOR'S RATING SHEET

Rate Each Trainee Individually

Trainee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Instructor Name: \_\_\_\_\_

THE TRAINEE	COMMENTS	RATING	
Expired or discontinued medication is handled according to facility policy			
Describe your facility policy regarding: 1. How to dispose of a drug, if contaminated (dropped, spit out by resident, etc.) 2. How to dispose of a drug if the resident refuses 3. How to dispose of a controlled drug			
Identify facility forms for disposal			
In the space below add any facility specific steps that must be followed			
1. 2. 3.			
<b>RATING DESIGNATION: A = ACCEPTABLE U = UNACCEPTABLE</b>			

## **TASK 1.10 Trainee Handout**

### **Storing and securing all Medications**

Your facility may use one or more systems of packaging or drug distribution for medication management.

According to federal and state law or regulations and good practices, the following apply to drugs:

#### **Drug Prescription Containers:**

All drugs must be stored in the original containers in which they were dispensed by the licensed pharmacist. The labels on these containers must be kept intact and readable.

**DO NOT MAKE ANY MARKS OR CHANGES ON THE LABEL.** Changes can only be made by a pharmacist.

#### **Locked Storage:**

All medications must be stored in a locked area (e.g. locked room, locked cabinet, locked container in a refrigerator). There must be sufficient storage space and adequate lighting. Topical medications must be stored separately from oral medications.

#### **Key to Locked Storage:**

The keys to the locked medication storage must be kept on the person who is responsible for medication administration and accessible only to authorized medication administration staff.

#### **Controlled Substances:**

The facility must be accountable for all Schedule II drugs. You will know a prescription is for a controlled substance because the RN will document this on the MAR. Keep controlled substances in a secure locked container or cabinet with two different keys to protect them. The key to the separately locked Schedule II drugs shall not be the same key used to gain access to non-scheduled drugs.

## Activities:

1. Mary, an AMAP, received a resident's Amoxicillin from the pharmacist to the facility. How should she store this medication?
2. An AMAP receives a resident's newly prescribed medication, Darvocet N 100 (a controlled substance). She gives it to the facility supervisor who places it in a locked cabinet in an unlocked room.

Is this medication stored according to regulations? If not, how should it be stored?

3. AMAP Kevin is responsible for storing medications. He places a resident's medication, Percodan (a controlled substance) in the locked drawer of the locked medications cabinet and returns the key to his pocket.

Is this medication stored properly according to law? If not, how should it be stored?

4. A resident received a prescription for a controlled substance which requires refrigeration. The place where controlled substances are normally kept was not refrigerated so the AMAP put the medication into an unlocked refrigerator and told residents not to touch it.

Was this medication stored according to regulations? If not, how should it be stored?

## TASK 1.10 EVALUATION

### Storing Medications

#### INSTRUCTOR'S RATING SHEET

Rate Each Trainee Individually

Trainee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Instructor Name: \_\_\_\_\_

THE TRAINEE	COMMENTS	RATING	
Stored medication in the original container dispensed by pharmacist			
Reviewed pharmacy label for all instructions and legibility			
Stored all medications in a locked system or locked refrigerator			
Stored controlled substances in a secure cabinet or container. Schedule II drugs protected by 2 locks with two separate keys.			
Used an accounting system for all controlled substances and counted according to applicable regulations and designated facility policy			
Notified nurse when controlled substance count incorrect for further instructions			
<b>RATING DESIGNATION:    A = ACCEPTABLE    U = UNACCEPTABLE</b>			

### 1.11 Maintain an Inventory of Controlled Medications

- Every facility has policies and procedures that account for controlled drugs and a quality assurance system to assure a valid counting system.
- Should you think the count is wrong, or note pills are disappearing, discuss the problem with the RN.
- Drug diversion is a criminal action, and the facility is required to report suspected criminal activity to the West Virginia State Police, Bureau of Criminal Investigation at 304-558-2600 or the local police department and OHFLAC.
- Special forms are use to document the proof of use for each controlled drug

In the space below, summarize the designated facility procedure for controlled drugs.

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Contact \_\_\_\_\_ immediately, if the drug count is not correct.

Demonstrate the proper process to follow for completion of a proof of use form for a controlled drug.

## TASK 1.11 EVALUATION

### Demonstration of the Use of Declining Inventory Sheet for control drugs

#### INSTRUCTOR'S RATING SHEET

Rate Each Trainee Individually

Trainee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Instructor Name: \_\_\_\_\_

THE TRAINEE	COMMENTS	RATING	
Explained the knowledge of Federal and State regulations pertaining to controlled medications			
Demonstrated accuracy when counting controlled medications			
Explained the components of facility policy concerning controlled medications			
Demonstrated proper use of the declining inventory sheet			
<b>RATING DESIGNATION:    A=ACCEPTABLE    U=UNACCEPTABLE</b>			

## **TASK 1.1 Medication Delivery systems**

There are several types of delivery systems for resident medications. Medications may be supplied in the following ways:

1. Prescription bottles
2. Unit-dose blister packs
3. Multi-dose delivery systems
4. Medication samples

For each type of delivery system you must check the following:

- resident name on packaging
- drug name
- drug dose
- special instructions for administration or directions for use
- prescriber name
- expiration date

### **Multi dose delivery system:**

Each multi-dose medication packet must meet the following criteria:

1. There are no more than four (4) medications per package unless all medications in the packet are the same.
2. The following information must be listed on the medication package:
  - resident name
  - drug name (both generic and brand where applicable)
  - drug dose
  - drug color
  - drug shape
  - any numbers on the drug
  - any other description on the drug i.e. scoring, capsule tablet, etc.
  - RX number
  - Lot number
  - directions for use i.e. time, route etc.
  - prescriber name
  - expiration date

General procedure: Make sure that the package meets the above listed criteria. Identify each medication using comparison with the package criteria and the MAR. If a medication cannot be identified, call the RN for directions – **DO NOT GIVE THE DOSE** or permit the resident to take the medication. Administer the medication only when you have been able to follow the six rights of medication administration:

- Right resident
- Right drug
- Right dosage
- Right time
- Right route
- Right documentation/record

When administering medications for this type of packaging, you must:

- identify each pill separately
- compare the resident name on the package with the MAR and make sure that they agree
- compare MAR drug name and name on package to make sure they agree
- compare MAR drug dose and dose on package to make sure they agree
- compare MAR directions and directions on package to make sure they agree
- compare the pill in the package with the description on the package.  
Make sure the color, shape, numbers and description all match.

Medication samples: Medication samples may be utilized when there is a clear and specific physician order for the medication. Samples will not contain a pharmacy label. The packaging must clearly indicate the drug name and dosage. The RN must provide clear instructions to the staff regarding the use of the medication sample.

**When in doubt – don't**

**And**

**Notify the RN**

**Task 1.12 Evaluation**

**Medication Delivery Systems**

**INSTRUCTOR'S RATING SHEET**

**Rate Each Trainee Individually**

**Trainee Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Instructor Name:** \_\_\_\_\_

<b>THE TRAINEE</b>	<b>COMMENTS</b>	<b>RATING</b>	
Identified at least four different types of medication delivery			
Verbalizes each area of identification on the multi-dose delivery system			
Demonstrated proper procedure for medication administration for each type of delivery system			
<b>RATING DESIGNATION:    A = ACCEPTABLE        U = UNACCEPTABLE</b>			

## Task 2.1 Measuring and Recording Vital Signs

A person's temperature, pulse, respirations and blood pressure vary within certain limits during any 24-hour period. Many factors affect vital signs including sleep, activity, eating, weather, noise, medications, fear, anxiety and illness.

Vital signs are measured to detect changes in normal body function. They also tell how a person is responding to treatment. Normal measurements for each resident will be included on the MAR. Vital signs may differ dramatically from resident to resident. **What is normal for one person may not be normal for another. What is normal for the resident is what the resident normally runs.** The RN will document on the MAR whether vital signs must be taken prior to medication administration.

Unless otherwise ordered, vital signs are taken with the resident sitting or lying at rest. They must be measured accurately. If you are ever unsure of your measurements, promptly ask the RN to re-check them. Vital signs must be accurately reported and recorded. Any vital sign that is changed from a previous measurement or vital signs that are above or below the normal range are reported to the RN immediately.

### Pediatric Vital Signs

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These vital signs remain relatively constant throughout our adult life. However, as infants and children grow and age, the normal range changes. Two tables of normal vital signs for the pediatric population are presented below.

Age (yr)	Respiratory Rate (breaths/min)	Heart Rate (beats/min)
<1	30-60	100-160
1-2	24-40	90-150
2-5	22-34	80-140
6-12	18-30	70-120
>12	12-16	60-100
Lower limits of systolic pressure†		
0-28 days: 60 mmHg 1-12 months: 70 mm Hg 1-10 years: 70 mm Hg + (2× age in years)		

Reference: Rosen's Emergency Medicine: Concepts and Clinical Practice 5th Edition

## Vital Signs at Various Ages

Age	Heart Rate (beats/min)	Blood Pressure (mm Hg)	Respiratory Rate (breaths/min)
Premature	120-170 * <sub>-</sub>	55-75/35-45 <sub>±</sub>	40-70 <sub>±</sub>
0-3 mo	100-150 * <sub>-</sub>	65-85/45-55	35-55
3-6 mo	90-120	70-90/50-65	30-45
6-12 mo	80-120	80-100/55-65	25-40
1-3 yr	70-110	90-105/55-70	20-30
3-6 yr	65-110	95-110/60-75	20-25
6-12 yr	60-95	100-120/60/75	14/22
12 * <sub>-</sub> yr	55-85	110-135/65/85	12-18

References: Behrman, Nelson Textbook of Pediatrics: 17th edition.

\* From Dieckmann R, Brownstein D, Gausche-Hill M (eds): Pediatric Education for Prehospital Professionals. Sudbury, Mass, Jones & Bartlett, American Academy of Pediatrics, 2000, pp 43–45.

† From American Heart Association ECC Guidelines, 2000.

Medically Reviewed by: [Benjamin C. Wedro, MD, FAAEM](#)

Last Editorial Review: 3/10/2008

## Adult Vital Signs

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### Temperature:

Oral (OR) 96.6 to 98.6 degrees

written as: T 98.6 (OR)

Tympanic/Otic (T) 98.6 degrees

written as: T 98.6 (T)

*Rectal (R) (one degree higher than normal)*

*Written as: T 99.6 (R)*

*Axillary (AX) (one degree lower than normal)*

*Written as: T 97.6 (AX)*

Infrared Thermometer

See manufacture guide

### Pulse Range:

60 to 90 beats per minute

Written as: P 88 (AP)

### Respiration Rate:

12 to 20 breaths per minute

Written as: R 18

## **Blood Pressure:**

The optimal blood pressure for minimizing the risk of cardiovascular problems (such as heart attack and heart failure and stroke) is below 120/80 mm Hg.

The blood pressure ranges listed below are for informational purposes only. Please check with the licensed physician regarding the standard of care related to individual care.

### **Normal Blood Pressure**

Below 130 Systolic (S)

Below 85 Diastolic (D)

### **High-normal blood pressure**

130-139 (S)

85-89 (D)

### **Stage 1: mild hypertension**

140-159 (S)

90-99 (D)

### **Stage 2: moderate hypertension**

160-179 (S)

100-109 (D)

### **Stage 3: severe hypertension**

180 or higher (S)

110 or higher (D)

Some medications used at the facility may require measurement of vital signs before administering. The RN must document the instructions for medications that require a vital sign measurement on the MAR. Remember it is the responsibility of the MD/RN to indicate parameters for holding medication. Some of these medications include:

Digoxin: Check apical pulse

Procardia: Check blood pressure

Morphine: Check respirations

Tylenol: Check temperature. Tylenol may be prescribed as a PRN medication and would only be given with an elevated temperature according to prescribed order. Notify nurse of abnormal elevation of temperature.

Common medication related symptoms that require measurement of vital signs and the need to notify RN:

Dizziness	Check blood pressure
Swelling of Ankles	Check pulse and blood pressure
Chest Pain	Check pulse, blood pressure, respiration

## 2.1 Procedure and Use of a stethoscope

A stethoscope is an instrument that is used to hear the respiration and heart sounds in the chest, and can be used to hear other sounds anywhere in the body. Some stethoscopes have both a Bell and a Diaphragm, but most are equipped with a diaphragm only.

**Diaphragm** - The diaphragm of the stethoscope is the flat part at the end of the tubing, with the thin plastic "drum-like" covering. The diaphragm is used to listen to high pitch sounds. Some stethoscopes have a diaphragm but no bell.

**Bell** - The bell of the stethoscope is the cup shaped part at the end of the tubing, usually opposite to the diaphragm. Not all stethoscopes have a bell. The bell is used to listen to low pitch sounds.

If you are using a stethoscope with both a bell and a diaphragm, you must twist the bell and diaphragm to the correct position to hear the heart or blood pressure. This is done by placing the earpieces of the stethoscope into your ears, twisting the bell and diaphragm and tapping on the bell or diaphragm to see which side is loudest.

Procedure for using a stethoscope:

- You will need a stethoscope and alcohol wipes
- Wash your hands, prior to using the instrument
- Clean the earpieces and diaphragm with the alcohol wipes
- If the diaphragm is cold and will be coming in direct contact with the resident's skin, it is helpful to warm it in your hand
- Keep background noise to a minimum (i.e. turn off radios, TVs)
- Ask the resident not to talk during this procedure
- Place the earpieces in your ears
- Keep the stethoscope tubing free from touching anything to avoid interfering noises
- Place the diaphragm in the proper place per the type of measurement you are performing (apical pulse, BP)
- After use, clean the earpieces and diaphragm with the alcohol wipes
- Wash your hands
- Document readings and report abnormal readings to RN

**Because stethoscopes are shared by staff and used on more than one resident, it is important to use medical asepsis to prevent the spread of germs.**

## 2.3 Checklist for Temperature:

Body temperature measures the balance between heat produced and lost by the body. In a healthy individual, body temperature is usually consistent.

### a. Oral Placement Procedure

- Have resident open mouth and raise tongue
- Place probe at the base of the tongue on either side
- Have resident lower tongue and gently close mouth. Tell them not to bite down
- Have resident hold probe in place - assist as needed
- At approved time remove probe from resident's mouth (see manufactures guidelines for time parameters)
- Follow steps for different types of thermometers per manufactures direction
- Record results

### b. **Rectal Temperatures: The RN must determine if it is appropriate for rectal temperatures to be taken in each facility.**

- *Collect additional supplies needed for this procedure. i.e. lubricant, toilet tissue, disposable gloves*
- *Provide for privacy*
- *Position the resident on his/her side with the upper leg flexed*
- *Wear gloves*
- *Place lubricant on tissue and lubricate the bulb end of the thermometer*
- *By lifting the upper buttock, expose the anus*
- *Insert the bulb end of the thermometer 1 inch into the rectum*
- *Hold the thermometer at all times to keep it from dislodging or breaking*
- *Remove at appropriate interval (when it beeps or as indicated)*
- *Clean the anal area to remove excess lubricant and/or stool*
- *Dispose of soiled supplies per facility policy*

- *Report abnormal readings to RN.*

**c. Axillary Placement Procedure**

***The RN must determine if it is appropriate for axillary temperatures to be taken in each facility.***

- *Provide for privacy*
- *Expose the underarm (axilla) of the resident*
- *Dry the underarm if needed*
- *Place the end of the thermometer in the center of the underarm*
- *Have the resident place his/her arm over the chest to hold the thermometer in place for 5-10 minutes or as required. (See manufacture guidelines for time parameters)*
- *Remove the thermometer.*
- *Follow instructions for use of different types of thermometers*
- *Remove the thermometer*
- *Remove and discard the plastic cover*
- *Read the thermometer*
- *Record the resident's temperature as instructed*
- *Clean the thermometer according to facility policy*
- *Record reading*
- *Report abnormal readings to RN.*

**d. Use of an electronic thermometer**

- *Collect the electronic thermometer and disposable covers*
- *Wash hands and wear gloves when indicated*
- *Make sure resident has not just consumed cold or hot liquids or food if you are taking an oral temperature. If they have, wait 15 minutes*
- *Insert the thermometer probe into the probe cover*

- Insert the thermometer into the mouth (*rectum or axilla*) following proper placement procedures
- Leave in place until the thermometer registers that the temperature has been measured (i.e. tone, flashing light)
- Read the temperature on display
- Press eject button, remove the probe and discard probe cover in a designated receptacle
- Return thermometer to charging unit
- Wash hands
- Record the temperature as instructed
- Report abnormal temperatures to RN

**e. Use of a Tympanic Thermometer**

Tympanic thermometers measure the temperature at the membrane in the ear

- Collect the tympanic thermometer and probe covers
- Wash hands and wear gloves when indicated
- Place cover on probe
- When obtaining a tympanic temperature on an
  - Adult: Pull external ear up and back by grasping at the midpoint with non-dominant hand
- Start the thermometer
- When the thermometer signals (tone, flashing light) read the temperature
- Remove probe from ear and press the eject button to discard the probe cover in a designated receptacle
- Return thermometer to charging unit
- Wash hands
- Record the temperature as directed
- Report abnormal results to the RN

## 2.4 Pulse Checklist

The pulse rate is the number of heartbeats felt in one minute. There are many factors that can change the pulse rate. Among these are exercise, fever, pain, and emotions.

**a. Radial Pulse:** This pulse is routinely used for vital signs

- \_\_\_\_\_ 1. Have resident sitting or lying
- \_\_\_\_\_ 2. Locate the radial pulse with your three middle fingers (Do not use your thumb.). The radial artery is on the thumb side on the inside of the wrist
- \_\_\_\_\_ 3. Note if the pulse is strong or weak, and regular or irregular
- \_\_\_\_\_ 4. Unless facility policy states otherwise, count the pulse for 30 seconds. Multiply the number of beats by 2
- \_\_\_\_\_ 5. Count the pulse for one (1) full minute if it is irregular
- \_\_\_\_\_ 6. If there is a change from the resident's norm or if the pulse rate is out of the normal range, notify the RN immediately
- \_\_\_\_\_ 7. Document the pulse rate as instructed

**b. Apical Pulse:** With certain heart medications, it is necessary to measure the apical pulse.

The apical pulse is on the left side of the chest slightly below the nipple. The heartbeat normally sounds like a "lub-dub." Each "lub-dub" is counted as one beat.

In order to measure an apical pulse you must use a stethoscope. Stethoscopes enable you to hear the heart beat by making it louder and to measure BP. Because stethoscopes are shared by staff and used on more than one resident, it is important to use medical asepsis to prevent the spread of microorganisms.

## Measuring the Apical Pulse

- \_\_\_ 1. Provide privacy for the resident for this procedure
- \_\_\_ 2. Explain procedure to resident
- \_\_\_ 3. Place the stethoscope earpieces in your ears
- \_\_\_ 4. Place the diaphragm over the apical pulse. This is located below the left nipple about two (2) to three (3) inches from the center of the chest.
- \_\_\_ 5. Count the pulse for one full minute
- \_\_\_ 6. Note if it is regular or irregular
- \_\_\_ 7. Assist the resident with clothing as needed
- \_\_\_ 8. Clean the stethoscope with alcohol wipes
- \_\_\_ 9. Wash your hands
- \_\_\_ 10. Document the pulse as instructed
- \_\_\_ 11. Report abnormal pulse rate or specified physician parameters to the RN

## 2.5 Respiration Checklist:

Respiration (the act of breathing) consists of breathing in (inhale) and out (exhale). The respiratory rate is affected by such factors as temperature, anxiety, and heart and lung disease.

### Procedure for measuring respirations

- \_\_\_\_\_ 1. After counting pulse (radial or apical) leave hand in place or leave stethoscope in place. (People sometimes change their breathing rates when they know they are being counted.) This keeps the resident from knowing their respirations are being measured.
- \_\_\_\_\_ 2. Start your count when the chest rises. Each rise and fall is one (1) respiration.
- \_\_\_\_\_ 3. Watch for depth (i.e. shallow or deep), pain, difficulty, regularity and if both sides of chest are rising equally.
- \_\_\_\_\_ 4. Count for 30 seconds and multiply by 2 unless otherwise directed.
- \_\_\_\_\_ 5. If respirations are in any way abnormal, count for one (1) full minute
- \_\_\_\_\_ 6. Wash your hands
- \_\_\_\_\_ 7. Document as directed
- \_\_\_\_\_ 8. Report any abnormal respirations or specified physician parameters to the RN.

## 2.6 Blood Pressure Checklist:

Blood pressure is the amount of force exerted against the blood vessel walls. The period when the heart muscle contracts is called systole (top number) and when it relaxes, it is called diastole (bottom number). The blood pressure reading reflects many conditions in the body. It is controlled by how forceful the heart contracts, how much blood the heart can pump with each heartbeat, and how easily the blood can flow through the blood vessels.

Blood pressure can actually change from minute to minute. This is why there is a fairly wide range for normal for the systole and diastole. Many factors can affect BP including age, stress, activity, pain, weight, smoking and medications.

Blood pressure is measured in millimeters (mm) of mercury (Hg.). The systolic pressure (heart is contracting) is written over the diastolic pressure (heart at rest). Readings that stay consistently above the normal range indicate hypertension. Readings that are below normal indicate hypotension.

The equipment used to measure blood pressure is generally a stethoscope and a sphygmomanometer, which consists of a cuff that encloses an inflatable rubber bladder to close the cuff tightly around the arm and a release valve to deflate the cuff.

There are three types of manometers: aneroid, mercury, and electronic. The aneroid types have a round dial and needle that points to the millimeter reading. The mercury type is more accurate and has an upright tube containing mercury. Pressure created by inflating the cuff moves the column of mercury upward. There are numerous types of electronic sphygmomanometers. The BP is usually displayed on the instrument along with the pulse. The cuff is automatically inflated and deflated. If electronic equipment is used in your facility, the RN should instruct you on its use.

Generally, there are three cuff sizes: child, adult and thigh. The width of the cuff is important. A cuff that is too narrow can yield a higher reading than the actual pressure or if it is too wide, it can yield a lower reading. A child-sized cuff should be used for a very thin adult. A thigh cuff should be used for obese persons.

**Please note: There are some circumstances when an arm cannot be used for BP measurement (i.e. same side as a breast removal, hemodialysis shunt etc.) The RN must note this on the MAR.**

## 2.7 Procedure for Measuring Blood Pressure

- \_\_\_\_\_ 1. Wash hands
- \_\_\_\_\_ 2. Make sure you have the right size cuff for the resident's size
- \_\_\_\_\_ 3. Wipe the stethoscope earpieces and diaphragm with alcohol wipes
- \_\_\_\_\_ 4. Have resident sitting unless otherwise instructed. The resident should have been at rest for 10-20 minutes prior to measurement. Make sure the environment is quiet
- \_\_\_\_\_ 5. Place the resident's arm so that it is level with the heart and the palm is up. The arm should be supported or resting on support
- \_\_\_\_\_ 6. The mercury model should be placed on a flat surface and be vertical at eye level. The aneroid should be placed directly in front of you.
- \_\_\_\_\_ 7. Expose the upper arm
- \_\_\_\_\_ 8. Close the valve on the bulb
- \_\_\_\_\_ 9. Locate the brachial artery located at the inner aspect of the elbow. You can feel for this pulse with your index and middle finger as you would a radial pulse
- \_\_\_\_\_ 10. Place the arrow on the cuff over the brachial artery and wrap cuff around the upper arm snugly. It should be placed an inch above the elbow.
- \_\_\_\_\_ 11. Place the stethoscope diaphragm on the brachial artery and the earpieces in your ears.
- \_\_\_\_\_ 12. Start inflating the cuff until you cannot hear the heart beat any longer. Continue to inflate the cuff 30 mmHg past the point you could no longer hear the beat.
- \_\_\_\_\_ 13. Start deflating the cuff at about 2-4 millimeters per second by turning the valve on the bulb counter clockwise
- \_\_\_\_\_ 14. When you hear the first sound, note that as the systolic reading
- \_\_\_\_\_ 15. Continue a slow, even deflation. At the point the sound disappears, this is the diastolic reading
- \_\_\_\_\_ 16. Deflate the cuff completely and remove it

- \_\_\_\_\_ 17. Clean the stethoscope earpieces and diaphragm with alcohol wipes
- \_\_\_\_\_ 18. Return the equipment
- \_\_\_\_\_ 19. Wash your hands
- \_\_\_\_\_ 20. Document the BP reading as instructed
- \_\_\_\_\_ 21. Report abnormal blood pressure readings or physician specified parameters to the RN

## 2.0 Vital signs

### Trainee Exercise

In the space below, describe step-by-step your facility's procedure for measuring and recording vital signs including the equipment used at the facility. Make note of the location where the instruments are kept. (If a special form is used at the facility to record vital signs, you might attach the form to this handout for reference.)

Measuring and recording temperature

Oral

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Otic/Tympanic or infrared thermometer

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*Rectal*

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*Axillary*

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Measuring and recording pulse

Radial

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Apical

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Measuring and recording respiration (breathing) \_\_\_\_\_

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Measuring and recording blood pressure

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The nurse(s) at the facility who should be contacted if a vital sign is not within the normal range are:

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What to do if you cannot reach the RN:

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## 2.0 Evaluation

### Measuring and Recording Vital Signs

#### INSTRUCTOR'S RATING SHEET

Rate Each Trainee Individually

Trainee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Instructor Name: \_\_\_\_\_

THE TRAINEE	COMMENTS	RATING	
Determined need for and accurately measured: temperature, pulse, respirations and blood pressure			
Properly recorded: temperature, pulse, respirations and blood pressure			
Contacted nurse when vital signs were not in the acceptable range			
Described the base line or "normal" measurements for each vital sign			
Identified at least three medications that require vital sign measurements and explained why			
<b>RATING DESIGNATION:    A = ACCEPTABLE        U = UNACCEPTABLE</b>			

## TASK 3.1 Trainee Handout

### Administering Oral Medications Correctly

#### General Procedure for Administering Oral Medication

1. Review MAR and follow the "six rights" when administering any medication.
2. Check for drug allergies
3. Wash Hands. Call the resident by name. Use facility policy for correct identification.
4. Take appropriate vital signs if required.
5. If resident questions color, size, anything--DO NOT GIVE THE DOSE or permit the resident to take the medication.
  - Check to be sure proper medication was taken from the container.
  - Check the pharmacy labeled container to see if there are explanations about a change.
  - If there are no explanations about the change and the medication is labeled as you would expect, follow facility procedure to notify nurse to see if there has been a dispensing error.
  - If nurse confirms the drug is what was ordered, but in a different form, explain this to the resident then administer.
6. Administer the medication. Remain with the resident until the medication has been swallowed.
7. After directly administering medications, document the administration of the medication following facility procedure.

#### Additional Information to Help You Administer Oral Medications

1. In general, it is best to take oral medication with a full glass of water. See that directions in the MAR are followed.
2. If a resident is taking a long-acting form of medication, each pill or caplet should be taken whole. Make sure the medication is not broken or crushed. Instruct the resident not to chew before swallowing. **These instructions will be written on the MAR by the RN.**
3. Never crush a tablet or capsule without a doctor's order. Observe any cautionary warning instructions on the medication container or MAR. Medications may have special coating and crushing may alter the effect of the drug or result in stomach irritation. Also, do not mix medication into food or drink unless ordered on the MAR and unless the resident is aware of the mixture. Observe resident consuming all of the mixture.

4. Oral medications may come in a number of different forms including pills, capsules, tablets, caplets, and liquids. If a resident has trouble swallowing the form prescribed, there may be another form available that would be easier to ingest. Have the nurse check with pharmacist or doctor.
5. If you must help the resident to put the medication into the mouth, use either a spoon or gloved hand and be sure the tablet, capsule, etc. is placed in the middle of the tongue for ease in swallowing. Removal of dentures may ease swallowing. Always follow with at least 4 oz. (½ glass) of water if not otherwise specified.
6. If a resident is taking liquid medication, they should swallow it from the unit dose container (when dispensed in such a container).

**DO NOT ADMINISTER MEDICATION TO A RESIDENT IF:**

- One or more of the following items are missing:
  - Medication Administration Record Sheet
  - Legible or readable Pharmacy or Medication label
- Resident states that he/she is allergic to this drug.
- You see a significant change in a resident's physical or emotional condition.  
**Contact the RN IMMEDIATELY.**
- You cannot verify all six rights of medication administration.

**WHEN IN DOUBT - DON'T**

**AND**

**NOTIFY THE RN**

**TASK 3.1 Evaluation**

**Administering Oral Medications Correctly**

**INSTRUCTOR’S RATING SHEET**

**Rate Each Trainee Individually**

**Trainee Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Instructor Name:** \_\_\_\_\_

THE TRAINEE	COMMENTS	RATING	
Reviewed the “six rights” before administering medication			
Called the resident by name. Identified resident by facility policy			
Check for drug and latex allergies			
<i>Assisted resident to check medication</i>			
Answered any questions about the medication to assure correctness, consulted the RN as necessary			
Followed steps for proper administration of oral medication			
Used medical asepsis and universal precautions for administration			
Completed appropriate documentation			
<b>RATING DESIGNATION:      A=ACCEPTABLE      U=UNACCEPTABLE</b>			

**TASK 3.2 Evaluation**

**Administering Eye Medications Correctly**

**INSTRUCTOR’S RATING SHEET**

**Rate Each Trainee Individually**

**Trainee Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Instructor Name:** \_\_\_\_\_

THE TRAINEE	COMMENTS	RATING	
Reviewed MAR and the “six rights” before administration			
Called the resident by name. Identified resident per facility policy			
Checked for drug and latex allergies			
Assisted resident to check medication			
If resident questioned the administration or the eye drops or which eye, answered any questions about the medication to assure correctness, consulted the RN as necessary			
Followed steps for proper administration of eye medication			
Used medical asepsis and universal precautions for administration			
Completed appropriate documentation			
<b>RATING DESIGNATION:    A=ACCEPTABLE    U=UNACCEPTABLE</b>			

## **TASK 3.2 Trainee Handout**

### **Perform Administration of Eye Medications**

#### **Steps in Using Eye Drops:**

1. Review the MAR and follow the “six rights” of medication administration
2. Check for drug and latex allergies
3. Identify which eye (left, right or both) to receive medication
4. Wash hands
5. Put on gloves
6. Tilt head back and with index finger of one hand pull lower eyelid away from eye to form a pouch
7. Drop medicine dose with other hand into the pouch and gently close eyes. Do not let the dropper touch eye or anything else
8. Tell resident to avoid blinking
9. Keep eyes closed for one (1) to two (2) minutes
10. If medication is for glaucoma or inflammation, use the index finger to gently apply pressure to the inside corner of the eye for one (1) or two (2) minutes. (This will keep the medication from being absorbed into the body system from the tear duct)
11. With eye closed, gently wipe off excess medication from skin surrounding the eye. Use a clean tissue for each eye. Wipe from inside to the outside of the eye
12. Do not allow the dropper tip to touch any surface including the eye
13. Keep the container tightly closed
14. Separate the administration of two (2) or more eye medications by at least fifteen (15) minutes
15. Be aware of any cautionary warnings (e.g. shake well)
16. Complete appropriate documentation

#### **Steps in Using Ophthalmic Ointments**

1. Follow steps 1 through 5 above
2. Squeeze a thin strip of ointment into the eye pouch; about 1/3 inch – or according to doctor’s orders.
3. Gently close eyes and keep them closed for one (1) or two (2) minutes
4. Remove and dispose of gloves
5. Do not allow tip of tube to touch any surface including the eye
6. Wipe the tube clean with a tissue and keep tightly closed
7. Complete appropriate documentation

**TASK 3.3 EVALUATION**

**Administering Ear Medications Correctly**

**INSTRUCTOR'S RATING SHEET**

**Rate Each Trainee Individually**

**Trainee Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Instructor Name:** \_\_\_\_\_

THE TRAINEE	COMMENTS	RATING	
Reviewed MAR and followed the "six rights" before administration			
Called the resident by name. Identified the resident using facility policy			
Check for drug and latex allergies			
<i>Assisted resident to check medication</i>			
If resident questioned the administration of the drops or which ear, answered any questions about the medication to assure correctness, consulted the RN as necessary			
Followed steps for proper administration of ear medication			
Used medical asepsis and universal precautions for administration			
Completed appropriate documentation			
<b>RATING DESIGNATION:      A=ACCEPTABLE      U=UNACCEPTABLE</b>			

## TASK 3.3 Trainee Handout

### Perform Direct Administration of Ear Drops

#### Steps in Using Ear Drops:

1. Review MAR and follow the “six rights” of medication administration
2. Check for drug and latex allergies
3. Identify which ear (left, right or both) to receive medication
4. Wash hands
5. Put on gloves
6. Warm bottle of drops in your hand. Follow directions on label (ex: shake medication). Draw medicine into dropper if necessary.
  - a. Instruct resident to lie down or tilt head so the ear into which medicine is placed is facing up:  
Remember:
    - Adult: Pull external ear up and back by grasping at the midpoint with non-dominant hand.
    - In children, hold the earlobe down and back.
  - b. Drop medicine dosage in the ear canal. Do not insert dropper in ear or allow dropper to touch any surface
  - c. Instruct resident to hold position for several minutes for the medicine to run to the bottom of the ear canal
  - d. Insert a clean cotton ball into the outer ear opening to prevent the medicine from running out
7. Remove and dispose of gloves
8. Wash hands
9. Complete appropriate documentation

**TASK 3.4 Evaluation**

**Administering Nasal Medications Correctly**

**INSTRUCTOR'S RATING SHEET**

**Rate Each Trainee Individually**

**Trainee Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Instructor Name:** \_\_\_\_\_

<b>THE TRAINEE</b>	<b>COMMENTS</b>	<b>RATING</b>	
Reviewed the "six rights" before administration and reviewed MAR for directions			
Called the resident by name. Identified the resident using facility policy			
Check for drug allergies			
Assisted resident to check medication			
Answered any questions about the medication to assure correctness, consulted the RN as necessary			
Provided privacy and followed steps for proper administration of nasal medication			
Used medical asepsis and universal precautions for administration			
Completed appropriate documentation			
<b>RATING DESIGNATION:    A=ACCEPTABLE    U=UNACCEPTABLE</b>			

## **TASK 3.4 Trainee Handout**

### **Perform Direct Administration of Nasal Medications**

#### **Steps in Using Nasal Drops:**

1. Review MAR for directions and review “six rights” of medication administration. The nasal drops are only to be used for the prescribed patient.
2. Check for drug allergies
3. Wash hands and put on gloves, provide for privacy
4. Instruct resident to blow nose gently
5. With the resident in an upright position, instruct resident to tilt head back while standing or sitting up. In a supine position (lying flat on back), hang head over the side of the bed
6. Check dropper for cracks and make sure it is not clogged. Do not let dropper touch anything. Draw medication into dropper
7. Place prescribed number of drops in each nostril
8. Instruct resident to keep head tilted upright for a few minutes to allow medicine to work
9. Rinse tip of dropper in hot water and dry with a tissue.
10. Recap tightly after use
11. Remove gloves and wash hands
12. Complete appropriate documentation

#### **Steps in Using Nasal Sprays:**

1. Review MAR for directions and review “six rights” of medication administration
2. Wash hands and put on gloves
3. Blow nose gently
4. Instruct resident to sniff briskly while squeezing bottle quickly and firmly
5. Spray once or twice in each nostril per MD orders
6. Wait three to five minutes to allow medicine to work
7. Rinse tip of spray bottle in hot water and dry with a tissue
8. Recap tightly after use
9. Remove gloves and wash hands
10. Complete appropriate documentation

## TASK 3.5 EVALUATION

### Administering Topical Medications Correctly

#### INSTRUCTOR'S RATING SHEET

Rate Each Trainee Individually

Trainee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Instructor Name: \_\_\_\_\_

THE TRAINEE	COMMENTS	RATING	
Reviewed the "six rights" before administration and reviewed MAR for directions			
Check for drug allergies			
Called the resident by name. Identified resident using facility policy and provide for privacy			
<i>Assisted resident to check medication</i>			
Answered any questions about the medication to assure correctness, consulted the RN as necessary			
Followed steps for proper administration of topical medication			
Used medical asepsis and universal precautions for administration			
Completed appropriate documentation			
<b>RATING DESIGNATION:    A=ACCEPTABLE    U=UNACCEPTABLE</b>			

## **TASK 3.5 Trainee Handout**

### **Perform Direct Administration of Topical Medications**

#### **Steps in Using Topical Medications:**

1. Review “six rights” of medication administration and review MAR for directions
2. Wash hands
3. Check for drug allergies
4. Wear latex gloves, provide for privacy (make sure that resident is not allergic to latex)
5. With gloved finger or tongue blade, apply a thin film of cream, ointment, or lotion to the affected area
6. Do not cover with a bandage unless directed to do so by doctor or nurse
7. Promptly replace cap on the cream, ointment or lotion
8. Remove and dispose of gloves. Wash hands immediately.
9. Complete appropriate documentation

If using a medicated patch, be sure the pharmacist’s directions are carefully followed. Make sure all old patches have been removed prior to placing new patch. Indicate in documentation the site where the patch was applied. Generally, the date of application should be documented on the patch.

Never place topical medication in the mouth unless specifically ordered to be used in the mouth.

**TASK 3.6 Evaluation**

**Administering Vaginal Suppositories Correctly**

**INSTRUCTOR'S RATING SHEET**

**Rate Each Trainee Individually**

**Trainee Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Instructor Name:** \_\_\_\_\_

<b>THE TRAINEE</b>	<b>COMMENTS</b>	<b>RATING</b>	
Reviewed the "six rights" before administration and review MAR for directions			
Called the resident by name. Identified the resident using facility policy			
Check for drug and latex allergies			
Assisted resident to check medication			
Answered any questions about the medication to assure correctness, consulted the RN as necessary			
Followed steps for proper administration of vaginal suppositories and provided for resident privacy			
Used medical asepsis and universal precautions for administration			
Completed appropriate documentation			
<b>RATING DESIGNATION:      A=ACCEPTABLE      U=UNACCEPTABLE</b>			

### **3.6 Trainee Handout**

#### **Direct Administration of Vaginal Suppositories**

##### **Steps in Using Vaginal Suppositories:**

1. Wash hands
2. Provide for privacy
3. Check for drug and latex allergies
4. Latex gloves must be worn
5. Use the special applicator that comes with the product
6. Have resident lie back with legs drawn up and knees separated
7. Using applicator, insert suppository into vagina as far as you can without using force
8. Release suppository by pushing the plunger
9. Wash applicator with hot, soapy water
10. Remove and dispose of gloves and wash hands thoroughly
11. Complete appropriate documentation

**TASK 3.7 Evaluation**

**Administering Rectal Suppositories**

**INSTRUCTOR'S RATING SHEET**

**Rate Each Trainee Individually**

**Trainee Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Instructor Name:** \_\_\_\_\_

THE TRAINEE	COMMENTS	RATING	
Review the "six rights" before administration and reviewed MAR for directions			
Called the resident by name. Used facility policy for identifying a resident			
Checked for drug and latex allergies			
Assisted resident to check medication			
Answered any questions about the medication to assure correctness, consulted the RN as necessary			
Provided for resident privacy and followed steps for proper administration of rectal suppository			
Used medical asepsis and universal precautions for administration			
Completed appropriate documentation			
<b>RATING DESIGNATION:      A=ACCEPTABLE      U=UNACCEPTABLE</b>			

### **3.7 Trainee Handout**

#### **Administration of Rectal Suppositories**

##### **Steps in Using Rectal Suppositories:**

1. If suppository is too soft to insert, place it in refrigerator for up to 30 minutes or run cold water over it **before** removing the wrapper
2. Followed the six rights of medication administration and reviewed the MAR for directions
3. Check for drug and latex allergies
4. Wash hands
5. Provide for privacy
6. Latex gloves must be worn
7. Remove foil wrapper from suppository
8. Lubricate suppository with KY jelly as needed
9. Have resident lie down on side with leg flexed and push suppository into the rectum with gloved index finger
10. Bathe and dry rectal area
11. Remove gloves and wash hands thoroughly
12. Complete appropriate documentation

## TASK 3.8 EVALUATION

### Administering Inhalation Products

#### INSTRUCTOR'S RATING SHEET

Rate Each Trainee Individually

Trainee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Instructor Name: \_\_\_\_\_

THE TRAINEE	COMMENTS	RATING	
Followed the "six rights" before administration and reviewed the MAR for directions			
Called the resident by name. Identified the resident using facility policy. Provide privacy.			
Check for drug allergies			
Assisted resident to check medication			
Answered any questions about the medication to assure correctness, consulted the RN as necessary			
Followed steps for proper administration of inhalation products and provide privacy			
Used medical asepsis and universal precautions for administration			
Completed appropriate documentation			
<b>RATING DESIGNATION:    A=ACCEPTABLE    U=UNACCEPTABLE</b>			

**TASK 3.8 EVALUATION**

**Administering Nebulizer Treatments**

**INSTRUCTOR'S RATING SHEET**

**Rate Each Trainee Individually**

**Trainee Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Instructor Name:** \_\_\_\_\_

THE TRAINEE	COMMENTS	RATING	
Reviewed the "six rights" before administration and reviewed MAR for directions			
Called the resident by name. Identified the resident using facility policy. Provide privacy.			
Check for drug allergies			
<i>Assisted resident to check medication</i>			
Answered any questions about the medication to assure correctness, consulted the RN as necessary			
Followed steps for proper administration of nebulizer treatment products			
Used medical asepsis and universal precautions for administration			
Completed appropriate documentation			
<b>RATING DESIGNATION:      A=ACCEPTABLE      U=UNACCEPTABLE</b>			

### 3.8 Trainee Handout

#### Administer Inhalation Products

When administering medication through an oral inhaler for inhalation therapy, be sure that the following steps are carried out.

1. Review Medication Administration Record for directions
2. Use the “six rights” of medication administration
3. Check for drug and latex allergies
4. Wash hands
5. Put on gloves
6. Provide for resident privacy
7. Shake the inhaler immediately before each use. (unless otherwise noted.)
8. If using the inhaler for the first time or after a prolonged period, test it by **spraying into the air before spraying** it into the mouth. (Check package directions first)
9. Remove cap from the mouthpiece
10. Have resident breathe out fully through mouth to empty lungs as
11. completely as possible
12. Place mouthpiece fully into the mouth, holding the inhaler upright. Have the resident close lips around the inhaler
13. Squeeze the inhaler and at the same time have the resident breathe in deeply through the mouth
14. Have resident hold breathe as long as possible
15. Remove the inhaler from the mouth and have the resident breathe out
16. Repeat the inhalation process as directed by the doctor’s order - wait one to two minutes between puffs. If more than one inhaler is being used, note the instructions on the MAR for spacing them
17. Rinse mouth with water if steroid used
18. Clean the inhaler and dry it thoroughly
19. Remove and dispose of gloves
20. Wash hands after procedure
21. Complete appropriate documentation

When administering medication through a Nebulizer for inhalation therapy, be sure that the following steps are carried out.

1. Follow the six rights of medication administration and review MAR for directions
2. Wash hands
3. Verify information on medication administration record by comparing it for the individual’s name, dosage, allergies and time ordered. Check the label three times:
  - when reviewing the medication record
  - before removing the medication from the storage area

- be
  - fore placing the medication in the nebulizer
4. Check equipment and clean if necessary
  5. Identify the individual
  6. Provide privacy and tissues to the individual
  7. Explain the procedure to the individual. Assist the individual to a sitting position
  8. Take and record pulse and respiration before beginning treatment, if ordered.  
Compare to the medication records to ensure both vital signs are within the acceptable range
  9. If vital signs are not within limits prescribed, notify the RN
  10. Wash hands and put on disposable gloves
  11. Connect nebulizer to power source
  12. Add medication to the nebulizer medication administration compartment per the medication record
  13. Place in the individual's mouth having them use their lips to form a tight seal on the mouthpiece
  14. Turn the machine on and have the resident breathe deeply; the medication works better with deep inhalations
  15. Per RN instructions or packaging insert, take and record the individual's pulse and respirations when the medication is half-gone. If the heart rate increases by 20, stop the treatment and contact the RN
  16. If appropriate, continue the treatment until all medication is given, usually 10 - 15 minutes
  17. Take and record the individual's pulse and respirations at the end of the treatment and document the effects of the treatment
  18. Remove gloves and dispose of appropriately according to the facility's policy
  19. Wash hands
  20. Clean and replace equipment as specified
  21. Document:
    - a. Medication given
    - b. The initials of the person giving the medication
    - c. Pulse and respirations before, during, and after the treatment and document any actions taken as a result of an abnormal reading
    - d. Note any complaints and actions taken