

LESSON PLAN: 11

COURSE TITLE: MEDICATION TECHNICIAN

UNIT: IV PREPARATION AND ADMINISTRATION

SCOPE OF UNIT:

Guidelines and procedures for preparation, administration, reporting, and recording of oral, ophthalmic, otic, topical, transdermal, oral metered dose inhaler, nasal, rectal, vaginal, as well as administration of oxygen by nasal cannula.

INFORMATION TOPIC: IV-11 OR DEMONSTRATION:

BASIC GUIDELINES
(Lesson Title)

OBJECTIVES – THE STUDENT WILL BE ABLE TO:

1. Identify general principles in medication administration.
2. Identify responsibilities in preparing medications.
3. Identify responsibilities in administering medications.
4. Identify what should be reported to the charge nurse.
5. Identify information to be recorded on medication chart.
6. List the five “Rights” of medication administration.
7. Identify different medication errors.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Video Presentation “General Principles of Drug Administration in the Long-Term Care Facility.”
2. HO 29: Do Not Crush List.
3. HO 30: Incident Report Form.
4. HO 31: Guidelines for “Leave of Absence” (LOA) Medications for Long-Term Care Facilities.

INFORMATIONAL ASSIGNMENT

Read Lesson Plan 11 prior to class and be prepared to discuss the information presented.

INTRODUCTION:

Medications are an important part of the care plan for residents in long term care facilities. Medication errors cause 7,000 deaths annually and account for 20% of all medical errors. In Missouri, the most frequent deficiencies in LTC facilities are related to medications. By following the general principles for medication administration, the risk of errors and resident injuries can be dramatically reduced.

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OUTLINE:

- I. General Principles of Medication Administration
 - A. Concentrate on safe preparation and administration of medications. Avoid distractions and interruptions.
 - B. Wash hands or cleanse hands with antibacterial gel before preparing medication and before and after resident contact. Use gloves when necessary.
 - C. Note the diagnosis and reason for each medication.
 - D. Note resident allergies.
 - E. Know the medications – if in doubt consult the supervising nurse, reference book, pharmacist, or physician. Do not give a medication until you know
 1. Normal dosages.
 2. Expected results.
 3. Common side effects.
 4. Contraindications for use.
 5. Specific guidelines for administration (e.g., give with food; give ½ hour before meals, etc.).
 - F. Administer only medications that you have prepared.
 - G. Prepare, administer, and record medications within one hour before or after the scheduled time. If unable to complete the medication pass in the time permitted, notify the charge nurse immediately.
 - H. Review new medication orders with a licensed nurse or pharmacist before giving initial dose for verbal or telephone orders.
 - I. Know how to check the physician's order with the MAR. The order should include:
 1. Name of the drug.
 2. Dosage and form to be administered.
 3. Route of administration (if other than oral).

4. Frequency of administration.
 5. PRN orders must also include the reason to give the medication and time parameters such as “every 4 hours prn pain.” Always check with the licensed nurse before giving prn medications.
- J. Clean up after medication administration.
1. Clean medication trays, the top of the cart, inside of drawers and cabinets.
 2. Wipe up spills or drips from liquid containers paying special attention to labels.
 3. Make sure all medications are stored properly.
 4. Verify all medications are appropriately secured in a locked cart, medicine room, or cabinet.
 5. Empty the trash container on the medication cart.
 6. Restock supplies such as medicine cups or spoons as needed.

II. Five Rights of Medication Administration

To avoid medication errors, remember the five “Rights” of Medication Administration.

- A. Right resident.
- B. Right drug.
- C. Right dose.
- D. Right route.
- E. Right time.

In recent years "Right Charting" has been considered by some to be a “right” as well, however, documentation errors are viewed differently than actual errors in the administration of the medication.

III. Preparation of Medications

- A. Arrive in your work area on time and ready to begin work.
- B. Obtain report from CMT on the previous shift and the charge nurse.
- C. Complete the controlled substance count per facility policy.

- D. Wash hands or cleanse with antibacterial gel.
- E. Gather all necessary equipment such as stethoscope and BP cuff to avoid interruption.
- F. Check medication cart for supplies such as medicine cups and applesauce; restock as needed.
- G. Clean, organize and set up your work surface.
- H. Follow acceptable Infection Control guidelines.
 - 1. Wash hands or cleanse with antibacterial gel prior to preparing medications and before and after resident contact.
 - 2. Avoid touching tablets or capsules. From a container, pour into the lid then dispense into a medication cup. From a punch card, dispense directly into the medication cup.
- I. Compare label of medications bottle or unit dose package with the medication card or medication administration record (MAR). The information must match exactly.
 - 1. Check the resident's name.
 - 2. Check the name of drug, dosage form, and designated route of administration.
 - 3. Check the expiration date on the medication.
 - 4. Check the MAR for resident allergies.
 - 5. Check the label three times and compare with MAR; they must match exactly.
 - a. Check when taking the medication from storage.
 - b. Check before removing the medication from the package.
 - c. Check when returning the medication to storage.
 - 6. Always store medications in the container in which they were received from pharmacy.
 - 7. Any medication that is expired should be set aside for disposal. Medications must be destroyed in the facility by a pharmacist and a licensed nurse or two licensed nurses. Follow facility policies and regulations regarding medication disposal.

8. Return any container that is damaged, incorrect, or with illegible label to pharmacy for re-labeling.

NOTE: Only the pharmacist can put a new label on the container. The CMT is not permitted to write on the label but may apply a change of direction sticker.

9. Be cautious when reading label of look-alike or sound-alike medications.
- J. Check medication for deterioration – abnormal color, smell, or texture.
- K. Follow manufacturer’s guidelines for administration of medications. (e.g., administer on an empty stomach, resident to remain upright for 30 minutes after administration, etc.).
- L. Preparing tablets.
 1. Crushing.
 - a. A doctor’s order is required to crush medications.
 - b. Any medications appearing on the “DO NOT CRUSH” list should not be crushed (e.g., enteric coated, time released) (HO 29).
 2. Most medications can be mixed in a small amount of food (e.g., applesauce) for easier swallowing. Never place medications on the resident's meal tray.
 3. Follow the facility policy and procedure and manufacturer’s instructions for crushing medications. There are many different types of pill crushers on the market. Make sure to thoroughly clean the pill crusher before and after each use to minimize the chance of medication contamination.

CAUTION: Be certain it is not contraindicated before mixing medications with food.

- M. Preparing liquid medications.
 1. Observe the physical appearance of the product. Check the label for special handling and administration instructions such as “shake well” or “do not shake.”
 2. Remove the cap from the bottle and set it upside down on a clean surface to avoid contaminating the cap.
 3. Hold the bottle with the label next to palm of your hand so you pour out of the bottle on the opposite side of label. This prevents medication from running down the bottle and obscuring the label.

4. Use the proper measuring device: a calibrated medicine cup, dropper, or syringe.
 5. Place the medication cup on a flat surface at eye level. Read the measurement at the bottom of meniscus, the lowest point of the liquid in the cup.
 6. When liquid medications are supplied in a pre-measured cup, remove the lid carefully so as not to spill the contents.
 7. Dilute in proper liquids when required by manufacturer's guidelines (e.g., potassium chloride (KCl) liquid in juice or water).
- N. Prepare and organize tray in order of administration (traditional).
- O. Prepare and administer one resident's medications at a time (unit dose; also called modified unit dose or modified traditional).
- P. Transport medications safely. All medications should be clearly identified.
- Q. Never allow a medicine tray or unlocked medication cart out of your sight. Lock the cart if you cannot see it.
- R. Never leave medications unattended on top of the cart.
- S. Cover or close MAR to maintain privacy of the resident's records.

IV. Administration of Medications

- A. Knock on the door before entering the resident's room and wait for permission to enter.
- B. Identify yourself and explain your purpose.
- C. Identify the resident – compare with the med card or MAR.
 1. ID band.
 2. Current picture identification.
 3. Third party identifies resident.
 4. Have the resident tell you his/her name (may be done in addition to one of the above).
- D. Make necessary resident observations prior to administering medication (e.g., check apical pulse prior to dispensing digoxin or check blood pressure according to doctor's orders prior to dispensing antihypertensive).

- E. Do not dispense medication or punch medication from the bubble card until you see the resident.
 - F. Give the resident adequate water. Encourage the resident to take a drink before taking medication to lubricate throat and assist in swallowing medications.
 - G. Stay with the resident (assist as necessary) until all medications are taken.
 - 1. Verify consumption of the medication; do not delegate responsibility to another.
 - 2. Never leave medications at the resident's bedside to be taken later.
 - 3. Discard the empty medication cup in the resident's room and wash hands or use antibacterial gel before moving on to the next resident.
 - H. Administer in a systematic pattern to avoid omissions.
 - I. Administering tablets or capsules.
 - 1. Sublingual – placed under the tongue to dissolve; NO water is given.
 - 2. Buccal – placed between cheek and gum to dissolve; NO water is given.
 - 3. Lozenges – placed in the mouth to dissolve, NO water is given.
 - J. Administering liquids
 - 1. Measure carefully before giving.
 - 2. Cough medication – unless the resident is on a fluid restriction, encourage increased water intake before giving cough medication. Cough medications should be given after other ordered medications and should NOT be followed by water or other liquids.
 - K. Follow facility's policy for medication administration when resident is away from the premises.
- V. Report to the Licensed Nurse
- A. Unusual symptoms new to the resident – hold medication.
 - B. Abnormal vital signs – hold medication.
 - C. Refusal to take a medication or suspicion that resident is not swallowing medications.
 - D. Administration problems.

- E. Adverse drug reaction.
- F. Medication error.
- G. Any PRN medications given and results.

V. Principles of Medication Documentation

- A. Purposes of documentation.
 - 1. Communication tool with other healthcare team members.
 - 2. Legal document – permanent record of care the resident received.
 - 3. Reimbursement from government agencies or insurance companies.
- B. Medications should be recorded as they are dispensed to each resident by the person who administered the medication.
- C. What to record.
 - 1. Name of drug.
 - 2. Dosage and dosage form.
 - 3. Time medication was given.
 - 4. Route by which the medication was given.
 - 5. Initial and name of person administering the medication.
- D. Refusal/omission of a dose.
 - 1. Circle the time the dose should have been given and place your initials inside of the circle.
 - 2. Document why the medication was omitted on the back of the MAR.
 - 3. Notify the charge nurse of what medications were omitted and why.
- E. PRN medications.
 - 1. On front of MAR initial under the date the medication was given.
 - 2. On the back of the MAR document.
 - a. Date and time medication was given.
 - b. Name, dosage and route of medication.

- c. Why medication was given. If given for pain, include the pain scale or behavior indicators.
 - d. Results of the prn medication.
- 3. Signature.

VI. Medication Errors

- A. Errors may be charting or documentation errors.
 - 1. Inaccurate spelling of the resident's or doctor's name.
 - 2. Failure to record a resident's or doctor's full name on subsequent MAR or physician order sheets.
 - 3. No date (include month, day and year).
 - 4. Wrong date.
 - 5. Failure to record an unusual condition, symptom, reaction, or PRN results.
 - 6. Failure to chart medications when given.
 - 7. Failure to get doctor's signature on verbal orders.
 - 8. Failure to sign a record when required.
 - 9. Failure to identify initials on medication record.
 - 10. Failure to chart a change in a medication order.
 - 11. Failure to chart refusal of a medication.
- B. May be an actual medication error. Types of medication errors:
 - 1. Wrong resident – medication is given to the wrong person.
 - 2. Omission – any dose of medication that is not given as ordered by the physician.
 - 3. Wrong dosage – any dose that is either above or below the correct dosage.
 - 4. Extra dosage – any dose that is given in excess of the total number of times ordered by the physician.

5. Unordered drug – the administration of any medication not ordered for that resident.
 6. Wrong dosage form – a dosage form which is different from the form ordered by the physician.
 7. Wrong time – any medications given more than 1 hour before or after it was schedule to be given. This does not include PRN orders.
 8. Wrong route of administration – the administration of a drug by a different route than was specified by the physician (e.g., giving by mouth a drug ordered by injection).
- C. All medication errors require the completion of an incident report form (per facility policy) and should be reported to the charge nurse immediately (HO 30).

VIII. Leave of Absence Medication (HO 31)

- A. LOA medications are provided when the resident will be away from the facility at the time he/she is scheduled to receive a medication.
- B. Each facility develops a policy and procedure for providing LOA medication.
- C. Facility staff are not permitted to repackage or dispense medication.

IX. Summary and Conclusion

- A. General principles of medication administration.
- B. Preparation of medications.
- C. Administration of medications.
- D. Report to the licensed nurse.
- E. Record on medication chart.
- F. Five rights of medication administration.
- G. Medication error.

In this lesson, we've covered key points in the administration of medications that can virtually eliminate medication errors. Remember the five "RIGHTS" to medication administration, concentrate and avoid interruptions, and know about your resident and his/her drug regimen.