

AMAP-RN Orientation Curriculum

BOOK 1

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

Part I

Task 1.1 Scope and limitations of AMAP staff

Define the **Approved Medication Assistive Personnel (AMAP)** scope of authority and limitations of responsibility in administering medications according to WV State Code 16-50-1 et seq., and Legislative Rule 64-60 and all other applicable licensing regulations.

Performance Objectives

- Explain the meaning of "delegation" and "medication administration".
- Identify the circumstances under which the AMAP may administer medications.
- Identify the settings in which the AMAP may administer medications.
- Identify the types / routes of medication administration, which the RN may delegate to the AMAP.
- Identify the types / routes of medication administration, which the RN may NOT delegate to the AMAP.

Outline

- Definitions
- Facilities that may use AMAP's to administer medications
- Medication administration routes
- AMAP limitations
- Eligibility requirements for AMAP
- RN responsibilities

Activities

- Review definitions
- Discuss circumstances when medication administration may be delegated
- Review eligibility requirements for staff to be trained to administer medications
- Review settings where medication administration may be delegated
- Review limitations for medication administration when delegated to the AMAP
- Discuss all approved routes for medication administration by the AMAP

Evaluation

- Have each AMAP trainee complete the worksheet. Review answers and re-educate as needed.

Discussion

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 only 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 individual with mental retardation)
- Assisted living residences (ALR) (formerly known as personal care and 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

3. There are various routes by which an AMAP is permitted by law to administer medications. The proper route for administration of each must be specified in the physician's order. If the AMAP is administering medications, and the route is not specified on the MAR or order, she should immediately notify the RN. The RN is responsible for clarification of the physician's order and correct transcription onto the medication record.

- Oral – swallowed by mouth
- Sublingual – dissolved under the tongue
- Topical / Transdermal – applied to the skin, absorbed from a patch
- Eye (ophthalmic) – drops or ointments instilled / 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

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**

5. **An AMAP cannot transcribe a new physician order on the MAR.**

To be eligible for training and testing to become an AMAP and to administer medications in a facility, the candidate must:

- Have a high school diploma or GED and be able to read, write and understand English;
- 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 certified in CPR and First Aid (and maintain certification);
- Participate in the thirty (30) plus hour State-approved training program provided by a RN who has completed the State-approved RN Orientation course;
- Pass the State-approved written, computer-based competency test administered by the contracted Vendor after the training program;
- Be monitored and supervised by an RN; and
- Participate in a retraining program from an RN every two (2) years.

The RN is responsible for monitoring the facility staff members authorized to administer medications.

The RN must be available to the AMAP twenty-four (24) hours a day to respond to questions or concerns.

The RN must ensure that the facility maintains a file on site on each AMAP, verifying that they have met all eligibility requirements. Each AMAP's file must include a copy of his/her certificate indicating passing the State-approved competency test. It must also include evidence of all quarterly observations and the two (2) year retraining documentation. Medication error reports and any additional training should also be made part of the AMAP file. The RN is responsible for this documentation.

Note:

The registered professional nurse may withdraw authorization for an AMAP if the RN determines that the AMAP is not performing medication administration in

accordance with the training and written instructions. If the RN finds that any AMAP has falsified information to become an AMAP, immediate steps must be taken to revoke the AMAP's privileges and appropriate notification sent to OHFLAC.

Task 1.2 Medical Terminology and Abbreviations

Performance Objective

Given a list of medication terms and abbreviations, the AMAP trainee must be able to match the term with the correct abbreviation with at least 90% accuracy.

Outline

Review common medical terms and their abbreviations for medication administration and documentation.

Activities

Review handout on abbreviation list and any facility specific abbreviations. Explain each abbreviation and provide examples of how each would be used. Discuss “error prone” abbreviations and ways to prevent misinterpretation. Allow time for trainees to review abbreviations and practice using them. May use flash cards for review and practice.

Evaluation

The AMAP trainee must complete the worksheet for identification of common abbreviations. If trainee does not complete the worksheet with 90% accuracy, provide additional instruction.

Discussion

To administer medications safely, the AMAP 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

č: With

DNR: Do not resuscitate. This is a specific order to not revive a patient artificially if he/she experiences cardiac or respiratory arrest. If a patient has a DNR order, he/she is not to receive CPR.

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 for several hours prior to the procedure.
O2: Oxygen
oz: Ounce
P: Pulse. This is 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. It is one of the “vital signs”.
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 is responsible for teaching these abbreviations and terms to AMAP staff. This instruction must include their proper use. The RN must approve the use of any other abbreviation not identified on the list for use in the facility and include these in the discussion. Review uses of each abbreviation with trainee(s). Discuss common errors or misinterpretations of abbreviations. Instruct trainees to contact the RN anytime they do not clearly understand an abbreviation.

Task 1.3 Medications

Performance Objectives

The AMAP trainee will be able to:

- Identify the difference between prescription medications and non-prescription / over-the-counter medications
- Verbalize the definition of a controlled substance and give an example
- Describe the purpose and other effects of medications
- Identify resources for obtaining medication information
- Verbalize the most common medications administered in your facility including the purpose and common side effects
- Identify specific types of medications and examples of each medication type

Outline

1. Drugs / medications
 - a. Prescription medications
 - Control drugs / Schedule I-V
 - Non-control drugs
 - b. Non-prescription / over-the-counter drugs
2. Medication purpose and other effects
 - a. Desired effect
 - b. Side effects and unwanted effects
 - c. Drug interactions
 - d. No apparent effect
3. Resources for medications / drug information

Activities

Give trainees the hand out material included in this unit and any other available material related to this topic that would be helpful to the trainees. Explain that the purpose of any medication is to achieve the desired or beneficial effect of the medication.

Review the five (5) common purposes and give examples of the kinds of medications used to produce each.

Explain unwanted effects. Give examples of these effects which trainees are likely to encounter at the facility.

Conduct a discussion of the unwanted effects produced by interactions of two (2) or more drugs taken at the same time.

Emphasize the importance of observing for potential and notifying the RN of side effects, unwanted effects, and drug interactions.

Discuss the difference of prescription drugs and over-the-counter drugs. Provide trainees with examples.

Review definition of a narcotic and Schedule I – V drugs. Give examples of narcotics administered in the facility.

Review chart on different types of medications, their purpose and side effects.

Discuss any other medications that may be used in your facility that are not on the list.

Evaluation

Have each trainee demonstrate his or her knowledge of purpose and effects of medications. Have the trainee answer at least two (2) questions about the unwanted effects of medications. Evaluation may be a simulation or take place on-the-job while the trainee cares for a resident at the facility. A case and questions are included in the instructor materials section of this unit for use with a simulated evaluation. Evaluation guidelines are included. Provide additional instruction for trainees *who do not achieve 100% accuracy*.

Discussion

The RN must review and discuss the following issues:

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 e.g., antitussives and antidiarrheals).

Narcotic: A central nervous system depressant agent containing an opioid or a drug that has morphine-like actions. A narcotic:

- Is designated as a controlled substance
- Has a high potential for abuse
- Requires special storage and usage, reporting, and destruction procedures
- Cannot be dispensed without a doctor's prescription
- Can only be administered by the AMAP when the medication order is written with specific parameters that preclude independent judgment.

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, security for control drugs, accessibility, and requirements for counting control drugs and destruction policy. (See Section 1.11.)

Non-controlled Drugs

All other prescription drugs not on the Board of Pharmacy controlled substance list.

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

- Can be purchased by the consumer without a prescription
- Physician order needed for use in the facility
- Can be administered by the AMAP
- Can produce unwanted effects
- May interact with prescription drugs or foods
- Must have facility specific policies in place for administration

2. Purpose and effects of medications

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:

- Desired effect
- Unwanted effect (sometimes called side effects or adverse drug reactions)
- Drug interactions
- No apparent effect

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.

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

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

Unwanted effects may be unexpected and unpredictable. Many elderly individual become confused when starting on a new drug. Some individual 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. The AMAP must encourage the resident to report any changes and be observant for complaints. Any behavioral or physical changes which may be drug related must be reported to the RN.

Examples of unwanted effects can including, but are not limited to:

- Rashes
- Diarrhea
- Vomiting
- Fainting
- Lightheadedness
- Blurred vision
- Confusion
- Irritability
- Agitation
- Lethargy

Drug Interactions:

When a person is taking two (2) or more drugs at one (1) time, the drugs may interact with each other. The greater number of drugs taken, the greater the chance for interaction. Drug interactions may:

- Increase the effects of one (1) of the drugs – this is called “potentiation”
- Decrease the effects of one (1) or more of the drugs – this is 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.

No Apparent Desired Effect:

Different drugs require different amounts of time before their effects are observable. For this reason, the RN can tell the AMAP how long before the expected action can be seen. If the time expected has gone by, and no apparent desired effect from 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.

Poison Control Hotline 1-800-222-1222
Provides Information on Poisons and Drug Identification

This important number should be posted in the facility: Review with AMAPs when to call this number.

Resources for Drug/medication Information:

Use drug reference materials and have the trainee look up medications used frequently for facility residents. Each facility must have a current (updated yearly) drug reference book available to staff. Review listed drug purpose and side effects. Ensure that the trainee knows where to find reference material and how to look up drug information. Additional reference materials are available from the pharmacist and pharmaceutical manufacturers. The inserts obtained from the pharmacy are a good reference for the AMAP. Review medication chart and discuss drug types, name (generic / brand), purpose and common side effects.

When a new medication is ordered for a resident / client that has not been included in the training and/or curriculum, the RN must provide specific training about that medication. Before administering a medication, the AMAP should know the name of the medication, its purpose, and common side effects for the new medication.

Licensed health care professionals who can provide medication information to residents:

- Doctors
- Nurses
- Pharmacists
- Dentists
- Podiatrists
- Optometrists
- Nurse Practitioners
- Physician Assistants

Other medication information resources:

- Facility drug reference book (must be current)
- Drug information inserts
- Pharmacy print-outs
- On-line web sites (where available)

Have the trainee look up Dilantin (or other facility-appropriate medication) in a resource provided at the facility, to identify the common desired and undesired effects of the medication. (Examples: If there were no change in seizures after 7-10 days of taking Dilantin, this would be called "no apparent desired effect". If a resident would experience severe drowsiness after taking Dilantin and a sedating cold medication within an hour of each other, this is likely to be the result of a drug interaction.)

Not all side effects are included in this list.

Drug Type	Name of Drug	Purpose	Side Effects
Anti-infective drugs	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
Respiratory tract drugs	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
	Antihistamines (Dimetane, Chlor-Trimton, Dimetapp, Dramamine, Benadryl, Claritin, Zyrtec)	Allergic reactions, Rhinitis, motion sickness	Drowsiness, confusion, fatigue, dry mouth, nervousness
Central Nervous System Anti-psychootics	Clozaril	Schizophrenia	Drowsiness, sedation, rigidity, akathesia, blood pressure changes, leucopenia, granulocytosis
	Geodon	Schizophrenia	Somnolence, akathesia, 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
Central Nervous System	Xanax	Anxiety, panic disorders	Drowsiness, headache, dizziness

	Tranxene, BuSpar, Valium, Ativan	Anxiety	Drowsiness, headache, dizziness
Central Nervous System System <u>Narcotic / opioid analgesics</u>	Darvocet N, Darvon N, Endocet, Fiorcet, Fiorinal, Lortab, Percodan, Vicodin, Tylenol with Codeine	Pain	Sedation, dizziness, physical dependence
Central Nervous System <u>Non-narcotic analgesic</u>	Tylenol, Aspirin Motrin, Advil	Pain, arthritis, fever	Headache, dizziness, gastric distress
	Celebrex	Arthritis	Dizziness, headache
Central Nervous System <u>Anti-convulsants</u>	Dilantin	Prevent and control seizures	Dizziness, headache, constipation, agranulocytosis
	Phenobarbital	Epilepsy	Dizziness, hypotension
	Mysoline, Primidone	Seizures	Drowsiness, fatigue, vertigo
	Topamax	Adjunctive therapy for seizures	Confusion, agitation, dry mouth, leukopenia
	Depakene, Depakote	Seizures, treatment of mania, prevention of migraines	Sedation, depression, increased appetite, hyperactivity
	Trileptal	Seizures	Fatigue, headache, dizziness
	Neurontin, Tegretol	Seizures, neuralgia	Fatigue, dizziness
Central Nervous System	Elavil	Depression	Tremor, anxiety, headache

	Wellbutrin, Wellbutrin SR	Depression	Headache, anxiety, hyper/hypotension
	Celexa	Depression	Dizziness, fatigue, tremor, tachycardia
	Sinequan	Depression	Dizziness, weakness, dry mouth
	Lexapro	Depression	Dizziness, tremor, hypertension
	Prozac	Depression, bulimia, panic disorder	Fatigue, headache, dizziness
	Serzone	Depression	Headache, dizziness, hypotension
	Paxil	Depression, OCD, panic disorder, PTSD	Dizziness, tremor, dry mouth, anxiety
	Zoloft	Depression, OCD, panic disorder, PTSD	Headache, tremor, dizziness, anxiety, dry mouth
	Effexor	Depression, anxiety	Headache, tremor, dizziness, anxiety, dry mouth
Cardiovascular system drugs	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
Diuretics	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
Hormonal drugs <u>Antidiabetics</u>	Glipizide, Glucotrol	Lower glucose level in Type II Diabetes and replace insulin therapy	Dizziness, headache, nausea, constipation
	Glyburide, DiaBeta, Micronase	Improve glycemic control	Nausea, heartburn, leukopenia
	Avandia	Lower glucose level in Type II diabetes	Fatigue, headache, diarrhea
	Starlix, Amaryl	Lower glucose level in Type II diabetes	Dizziness

Hormonal drugs <u>Thyroid Hormones</u>	Synthroid, Levoxine	Thyroid replacement hormone	Nervousness, headache, tachycardia, diarrhea, weight loss
Hormonal drugs <u>Estrogen</u>	Estrace, Premarin	Osteoporosis, menopausal symptoms	Headache, dizziness, hypertension
Gastrointestinal tract drugs <u>Anti-ulcer</u>	Zantac, Tagamet, Nexium, Pepcid, Prilosec, Prevacid, Protonix, Carafate	Gastric ulcer, reflux, heartburn	Dizziness, headache
Gastrointestinal tract drugs <u>Antacids</u>	Tums, Maalox, Rolaids, Mylanta	Antacid	Headache, irritability
Gastrointestinal tract drugs <u>Laxatives</u>	Fiberall, Surfak, Enulose, Magnesium Citrate, Citrucel, Metamucil, Senokot, Milk of Magnesia	Constipation	Cramping, diarrhea
Ophthalmic Drugs	Tobrex	Ocular infections	Burning, itching, swelling
	Pilocarpine, Alphagen, Xalatan, Timoptic, Travatan	Glaucoma	Dizziness, eye irritation, headache
	Visine	Eye irritation	Headache, blurred vision
Otic Drugs	Chloromycetin Otic	Ear infection	Itching, burning

	Cerumenex	Impacted cerumen	Itching
Nasal Drugs	Beconase, Rhinocort, Flonase	Rhinitis, seasonal allergies	Headache
	Afrin, Neo-syneprine	Nasal Congestion	Headache, dizziness

Recognizing Purpose and Effects of Medications

Case and Questions

The following case and questions may be used by the instructor to evaluate trainees on their ability to identify the general purpose and effects of medication and to answer questions about unwanted effects. Have individual trainees respond orally to the following case situation and the 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?

Task 1.4 Demonstrate the “six rights” of medication administration.

Performance Objective

Be able to identify and understand the “six rights” of medication administration and apply the principles for making sure the “six rights” are followed.

Outline

- Review the “six rights” of medication administration
- Review procedures for ensuring the “rights”

Activities

- Review all information on the six rights of medication administration and explain steps for following each right
- Discuss the importance of each right and have trainee demonstrate how they will follow the process
- Discuss examples of compliance and non-compliance with the six rights

Evaluation

The trainee must demonstrate steps for the six rights in a simulation or on-site with direct supervision. Rate performance. Provide additional training if trainee performance is not acceptable.

Discussion

A. Review the “six rights”:

1. Right resident
2. Right drug
3. Right dosage
4. Right time
5. Right route
6. Right record / documentation

B. Procedure for ensuring “six rights”:

1. **Right resident** – Always check by looking for an identification source.

Examples include a photograph of the resident on the MAR, and asking the person to tell you her/his name if you are not sure. Follow your facility policy for identifying a resident. It could prevent you from making an error. Avoid distractions. A lot of activity can cause you to make a mistake, even when you know everyone well.

- Know the residents
- Check with other staff if you are not familiar with resident
- Check resident identification source per facility policy i.e., picture or armband
- Check for latex and drug allergies

2. Right drug

- Compare MAR and pharmacy label
- Double check to make sure the MAR and pharmacy label agree; if not, contact the RN

3. Right dosage

- Compare MAR and pharmacy label to make sure they match.

4. Right time – The pharmacy label and MAR will provide directions as to when and/or how often a drug should be given. The facility should have a time schedule for administering drugs. The RN must fill in the time schedule on the MAR. Medications must be administered no earlier than one (1) hour before the scheduled time and no later than one (1) hour after the scheduled time.

- Follow time schedule for the facility or specific time as indicated on the MAR. Medications must be administered no more than thirty (30) minutes before the scheduled administration time and no more than thirty (30) minutes after the scheduled time.
- Adhere to specific administration instructions on the MAR if different from facility's schedule.
- Observe any cautionary warnings on the medication container and on the MAR

Facility Time Schedule for Administering Drugs:

Once a day : _____

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): _____

Every night at bedtime: _____

Some drugs have special instructions and 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.** The RN is responsible for ensuring that each prn medication has specific guidelines with clear parameters for administration **and documentation of its efficacy.**

5. Right route

- Double check the MAR to determine drug is in form ordered by the prescriber.
- Review the MAR and pharmacy label for special administration directions.
- If doubt exists as to whether a drug is in the correct form or can be administered as ordered, contact the RN

Routes of Administration - 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 AMAP to know the dosage form and route of administration for each medication. The MAR and pharmacy label must indicate which route to use for administration.

ROUTE	DOSAGE FORMS
Oral (by Mouth)	Capsule, Tablet, Liquid, Spray, Lozenge, Inhaler, Sublingual
Sublingual	Tablet, Liquid (spray)
Buccal	Tablet, Liquid
Topical (on the Skin)	Cream, Ointment, Liquid, Powder, Spray, Gel, Patch (Transdermal)
Ophthalmic (in the Eyes)	Liquid (Drops), Ointment
Otic (in the Ears)	Liquid (Drops), Ointment
Nasal (in the Nose)	Spray, Liquid (Drops), Ointment, Nebulizer
Rectal* (in the Rectum)	Suppository, Ointment, Cream, Liquid (enemas)

ROUTE	DOSAGE FORMS
Vaginal* (in the Vagina)	Aerosol Foam, Ointment, Cream, Liquid (Douche), Jelly, Gel, Suppository
<p>*An AMAP may only administer suppositories, or apply medication externally to these areas. This may not be applicable in your particular facility type. Check with your designated Program Manager for validation.</p>	

6. **Right record** (documentation) – Make sure that the AMAP identified the right resident’s record, verified that the prescription medication and order on the MAR match, and documented the AMAP’s initials as required for each medication administered at the correct time.

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

- 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 every resident’s treatment. Medical charts can be used in court as legal evidence.
- Documentation protects the healthcare member and the facility from liability proving what the healthcare member 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 the medication, never before.
- When charting a 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.”
- The efficacy of all PRN medications must be documented in time intervals according to policy such as after two (2) hours or four (4) hours. This would be based on specific time ordered for the medication. Efficacy of medication requires assessment.
- **The PRN order must be written with specific guidelines that include dose, frequency, and purpose.** The RN is responsible for ensuring that each prn medication has specific guidelines with clear parameters for administration and documentation of its efficacy.

- Chart facts, not opinions.
- Write neatly and legibly.
- If you make a mistake, draw one (1) line through it and initial to the side and date.
- Never erase something that has already been charted.
- Never use “white out”.
- Make sure you date and time each entry.
- **Always remember if you did not chart it, you did not do it.**

Activities

Review handout material available in this unit and any other materials available and relevant to this task that would be helpful. Using a flip chart, chalk board, etc., list the “six rights” of medication administration.

Discuss the importance of observing these rights **EACH** time medications are administered.

Explain the procedures to follow to ensure each of the “six rights”.

In the space provided on the unit handout, have the trainees fill in facility procedure for ensuring the “six rights”. Encourage trainees to use this as a reference.

Conduct a question and answer session to determine that trainees understand the “six rights”, the procedures for ensuring the rights, and the importance of following the procedures each time medication is administered.

Explain that documentation, an important follow up to medication administration, will be covered in a subsequent task area.

Provide opportunities for trainees to practice demonstrating the “six rights” in simulated or supervised on-the-job medication administration.

Observe performance and give feedback. Provide additional instruction as needed.

Evaluation

Have each trainee demonstrate his or her ability to carry out the procedures for ensuring the “six rights” of medication administration. Evaluation may be a simulation or take place on-the-job while trainee administers medication. Use a rating sheet to evaluate performance. An approved rating sheet is provided in this unit.

It is suggested that this evaluation be conducted in conjunction with the evaluation of other tasks dealing with administering medication, especially Tasks 1.5. (Labels and Medication

Administration Record) and 1.7. (Organize to administer medications).

Task 1.5 Reading Pharmacy Labels and MAR

Performance Objective

The trainee will be able to read with 100% accuracy a sample of pharmacy labels and MAR and be able to identify prescribed dosages and instructions on each. The trainee will be able to explain the difference between generic and brand name medications.

Outline

- Identify information on a pharmacy label
- Read the Medication Administration Record (MAR)

Activities

Trainees must have completed training on medical abbreviations and terminology prior to beginning this section. Refer trainees to the handout included in Task 1.2.

Line by line, go over the label on the handout. Explain the information presented on each line. Point out that, while pharmacy labels may vary from pharmacy to pharmacy, all should contain the information presented on the sample.

Have trainees compare the labels in the practice section of the handout and on a MAR. Have trainees interpret the labels and a MAR included in the practice section of the handout. Provide feedback and further explanation if indicated.

Explain that pharmacists may substitute a generic drug for a brand name in some cases.

Emphasize that Approved Medication Assistive Personnel must check with the nurse before administering a medication if the drug name is different from what the label says and what is ordered.

Evaluation

Provide each trainee with at least three pharmacy labels and MAR and have them read and describe each label and each MAR listing. Also assisting a resident with label explanation may be simulated or may take place on the job as the trainee helps a resident self-administer medication. Each label must be explained with 100% accuracy.

Discussion

Reviewing Pharmacy Labels

1. Pharmacy information:
 - a. Name
 - b. Address
 - c. Telephone number
 - d. Pharmacist in charge

2. Resident name

3. Medication information:

- a. Name
- b. Strength
- c. Quantity
- d. Directions for use and cautionary warnings
- e. Number of times it may be refilled without a new prescription
- f. Date of dispensing
- g. Expiration date
- h. Manufacturer, if generically substituted.

NOTE: The label may carry both the generic name and the brand name, provided that the brand name is preceded by the words "generic substitute for..." or similar terminology.

4. Following the "six rights" when reading the pharmacy label

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

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		
Qty: 100		
Dr. Alzheimer	Refills: 6	Exp: 6/14/20XX
Cognex 40 mg	Take one capsule four times daily.	

Reading the Medication Administration Record (MAR)

Provide a sample MAR in the format used by the facility.

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

- Name of the resident
- Name of the drug and strength
- Amount of drug ordered (dose)
- Time to be administered
- Route of administration
- Special instructions for storage or administration
- Place for signature / initials of person administering drug
- Place for noting reason medication not administered with date and time
- Place for noting medication error

Performance Objectives

- Explain how infections can be transmitted from one person to another
- Demonstrate proper hand washing techniques
- Demonstrate proper use of gloves
- Review facility Infection Control Plan or policies
- Identify when hands should be washed
- Identify when gloves should be worn
- Identify what to do if exposure to blood and body fluids occurs

Outline

A. How infections occur

- Pathogen
- Reservoir
- Portal of exit
- Transmission
- Portal of entry
- Host

B. Use of medical asepsis

- Common daily practices
- Hand washing routine and use of hand sanitizer
- Additional procedures including Universal Precautions

Activities

- Explain the rationale for close observance of infection control
- Explain how pathogens are transmitted from one person or place to another
- Explain the Infection Control Policy for your facility
- Explain the importance of hand washing
- Demonstrate good hand washing technique
- Explain situations where gloves should be worn

- Demonstrate proper use and disposal of gloves
- Discuss disposition of contaminated equipment, linens
- Discuss what to do if exposure to blood or body fluids occurs
- Discuss use of hand sanitizers

Evaluation

- Trainee must explain the need for Infection control practices and facility policy
- Trainee must describe how infections are spread
- Identify practices that prevent the spread of infection
- Explain the procedure for handling of contaminated equipment or linens
- Explain what to do if you are exposed to blood or body fluids

Discussion

Infection Control - Using Medical Asepsis & Universal Precautions

Facility staff, including AMAPs, must be responsible for protecting the residents and themselves from infection. This can be achieved by utilizing good infection control practices.

Review how 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 through a 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 Bloodborne Pathogen Standard issued by the Centers for Disease Control and Prevention (CDC) helps to prevent the spread of infection. This standard requires all health care workers to consider the

body fluids of all patients (residents) potentially contaminated with communicable blood-borne organisms by use of Universal Precautions.

Explain that 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.

Review the common aseptic practices that should be practiced in all settings to prevent the spread of infections. Discuss hand washing and when employees should wash hands:

- Always wash hands after urination, bowel movements and changing of sanitary products
- Wash 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)
- Wash hands before preparing or eating food
- Cover the mouth and nose when coughing or sneezing
- Practice good daily hygiene

One (1) of the most important (and easiest) ways to prevent infection is hand washing. Hands are one (1) of the most common transmitters of pathogens from one (1) person or item to either yourself or another person. Hands should be washed BEFORE and AFTER providing any type of care.

Hand Washing Procedure

1. Make sure that soap and some sanitizing method of drying your hands are available.
2. Move watch and sleeves (if applicable) up arms approximately 5 inches.
3. If a paper towel is used, turn the faucet on using a paper towel and adjust water temperature for comfort.
4. Toss the paper towel into wastebasket.
5. Wet the wrists and hands thoroughly, keeping them below elbow level to keep microorganisms from moving 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 1 to 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. If utilizing hand sanitizer, the AMAP must actually wash hands with each third client.

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 the items 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 with the RN.
12. If you would have any direct exposure to blood or body fluids follow the facility policy for exposure, and notify the RN.

Task 1.7 Organize to Administer Medications to One or More Residents

Performance Objective

Assemble medications and equipment needed for preparing medications and administer medications to residents following proper procedure. All steps of the procedure must be performed acceptably according to the rating sheet.

Outline

Organizing to administer medications to one (1) or more residents

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 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 a 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

Activities

Have the trainee collect Medication Administration Records for five (5) to ten (10) residents at the facility. (Prepare sample MARs if needed)

Have the trainee describe the process and procedures to follow when administering medications to these residents in the facility.

The trainee must identify where each residents' medications are stored.

Discuss the planned time for administering medications and have trainee identify when each medication should be administered. Staff must administer medications no more than one (1) hour) before or one (1) hour after the scheduled medication administration time.

The trainee must identify two (2) important steps they must perform before actually giving a resident his/her medications.

Review with the trainee what to do if a resident's pill is dropped on the floor.

The trainee must demonstrate what to do after they have finished giving medications.

Evaluation

Provide each trainee with access to resident and medication. Provide equipment needed for administering medications. Have each trainee give several residents their medications according to MAR. This evaluation may be simulated or conducted on the job. Use a checklist to evaluate trainee performance. Provide additional assistance for trainees whose performance is not acceptable according to the rating sheet.

Task 1.8. A. Documentation – Medication Administration Records (MAR) and Other Medication Forms

Performance Objective

The trainee will be able to document medication administration correctly on the medication administration record and to document a resident / client's refusal to take medications appropriately. The trainee will be able to recognize and correctly document all medication errors.

Outline

Documentation

- RN review of MARs
- New physician orders / scripts
- Administration documentation
- Medication deliveries

Activity

- Explain the importance of properly documenting all medication administered at the facility.
- Explain and show completed examples of any forms that are required. Make sure each trainee has copies of each form utilized at the facility related to this process.
- Review handout materials included in this unit and any other appropriate materials related to the tasks that would be helpful to them.
- Explain and demonstrate the correct method of using medication administration records and/or other forms that the trainees will use at a facility to document medication administration.
- Observe trainees as they practice documenting medication administration.

Evaluation

This evaluation may be simulated or conducted on the job. Use a checklist to evaluate trainee performance. Provide additional assistance for trainees whose performance is not acceptable according to the rating sheet.

Discussion

Review documentation “do’s” and “don’ts”. Discuss what to do 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 prior to the medication being administered to the resident. This may occur in several ways, such as from a pharmacy-generated MAR or by

the RN transcribing the information onto the MAR. Whichever method is used, it is the RN's responsibility to assure that the medications are correctly entered onto the MAR and reviewed by the RN before being administered by the AMAP staff.

Any time there is a change in a medication order, the RN must be notified. The facility must have a procedure in place to assure that the RN is able to review the physician order and to transcribe and/or review the new order onto 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. These functions must never be delegated to the AMAP staff. 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, the AMAP should follow facility policy regarding any discontinued or unused medication. If there is a discrepancy between the MAR and the prescription, notify the RN.

The AMAP cannot take and transcribe any new order onto the MAR. This includes verbal and telephone physician's orders.

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, but the RN must provide a signed copy of the MAR to the facility prior to administration of the medication by the AMAP.

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.

Review with all trainees the process to follow when pharmacy deliveries or new medications are received in the facility including documentation requirements. Review information to be given the resident regarding medication changes.

Task 1.8.B. Documentation – Reporting and Documenting a Resident / Client's

Refusal of Medication

Performance Objective

Given a case of a resident's refusal to take medication, follow proper procedure for reporting the refusal to the registered nurse and for documenting the incident.

- To demonstrate proper procedure for encouraging resident to take medications
- To verbalize proper procedure for reporting resident refusal of medication

Outline

Reporting to RN regarding resident refusal to take medication

- Explain to resident the importance of taking the medication as prescribed
- Encourage resident to cooperate
- Do not force resident to take medication. Remember the resident's right to refuse
- Call RN and follow his/her instructions
- Document how the drug was disposed of in accordance to facility protocol, if applicable
- Document drug refusals

Activities

- Explain the importance of following facility procedure for the resident's refusal to take medication. Remind trainees of resident rights.
- Explain that a resident may be cooperative after a short interval if they are re-approached in a matter of fact manner.
- Demonstrate in a real situation or a role-play how to explain the importance of medication and how to encourage residents to take it.
- Have trainees identify the appropriate nurse at the facility to contact regarding resident's refusal to take medication.
- Show and explain the proper format for written documentation of medication refusal.
- During training, have the trainee document the following:
 - Names of nursing personnel to contact
 - Procedure for contacting
 - Procedure for documenting refusal incidents according to facility policy.
- Allow trainees to role-play proper procedure and tactful techniques for handling a resident's refusal to take medication. Observe and provide constructive feedback.

- Allow trainees to practice reporting and documenting a refusal either real or simulated.
- A few situations, describing a resident's refusal to take medication, are included in the instructor material for use in demonstration, practice and/or evaluation.
- Provide additional review and discussion if necessary.
- Set up a simulation in which a resident refuses medication. Have each trainee follow procedure for handling the refusal including contacting appropriate nursing personnel and providing written documentation according to facility policy. Use a checklist to evaluate task performance. A checklist is provided in this training task. Provide additional instruction for trainees who do not perform the task acceptably according to the checklist.

Evaluation

Set up a simulation of resident refusal to take medication. Each trainee must demonstrate procedure for all required notifications and documentation.

Task 1.8.C. Documentation – Documenting Medication Errors

Performance Objectives

- Given two (2) practice examples of medication errors, be able to document each according to designated policy and procedure with 100% accuracy.
- Recognize a medication error when it occurs.

Outline

Document of medication errors

1. Importance of documenting medication errors promptly according to facility policy and procedures
2. Errors in administering medication
 - a. Wrong medication is given to a resident
 - b. Wrong resident is given a medication
 - c. Wrong dosage of a prescribed medication is given
 - d. Medication is given at wrong time or not given at all
 - e. Wrong route of administration is used
 - f. Medication is not available
 - g. Wrong form of medication is administered (i.e., liquid for a tablet, extended release for regular release)
3. Facility procedure for documenting medication errors
4. Notify the RN

Activities

Explain what is meant by documenting medication errors and why it is important to do so promptly and according to policy and procedure. Explain and discuss the types of medication errors that must be documented. Give trainees the handout included in the unit, which lists the types of medication errors with examples. Show trainees examples of medication errors documented in resident records.

Demonstrate correct procedure for documenting errors.

Give trainees several examples of medication errors and sample medication administration sheets and/or other designated forms and have them practice documenting the given examples.

Evaluation

- Provide each trainee with two (2) examples of medication errors. Select examples that are relevant to the facility.
- Provide sample forms. Have trainees record the medication errors following designated procedure.
- Evaluate their work. Provide additional instruction for those who do not perform the task with 100% accuracy.

Discussion

Recognizing Medication Errors

Review each example with trainee:

A medication error must be documented if any of the following conditions occur:

1. The wrong medication is administered to a resident / client

Example: Mrs. Kent is given Amoxicillin instead of Tetracycline

2. The wrong resident / client 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 1.9 Disposal of Medications

Performance Objective

The trainee will demonstrate and verbalize proper procedure for disposing of the medications per facility policies and procedures.

Outline

Review facility policy for disposal of the following:

- Discontinued medications
- Expired medications
- Over-the-counter drugs
- Controlled substances (secure only - destruction by the RN)
- Contaminated drugs (re: dropped or spit out)
- Refused drugs

Activities

Explain the procedures for disposing of medications. Emphasize procedure for disposing of prescription drugs. (Controlled substances can only be disposed of by the RN.) Explain any special procedure carried out at the facility. Provide copy of facility policy to each trainee.

Review handout in this unit or other appropriate information. During training, have trainees record the steps of the specific facility procedure.

Give trainees examples of medications (non-controlled substances only) that must be disposed of and have them verbalize or demonstrate the procedure for disposing of the medications. Review steps if necessary. AMAPs cannot dispose of controlled drugs. The facility policy must address how the AMAP is to secure a controlled drug for destruction by the RN and Pharmacist.

Discuss facility's responsibility for resident medications when the resident leaves the facility.

Evaluation

Give each trainee at least two (2) examples of medications and have them describe verbally or in writing the proper procedure for disposing of each medication per regulations. Evaluate according to topical outline and provide additional instruction for trainees who do not describe the procedure with 100% accuracy.

Task 1.10 Store and secure all medications

Performance Objective

Given information regarding guidelines for storing medications at the facility and several examples of medication including controlled substances, demonstrate proper procedure for storing and securing these medications. Performance must be acceptable according to a rating sheet.

Outline

- Storing medications properly
- Comply with all applicable Federal and State laws
- Comply with licensing agency regulations: All medications must be secure and accessible only to staff authorized to administer medications.
- The AMAP responsible for administering medications must keep keys on his/her person
- Keep controlled substances in a secure locked container or cabinet. Schedule II drugs are stored so they are protected by two locks. The key to the separately locked Schedule II drugs shall not be the same key used to gain access to non-scheduled drugs.
- Do not write on labels. This is a function of a licensed physician or pharmacist under Federal law.
- Observe special instructions on label provided by pharmacist, e.g., "Store in refrigerator."

Activities

Give trainee the handout included in this unit and any other appropriate material available.

Discuss the importance of properly storing medications.

Explain and demonstrate the procedure for storing medications. Make sure trainees know where drugs are stored and which individuals have the keys to locked storage cabinets.

Explain and show examples of accounting systems for controlled substances. Point out special labeling on these drugs.

Give trainees examples of several medications used at the facility including a controlled substance. Have them practice telling or demonstrating how to properly store each medication, properly document and account for a controlled drug and describe what to do if the drug count is incorrect.

Provide additional review if necessary.

Evaluation

Give each trainee at least two (2) medications in the original container dispensed by the pharmacist. One (1) of the medications should be a controlled substance. Have the trainee demonstrate designated procedure for storing and accounting for each medication. This evaluation may be conducted as a simulation or may take place “on the job” at the facility. Rate each trainee's performance using a rating sheet. Provide additional instruction for trainees who do not receive acceptable rating on each component of the rating sheet.

Task 1.11 Maintaining an Inventory of Controlled Medications

Performance Objective

Following an overview of procedures for maintaining inventory and the necessary forms, demonstrate how to maintain an inventory of the medications. Completed inventory forms must be 100% accurate.

Outline

Maintaining an inventory of controlled medications on the declining inventory sheet

- Importance of maintaining accurate inventory
- Review facility procedure regarding drug count and receipt of control refills from the pharmacy
- Give special attention to counting controlled substances
- Describe documenting any difference between the number of pills
- IMMEDIATELY Notify the RN of any discrepancies

Activities

Discuss the importance of maintaining an accurate inventory of medications used at a facility. Emphasize the importance of keeping accurate counts of controlled substances.

Explain and demonstrate procedure for maintaining an inventory of medications. Show any special forms used to record count. Make sure that trainees have copies of forms used at the facility.

Explain what to do if a difference is found between the numbers of pills on hand and the number that should be on hand. Describe documentation of a discrepancy. Allow the trainees to practice counting, recording medication on hand, and documenting for inaccuracies. Provide additional review if needed.

Evaluation

Give each trainee the forms needed to maintain a medication inventory. Have each trainee complete and record a sample inventory count of medications. Evaluate the completed forms. Provide additional instruction for trainees whose completed medication inventory forms are not accurate.

Discussion

Maintain an Inventory of Controlled Medications

The pharmacist must maintain records of the amount of controlled drugs filled for each client for whom he/she provides the drug. Records are checked by agents of the Federal Drug Enforcement Agency (DEA). Each health care professional with prescriptive authority has a special number that allows close monitoring of all controlled drugs. It is called the DEA number

and is usually printed on the prescription label and prescription form the doctor uses.

Counting Controlled Drugs

- 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 the Office of Health Facility Licensure and Certification.

Task 1.12 Medication delivery systems

Performance Objectives

- Identify different medication delivery systems
- Demonstrate correct procedure for medication administration for each type of delivery system

Outline

Medication Delivery systems:

1. Prescription bottles
 - a. Six Rights of Medication administration
 - b. Proper technique for pouring/removing pill from container
2. Unit-dose blister packs
 - a. Six Rights of Medication administration
 - b. Proper technique for removing pill from packaging
3. Multi-dose delivery systems
 - a. Six Rights of Medication administration
 - b. Proper technique for removing pill from packaging
4. Medication samples
 - a. Six Rights of Medication administration
 - b. Proper technique for removing pill from packaging

Activities

Review each different type of medication delivery systems that the facility accepts.

Have each trainee demonstrate proper procedure for administering medications for each type of delivery system. For practice purposes, have one (1) or more medications in a packet that cannot be properly identified. Emphasize the circumstances under which medication should not be given and the RN be notified. Review any other types of medication delivery systems that the facility may accept that is not listed above.

Evaluation

Have trainee set up medications from each delivery system for administration. This evaluation may be simulated or conducted on site. Use a checklist to evaluate trainee performance. Provide

assistance as needed. Performance must be acceptable according to rating sheet.

Multi dose delivery systems

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's 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 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

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 administer and notify the RN

Part II

Task 2.1 Measuring and Recording Vital Signs Prior to Medication Administration

Performance Objective

Assemble the equipment for measuring vital signs and the necessary forms for recording them. Measure and record temperature, pulse, respiration, and blood pressure. These procedures must be performed according to rating sheet.

With assistance of RN:

- Determine baseline temperature range
- Determine baseline pulse range
- Determine baseline respiratory rate
- Determine baseline or acceptable blood pressure range

Outline

1. Measuring and recording vital signs
 - A. Determining when to measure vital signs
 - 1) Nurse's instruction on the MAR
 - 2) Required by facility policy and procedure
2. Using a Stethoscope
3. Determining baseline or "normal" vital signs
 - A. Baseline temperature range
 - B. Baseline pulse range
 - C. Baseline respiratory rate
 - D. Baseline or acceptable blood pressure range
 - E. Regular vs. irregular

4. Procedure for measuring and recording vital signs (Temperature, Pulse, Respirations, and Blood Pressure)
 - A. Review of procedure for measuring vital signs
 - 1) Temperature and recording
 - a. Oral
 - b. Rectal
 - c. Otic (Tympanic)
 - d. Axillary
 - d. Infrared Thermometer
 - 2) Pulse Documentation
 - a. Radial
 - b. Apical
 - 3) Breathing (respiratory rate)
 - 4) Blood Pressure
 - B. Review of procedure for recording the measurements
 - 1) Proper abbreviations
 - 2) Proper facility forms if any
5. Follow-up regarding vital signs
 - A. Review instructions for each resident in the MAR regarding whether to give medication for specific vital signs
 - B. Record vital sign measurements
 - C. Contact nurse to report abnormal vital signs as specified in the MAR. Follow nurse's instructions and document direction given by the RN.
 - D. Report vital sign measurements to resident and indicate that the RN will be contacted regarding abnormal vital signs.

Task 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 some 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:

1. You will need a stethoscope and alcohol wipes
2. Wash your hands, prior to using the instrument
3. Clean the earpieces and diaphragm with the alcohol wipes
4. 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
5. Keep background noise to a minimum (i.e. turn off radios, TVs)
6. Ask the resident not to talk during this procedure
7. Place the earpieces in your ears
8. Keep the stethoscope tubing free from touching anything to avoid interfering noises
9. Place the diaphragm in the proper place for the type of measurement you are performing (apical pulse, BP)
10. After use, clean the earpieces and diaphragm with the alcohol wipes
11. Wash your hands
12. 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.

Task 2.2 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 baseline 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

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 *	55-75/35-45†	40-70‡
0-3 mo	100-150 *	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 _ 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](#)

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Adult Vital Signs

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 manufacturer's parameters

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.

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 the RN:

Dizziness Check blood pressure

Swelling of Ankles Check pulse and blood pressure

Chest Pain Check pulse, blood pressure, respiration

Task 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.

Before teaching how to take temperatures and which method to use, it is advisable that the RN determine which method or procedure is applicable to their facility type and the clientele this procedure will be used on. The RN is only to provide training on the facility approved method.

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 (2-3 minutes)
- Follow steps for different types of thermometers per manufactures direction
- Record results

Rectal Placement Procedure

- 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

Axillary Placement Procedure

- 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
- 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

Use of an Electronic or Infrared Thermometer

- Collect the electronic or infrared 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 or place the thermometer into the mouth (*if applicable, forehead, ear, 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 the RN

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 the 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

Task 2.4 Checklist for Pulse

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.

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

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.

- _____ 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

Task 2.5 Checklist for Respirations

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. (Individual 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.

Task 2.6 Checklist for Blood Pressure

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.

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 over 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 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

Activities

Discuss with the trainee, the specific type of documents and the way to document appropriately on the document/form used by your facility. On each trainee's handout included in this unit, have

trainees write in the procedure followed at your facility for measuring and recording vital signs.

If possible, have trainees to work in pairs to practice measuring oral temperature, blood pressure, respirations and pulse. Have them record the vital signs using the forms specific to your facility.

Trainees may also practice the measurement of vital signs with supervision by the RN while on the job.

Observe technique and provide feedback and additional instruction if necessary.

Explain to trainees what symptoms indicate the need for staff to check resident/client vital signs.

Guide the trainees to make a list of any specific medications that may require the measurement of vital signs before administration. Have the trainee(s) list resident symptoms that may require staff to check resident vital signs.

Explain and list on flip chart or chalk board the baseline vital sign measurements or ranges. Show examples of vital signs recorded on resident records.

Explain and demonstrate the procedure for measuring each vital sign. A film or video may be used.

Evaluation

Provide each trainee with the equipment needed to measure and record vital signs and the forms for recording them. Have trainees demonstrate the proper procedure for measuring and recording oral temperature (rectal temperature may be explained using a diagram), pulse, respiration (breathing), and blood pressure.

The instructor may measure the vital sign himself / herself to ensure that the trainee got the proper measurement.

Have the trainee record each measurement properly. Have trainees discuss the measurement as to whether it is within baseline range and tell what steps should be taken if the measurement is not within the baseline range for the resident.

Evaluate trainees individually using a checklist. Evaluations may be conducted as a role-play or may take place as trainees provide care to clients/residents at the facility. A rating sheet is provided in the unit. Provide additional review and practice for trainees who do not receive an acceptable rating according to the rating sheet.

Part III

Administration of Medications by Different Routes

Introduction

In this section, trainees will learn how to administer medications through prescribed routes. These include:

- By mouth - sublingual or buccal (oral medications)
- Eyes (ophthalmic products)
- Ears (otic medications)
- Nose (nasal products)
- Skin (topical products)
- Vagina (vaginal suppositories)
- Rectum (rectal suppositories)
- Breathing (inhalation products)

When giving a medication, the following should occur regardless of the type of medication given.

- Assure privacy and confidentiality of resident
- Give this task your full attention
- Never substitute one patient's medication for another patient
- Assure the work area is clear and well lit
- Prepare medications for one resident at a time
- Ask the resident their name
- Check the resident's medication record and check the resident's picture on the health record/MAR
- Review the health/medication record for medication to be given, and latex and drug allergies
- Wash hands
- Explain the procedure to the resident
- Retrieve medication from secured storage area, checking label for name, medication, time, route, and dose
- Check the expiration date. Alert the RN if it is expired and do not give
- Check MAR/residents record for allergies
- Double-check the label and compare with the residents medication record. Read label for instructions
- Do not give the medication if it is contaminated

- Do not leave the medication unattended
- When finished giving the medication, store appropriately in a locked storage area
- Wash hands
- Record immediately per facility policy and procedure, the resident's name, time, medication, dose, route, person administering the medication, and any unusual observations or situations, such as the resident's refusal to take the medication.

Each "task area" in Part III provides instruction in the direct administration of medication. The RN, in collaboration with the attending physician, will determine whether a resident requires the administration of medications by the facility staff or can self-administer medication.

Part III task areas require that trainees demonstrate competence in direct administration of medications by the ordered route.

Task 3.1 Administering Oral Medications Correctly

Performance Objective

Given at least two (2) oral medications, obtaining needed supplies, administer the medications to a resident and document the administration. Performance must be acceptable according to the rating sheet.

Outline

Administering oral medication and documenting administration

- A. General procedure for administering oral medication
 - 1. Administer medication only when you are sure the six rights are being carried out **and** the resident does not have any drug or latex allergies: Right Resident, dose, drug, time, route, record/document. Compare Medication label with the MAR three (3) times to ensure accuracy. Wash hands before handling medications.
 - 2. Address resident by name. Follow facility policy for identifying a resident
 - 3. Perform any required activity such as T, P, R, and BP
 - 4. If resident questions the medication, do not administer and make additional checks and/or contact the RN
 - a. Check MAR again
 - b. Check to ensure proper medication was taken from storage
 - c. Check pharmacy label and MAR for change in direction
 - 5. If medication is in liquid form, identify proper procedure for pouring
 - 6. Observe the resident swallow the medication.
 - 7. Document all medications administered on the MAR immediately after administration.
- B. Specific procedure for administering oral medication:
 - 1. Usually best to take medications with full glass of water (check MAR for directions).
 - 2. Long-acting forms of medication should not be broken, crushed or chewed before swallowing.
 - 3. Liquid medications will be given in their unit dose container if provided.

4. If liquid medication is not in unit dose form, follow proper procedure for pouring. Use only specially marked measuring devices to measure doses. Liquid medications should be measured at eye level. **Place measuring cup on level surface. Pour the medication on the side away from the label to keep the label clean. Wipe off excess from the bottle.**
5. If resident has trouble swallowing a medication, check with the nurse for other available form of medication. Check with the RN prior to placing medication in any food.
6. Have resident place tablets, capsules, etc. in middle of the tongue, sublingual or buccal, if applicable.
 - a. Removing dentures helps with swallowing if edentulous (without teeth)
 - b. Follow with at least a half ($\frac{1}{2}$) cup water
7. Do not crush pills without a doctor order

C. Caution WHEN NOT to give medication - **WHEN IN DOUBT, DON'T**

1. Missing items
 - a. Medication record or administration sheet
 - b. Illegible pharmacy label
2. Resident exhibits significant change in status
3. Any doubts about the six rights
4. **Over-the-counter medications cannot be administered without an doctor's order / prescription.**

D. Documentation of medication administration

1. Done immediately after medication is administered
2. Use proper forms (medication administration sheet or other form(s) used at facility)
3. Document refusals (task area 1.8.b) *Notify the RN of refusals*
4. Document medication errors (task area 1.8.c)
5. Document PRN medication administration
 - a. Document reason for giving PRN drugs and outcome (effects)
 - b. Document notification of RN per facility policy
 - c. Document how resident condition met defined parameters for need of PRN

- medication
- d. The RN must be notified if there is ANY question about whether or not to give any medication including a PRN medication

Activities

Ask some "what ifs" to get trainees to think through the required procedure. Examples:

- "What if a resident says the tablet she usually takes at this time is light blue and this one is red?"
- "What if a resident wants to crush a long lasting form of medication so it will be easier to swallow?"

Evaluation

Provide each trainee with at least two (2) oral medications and any other supplies needed to administer the medications. Have each trainee demonstrate proper procedure for administering the medications. This evaluation may take place as a simulated experience or during administration to a resident at the facility. Evaluate each trainee using the rating sheet.

For efficiency, suggest conducting this evaluation in conjunction with the evaluations of other tasks dealing with administering medications to residents.

Discussion

Explain the importance of and demonstrate proper procedure for administering oral medication. (Include all the different facility delivery systems.)

Emphasize the circumstances under which medication should NOT be given. Explain the procedure for contacting appropriate persons and carrying out required checks.

Explain and demonstrate how to document medication administration using facility forms.

Explain that, in addition to the written documentation, it is important to report verbally, to incoming and ongoing staff, any significant information about residents and their medication administration. Emphasize that such communication facilitates care of residents.

Point out that refusals to take medication and medication errors must be documented. Tasks 1.8.b and 1.8.c deal with reporting and documenting these occurrences.

Allow trainees to practice with the administration of oral medications during a simulated situation or during supervised care of clients/residents at the facility. Have them practice documenting the administration.

Observe practice and provide feedback. Provide additional review if needed.

Task 3.2 Direct Administration of Eye Medication (Ophthalmic Preparations)

Performance Objective

Given an eye medication and the necessary supplies, directly administer eye medications according to Medication Administration Record (MAR). Performance must be acceptable according to rating sheet.

Outline

Administration of eye medications

A. Proper use of eye drops

1. Review MAR. Follow the “six rights” of medication administration
2. Identify which eye (right, left or both) to receive medication
3. Wash hands
4. Put on gloves
5. Clean eye with warm moist cloth prior to administering medication.
6. Check dropper for patency (if dropper being used)
7. Hold dropper tip down
8. Do not let dropper touch anything
9. Shake drops if indicated and extract desired amount of medication into dropper.
10. Instruct resident to lie down or tilt head back
11. Use index finger of one (1) hand to pull lower lid down to form a pocket, bracing remaining fingers against cheek
12. With other hand, place dropper or dispensing bottle as close to eye as possible without touching it.
13. Drop prescribed amount into pocket of lower lid
14. Keep eyes closed for one to two minutes. Press finger against inner corner of eye one (1) minute to prevent medication from entering tear duct if medication is for glaucoma or inflammation. Tell resident to avoid blinking.
15. Replace cap
16. With eye closed, gently wipe off excess from skin surrounding the eye with a

tissue. Use a separate tissue for each eye

17. Remove and discard gloves
18. Wash hands
19. Complete appropriate documentation
20. When two (2) or more eye medications are being administered, they should be scheduled at least 15 minutes apart

B. Proper use of eye ointment

1. Review MAR and follow six (6) rights of medication administration
2. Identify which eye (right, left, or both) to receive medication
3. Wash hands
4. Put on gloves
5. Wash eye with warm moist cloth
6. Instruct resident to tilt head back and up
7. Remove cap and keep tip of applicator from touching anything
8. Use index finger of one hand to pull lower lid down to form pocket, brace remaining fingers against cheek
9. Hold tube between thumb and forefinger of other hand, placing tube close to eye without touching it
10. Place 1/3 inch strip of ointment in pocket
11. Close eye for 1 to 2 minutes
12. Wipe the tube with a clean tissue
13. Replace cap promptly
14. Remove and dispose of gloves
15. Wash hands
16. Complete appropriate documentation

Activities

Review trainee handout.

Explain and demonstrate the procedure for proper administration of eye drops and eye ointments. If conducting a simulated demonstration, show each step of the procedure without actually putting drops or ointment into the eye.

Evaluation

Provide each trainee with supplies needed to administer eye medications. Have each trainee demonstrate proper procedure for administering the medications. This evaluation may take place as a simulated experience or during administration to a resident at the facility. Evaluate each trainee using the rating sheet

Task 3.3 Perform Direct Administration of Ear Medication

Performance Objective

Assemble the ear drops and the necessary supplies, and perform direct administration of ear drops according to the Medication Administration Record (MAR). Performance must be acceptable according to a rating sheet.

Outline

Administration of ear drops

1. Review MAR and follow the “six rights” of medication administration
2. Identify which ear (right, left or both) to receive medication
3. Wash hands
4. Put on gloves
5. Warm bottle of drops in hand
6. Follow directions on label (ex: shake)
7. Draw medicine into dropper
8. **Avoid letting dropper touch anything**
9. Tilt affected ear up or instruct resident to lie on side. Pull ear lobe up and back for adult. In children, hold the earlobe down and back.
10. Place prescribed amount of drops in ear.
11. Do not insert dropper into ear
12. Allow drops to run in
13. Keep ear tilted back for a few minutes or insert soft ball of cotton in the outer ear
14. Remove and dispose of gloves
15. Wash hands
16. Complete appropriate documentation

Activities

Review trainee handout.

Explain and demonstrate the procedure for proper administration of ear medications. If conducting a simulated demonstration, show each step of the procedure without actually putting drops or ointment into the ear.

Evaluation

Provide each trainee with supplies needed to administer ear medications. Have each trainee demonstrate proper procedure for administering the medications. This evaluation may take place as a simulated experience or during administration to a resident at the facility. Evaluate each trainee using the rating sheet.

Task 3.4 Perform Direct Administration of Nasal Medication

Performance Objective

Given nasal drops and nasal spray and necessary supplies, perform direct administration of nasal drops and nasal spray according to Medication Administration Record (MAR). Performance must be acceptable according to the rating sheet.

Outline

Administration of Nasal Drops

1. Follow the “six rights” of medication administration. Review MAR for directions. Provide privacy.
2. Wash hands.
3. Put on gloves.
4. Instruct the resident to blow nose gently.
5. Instruct resident to tilt head back while standing or sitting up or lie down and hang head over the side of the bed.
6. Check the dropper for patency.
7. Do not let the dropper touch anything.
8. Draw medicine into the dropper.
9. Place prescribed number drops into nostril.
10. Remain in position for few minutes.
11. Rinse the tip of the dropper in hot water and dry with a tissue. Replace cap promptly.
12. Remove and dispose of gloves.
13. Wash hands.
14. Complete appropriate documentation.

Administration of Nasal Sprays

1. Follow the “six rights” of medication administration. Review MAR for directions. Provide privacy.
2. Wash hands.

3. Put on gloves.
4. Instruct the resident to blow nose gently.
5. With resident's head upright, spray medicine into each nostril.
6. Sniff briskly, while squeezing bottle quickly and firmly.
7. Spray once or twice or in each nostril per MD orders.
8. Rinse sprayer in hot water and dry with a tissue. Replace cap promptly.
9. Complete appropriate documentation.

Activities

Review trainee handout.

Explain and demonstrate the procedure for proper administration of nasal spray medications. If conducting a simulated demonstration, show each step of the procedure without actually putting drops or spray into the nose.

Evaluation

Provide each trainee with supplies needed to administer nasal spray medications. Have each trainee demonstrate proper procedure for administering the medications. This evaluation may take place as a simulated experience or during administration to a resident at the facility. Evaluate each trainee using the rating sheet.

Task 3.5 Perform Direct Administration of Topical Medications

Performance Objective

Given a topical preparation and the necessary supplies, administer the topical preparation according to Medication Administration Record (MAR). Performance must be acceptable according to a rating sheet.

Outline

Administration of Topical Medications

1. Use the “six rights” of medication administration and review MAR for directions.
2. Wash hands.
3. Put on gloves, provide for privacy.
4. Using gloved hand or tongue blade, apply thin film of cream, ointment, or lotion to affected area.
5. Do not cover with a bandage unless directed to do so by the RN or MD.
6. Replace container top promptly.
7. Remove and dispose of gloves. Wash hands immediately.
8. Complete appropriate documentation.

Activities

Review trainee handout.

Explain and demonstrate the procedure for proper administration of topical medications. If conducting a simulated demonstration, show each step of the procedure without actually applying a topical medication.

Evaluation

Provide each trainee with supplies needed to administer topical medications. Have each trainee demonstrate proper procedure for administering the medications. This evaluation may take place as a simulated experience or during administration to a resident at the facility. Evaluate each trainee using the rating sheet.

Task 3.6 Perform Direct Administration of Vaginal Suppositories

Performance Objective:

Given vaginal suppositories and the necessary supplies, directly administer vaginal suppositories by showing or explaining each step in the procedure. Performance must be acceptable according to the rating sheet.

Outline

Administration of vaginal suppositories

1. Follow the “six rights” of medication administration and review the MAR for directions.
2. Provide for resident privacy.
3. Wash hands.
4. Put on latex gloves.
5. Resident should lie on back with legs drawn up and knees separated.
6. Use the special applicator supplied with the product.
7. Using applicator, insert suppository into vagina as far as you can without using force.
8. Release suppository by pushing in plunger.
9. Wash applicator with hot, soapy water.
10. Remove and dispose of gloves.
11. Wash hands.
12. Complete appropriate documentation.

Activities

Explain and demonstrate the procedure for proper administration of vaginal suppositories into the vagina. Use diagrams if needed.

Evaluation

Provide each trainee with supplies needed to administer vaginal suppositories. Have each trainee demonstrate proper procedure for administering the suppository. This evaluation may take place as a simulated experience or during administration to a resident at the facility. Evaluate each trainee using the evaluation sheet.

Task 3.7 Perform Direct Administration of Rectal Suppositories.

Performance Objective

Given rectal suppositories, demonstrate how to administer rectal suppositories by showing or explaining each step in the procedure. Performance must be acceptable according to a checklist.

Outline

Administration of rectal suppositories

1. Follow the “six rights” of medication administration and review the MAR for directions.
2. If suppository is too soft to insert, place in refrigerator briefly or run cold water over it before removing the wrapper.
3. Provide resident privacy.
4. Wash hands.
5. Apply / wear latex gloves.
6. Have resident lie on side facing away from you with upper leg flexed.
7. Remove foil wrapper.
8. Lubricate suppository with KY jelly when necessary.
9. Push suppository into rectum with gloved index finger approximately two (2) inches.
10. Bathe and dry rectal area.
11. Remove gloves and wash hands thoroughly.
12. Complete appropriate documentation.

Activities

Review trainee handout.

Explain and demonstrate the procedure for proper administration of rectal suppositories. Use diagrams if needed.

Evaluation

Provide each trainee with supplies needed to administer rectal suppositories. Have each trainee demonstrate proper procedure for administering the suppository. This evaluation may take place as a simulated experience or during administration to a resident at the facility. Evaluate each trainee using the rating sheet.

Task 3.8 Perform Direct Administration of Inhalation Medications

Performance Objective

Given inhalation products, demonstrate how to administer inhalation products by showing or explaining each step in the procedure. Performance must be acceptable according to a checklist.

Outline

Assisting with the use of an inhaler

1. Review MAR for directions
2. Follow the “six rights” of medication administration and provide for patient privacy
3. Wash hands
4. Put on gloves
5. Shake inhaler immediately before each use, unless otherwise noted
6. Remove cap from the mouthpiece
7. Test inhaler by spraying into air before using for the first time or in cases where the inhaler has not been used for a prolonged period. (Some inhalers cannot be test sprayed, check manufacturer’s instructions)
8. Instruct resident to breathe out fully through mouth, empty lungs as completely as possible
9. Instruct resident to place mouthpiece fully into the mouth, holding inhaler upright and closing lips around it
10. **Squeeze the inhaler as resident breathes in deeply through the mouth**
11. Have resident hold breath as long as possible
12. Before breathing out, remove inhaler from mouth (**wait one to two minutes between puffs**)
13. When more than one inhaler is being used, the RN will indicate how to space administration on the MAR
14. Repeat inhalation process as described in MAR

15. Rinse mouth with water if steroid used
16. **Clean inhaler frequently and dry thoroughly**
17. Store inhaler according to package insert (some inhalers must be stored upright)
18. Remove and dispose of gloves
19. Wash hands to remove medication
20. Complete appropriate documentation

Activities

Review trainee handout.

Explain and demonstrate the procedure for proper administration of inhalation medications. Use diagrams if needed.

Evaluation

Provide each trainee with supplies needed to administer inhalation medications. Have each trainee demonstrate proper procedure for administering the medications. This evaluation may take place as a simulated experience or during administration to a resident at the facility. Evaluate each trainee using the evaluation sheet.

Task 3.8 Administering Nebulizer Treatment

Performance Objective

Assemble nebulizer and medication and demonstrate how to administer products using a nebulizer machine.

Outline

1. Follow the six rights of medication administration and review the 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 (3) times:
 - When reviewing the medication record;
 - Before removing the medication from the storage area; and
 - Before 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 the nebulizer to the 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.

Activities

Reviews trainee handout

Explain and demonstrate the procedure for proper administration of nebulizer treatment and medications. Use diagrams if needed

Evaluation

Provide each trainee with supplies needed to administer a nebulizer treatment. Have each trainee demonstrate proper procedure for administering the medications. This evaluation may take place as a simulated experience or during administration to a resident at the facility. Evaluate each trainee using the evaluation sheet.

TRAINEE COMPLETION FORM

Upon completion of the Medication Training Program, this form is to be completed by the AMAP RN and maintained in the personnel file.

Facility Name :

Trainee's Full Name:

Last

First

Middle

Date class started:

Numbers of Class hours:

Class ended on:

Skills Checklist completed :

Written Score:

Date State Tested:

Trainee

Date

AMAP RN

Date

TRAINEE TASK RECORD

Medication Assistive Personnel Training Program

Trainee Name:

Facility:

Place a check beside the task to indicate that the trainee has performed the task in an acceptable manner; that is, achieving an acceptable rating on each component of a rating sheet or checklist, or achieving the accuracy standard designed for a written evaluation. The instructor's initials and the date must be placed beside the check.

TASKS

Part I : Preparing to Function Effectively in Administering Medications

	RN	DATE
1. Understand the Medication Assistive Personnel scope and limits of responsibility in administering medication, in relation to Department of Health & Human Resources Licensing regulations		
2. Identify medication terminology and abbreviations		
3. Medications		
4. Demonstrate the "six rights" of medication administration		
5. Reading pharmacy labels and the MAR		
6. Use medical asepsis and universal precautions for infection control		
7. Organize to administer medications to one or more residents		
8. Documentation		
9. Disposal of Medications		
10. Store and secure all medications		
11. Maintain an inventory of medications		
12. Medication delivery systems		
PART II: 2.0 Measure and record vital signs		
PART III: Administering oral, ear, nasal, topical, vaginal, rectal, and inhalation medications:		
3.1 Demonstrate the ability to administer oral medications		
3.2 Demonstrate the ability to administer eye medications		
3.3 Demonstrate the ability to administer ear medications		
3.4 Demonstrate the ability to administer nasal drops and nasal medications		

3.5	Demonstrate the ability to administer topical medications		
3.6	Demonstrate the ability to administer vaginal suppositories		
3.7	Demonstrate the ability to administer rectal suppositories		
3.8	Demonstrate the ability to administer inhalation medications		

I understand these tasks and procedures and feel comfortable performing them.

Student comments:

Student:

Signature

Date

Instructor comments:

Instructor:

Signature

Date

MEDICATION PASS OBSERVATION WORKSHEET

Facility		AMAP	
Date		Observed by	Time

Directions: Check Yes, No, or N/A

Task Met

PREPARATION	Yes	No	N/A
1. Medication cart or storage area:			
a. Prepared prior to pass			
b. Clean/organized/ no meds on top			
c. Always visible to AMAP			
2. Keys retained by AMAP at all times			
3. Juice, water, applesauce covered properly			
4. Client/resident identified per policy			
5. Vital signs taken per policy before medication is poured			
6. Hands washed using appropriate technique			
7. Patient positioned properly			
MEDICATION ADMINISTRATION			
8. Medication removed from container properly			
9. Label checked times three (3)			
10. Client/resident observed to insure medication is swallowed			
11. MAR initialed immediately after administration			
12. If necessary, Controlled Substance log signed immediately			
13. Medications administered at correct time.			
14. Full cup of fluid offered			
15. Correct dose administered			
A. Meds crushed using proper technique			
B. Can medication be crushed?			
C. Does MAR say "crush"?			
16. Liquids poured at eye level with label in palm			
17. Eye drops:			
A. Client/resident seated and instructed to put head back			
B. Hands washed appropriately			
C. Separate tissues used for each eye			
D. Drops instilled per order			
	Yes	No	NA

18. Inhaler administration			
A. Inhaler shaken well			
B. Instructed client/resident to breathe out fully			
C. Instructed client/resident to breathe in deeply while depressing the top of the canister.			
D. Instructed client/resident to hold breath as long as possible.			
E. Waits one (1) minute between puffs of same medication			
F. Waits five (5) minutes between puffs of two different meds			
19. Medication pass is not interrupted			
20. Charts omissions, e.g. prn medication, refusals, etc.			
21. Narcotic drawer is locked during medication pass			
22. Medication cart is locked and/or within site at all times			
23. AMAP full signature on MAR with initials for reference or on master signature list			
24. Client/resident rights observed			
A. Knocks on door			
B. Medication patches, creams, etc. are applied in privacy			
C. Appropriate response to medication refusal			
D. Treats client/resident with respect			
25. Control drug inventory correct			
Comments:			
Number of client/residents observed		Number of errors	
Number of meds passed (Minimum of 15 medications)		AMAP error rate	

***This form must be maintained in the facility for AMAP re-training only.
(Do not submit to OHFLAC).***

Addendum A Forms

To obtain a legible hardcopy of all forms refer to the Office of Health Facility Licensure and Certification website at www.wvdhhr.org/ohflac/amap

APPLICATION - AMAP RN ORIENTATION

APPLICANT INFORMATION

Full Name:

Date:

Last

First

M.I.

Address:

Street Address

Apartment / Unit #

City

State

ZIP Code

Phone:

() _____

E-mail Address: _____

RN License #: _____

FACILITY

Facility or Agency
Name:

Address:

Facility Type:

(Check one)

ICF/MR

Assisted Living Facility

Private Residence

Behavioral Health Facility

In accordance with the Medication Administration by Unlicensed Personnel Act (W.Va. Code 16-50), for a registered professional nurse (RN) to receive authorization to train facility staff members to administer medications, the RN must: 1) meet all of the requirements outline in the Act, and 2) have completed an approved registered nurse orientation course provided by WVDHHR.

YES NO

Are you currently practicing as an actively licensed registered professional nurse in good standing in West Virginia? (Please submit a photocopy of your current RN license to this office for review.)

YES NO

Have you practiced as a registered professional nurse in a position or capacity requiring knowledge of medications in the **immediate two years** prior to completing this application?

YES NO

Are you familiar with the nursing care needs of residents in the type of facility in which the unlicensed personnel will be administering medications (i.e., intermediate care facility for the mentally retarded, assisted living, behavioral health group home, private residence in which health care services are provided under the supervision of an RN, or an adult family care home that is licensed by or approved by the department)?

YES NO

Are you knowledgeable of all of your facility's policies and procedures pertaining to the medication administration, as well as W.Va. State Code 16-50?

IMMEDIATE PAST EMPLOYMENT

Employer:

Phone:

() _____

Address:

State: _____

Job Title:

From: _____

To: _____

Responsibilities: _____

PREVIOUS EMPLOYMENT

Employer: _____ Phone: () _____
Address: _____ State: _____
Job Title: _____ From: _____ To: _____
Responsibilities : _____

PREVIOUS EMPLOYMENT

Employer: _____ Phone: () _____
Address: _____ State: _____
Job Title: _____ From: _____ To: _____
Responsibilities: _____

REQUIRED DOCUMENTATION

Please submit the following documentation for review to this office:

- 1) Provide a description of your affiliation with the facility in which you wish to conduct the class, with written verification of your affiliation from the administrator of the facility.
- 2) If you are not registering on-line, please attach **Items #1** to this application and submit to the address listed below.

This orientation course will be offered as a web-based program at the address listed below. This office will notify all participants, as well as the facilities, in writing with the pertinent information required to access the web-based tutorial course.

List 3 date choices that you would be available to take the course 1. _____ 2. _____ 3. _____

A copy of the manual can be obtained from the OHFLAC webpage @ WWW.WVDHHR.ORG/OHFLAC, select AMAP on the left hand side of the page. If you have any questions, please contact OHFLAC AMAP RN-Orientation Attention: Nurse Aide Program – OA II.

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to being granted the privilege to take the RN Orientation course, I understand that false or misleading information in my application may result in this privilege being revoked and I may be reported to the WV RN Board.

Signature: _____ Date: _____

Mail applications to:

OHFLAC – AMAP RN-Orientation
408 Leon Sullivan Way
Charleston, WV 25301-1713
Attention: AMAP- RN Orientation/NA Program - OA II
Telephone: (304) 558-0688 Fax: (304) 558-1442

AMAP NOTIFICATION CHANGE FORM

This form is to notify the **appropriate OHFLAC program** when one of the following occurs:

- 1) AMAP withdrawal (permanent or temporary) of privileges to administer medications.
- 2) Facility policies and procedure changes.

1. Facility – Policy and Procedure Changes

AMAP policy and procedure *(please attach a copy of the revisions for approval)*

Facility

Name: _____

Address: _____

Facility type:	ICF/MR:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Assisted Living:	YES <input type="checkbox"/>	NO <input type="checkbox"/>
	Private Residence:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Behavioral Health:	YES <input type="checkbox"/>	NO <input type="checkbox"/>

FOR **BEHAVIORAL HEALTH FACILITY** TYPE, MAIL OR FAX THIS FORM TO THE PROGRAM LISTED BELOW:

ATTENTION: JAMES COOPER, PROGRAM MANAGER II

OHFLAC – BEHAVIORAL HEALTH PROGRAM
408 LEON SULLIVAN WAY
CHARLESTON, WV 25301-1713
FAX: 304.558.2515

FOR **ASSISTED LIVING, OR PERSONAL CARE** FACILITY TYPE, MAIL OR FAX THIS FORM TO THE PROGRAM LISTED BELOW:

ATTENTION: SHARON KIRK, NURSING DIRECTOR II

OHFLAC – ASSISTED LIVING PROGRAM
408 LEON SULLIVAN WAY
CHARLESTON, WV 25301-1713
FAX: 304.558.2515

2. AMAP - Privileges Changes

_____ / _____ / _____

 AMAP name: _____ AMAP – Birth Date (MM /DD /YYYY): _____

Specific Reason(s) for withdrawal of privileges: _____

Privileges withdrawn *(Please attach a copy of the RN's withdrawal letter that notifies the AMAP that their privileges were withdrawn)*

For AMAP privilege changes, submit this form to the program listed below:

OHFLAC – AMAP-RN ORIENTATION
408 LEON SULLIVAN WAY
CHARLESTON, WV 25301-1713
FAX: 304.558.1442
ATTENTION: AMAP-RN ORIENTATION/NA PROGRAM

Facility name _____

RN name: _____ RN License # _____ Date: _____

RN signature required

RETRAINING VERIFICATION FORM - AMAP

The purpose of this form is for the facility to verify and document the mandatory two (2) year retraining of an AMAP, or new employee who was trained at another facility. This document is to be kept in the employee's file and presented to the OHFLAC representative, upon request.

AMAP staff cannot administer medication until retraining is completed by an authorized AMAP RN.

RETRAINING INFORMATION – AMAP

NAME: _____ SS#: XXX-XX- ____-____

SITE OF INITIAL TRAINING: _____

FACILITY NAME: _____

FACILITY ADDRESS: _____

DATE PASSED STATE TEST: _____

RETRAINING VERIFICATION

Documentation of the method used to retraining must be attached to this form (e.g., the medication pass checklist, testing, etc.).

DATE OF THE TRAINING: _____

FACILITY / PROGRAM NAME: _____

ADDRESS: _____

AMAP RN NAME: _____

(PLEASE PRINT)

AMAP RN SIGNATURE: _____ DATE: _____

Statement: By signing this form, I verify that the unlicensed medication personnel listed above has demonstrated competency to administer medication for this facility.

OHFLAC-AMAP

AMAP PERSONNEL - VERIFICATION FORM

The purpose of this form is for documenting verification of an individual's status with the West Virginia AMAP program. A screen print-out of the online look-up at wvdhhr.org/ohflac/amap, or email notice from Office of Health Facility Licensure and Certification is also acceptable.

GENERAL INFORMATION

Please complete the following information regarding the individual BEFORE calling OHFLAC's AMAP program.

AMAP NAME: _____

BIRTH DATE: ____/____/____
(MM /DD /YYYY)

SPECIFIC REASON(S) FOR
WITHDRAWAL: _____

To verify whether the candidate has been placed on the NURSE AIDE ABUSE REGISTRY, contact OHFLAC's AMAP Program at 304-558-0050. Document the information received from OHFLAC on this form.

YES

NO

Is the individual's name and/or social security number listed with the NURSING ASSISTANT ABUSE REGISTRY?

If the answer to the above question is "yes", please record the date that the individual's name was placed on the NURSE AIDE ABUSE REGISTRY?

(Date)

YES

NO

Has this individual's AMAP privileges been withdrawn before by another supervising RN? If so, when _____

This information was obtained from: _____

(Name of the OHFLAC employee you spoke with)

This information was received by: _____

(Your Name and Title)

(Date)

This form serves as acceptable documentation for the Office of Health Facility Licensure and Certification surveyor to demonstrate compliance with screening requirements.

The completed form must be maintained on file at the facility.