LESSON PLAN: 13

COURSE TITLE: MEDICATION TECHNICIAN

UNIT IV: PREPARATION AND ADMINISTRATION

EVALUATION ITEMS:

NAME OF STUDENT: _____

PREPARE, ADMINISTER, REPORT, AND RECORD ORAL MEDICATIONS

EQUIPMENT:

1. Medicine cups
2. Medicine records/cards
3. Medication
4. Medication tray
5. Water glasses
6. Spoons
7. Straws
8. Paper towels
9. Water/juice in a covered pitcher
10. Applesauce/jelly/pudding in a covered container marked with the date opened

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands or use facility approved antibacterial hand cleanser if handwashing facilities are not available.		
2. Review and verify medication administration records/cards with physician's order according to facility policy. Check for allergies. Obtain vital signs if required.		
3. Assemble equipment: medication tray, medication cups, single-use paper towel, individual medications, cups, spoons, straws, water, juice, applesauce, jelly, pudding, etc.		
4. Organize medications in the order of administration. Review medication reference materials for any medications with which you are not familiar.		
5. Wash hands if contaminated.		
6. Remove first resident's medication bin from storage and place on work counter.		
7. Check medication record/card and remove that container of medication from bin. Verify medication strength, dose and labeled direction on the medication administration record (MAR) against the label on the card or bottle.		

8. Prepare medication: Tablets and capsules – Pour into cap then into medication cup when pouring from bottle. From bubble card or other container, punch or pour directly into medication cup. Medications may be crushed according to the doctor's order and manufacturer's guidelines. Liquids – shake liquid if it is labeled to be shaken. Holding label to palm, pour into calibrated cup at eye level. Powders – Pour into medicine cup and dilute with appropriate liquid. Drops – Measure vertically into cup and dilute with appropriate liquid.		
9. Check medication record/card with the label again.		
10. Place medication card and identification on the medicine tray.		
11. Check the label against the MAR a third time and return the medication container to appropriate storage.		
12. Document the medication on the MAR according to facility policy, making sure that the MAR is signed.		
13. Continue same procedure until the resident's medications for the time period are prepared.		
14. Return the medication bin to the storage cabinet. CAUTION: Prepare only one resident's medications at a time.		
15. Knock on the resident's door and wait for permission before entering.		
16. Identify yourself, and explain your purpose as you approach the resident with the medication.		
17. Identify the resident by calling his/her name and checking ID bracelet, picture, or with a knowledgeable third person.		
18. Hand the medication to resident with a glass of water if needed. An adequate and appropriate amount of fluids (4-8 oz) should be offered with the medication. Be aware of residents who require thickened liquids. For medications that must be given with food, provide a small snack as permitted on the resident's diet if the medication is not being given immediately after a meal. NOTE: The medication pass should not be interrupted.		
19. Assist resident as needed.		
20. Remain with resident until medication is swallowed.		
21. Discard contaminated medication cup in appropriate container.		
22. Wash hands.		
23. Proceed to next resident.		
24. When the medication pass is complete, return all equipment to medication preparation area. Report and record essential information.		
25. Sanitize and store equipment.		

The student has satisfactorily completed the procedure "PREPARE, ADMINISTER, REPORT, AND RECORD ORAL MEDICATIONS" according to the steps outlined.

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Instructor's Signature Date
(Verifying Satisfactory Completion)

LESSON PLAN: 13

COURSE TITLE: MEDICATION TECHNICIAN

UNIT IV: PREPARATION AND ADMINISTRATION

EVALUATION ITEMS:

NAME OF STUDENT: _____

PREPARE, ADMINISTER, REPORT, AND RECORD OPHTHALMIC MEDICATIONS

EQUIPMENT:

1. Medication tray
2. MAR/Medication card
3. Medication
4. Tissues
5. Gloves

NOTE: This procedure must be separate from administration of oral medications.

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands. Using antibacterial hand cleanser is NOT appropriate when administering ophthalmic medications.		
2. Review and verify medication administration records/medication cards with physician's order according to facility policy. Check for allergies.		
3. Assemble the equipment: medication tray, medication administration record/card, medication, gloves, and tissues.		
4. Check that medication has been opened no longer than six months. Check solution for correct color and presence of sediment. Do not use if discolored or an unusual sediment is present. Shake if the medication is a suspension. Medication should be at room temperature unless specified otherwise. New bottles of medications should be marked with the date and time it was opened.		
5. Check the medication record/card with the label when medication is removed from the resident's individual compartment in the external storage area. Review medication reference materials for any medications with which you are not familiar.		
6. Check the medication record/card and the label again.		
7. Place the medication card with identification on the tray with the medication.		
8. Document the medication on the MAR according to facility policy, making sure that the MAR is signed.		
9. Place tissues on tray.		
10. Carry the tray to the resident's room.		
11. Knock on the resident's door and wait for permission before entering.		
12. Identify yourself, and explain your purpose as you approach the resident with the medication.		

13. Identify the resident by calling his/her name and checking ID bracelet, picture, or with a knowledgeable third person.		
14. Position the resident (sitting or lying) with head tilted backward.		
15. Observe the affected eye(s) for unusual conditions that may need to be reported.		
16. Wash hands and put on gloves.		
17. Cleanse the eye with a tissue, wiping for the inner corner outward. Dispose of tissue(s). CAUTION: Use a clean tissue if other eye is to be medicated. Use another tissue if a second wiping is needed.		
18. Check the medication record/card with the label.		
19. Ask the resident to look upward.		
20. Hold lower eyelid away from the eye to form a pouch. A. For eye drops: a. Instill drop into the pouch, never directly onto the center of the eyeball. b. With a finger, apply pressure to the inside corner of the eye (inner canthus) for one (1) minute. If an additional drop for the same medications to be given, wait one minute before administering the second drop. If a different medication is to be given, wait five minutes before instilling the second eye drop. B. For eye ointments: a. Apply ointment in a thin strip along the inside of the lower eyelid. If the ointment is given after an eye drop, wait five minutes after administering the drop before administering the ointment. CAUTION: Do not contaminate the dropper or ointment by touching any part of the eye.		
21. Instruct resident to close eyes gently and keep eyes closed for a few minutes. CAUTION: Warn resident not to squeeze eyelids together.		
22. Blot excess medication from cheek with tissue. CAUTION: Do not wipe medication out of eye.		
23. Remove gloves and dispose in appropriate container. Wash hands.		
24. Read label of medication again as it is returned to the external storage area.		
25. Report unusual symptoms to licensed nurse and record essential information.		`

The student has satisfactorily completed the procedure "PREPARE, ADMINISTER, REPORT, AND RECORD OPHTHALMIC MEDICATIONS" according to the steps outlined.

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Instructor's Signature Date
(Verifying Satisfactory Completion)

LESSON PLAN: 13

COURSE TITLE: MEDICATION TECHNICIAN

UNIT IV: PREPARATION AND ADMINISTRATION

EVALUATION ITEMS:

NAME OF STUDENT: _____

PREPARE, ADMINISTER, REPORT, AND RECORD OTIC MEDICATIONS

EQUIPMENT:

1. Medication tray
2. MAR/Medication card
3. Medication
4. Cotton balls
5. Gloves.

NOTE: This procedure must be separate from administration of oral medications.

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands. Use facility approved antibacterial hand cleanser if handwashing facilities are not available.		
2. Review and verify medication administration records/medication cards with physician's order according to facility policy. Check for allergies.		
3. Assemble the equipment: medication tray, medication administration record/card, medication, gloves, and cotton balls.		
4. Check the expiration date and that medication has been opened no longer than six months. Check solution for correct color and presence of sediment. Do not use if discolored or unusual sediment is present; shake suspensions. Medication should be at room temperature unless specified otherwise. New bottles of medications should be marked with the date and time it was opened.		
5. Check the medication administration record/card with the label when medication is removed from the resident's individual compartment in the external storage area. Review medication reference materials for any medications with which you are not familiar.		
6. Check the medication record/card with the label again.		
7. Place medication card with identification on the tray with the medication.		
8. Document the medication on the MAR according to facility policy making sure that the MAR is signed.		
9. Place cotton balls on tray.		
10. Carry the tray to the resident's room.		
11. Knock on the resident's door and wait for permission before entering.		
12. Identify yourself, and explain your purpose as you approach the resident with the medication.		

13. Identify the resident by calling his/her name and checking ID bracelet, picture, or with knowledgeable third person.		
14. Wash hands and put on gloves.		
15. Position the resident. Lower the head of the bed if possible and turn resident's head to opposite side. If in a chair, tilt head sideways.		
16. Clean the external ear with a cotton ball.		
17. Observe the condition of the affected ear.		
18. Read medication record/card and medication label again.		
19. Draw the medication into the dropper.		
20. Pull the ear lobe gently backward and upward for adults, downward, and backward for children.		
21. Instill the number of drops ordered in the ear canal. Direct ear drops toward the side of the ear canal to prevent air from being trapped. CAUTION: Do not contaminate the dropper by touching any part of the ear canal.		
22. Place a clean cotton ball loosely in the ear. CAUTION: Do not push hard on the cotton ball.		
23. Instruct the resident to maintain the same position for two to three minutes.		
24. Wait at least give minutes to instill drops into the other ear if both ears are to be medicated.		
25. Remove and dispose of gloves properly. Wash hands.		
26. Read label when returning medications to external storage area.		
27. Report unusual symptoms to licensed nurse and record essential information.		

The student has satisfactorily completed the procedure "PREPARE, ADMINISTER, REPORT, AND RECORD OTIC MEDICATIONS" according to the steps outlined.

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Instructor's Signature Date
(Verifying Satisfactory Completion)

LESSON PLAN: 13

COURSE TITLE: MEDICATION TECHNICIAN

UNIT IV: PREPARATION AND ADMINISTRATION

EVALUATION ITEMS:

NAME OF STUDENT: _____

PREPARE, ADMINISTER, REPORT, AND RECORD TOPICAL MEDICATIONS

EQUIPMENT:

1. Medication tray
2. MAR/Medication card
3. Medicine cup
4. Medication
5. Clean applicators (tongue blade, cotton swab, etc.)
6. Gloves
7. Small plastic trash bag

NOTE: This procedure must be separate from administration of oral medications.

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands or use facility approved antibacterial hand cleanser if handwashing facilities are not available.		
2. Review and verify medication administration records/cards with physician's orders according to facility policy. Check for allergies.		
3. Assemble equipment: individual medication tray, medication record/card, medicine cup, medication, clean applicators (tongue blade, cotton swab, etc.), gloves, and a small plastic trash bag.		
4. Check medication record/card with label when removing medication from resident's individual compartment in external storage area. Review medication reference materials for any medications with which you are not familiar.		
5. Remove medication from container. If the medication is supplied in a jar, use a clean applicator to remove the amount of medication needed and place it in a medicine cup.		
6. Check label with medication record/card again.		
7. Prepare the medication and place on the same tray with identification.		
8. Check the label on the container a third time.		
9. Document the medication on the MAR according to facility policy, making sure that the MAR is signed.		
10. Carry the tray to the resident's room.		
11. Knock on the resident's door and wait for permission before entering.		
12. Identify yourself, and explain your purpose as you approach the resident with the medication.		

13. Identify the resident by calling his/her name and checking ID bracelet, picture, or with a knowledgeable third person.		
14. Provide for privacy.		
15. Expose only the area to be treated.		
16. Wash hands and put on gloves.		
17. Open applicator package.		
18. Observe skin for unusual symptoms.		
19. Apply medication gently to skin according to doctor's orders and manufacturer's instructions.		
20. Place applicator in a plastic trash bag. Dispose of trash bag according to facility policy. CAUTION: Do not place trash bags in resident's trash can.		
21. Remove gloves and wash hands.		
22. Clean ointment tubes and applicators or bottles according to facility policy and return to storage.		
25. Report unusual findings to the licensed nurse. Report and record essential information.		

The student has satisfactorily completed the procedure 'PREPARE, ADMINISTER, REPORT, AND RECORD TOPICAL MEDICATIONS" according to the steps outlined.

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Instructor's Signature Date
(Verifying Satisfactory Completion)

LESSON PLAN: 13

COURSE TITLE: MEDICATION TECHNICIAN

UNIT IV: PREPARATION AND ADMINISTRATION

EVALUATION ITEMS:

NAME OF STUDENT: _____

PREPARE, ADMINISTER, REPORT, AND RECORD TRANSDERMAL PATCHES

EQUIPMENT:

1. Medication tray
2. MAR/Medication card
3. Medication (Transdermal patch)
4. 2 pair of gloves.
5. Tissues
6. Small plastic trash bag

NOTE: This procedure must be separate from administration of oral medications.

CAUTION: Follow specific manufacturer's instructions before applying a new transdermal patch.

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands. Use facility approved antibacterial hand cleanser if hand-washing facilities are not available.		
2. Review and verify medication administration records/medication cards with physician's order according to facility policy. Check for allergies. Obtain vital signs if required.		
3. Assemble equipment: individual medication tray, medication record/ card, tissue, small plastic trash bag, transdermal patch, and two (2) pair of gloves.		
4. Check medication record/card with label when removing medication from resident's individual compartment in external storage area. Review medication reference materials for any medication with which you are not familiar.		
5. Remove medication from container.		
6. Check label with medication record/card again.		
7. Prepare the medication and place on the same tray with identification.		
8. Check the label on the container a third time.		
9. Document the medication on the MAR according to facility policy, making sure that the MAR is signed.		
10. Carry tray to resident's room.		
11. Knock on the resident's door and wait for permission before entering.		
12. Identify yourself, and explain your purpose as you approach the resident with the medication.		

13. Identify resident by calling his/her name and checking ID bracelet, picture or with knowledgeable third person.		
14. Wash hands and put on gloves.		
15. Position resident, exposing only the area to which the medication will be applied and explain the procedure.		
16. Locate and remove any old patches. CAUTION: Follow specific manufacturer's instructions when removing old patches.		
17. Clean any residual medication from the skin with a tissue.		
18. Remove gloves pulling the glove over the use Transdermal patch and place gloves and used patch in a small plastic trash bag. Dispose of the trash bag according to facility policy. CAUTION: DO NOT PLACE IN RESIDENT'S TRASH CAN! Old Transdermal patches must be disposed of properly. They are very hazardous to children and animals. Never touch the medication on the transdermal patches.		
19. Wash hands and put on gloves.		
20. Open drug packet and remove disk.		
21. Label Transdermal patch with date, time, and your initials.		
22. Apply disk to appropriate, dry, clean, and hairless site. NOTE: Sites should be rotated to avoid irritation. CAUTION: Apply the system promptly upon its removal from the protective pouch to prevent evaporative loss of medication. Do not use if Protective pouch has been opened or damaged.		
23. Remove and dispose of gloves in an appropriate container.		
24. Wash hands immediately.		
25. Report unusual symptoms to the licensed nurse. Report and record essential information.		

The student has satisfactorily completed the procedure "PREPARE, ADMINISTER, REPORT, AND RECORD TRANSDERMAL PATCHES" according to the steps outlined.

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Instructor's Signature Date
(Verifying Satisfactory Completion)

LESSON PLAN: 13

COURSE TITLE: MEDICATION TECHNICIAN

UNIT IV: PREPARATION AND ADMINISTRATION

EVALUATION ITEMS: NAME OF STUDENT: _____

PREPARE, ADMINISTER, REPORT, AND RECORD ORAL METERED DOSE INHALER MEDICATIONS

EQUIPMENT:

1. Medication tray
2. MAR/Medication card
3. Medication
4. Gloves
5. Tissues
6. Glass of water if needed

NOTE: This procedure must be separate from administration of oral medications.

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands. Use facility approved antibacterial hand cleanser if hand-washing facilities are not available.		
2. Review and verify medication administration records/medication cards with physician's order according to facility policy. Check for allergies.		
3. Assemble equipment: medication tray, medication record/card, medication, tissues, gloves, glass of water (if needed).		
4. Check medication record/card with label when removing medication from resident's individual compartment in external storage area. Review medication reference materials for any medications with which you are not familiar.		
5. Remove medication from container.		
6. Check label with medication record/card again.		
7. Prepare the medication and place on the same tray with identification.		
8. Check the label on the container a third time.		
9. Document the medication on the MAR according to facility policy, making sure that the MAR is signed.		
10. Carry the tray to resident's room.		
11. Knock on the resident's door and wait for permission to enter.		
12. Identify yourself and explain your purpose as you approach the resident with the medication.		
13. Identify resident by calling his/her name and checking ID bracelet, picture, or with a knowledgeable third person.		
14. Position the resident sitting or lying with head of bed elevated at least 30 degrees.		
15. Remove cap from mouthpiece.		

16. Shake container vigorously.		
17. Position container upside down.		
18. Tilt resident's head back (hyperextend) slightly.		
19. Instruct resident to breathe out.		
20. Closed mouth technique: A. Instruct resident to close lips on inhaler and to be inhaling slowly. Activate inhaler after resident begins inhaling.		
21. Open mouth technique (optional for steroid inhalers): A. Inhaler is held 1-2 inches from mouth. Activate inhaler at same time resident begins inhaling slowly.		
22. Instruct resident to hold breath 5-10 seconds or as long as possible.		
23. Instruct resident to breathe out slowly (generally no audible breath sounds.		
24. Wait at least one minute before giving a second inhalation (if ordered) of the same medication. Shake container before each administration. If giving two different medications, wait at least 5 minutes before administering the second medication.		
25. For steroid inhalers, have resident rinse mouth after use to minimize fungus overgrowth and dry mouth. NOTE: If resident is using a bronchodilator, it should be used several minutes before the steroid is administered to enhance penetration of the steroid into the bronchial tree.		
27. Wash hands.		
28. Read label again as medication is returned to cart or storage area.		
29. Report unusual symptoms to the licensed nurse. Report and record essential information. NOTE: Follow manufacturer's instructions for administration of discus inhalers such as Advair.		

The student has satisfactorily completed the procedure "PREPARE, ADMINISTER, REPORT, AND RECORD ORAL METERED DOSE INHALER MEDICATIONS" according to the steps outlined.

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Instructor's Signature Date
(Verifying Satisfactory Completion)

LESSON PLAN: 13

COURSE TITLE: MEDICATION TECHNICIAN

UNIT IV: PREPARATION AND ADMINISTRATION

EVALUATION ITEMS:

NAME OF STUDENT: _____

PREPARE, ADMINISTER, REPORT, AND RECORD NASAL MEDICATIONS

EQUIPMENT

1. Medication tray
2. MAR/Medication card
3. Medication
4. Tissues
5. Gloves
6. Alcohol wipes

NOTE: This procedure must be separate from administration of oral medications.

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands or use facility approved antibacterial hand cleanser if handwashing facilities are not available.		
2. Review and verify medication administration records/cards with physician's orders according to facility policy. Check for allergies.		
3. Assemble equipment: medication tray, medication record/card, medication, tissues, alcohol wipes, and gloves.		
4. Check medication record/card with label when removing medication from resident's individual compartment in external storage area. Review medication reference materials for any medications with which you are not familiar.		
5. Remove medication from container.		
7. Check label with medication record/card again.		
8. Prepare the medication and place on the same tray with identification. new pumps should be opened and primed prior to initial use.		
9. Check the label on the container a third time.		
10. Document the medication on the MAR according to facility policy, making sure that the MAR is signed. Alternate nostrils and record nostril treated on MAR.		
11. Place tissues and alcohol wipes on the tray.		
12. Carry tray to the resident's room.		
13. Knock on the resident's door and wait for permission before entering.		
14. Identify yourself and explain your purpose as your approach the resident with the medication.		
15. Identify the resident by calling his/her name and checking ID bracelet, picture, or with a knowledgeable third person.		
16. Wash hands and put on gloves.		

17. Observe for nasal secretions. Instruct resident to blow nose gently and wipe clean.		
18. Position the resident: A. Lying down for nose drops. B. Sitting up for nasal spray with head tilted back slightly.		
19. Read medication record/card and medication label again.		
20. Administer the dosage: A. Drop the number of drops into the nose toward the septum without touching the nasal membrane. B. Insert nasal spray nozzle gently into the nose and spray.		
21. Wipe away excess medication with tissue.		
22. Instruct resident NOT to blow nose or sniff for a few minutes.		
23. Wipe nozzle of spray with alcohol wipe.		
24. Remove and dispose of gloves properly. Wash hands immediately.		
25. Read label again with returning the medication to external storage area.		
26. Report unusual symptoms to the licensed nurse. Report and record essential information.		

The student has satisfactorily completed the procedure "PREPARE, ADMINISTER, REPORT, AND RECORD NASAL MEDICATIONS" according to the steps outlined.

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Instructor's Signature Date
(Verifying Satisfactory Completion)

LESSON PLAN: 13

COURSE TITLE: MEDICATION TECHNICIAN

UNIT IV: PREPARATION AND ADMINISTRATION

EVALUATION ITEMS:

NAME OF STUDENT: _____

PREPARE, ADMINISTER, REPORT, AND RECORD VAGINAL MEDICATIONS

EQUIPMENT:

1. Medication tray
2. MAR/Medication card
3. Medication
4. Water soluble lubricant
5. Medication cup
6. Paper towels
7. Tissues
8. Gloves

NOTE: This procedure must be separate from administration of oral medications.

CHECK IF THE STUDENT DID FOLLOWING	YES	NO
1. Wash hands or use facility approved antibacterial hand cleanser if handwashing facilities are not available.		
2. Review and verify medication record/card with physician's order according to facility policy. Check for allergies.		
3. Assemble equipment: medication tray, medication record/card, medication, tissues, gloves, water soluble lubricant, tissues and paper towels.		
4. Check medication record/card with label when removing medication from resident's individual compartment in external storage area.. Review medication reference materials for any medications with which you are not familiar.		
5. Remove medication from container.		
6. Check label with medication record/card again.		
7. Prepare the medication and place on the same tray with identification.		
8. Check the label on the container a third time.		
10. Squeeze small amount of water-soluble lubricant on paper towel (if needed).		
11. Document the medication on the MAR according to facility policy, making sure that the MAR is signed.		
12. Read label again when returning the medication container to the external storage area.		
13. Carry tray to resident's room.		
14. Knock on the resident's room and wait for permission to enter.		

15. Identify yourself, and explain your purpose as you approach the resident with the medication.		
16. Identify resident by calling her name and checking ID bracelet, picture, or with knowledgeable third person.		
17. Provide privacy.		
18. Position resident on back with knees raised or in another appropriate position and cover the legs to provide warmth.		
19. Remove wrapper from suppository or applicator.		
20. Lubricate suppository or applicator (if needed).		
21. Ask resident to relax and breathe deeply.		
22. Retract labia expose vaginal orifice with one hand. Observe for any unusual symptoms or drainage.		
23. Insert applicator or suppository into the full length of the vagina.		
24. Remove applicator slowly.		
25. Wipe excess lubricant from vagina with tissues.		
26. Dispose of disposable applicator, tissues, and paper towels according to facility policy.		
27. If using a reusable applicator, clean applicator according to manufacturer's guidelines.		
28. Remove gloves and dispose of in an appropriate container; wash hands.		
29. Return reusable applicator to external storage area.		
30. Report unusual symptoms to the licensed nurse. Report and record essential information.		

The student has satisfactorily completed the procedure "PREPARE, ADMINISTER, REPORT, AND RECORD VAGINAL MEDICATIONS" according to the steps outlined.

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Instructor's Signature Date
(Verifying Satisfactory Completion)

LESSON PLAN: 13

COURSE TITLE: MEDICATION TECHNICIAN

UNIT IV: PREPARATION AND ADMINISTRATION

EVALUATION ITEMS:

NAME OF STUDENT: _____

PREPARE, ADMINISTER, REPORT, AND RECORD RECTAL MEDICATIONS

EQUIPMENT:

1. Medication tray
2. MAR/Medication record
3. Medication
4. Gloves
5. Water-soluble lubricant
6. Tissues
7. Paper towels
8. Medication cup

NOTE: This procedure must be separate from administration of oral medications.

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands or use facility approved antibacterial hand cleanser if handwashing facilities are not available.		
2. Review and verify medication administration records/cards with physician's order according to facility policy. Check for allergies.		
3. Assemble equipment: medication tray, medication record/card, medication, gloves, water soluble lubricant, tissues, paper towels.		
4. Check medication record/card with label when removing medication from resident's individual compartment in external storage area. Review medication reference materials for any medications you are not familiar with.		
5. Remove medication from container.		
7. Check label with medication record/card again.		
8. Prepare the medication and place on the same tray with identification.		
9. Check the label on the container a third time.		
10. Squeeze small amount of water-soluble lubricant on paper towel.		
11. Document the medication on the MAR according to facility policy, making sure that the MAR is signed.		
12. Read label again when returning the medication container to the external storage area.		
13. Carry tray to resident's room.		
14. Knock on the resident's door and wait for permission to enter.		
15. Identify yourself, and explain your purpose as your approach the resident with the medication.		

16. Identify resident by calling his/her name and checking ID bracelet, picture, or with a knowledgeable third person.		
17. Provide privacy.		
18. Wash hands and put on gloves.		
19. Position resident on left side and expose only the buttocks area. Note: make sure resident is clean of urine or feces. If necessary, provide peri care. If peri-care is given, remove gloves, wash hands, and put on clean gloves for administration.		
20. Remove wrapper from suppository or applicator.		
21. Lubricate suppository or applicator.		
22. Ask resident to relax and to breathe through mouth. Explain to resident that he/she will feel pressure on the rectum but that he/she should not try to push or defecate.		
23. Separate buttocks and insert suppository into rectum beyond the sphincter and against rectal wall (up to middle joint of finger). CAUTION: Do not embed suppository into fecal material.		
24. Remove finger.		
25. Wipe excess lubricant from anus.		
26. Remove gloves and discard in appropriate container.		
27. Wash hands.		
28. Make the resident comfortable with the call light within reach.		
29. Observe resident every five to ten minutes following insertion for results if necessary for medication administered.		
30. Report unusual symptoms to the licensed nurse. Report and record essential information.		

The student has satisfactorily completed the procedure "PREPARE, ADMINISTER, REPORT, AND RECORD RECTAL MEDICATIONS" according to the steps outlined.

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Instructor's Signature Date
(Verifying Satisfactory Completion)

LESSON PLAN: 13

COURSE TITLE: MEDICATION TECHNICIAN

UNIT IV: PREPARATION AND ADMINISTRATION

EVALUATION ITEMS:

NAME OF STUDENT: _____

ADMINISTER OXYGEN BY NASAL CANNULA

EQUIPMENT:

1. MAR/Medication card
2. Oxygen tank on cart or concentrator with flowmeter
3. Humidifier jar, if ordered
4. Nasal cannula
5. Oxygen in use/NO SMOKING sign
6. Sterile distilled water or other solution (if needed)

NOTE: This procedure must be separate from administration of oral medications.

CHECK IF THE STUDENT DID THE FOLLOWING	YES	NO
1. Wash hands or use facility approved antibacterial hand cleanser if handwashing facilities are not available.		
2. Review and verify medication administration records/cards with physician's order according to facility policy.		
3. Assemble equipment: O_2 tank on cart or oxygen concentrator with flowmeter, nasal cannula, humidifier, Oxygen in Use/NO SMOKING sign, and sterile distilled water (if needed).		
4. If a humidifier is needed, fill humidifier to mark with sterile distilled water unless otherwise ordered. A humidifier is not usually required if the resident is receiving oxygen at less than 3L/min.		
5. Take equipment to the resident's room.		
6. Identify yourself, and explain your purpose as you approach the resident.		
7. Identify the resident by calling his/her name and checking ID tag, picture, or with knowledgeable third person.		
8. Place oxygen tank or concentrator at the bedside near the head of bed. CAUTION: Anchor tanks according to facility policy.		
9. Connect cannula and tubing to oxygen system.		
10. Turn the system on and set flow rate at number of liters per minute as ordered by the physician. NOTE: Make sure oxygen is flowing through the cannula.		
11. Place tips of cannula into the resident's nose. CAUTION: Tips should not extend into the nose more than one inch.		

12. Adjust tubing to resident's comfort, snug enough to secure the cannula in the nose but not tight enough to cause pressure on the resident's ears.		
13. Adjust flow rate as ordered.		
14. Check vital signs and observe for unusual symptoms.		
15. Post the NO SMOKING sign in sight of visitors and the resident and instruct them not to smoke.		
16. Observe resident frequently for: a. Proper rate of flow. b. Proper adjustment of cannula tubing. c. Condition of skin under cannula tubing. d. Shortness of breath or difficulty breathing. e. Change in mental status.		
17. Report unusual symptoms to the licensed nurse. Report and record essential information.		

The student has satisfactorily completed the procedure "ADMINISTER OXYGEN BY NASAL CANNULA" according to the steps outlined.

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Instructor's Signature Date
(Verifying Satisfactory Completion)