MEDICATION ADMINISTRATION 8Hr

Prepared By Michelle Broomfield RN

PURPOSE

The purpose of this course is to provide training regarding procedures for accurate medication administration, Safe storage, handling, and disposal of medications, comprehensive understanding of and compliance with medication instructions on a prescription label, a health care practitioner's order, and proper completion of a MAR form, review of the medical indications and purposes for commonly used medications, their common side effects, and symptoms of adverse reactions, the proper administration of oral, transdermal, ophthalmic, otic, rectal, inhaled and topical medications, safety and sanitation practices while administering medication, medication administration documentation and record-keeping requirements, medical errors and medical error reporting, determinations of need for medication administration assistance and informed consent requirements, procedural arrangements for clients who require medication offsite and validation requirements. The course also reviews rules regarding over-the-counter and sample prescription medications, knowledge with the standards applying to the use of medications as chemical restraints, knowledge of the conditions warranting the services of a licensed pharmacist and nursing consultant, and documentation standards, knowledge of methods to correct deficiencies in medication practices.

OBJECTIVES

At the conclusion of the course the participants will be able to:

1. Discuss compliance with medication instructions on a prescription label, a health care practitioner's order, and proper completion of a MAR form
2. Describe the seven Rights of medication administration
3. Describe Safe storage, handling, and disposal of medications
4. Describe infection control principles related to medication administration.
5. Describe several route procedures.
6. Describe age related route and form considerations.
7. Describe the medical indications and purposes for commonly used medications, their common side effects, and symptoms of adverse reactions
8. Describe the components of a complete Medication label.
9. Describe the proper administration of oral, transdermal, ophthalmic, otic, rectal, inhaled and topical medications
10. Discuss safety and sanitation practices while administering medications
11. Define the meaning of acceptable abbreviations.

12. Summarize the use, side effects, adverse reactions, contraindications and implications of common medication classifications.
13. Describe medication administration documentation and record-keeping requirements, medical errors and medical error reporting.
14. Discuss rules regarding over-the-counter and sample prescription medications,

15. Describe the standards applying to the use of medications as chemical restraints,

16. Describe documentation standards

17. Discuss methods to correct deficiencies in medication practices.

Section 1

Basic Medication Administration Information

FLORIDA ADMINISTRATIVE CODE CHAPTER 65G-7 REGARDING MEDICATION ADMINISTRATION

Review of Florida Administrative code regarding medication administration.

According to Florida Administrative code 65G-7.001 Definitions:

The terms and phrases used in this chapter shall have the meanings defined below:
(1) “Administration of medication” means the obtaining and giving of one or more doses of medicinal drugs by a legally authorized person to an Agency client for his or her consumption.

(2) “Area Office” is the local office responsible for managing one of the Agency’s fourteen service areas.

(3) “Authorized representative” means the client’s parent if the client is a minor, the client’s authorized guardian, court-appointed guardian advocate, health care surrogate, or a health care proxy appointed in accordance with Chapter 765, F.S., or any other client advocate legally authorized to make decisions on behalf of a client.

(4) “Central Office” is the Agency’s headquarters, situated at 4030 Esplanade Way, Suite 380, Tallahassee, FL 32399-0950; main phone number (850) 488-4257.

(5) “Client’s record” means a file maintained for each client that contains the client’s name and date of birth, written authorization for routine medical/dental care from the client or guardian and medical summary, the name address and telephone of the client’s physician and dentist, a record of the client’s illnesses and accidents, the legal status of the client, current services and implementation plan, and client financial documentation.

(6) “Controlled medication” means any substance enumerated in Schedules I, II, III, IV, and V in Section 893.03, F.S.

(7) “Corrective Action Plan,” for purpose of this rule, means a written plan of action developed by the Agency for the purpose of correcting cited deficiencies in compliance with this rule chapter.

(8) “Enteral medication” means medication delivered by tube via the body’s gastrointestinal system.

(9) “Facility” means a residential facility licensed under Chapter 393, F.S., or other facility staffed by direct service providers where Agency clients receive training, respite care, or other services on a regularly scheduled basis.

(10) “Inhaled medication” means the delivery of medication droplets or moisture suspended in a gas, such as oxygen, by inhalation through the nose or mouth.

(11) “Medical Case Manager” means a registered nurse or ARNP employed by the Agency to provide nursing consultation and technical assistance to an Area office regarding the medical care of Agency clients.

(12) “Medication Administration Record” or “MAR” means the chart maintained for each client which records the medication information required by this rule chapter. Other information or documents pertinent to medication administration may be attached to the MAR. A copy of the Agency’s form “Medication Administration Record,” APD Form 65G7-00 (3/30/08), incorporated herein by reference, may be obtained by writing or calling the Agency for Persons with Disabilities, at 4030 Esplanade Way, Suite 380, Tallahassee, FL 32399-0950; main phone number (850) 488-4257.

(13) “Medication Assistance Provider” means a direct service provider not otherwise licensed to administer medication who has successfully completed an agency-approved training course and has current validation to provide clients with medication administration or to assist clients with self-administration of medication.

(14) “Nebulizer” means an atomizer equipped to produce an extremely fine spray for deep penetration of the lungs.

(15) “Over-the-counter (OTC) medication” means a medication for general distribution and use without a prescription in the treatment of human illnesses, ailments, or injuries.

(16) “Ophthalmic medication” means a solution or ointment to be instilled into the eye or applied on or around the eyelid.

(17) “Oral medication” means any medication in tablet, capsule, or liquid form introduced into the gastrointestinal tract by mouth.

(18) “Otic medication” means solutions or ointments to be placed in the outer ear canal or applied around the outer ear.

(19) “Parenteral” means injected into the body through some route other than the alimentary canal.

(20) “Physician” means a doctor of medicine or osteopathy who holds a valid and active license in full force and effect pursuant to the provisions of Chapter 458 or 459, F.S., or the applicable laws of the state in which the service is furnished.

(21) “Prescribed medication” means simple or compound substances or mixtures of substances that are prescribed for the cure, mitigation, or prevention of disease or for health maintenance prescribed by a licensed practitioner authorized by law to prescribe such substances.

(22) “Prescription” means any order for drugs, medical supplies, equipment, appliances, devices, or treatments written or transmitted by any means of communication by a licensed practitioner legally authorized to issue such an order, or any order issued by the lawfully designated agent of such practitioner, intended to be filled, compounded, dispensed or furnished by a person authorized by the laws of the State to do so.

(23) “PRN” (“pro re nata”) means the administration of medication on an as-needed basis rather than according to a prescribed schedule.

(24) “Rectal medication” means any prescribed medication, capsule, enema or suppository to be administered via the rectum.

(25) “Supported living services” means the provision of supports necessary for an adult who has a developmental disability to establish, live in, and maintain his or her own household in the community.

(26) “Supervised self-administered medication” means direct, face-to-face observation of a client during the client’s self-administration of medication and includes instruction or other assistance necessary to ensure correct self-administration of the medication.

(27) “Topical medication” means a salve, lotion, ointment, cream, shampoo or solution applied locally to a body part.

(28) “Transdermal patch” means an adhesive patch containing a pre-measured amount of topical medication that is absorbed into the body via the epidermis (outer layer of skin) at a fixed rate.

(29) “Unlicensed” means, for purposes of this rule, not authorized, certified, or otherwise permitted by other Florida law to administer medication or to supervise self-administration of medication.

(30) “Validation” means an unlicensed direct service provider’s demonstration of competency in administering or supervising self-administration of a medication to a client, certified by a licensed, registered nurse or licensed physician following the provider’s successful completion of an Agency-approved medication administration training course. *Specific Authority 393.501 FS. Law Implemented 393.506 FS. History–New 3-30-08.*

According to Florida Administrative code 65G-7.002 Regarding; Determining Need for Assistance; Informed Consent Requirement:

(1) An Agency client’s need for assistance with medication administration or ability to self-administer medication without supervision must be documented by the client’s physician, physician assistant, or Advanced Registered Nurse Practitioner, licensed under Chapter 464, 458, or 459, F.S., to practice in the State of Florida, on an “Authorization for Medication Administration,” APD Form 65G7-01, (3/30/08), incorporated herein by reference. A copy of the form may be obtained by writing or calling the Agency for Persons with Disabilities, at 4030 Esplanade Way, Suite 380, Tallahassee, FL 32399-0950; main phone number (850) 488-4257.
(2) A client who is authorized, as provided above, to self-administer medication without supervision shall be encouraged to do so. The medication assistance provider shall assist the client by making the medication available and reminding the client to take medication at appropriate times.
(3) The medication assistance provider must maintain a current Authorization form, reviewed by the client’s physician, physician assistant, or ARNP at least annually and upon any change to the client’s medical condition or self-sufficiency which would affect the client’s ability to self-administer medication or to tolerate particular administration routes.
(4) An unlicensed provider is not authorized to administer medication or assist a client with self-administration of medication unless he or she has successfully completed an Agency-approved medication administration training course and has obtained a current validation.
(5) In addition to an executed Authorization for Medication Administration and before providing a client with medication assistance, a provider must also obtain from the client or the client’s authorized representative an “Informed Consent for Medication Administration” APD Form 65G7-02 (3/30/08) incorporated herein by reference.

A copy of the form may be obtained by writing or calling the Agency for Persons with Disabilities, at 4030 Esplanade Way, Suite 380, Tallahassee, FL 32399-0950; main phone number (850) 488-4257. The Informed Consent form must contain a description of the medication routes and procedures that the medication assistance provider is authorized to supervise or administer.

(6) The medication assistance provider may not also act as the client's health care surrogate or proxy, or sign the Medication Administration Informed Consent form referenced above. Providers or other facility staff may witness the execution of the form.

(7) A medication assistance provider will limit his or her assistance to the minimum necessary to ensure proper administration or self-administration of the medication while preserving the client's independence.

(8) The requirements of this rule chapter do not apply to the following:
(a) Health care practitioners whose professional licenses include administration of medication;
(b) Client family members or friends who provide medication assistance without compensation, as permitted by Section 464.022(1), F.S.;
(c) Providers employed by or under contract with State Medicaid intermediate care facilities for the developmentally disabled, regulated through Chapter 400, Part VIII, F.S., providers employed by or under contract with licensed home health agencies regulated under Chapter 400, Part III, hospices regulated under Chapter 400, Part IV, or health care service pools regulated through Chapter 400, Part IX, F.S., or providers employed by or under contract with assisted living facilities regulated through Chapter 429, Part I, F.S.; and
(d) Clients authorized to self-administer medication without assistance or supervision, as documented by an executed Authorization, APD Form 65G7-01 (3/30/08) incorporated herein by reference. A copy of the form may be obtained by writing or calling the Agency for Persons with Disabilities, at 4030 Esplanade Way, Suite 380, Tallahassee, FL 32399-0950; main phone number (850) 488-4257.

According to Florida Administrative code 65G-7.004 regarding Validation Requirements:

(1) An unlicensed provider applying for validation as a medication assistance provider must be assessed and validated at least annually, through demonstration, as competent to administer medication or to supervise the self-administration of medication. Successful completion of an Agency-approved medication administration course is a prerequisite to an assessment of competency validation.

(2) **Only a registered nurse licensed pursuant to Chapter 464, F.S., or a physician licensed pursuant to Chapter 458 or 459, F.S., may validate the competency** of an unlicensed direct service provider to provide medication administration assistance.
(3) The applicant for validation must complete an on-site assessment with 100% proficiency documented on a "Validation Certificate," APD Form 65G7-004 (3/30/08) incorporated herein by reference. A copy of the form may be obtained by writing or calling the Agency for Persons with Disabilities, at 4030 Esplanade Way, Suite 380, Tallahassee, FL 32399-0950; main phone number (850) 488-4257. The form must contain the following information:

(a) The name and address of the applicant being validated and, if an employee, the name of the employing entity;
(b) The date of assessment and validation;
(c) A description of the medication routes and procedures that the applicant is authorized to supervise or administer;
(d) Any limitations on the applicant's validation to administer medication, such as limitations on validated routes of medication administration;
(e) The printed name and original signature of the validating nurse or physician as it appears on his or her license; and
(f) The validating nurse or physician's license number and license expiration date.

(4) Successful assessment and validation requires that the applicant demonstrate in an actual on-site client setting his or her capability to correctly administer medication and supervise the self-administration of medications in a safe and sanitary manner as required by this rule chapter, including a demonstration of the following proficiencies:
(a) The ability to comprehend and follow medication instructions on a prescription label, physician's order, and properly complete a MAR form;
(b) The ability to administer medication by oral, transdermal, ophthalmic, otic, rectal, inhaled, or topical administration routes;
(c) The ability to obtain pertinent medication information, including the purpose of the medication, its common side effects, and symptoms of adverse reactions to the medication, either from the package insert that comes from the pharmacy, or a Physician's Desk Reference or other professionally recognized medication resource, and maintaining this information for easy access and future reference;
(d) The ability to write legibly, convey accurate information, and comply with medication administration record-keeping requirements;
(e) Knowledge of the proper storage and handling of medications;
(f) Knowledge of proper disposal of expired or unused medications;
(g) Knowledge of special requirements relating to storage and disposal of controlled medications;
(h) Requirements for obtaining authorizations for assistance with medication administration, authorization for self-administration of medication without supervision, and informed consent for medication assistance; and

(i) Adequate training on the correct positioning and use of any adaptive equipment or use of special techniques required for the proper administration of medication.
(5) When a client is prescribed a medication requiring an administration route for which the medication assistance provider has not been validated, the provider must obtain an assessment and validation for that specific administration route before administering the medication to the client.

(6) A medication assistance provider must be re-validated annually within the 60 days preceding the expiration of his or her current validation. An unlicensed provider may not under any circumstances administer or supervise the self-administration of medication before receiving validation or following expiration of an annual validation.

(7) Medication assistance providers who fail to acquire re-validation before the expiration of the current validation must retake the medication administration training course and obtain current validation before assisting with the administration or self-administration of medication.

(8) Any employer or contractor who offers medication assistance provider services is responsible for maintaining a record of the provider's training certification and annual validation and for making such records available for Agency review upon request. *Specific Authority 393.501 FS. Law Implemented 393.506 FS. History–New 3-30-08.*

According to Florida Administrative code 65G-7.005 regarding Medication Administration Procedures:

(1) Upon certification and validation as provided by this rule chapter, **unlicensed providers are authorized to assist with** the administration of prescribed medications via the following medication routes:

(a) Oral;
(b) Transdermal;
(c) Ophthalmic;
(d) Otic;
(e) Rectal;
(f) Inhaled; and
(g) Topical.

(2) A validated medication assistance provider must comply with the following requirements:

(a) Before providing any medication assistance, become familiar with the client's medical history and medication background and locate the name and contact numbers of the client's prescribing practitioner for consultation regarding the prescribed medications;

(b) Perform appropriate hand sanitation measures before providing medication assistance, with repeated sanitization as needed during medication administration;
(c) Assist only one client at a time with medication administration in a quiet location free from distraction;

(d) Following medication administration or assistance with self-administration, return each client's medication to its portable or permanent medication storage location before assisting another client;

(e) Limit administration, or assistance with self-administration, to medications prescribed in writing by the client's health care practitioner and properly labeled and dispensed in accordance with Chapters 465 and 499, F.S.;

(f) Immediately report torn, damaged, illegible, or mislabeled prescription labels to the dispensing pharmacist or health care practitioner and, if a client is residing in a residential facility, notify the facility supervisor;
(g) Check the directions and expiration date of each medication to ensure that expired prescription medications or those no longer prescribed are not administered;

(h) Verify that the correct medication is administered to the correct client, at the correct time, with the correct dosage, by the correct route, and for the correct reason, as prescribed by the health care practitioner;
(i) Observe complete ingestion of oral medication before leaving the client and before recording or documenting the administration of the medication on the MAR;

(j) Record the date, time, dosage, and name of each medication in the MAR immediately following administration and sign the entries;

(k) Observe the client **directly for a minimum of 20 minutes** following the **first three doses of a new or PRN medication** in order to detect and respond immediately to potential side effects, unless ordered differently by the prescribing health care practitioner, and review the MAR for any special instructions by the prescribing practitioner regarding required observations.

(3) A medication assistance provider may not assist with the administration of any OTC medication or medication samples without a written order by the client's primary care physician or Advanced Registered Nurse Practitioner.

(4) Medications may not be crushed, diluted, or mixed without written instructions from the prescribing health care practitioner in the MAR.

(5) The medication assistance provider is responsible for ensuring that the prescription for a medication is promptly refilled so that a client does not miss a prescribed dosage of medication. If the medication assistance provider is not responsible for routine refills of a medication, he or she shall notify the provider responsible for refilling the client's prescriptions that the client is in need of medication and document this notification.

(6) The medication assistance provider may not assist with PRN medications, including OTC medications, unless a health care practitioner has provided written directions for the medication. The provider must attach to the client's MAR a copy of the prescription or order legibly displaying the following information:

(a) The name of the medication;

(b) The prescription number, if applicable;

(c) The prescribed dosage; and

(d) Specific directions for use, including the medical basis for the medication, the time intervals for administration, the maximum number of doses, the maximum number of days that the medication should be administered, and conditions under which the health care practitioner should be notified.

MAY NOT PERFORM:

(7) A medication assistance provider ***may not*** perform the following acts of assistance:

(a) Prepare syringes for a client's use during the self-administration of medication via a subcutaneous, intra-dermal, intra-muscular or intravenous route;

(b) Administer, or supervise self-administration of, medications that are inserted vaginally, administered enterally, or administered via a tracheostomy;

(c) Mix or pour medications administered through intermittent positive pressure breathing machines or nebulizers, unless the medication assistance provider and client who self-administers medication with supervision have received one-on-one, step-by-step, training in the proper use and maintenance of such equipment from a certified equipment technician, respiratory therapist, or a registered nurse, with documentation in the client's file of the date of training, the name and qualifications of the persons providing the training, and a description of the breathing equipment that was the subject of the training;

(d) Administer medications via a subcutaneous, intra-dermal, intra-muscular or intravenous route;

(e) Perform irrigation of partial or full thickness wounds (such as vascular ulcers, diabetic ulcers, pressure ulcers, surgical wounds) or apply agents used in the debridement of necrotic tissues in wounds of any type; and

(f) Assist a client with medications for which the health care provider's prescription does not specify the medication schedule, medication amount, dosage, route of administration, purpose for the medication, or with medication which would require

professional medical judgment by the medication assistance provider. *Specific Authority 393.501 FS. Law Implemented 393.506 FS. History–New 3-30-08.*

According to Florida Administrative code 65G-7.007 regarding Storage Requirements:

(1) Medication assistance providers must observe the following medication storage requirements:
(a) Store each medication at the temperature appropriate for that medication, including refrigeration if required;
(b) Destroy any prescription medication that has expired or is no longer prescribed and document the medication disposal on a "Medication Destruction Record," APD Form 65G7-06 (3/30/08) incorporated herein by reference. A copy of the form may be obtained by writing or calling the Agency for Persons with Disabilities, at 4030 Esplanade Way, Suite 380, Tallahassee, FL 32399-0950; main phone number (850) 488-4257. Sign the Record before a third-party witness;

(c) Maintain medication samples in their original containers labeled by the dispensing health care practitioner with the client's name, the practitioner's name, and the directions for administering the medication. The medication assistance provider must initial and add to the label the date the medication is opened.
(d) Maintain OTC medications in their original stock containers.

(2) A residential facility or supported living client who does not require medication assistance or supervised self-administration may store his or her medication in secure, locked place within his or her room. However, a client's medications must be centrally stored and retrieved by the medication assistance provider if:
(a) The client's physician documents in the client's file that leaving the medication in the personal possession of the client would constitute a threat to the health, safety, or welfare of the client or others;
(b) The client fails to securely maintain the medication in a locked place;
(c) The medication assistance provider, facility administrator, or Agency determines that, based on the home's physical arrangements or the habits of other residents, the client's personal possession of medication poses a threat to the safety of others; or
(d) The client or the client's authorized representative requests that the client's medication be centrally stored.
(3) If the client requiring medication assistance is residing or receiving services in a facility setting, the medications must be centrally stored in a locked container in a secured enclosure.
(4) Either a licensed health care practitioner or medication assistance provider must securely maintain keys to the locked containers and storage enclosures containing controlled medications, and provide written procedural provisions for accessibility to medications in cases of emergency.

(5) Stored medications must be organized and maintained in a manner that ensures their safe retrieval and minimizes medication errors.
(6) Medications requiring refrigeration must be stored in a refrigerator. The medications shall be stored in their original containers either within a locked storage container clearly labeled as containing medications or in a refrigerator located in a locked, secured medication storage room.

(7) Each medication must be returned to its portable or permanent storage unit immediately following medication administration assistance.
(8) Controlled medication storage requires the following additional safeguards:
(a) The medications must be stored separately from other prescription and OTC medications in a locked container within a locked enclosure.
(b) For facilities operating in shifts, a medication assistance provider must perform controlled medication counts for each incoming and outgoing personnel shift, as follows:
1. The medication count must be performed by a medication assistance provider and witnessed by another medication assistance provider;
2. Both providers must verify count accuracy by documenting the amount of medication present and comparing that amount to both the previous count and number of doses administered between counts;

3. The providers must record the medication count on a “Controlled Medication Form,” APD Form 65G7-07 (3/30/08) incorporated herein by reference. A copy of the form may be obtained by writing or calling the Agency for Persons with Disabilities, at 4030 Esplanade Way, Suite 380, Tallahassee, FL 32399-0950; main phone number (850) 488-4257. The form must be signed and dated by the providers verifying the count; and
4. Immediately document and report any medication discrepancies to the facility supervisor.
(c) For facilities with only one medication assistance provider per shift, the medication assistance provider must conduct, document, and sign a daily medication count on the Controlled Medication Form; and
(d) For facilities with no shifts, the medication assistance provider must conduct, document, and sign a controlled medication count at least once each day on the Controlled Medication Form, using the same counting and documentation technique described above. *Specific Authority 393.501 FS. Law Implemented 393.506 FS. History–New 3-30-08.*

According to Florida Administrative code 65G-7.008, regarding Documentation and Record Keeping:

(1) An up-to-date MAR shall be maintained for each client requiring assistance with medication administration, except when the client is off-site. The medication assistance provider must document the administration of medication or supervision of self-administered medication immediately on the MAR, using either APD Form 65G7-00 (3/30/08), incorporated by reference at subsection 65G-7.001(12), F.A.C., or on an alternative MAR form that includes the following information:

(a) The client's name;
(b) Any client food or medication allergies;
(c) The name of each medication prescribed for the client;
(d) The medication strength (i.e., 5mg/ tsp);
(e) The prescribing health care practitioner for each medication;

(f) The date that the medication was ordered and any date the medication was changed (including D/C date);
(g) Prescribed dosage for each medication;
(h) Scheduled time of administration for each medication;
(i) Prescribed route of administration for each medication;
(j) Prescribed instructions for crushing, mixing or diluting of specific medications, if applicable;
(k) The dates each medication was administered;
(l) The initials and signature of the medication assistance provider who assisted with medication administration;
(m) A record of any medication dosage refused or missed, documented by the medication assistance provider responsible for administering the scheduled dosage, by drawing a circle around the appropriate space on the MAR form and initialing it; and
(n) The reasons for not administering a medication, annotated and initialed by the medication assistance provider in the comments section on the MAR form using the following system, or a comparable numbering and coding system containing the same information: 1 – home, 2 – work, 3 – ER/hospital, 4 – refused, 5 – medication not available (explain on back of MAR form), 6 – held by MD (explain on back of MAR), 7 – other (explain on back of MAR).

(2) Each client record must contain the following medication documentation readily available to the medication assistance provider and for Agency review upon request:
(a) Completed MAR forms;
(b) A list of potential side effects, adverse reactions, and drug interactions for each medication;
(c) A record of drug counts for each controlled medication;
(d) Written determination by the client's physician that the client requires assistance with the administration of his or her medications; and

(e) The original Informed Consent form permitting a medication assistance provider to assist with the administration of medication.
(3) The validated medication assistance provider or the provider's employer must maintain documentation that the medication assistance provider has completed an approved medication administration course and is currently validated as competent to assist with the administration of medication. *Specific Authority 393.501 FS. Law Implemented 393.506 FS. History–New 3-30-08.*

According to Florida Administrative code 65G-7.009 regarding Off-site Medication Administration:

(1) If a client will be away from a licensed residential facility or supported living home and requires during that time administration of medication by persons other than the medication assistance provider, the medication assistance provider must comply with the following requirements to assure that the client has appropriate medications during his or her absence:
(a) Provide an adequate amount of medication for administration of all dosages the client requires while away;
(b) Perform a count of the medication amounts provided to the client for administration during the absence and a second count of the medication amounts received upon the client's return;

(c) Record both medication counts in an "Off-site Medication Form," APD Form 65G7-08 (3/30/08), incorporated herein by reference. A copy of the form may be obtained by writing or calling the Agency for Persons with Disabilities, at 4030 Esplanade Way, Suite 380, Tallahassee, FL 32399-0950; main phone number (850) 488-4257.

(2) Medication may not be transferred from its original container to a weekly pill organizer or otherwise co-mingled unless the client's primary care provider determines that the client is able to self-administer that medication without supervision; in that case, only the client, the client's family member, or a legal guardian may transfer the medications from the original container.

(3) The medication assistance provider must provide the name and telephone number of a contact person and the name and telephone number of the client's prescribing practitioner to the person who will assist the client with medication administration while the client is offsite. *Specific Authority 393.501 FS. Law Implemented 393.506 FS. History–New 3-30-08.*

Basic Principles of Medication Administration

When you administer medications, there are some basic principles that must be followed such as:

- Providing privacy for the resident / patient.
- Perform hand hygiene/ wash your hands
- Always wash your hands before giving medications and wash hands again after you have given the medication to each resident/ individual.
- Effective communication is vital. Interact with the resident /individual and explain what you are going to do before you administer any medications.
- Answer the questions that the resident / individual has.
- Keep the resident /individual involved as much as possible in the process.

- When administering medication, you must give full attention to the task at hand (no distractions.

- Give the medications in a quiet location (free from noise /distractions).

- Checking vital signs (TPR BP) to measure or detect changes in normal body function.

- When you have questions or if you have a concern, or you are not sure about something, ALWAYS stop and ask for some assistance or clarification before you continue. Contact the appropriate supervisor or call the physician/practitioner.

- You cannot leave medications unattended (NEVER – not even for a few minutes).

CHECKING VITAL SIGNS

Measuring and Reporting Vital Signs

Vital signs are assessed or measured to check for changes in normal body function. They are also used to determine the resident's/ patient's response to treatment. Vital signs check also help you to recognize life-threatening situations and allows you to intervene appropriately. Vital signs, temperature, pulse, and respirations (TPR) and blood pressure (BP), will vary during certain limits within any 24-hour period. There are several factors that can affect vital signs.

Some factors that can affect vital signs include:

- Activity,
- Sleep,
- Drinking (hot or cold items),
- Eating,
- Weather condition,
- Exercise,
- Noise,
- Medications,
- Illness,
- Anxiety,
- Stress,
- Fear.

ACCURATE REPORT & RECORD

When assessing / checking vital signs;

Vital signs have to be accurately reported and recorded.

Changes in the vital signs

If there are changes in the vital signs (changed from the previous measurement) THIS MUST BE REPORTED to the supervisor /nurse immediately.

Normal range

Any vital signs that are above or below the normal range has to be reported ***immediately.***

Vital signs & equipment

Using a Stethoscope

A stethoscope is the equipment/ instrument that is used to listen to the sounds produced by the heart, lungs, as well as other body organs. The stethoscope can amplify the sounds within the body, so that they can be easily heard. The stethoscope has two earpieces that should fit snugly within the ears to block out external noise.

Blood Pressure (B/P)

Blood pressure is defined as the amount of force that is exerted against the walls of an artery by the blood.

Sphygmomanometer

Sphygmomanometer is the instrument that is used to measure the blood pressure.

Considerations when checking the blood pressure

Always choose the correct size of cuff. If you are using a blood pressure cuff that is too small or if the blood pressure cuff is too large for the resident's / patient's arm this may lead to an inaccurate reading,

When using an electronic BP machine, always check the device for accuracy according to the manufacturer's guidelines,

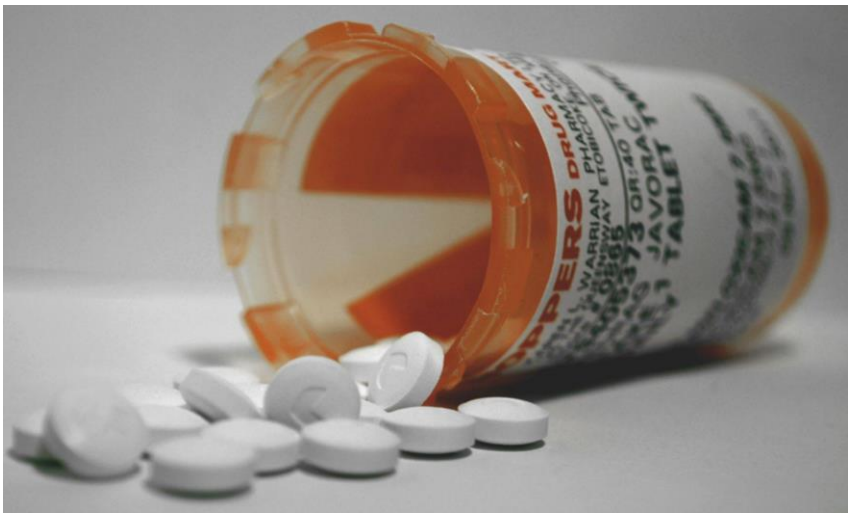
Always REPORT high and low blood pressures (follow the physician's order / facility's policy).

Factors That Can Affect Blood Pressure

Blood pressure can be affected by several factors and can change throughout the day / from minute to minute.

Some factors that can affect the blood pressure include:

- Pain,
- Age,
- Exercise,
- Stress /emotions,
- body size,
- Medications,
- Illness,
- Amount of blood in the system,
- Bleeding,
- Coughing.



Blood pressure has normal ranges.

The systolic pressure is recorded over the diastolic pressure. The average adult has a systolic pressure of 120 mm Hg and a diastolic pressure of 80 mm Hg.

To record this accurately, place the systolic pressure over the diastolic pressure as follows:

120/80 mm Hg.

When the blood pressure range is between 120/80 and 140/90 the condition is called prehypertension, which means the resident/ patient is at high risk for high blood pressure (CDC.gov 2014).

Some Terminologies

Diastole is the period of heart muscle relaxation

Diastolic pressure is the pressure within the arteries when the heart is at rest.

Hypertension is persistent blood pressure measurements that is above the normal systolic or diastolic pressures.

Hypotension is the condition in which the systolic blood pressure is below 100 mm Hg and the diastolic pressure is below 60 mm Hg.

Systole is the period of heart muscle contraction.

Systolic pressure is the amount of force that it takes to pump the blood out of the heart into the arterial circulation.

Checking the Pulse

Pulse rate is the number of heartbeats or pulses felt in 1 minute.

Count the number of heartbeats for one full minute;

For the radial heart rate, heart rate is measured at the thumb side of the inner wrist and

For apical heart rate, heart rate measured directly over the heart by using a stethoscope.

Pulse rate may also be obtained by using an electronic device.

Normal pulse rate range is 60 beats/minute to 100 beats/minute.

Some Terminologies

Pulse is the beat of the heart felt in the artery as a wave of blood passes through the blood vessel (artery).

Pulse deficit is the difference between the apical pulse rate and the radial pulse rate.

Checking Respirations

Respiration is defined as the act of breathing air into the lungs and out of the lungs (inhale /exhale).

Number of breaths the resident / patient takes per minute.

Normal range is 12 to 20 breaths per minute

One full breath is counted after the resident has inhaled and exhaled.

KEY POINTS

The resident /patient should be **unaware** that the respirations are being counted. If the resident / patient is aware they will change their breathing patterns and the assessment will not be accurate.

Position the resident /patient so that you can see rise and fall of the chest.

It is recommended that you count the respirations after taking the pulse, keep your fingers or stethoscope over the pulse site. The resident /patient will assume that the pulse is still being checked.

Check the respirations by watching the rise and fall of the chest, and count for 30 seconds, then multiply the number by 2 for the total number of respirations in ONE minute.

ALERT!!

If the resident /patient has an abnormal pattern, the respirations HAS TO BE COUNTED for 1 full minute.

Some Terminologies

Breathing air into the lungs – inhalation.

Breathing air out of the lungs - exhalation

Tachypnea: rapid (tachy) breathing (pnea) - the respiratory rate is usually greater than 24 respirations per minute.

Dyspnea is referred to as difficult, labored, or painful breathing.

Dyspnea difficult, labored, or painful
Difficult (dys)
Breathing (pnea)

Hyperventilation refers to respirations that are rapid and deeper than normal.
Hypoventilation refers to respirations that are slow, shallow, and may be irregular.

Apnea refers to the lack or absence of breathing

(Apnea) A= absence of

pnea = breathing.

Bradypnea is slow (brady) breathing (pnea); the respiratory rate is less than 10 respirations per minute.

Cheyne-Stokes refers to a pattern of breathing in which the respirations gradually increase in rate and depth and then become shallow and slow. Breathing may stop for a period between 10 to 20 seconds.

Checking body Temperature

Body temperature is defined as the amount of heat within the body that is a balance between the amount of heat produced and the amount of heat that is lost by the body.

Some factors that can affect body temperature include:

Activity,

food,

beverages,

weather,

Smoking.

Temperature can be measured using either the Fahrenheit or Celsius scale.

Normal body temperature in degrees Celsius or degrees Fahrenheit:

Oral- 97.6 to 99.6 F (36.5 to 37.5 C)

Rectal- 98.6 to 100.6 F (37.0 to 38.1 C)

Axillary- 96.6 to 98.6 F (36.0 to 37.0 C).

Information / Terminology

Common Abbreviations

Abbreviation means a shortened form of a word or phrase. Abbreviations can lead to some serious or life threatening errors, therefore there are guidelines in place. The Joint Commission has set guidelines and rules; all healthcare settings has to standardize abbreviations, acronyms and symbols that they are using. They are also required to adhere to a Do Not Use list.

Some abbreviations and their meanings are listed below.

ABBREVIATION and MEANING
a.c. =Before meals
ACL =Anterior cruciate ligament
ad lib= Freely
a/g ratio = Albumin to globulin ratio
AKA = Above the knee amputation
a.m. =Morning
ASA =Aspirin
b.i.d =Twice a day
BM =Bowel movement
BMP= Basic metabolic panel
BP =Blood pressure
BS =Blood sugar
Ĉ= with
CC= cubic centimeters
Cap =Capsule
C&S = Culture and sensitivity

CVA =Cerebrovascular accident
D.C. =Discontinue
Disp= dispense
DNR =Do not resuscitate
DVT= Deep venous thrombosis
ec = enteric coated
elix = elixir
ETOH =Alcohol
Ext =Extract
fl or fld =Fluid
g. or Gm. or g =Gram
Gr =Grain
gtt. =Drop
h. or hr. =Hour
H&H: = Hemoglobin and Hematocrit
H&P = History and physical examination
hs = At hour of sleep, bedtime
HTN= hypertension /high blood pressure
IM = Intramuscular
I.V. = Intravenous
L = liter
MAR = medication administration record
MEq =Milliequivalent
Min =Minute
Mg =Milligram
ML =Milliliters
NPO =Nothing by mouth
N/V = Nausea or vomiting
NTG =Nitroglycerin
O&P = Ova and parasites
O2 = oxygen
O.D.= Right eye
O.S.= Left eye
O.U.= Both eyes
Oz = ounce
ORIF = Open reduction and internal fixation
P= Pulse
p.c. =After meals
PERRLA = Pupils equal, round, and reactive to light and accommodation
p.m. =Evening
p.o. =By mouth
Post = after
prn =as needed
Pre = before
prn= as needed
q am= every morning

qh= every hour
q2h= every 2 hours
q3h=every 3 hours
q4h= every 4 hours
qid = four times daily
qhs=every night or at bedtime
qpm= each evening
R= respirations
R/O = Rule out
RLQ = Right lower quadrant
RUQ = Right upper quadrant
Š= without
SL = sublingual
SOB =Shortness of breath
Sol =Solution
ss. =One half
Stat =Immediately
SQ = Subcutaneous
Supp= suppository
susp. =Suspension
Syr. =Syrup
T= temperature
tab. =Tablet
Tbsp =Tablespoonful
Tsp = teaspoon
Tid =Three times a day
Tinc =Tincture
TPR= temperature /pulse /respirations
Top =Topically
tsp. =Teaspoon
UA or **u/a**= urinalysis
ung. =Ointment
VS = vital signs
Wt= weight

The Do Not Use List includes some of the following:

Do Not Use **u**, or **for unit**. Mistaken some times for zero. You must write “unit”
Do Not use iu for international unit. Mistaken for IV. Write “international unit”
Do Not Use Q.D., QD, q.d., qd (Daily). Mistaken for each other. Write “Daily”.
Do Not Use Q.O.D. QOD, q.o.d., qod (every other day). Write “every other day”
See the complete Do Not Use List (The Joint Commission
http://www.jointcommission.org/assets/1/18/Do_Not_Use_List.pdf**)**

Rights of Medication Administration

1. The Right Patient

ALWAYS check to make sure that you have the Right patient.
Two patients may have the same name, and the same birthday
Patients may be moved to a different room
Patients may switch beds within the same room

Identification Procedure

ALWAYS verify the name of the patient by getting:

Two verbal identifiers: *Ask the patient to state their full name*,
and their *Date of Birth (DOB).*

Check the ID bracelet very carefully
Check the identity of the patient before you help him/her with their medication.
It is mandatory for you to use *at least two (2)* identifiers- Use 2 methods to identify the patient. If you assist the wrong patient this may cause a fatal error.
You ***cannot*** use a bed or room number as identifiers. A patient may accidentally enter a room and even go to bed in the wrong room.

Some identifiers include the patient's:

- First, middle and last name,
- DOB – Date of Birth (month, day and year),
- Photograph,
- a medical record number/ code number given to that patient
- social security number.

Do NOT help with any medication if you cannot identify the patient. Tell your supervisor. It is an error when a patient takes another patient's medication. All medication errors have to be reported.

TIPS - RIGHT RESIDENT

Even when you know the resident / patient very well, mistakes can happen.

When medications are being administered to more than one resident /patient in a setting, or if you are preparing medications for more than one resident/patient at a time, you can easily become distracted and give the medications to the wrong resident /patient.

To make sure that you administer medications to the right resident /patient:

- Always prepare medication for one resident/patient at a time.
- Give full attention at all times when you are administering medications
- ALWAYS compare the resident's /patient's name on the prescription label, the
- medication order and the medication log (they should match).
- Do not stop to do something else while you are giving medications.
- Administer the medication to the resident/patient ***as soon as you prepare it.***
- Do not talk to others when you are administering medication.
- Let others know not to talk to you when you are administering medication.

2. The Right Medication

The right medication has to be the name of the medication ordered by the physician
The medication may belong to someone else in the facility /residence,
so ALWAYS verify the medication label.
Do NOT use any medication that has a label that you cannot read.
Do NOT use any medication unless it has a complete label.
Read and check the label against the medication record at least three times
(the 3 checks)
If the resident / patient say they do not take this medicine, STOP. Do not help. Report this to your supervisor. It is an error if a patient takes the wrong medication. This must be reported.

TIPS - RIGHT MEDICATION

To make sure that you are administering the right medication, you need to:

- Read the medication order.
- Make sure that the medication name on the Medication order matches the medication name on the label.
- Read the medication label carefully; some medications have more than one name: a brand name and generic name.

- Read the medication log carefully. Make sure that the medication name on the label, the medication order and medication log match before giving the medication.

- Carefully check the spelling of the medication.
- If you have any doubt about whether the medication name is correct, STOP and call the supervisor or the pharmacist before you administer the medication.

- Look at the medication carefully, if there is anything difference in shape, size, or color of the medication, ALWAYS call the pharmacist before you administer the medication; sometimes the pharmacy will send a different generic brand of the medication. However there might be times when a medication looks different because you have the wrong medication.

3. The Right Dosage

The resident / patient needs to take the right dosage (the amount of medication) that is ordered by the Physician or the Health care Practitioner, to achieve the desired effect of the medication. Taking too much of the medication can lead to an overdose. Take steps to reduce overdose errors. Taking too little of the medication will not achieve the desired effect of the medication. Follow the systems in place – for triple checking dosages. Make sure the medication is documented /recorded, so that a second dose is not accidentally given. Giving a half of the ordered dose of medication is also not the correct dosage. Not giving the right amount of the drug is also a medication error and has to be reported.

TIPS - The right dose

The right dose - how much of the medication you need to administer to the resident/patient at one time.

To determine the dose, you will need to know the **strength of each medication**.

For liquid medications, you will need to know the strength of the medication in each

Liquid measure (the dose equals the strength of the medication multiplied by the amount).

FOR EXAMPLE - MEDICATION LABEL:

RX #234561

TFSI Pharmacy
55 LAKELAND HILLS Street
Madison, Florida (863)000-0000

Mary Broad **Disp: 01/12/2017**

Lisinopril 20 mg Tab **(amt/supply 90)**

Take 2 tabs by mouth twice a day for high blood pressure

Dr. Felicia Woods

Lot# 096-00012 **Exp. Date: 11/20/2018 Refills: 3**

The strength of each Lisinopril tablet is 20 mg.

The dose is 40 mg twice daily.

Strength (20mg per pill) X Amount (2 tabs)= 40mg

Tips to avoid OVERDOSE!

Check with the pharmacist or the supervisor about any order that requires administering **more than 3 tablets or capsules of the same** medication in one dose.

MEDICATION / PRESCRIPTION LABEL:

CAUTION!**!!!** Nurses, CNAs, and unlicensed staff cannot change a prescription label.

Medication labels need to have:

(1) The patient's name,
(2) The name and form of the medication,
(3) Strength / Dosage and route of the medication,
(4) Quantity of drug
(5) Time / frequency the medication should be taken
(6) Any directions for use or special precautions
(7) Prescription date and number of refills
(8) Prescriber's / physician's name
(9) Pharmacy name, address, and phone number
(10) Prescription (Rx) number for pharmacy filing
(11) Expiration date/discard date/do not use by date

For example:

Pharmacy ALX
123 LANE
MB, Florida 33123 (863) 000-0000
Rx 7107465 *fill date orgRx 04/21/2015*
Patient: Felicia Br 4/21/2015
Take one Tablet by mouth three times daily *with food*
Amoxicillin 500mg TAB
Dr. Michel Conry
QTY 21
Discard after 04/20/2016
No refills- Dr. must Authorize

Some labels will also include the patient's address.

Examples of AUXILIARY Labels/ instructions:
Take With Food,
Shake Well Before Using
May Cause Drowsiness
Take With Plenty of Water
Do Not Drink Alcohol
Take Before or After Meals

Food and Drug Administration (FDA) announced new prescription drug labeling requirements that will clarify how medications might affect women who are pregnant or breastfeeding and men and women of reproductive potential. The final **"Pregnancy and Lactation Labeling Rule**" removes the previously used pregnancy letter categories – A, B, C, D, and X – and places information into three main categories:

- **Pregnancy:** Labor and delivery guidelines now fall under this category, which also now includes information for pregnancy exposure registries. Such registries track data on the effects of certain approved medications on pregnant and breastfeeding women.
- **Lactation:** Previously labeled "Nursing Mothers," this category provides information such as how much drug is secreted through breast milk and the potential effects on a breastfed infant.
- **Females and Males of Reproductive Potential:** This is a new category that includes information on how a certain medication might affect pregnancy testing, contraception, and infertility.

The new labeling changes went into effect on June 30, 2015. Over-the-counter medication labels will not be affected. The new rules are available for viewing online through the *Federal Register.*

4. The Right Time

Timing is also very important when administering medications. Some medications need to reach a consistent level in the bloodstream to work effectively. This means that the medications need to be taken at the right times to keep that level of medication in the system. Usually, the liver or kidneys will remove the medication from the blood and high levels of the medication can build up in the system which can lead to toxicity if that dose is taken too soon. Also, if the patient miss a dose or wait too long between the doses, there might not be enough of the medication in the body to work effectively.

The standard acceptable ***time is within one hour before or after*** the scheduled administration time or it is considered a medication error.

TIPS - RIGHT TIME

- Medications need to be given at the time of day that is written on the medication order.
- Some medications have to be administered only at specific times of the day.
- Some medications have to be given before meals
- Some medications need to be given one hour after meals
- Some medications have to be given at bedtime for the best effect.
- If no specific time is written on the medication order, notify the supervisor /charge nurse physician.
- Always compare the time on the prescription label, the medication order and the medication log (whenever they do not match - STOP and verify ALWAYS ask).

5. The Right Route

The right route / method of medication administration (how and where the medication goes into the body).

Some medications are taken into the mouth and swallowed, others enter the body through the eyes, nose, ears, vagina, rectum, ears, lungs, through a tube in the stomach, by injection or other routes mentioned in this course.

Check the medication label to find out the right route. If the medication label states by mouth and the medication is placed in the ear. This is an error and must also be reported.

TIPS - Right Route

Always compare the route of administration on:

- the prescription label,
- the medication order and
- the medication log.

6. The Right Documentation

The right documentation involves properly recording /documenting each dose offered on the patient's record. Document **only *AFTER*** you have assisted with the ordered medication. Never document that you assist with a medication before you have actually helped the resident /patient. You may be called to another task and another individual takes over; your documentation ahead of the task will stop the other nurse/personnel from assisting, because the documentation reflects that the patient has already received the medication when he/she did not. Document the time, route, and any other specific information, including refusal of medication. If the patient does not want to take the medication, notify the supervisor. Patient has a right to refuse; the supervisor will make sure that follow up is done with the resident /patient and the physician as needed.

Appropriate documentation is also required when the medication is not given; Always document when a medication ordered was not administered and the reason it was not administered.

TIPS FOR RIGHT DOCUMENTATION

- Every time a medication is administered, it has to be documented.
- The documentation of medication administration has to be done at the time that you give the medication.
- Always complete the documentation that is required on the medication log (MAR)
- Complete documentation using ink pen (blue ink or black ink) follow your facility's policy
- Never use pencil or white out
- DO NOT cross out or write over any documentation.
- If you make a mistake when you are documenting on the medication log, ***circle the mistake***, then write a note on the log to explain what happened.

7. Right Reason

Confirm the rationale for the ordered medication. Is the patient taking the Tylenol for the headache or for fever? If you are not sure of the reason for a medication, ALWAYS ask. Ask the doctor, pharmacist or the nurse. Knowing the reason for the medication will help you to check the patient for the desired effect. Always document your monitoring of the resident /patient and any other interventions that are applicable.

Monitor for the right response; this also involves observation of what happens afterward. Professionals are trained to know how medications move through the body, what the effect of the medication is, and what adverse effects may occur. Adverse effects may include allergic reactions to the drug, overdose of the drug, and drug interactions between multiple drugs.

Follow up to ensure resident / patient had the right response – does the resident /patient verbalize improvement; reports no further headache or on vital signs assessment there is no fever? Are there any adverse effects?

Common Routes of Medication Administration

Route of medication administration refers to the path by which the medication is taken into the body. Medications are made in various forms and for administration by different routes. Some routes may be unsafe or ineffective. This can be due to the patient's health conditions, such as unable to swallow, dehydration or other factors. Some medications can be administered by more than one route, for example Tylenol is available in tablet form, suppository and also in liquid etc. The tablet may be taken by mouth in tablet or liquid form; however, a child might not be able to take the tablet and able to take the liquid and/ or a suppository may need to be given by a nurse per rectum if the patient is unable to take the medication by mouth. The medication order has to state the form and the route that the physician wants the patient to take.

Route of administration will vary depending on:

- The property of the medication,
- The action of the medication,
- The desired effect,
- The patient's physical wellbeing,
- The patient's mental status,
- The patient's age.

SOME ROUTES OF ADMINISTRATION INCLUDE:

- oral route (taken by mouth)
- sublingual route (under tongue)
- buccal route (inside the cheek)
- otic (ear) medication is placed in the ear canal
- ophthalmic (eye) medication is placed in the pocket of the eye created when the lower eyelid is gently pulled down
- topical (medication is applied to the skin)
- nasal route (nose) –medication is placed in the nostril
- vaginal route (medication is inserted into the vagina)
- rectal (by rectum) medication is inserted into the rectum
- inhalation (by inhaling)medication is inhaled into the lungs
- nasogastric tube (tube in the nose to the stomach)
- gastrostomy tube (tube in the stomach)
- intramuscular (into the muscle)
- subcutaneous (under skin) medication is injected into the fat with a syringe
- intradermal (in the skin)
- intravenous (into the vein via an I.V)
- transdermal (through the skin e.g. a patch on the skin) medication is placed and affixed to the skin.

Common Dosage Forms of Medications

Forms of medications

Medications are made in various forms meaning that they are available in more than one form. Therefore, a tablet cannot be given if the order says liquid.

Different forms of medications include:

Capsule -

Regular and sustained release Capsule,

Available In a gelatin container that may be hard or soft.

Tablet -

Hard / compressed medication in oval, round, or square shape

Some tablets have enteric coating or other types of coatings, which delay release of the medication and should not be crushed or chewed.

Suppositories -

Suppositories may be administered by rectal and vaginal,

coned shaped, small solid medicated substance,

Melts at body temperature,

To refrigerate as directed by the manufacturer.

Liquid –

Different types of liquid medications:

Solution (a liquid containing dissolved medication)

Suspension (a liquid holding undissolved particles of medication)

The suspension must be shaken before measuring and administering to the resident.

Elixir –
Elixir – a sweet alcohol based solution in which medications are dissolved

Syrup –
Syrup is a liquid medication dissolved in a sugar water to disguise its taste

Inhalant

The medication is carried into the respiratory tract using oxygen, air or steam.

Inhalants may be used (PO) orally or nasally.

- Topical medications

Topical medications

Topical medications are applied directly to the skin surface.

Topical medications include the following:

Lotion;

a medication dissolved in liquid for applying to the skin

Ointment;

a semisolid substance for application of medication to the eyes or skin

Cream;

semisolid preparation holding medication so it can be applied to skin

Paste;

a semisolid substance thicker and stiffer than an ointment containing medications.

Powder

A fine, ground form of medication that may be used as on the skin or may be swallowed.

Shampoo;

liquid containing medication that is applied to the scalp and hair

Patches /transdermal;

medication encased in a square, round, or oval disc that is affix to the skin.

Aerosol sprays;

solution that holds the medication suspended until it is dispensed as a mist to spray on the skin.

Equipment and Supplies Used During Administration of Medication

Some equipment and supplies that are used during administration of medication includes:

- MAR for each resident /patient
- Medication cart
- Blood pressure cuff
- Stethoscope
- Blood glucose meter
- Water cups
- Water for resident to drink when taking PO medications
- Food (pudding, applesauce - to use when administering crushed medications)
- Calibrated plastic cups,
- oral syringes

- Droppers for oral liquid medications
- Soufflé cups for oral medications in pill or capsule form
- Alcohol wipes for cleansing with injections, or to clean equipment stethoscope or for accu checks etc
- Sharps container
- Lubricant for use with suppositories
- Insulin syringes (for insulin administration)
- Band-Aids (use with injections)
- Gloves (use when coming into contact with body fluids /blood such as administering injections, contact with mucus membranes; administering vaginal /rectal suppositories
- Paper towels, soap or alcohol based hand rubs to use before preparing medications or before administering medication to each resident/patient and after administration of
- medication to each resident/patient.

Medication Errors

According to Florida Administrative code 65G-7.006 regarding Medication Errors:

(1) A “medication error” is any of the following actions:
(a) Administration of a wrong medication;
(b) Administration of a wrong dose;
(c) Administration of medication via the wrong route;
(d) Administration of medication for any symptom, illness, or reason other than the one for which the medication was prescribed;

(e) Failure to administer medication or assist with self-administration within 60 minutes of the prescribed dosage time;

(f) Administration of a medication, or the provision of a self-administered medication, to the wrong client;

(g) Failure to immediately and accurately document administration on the MAR;

(h) Failure to fill newly prescribed medications within twenty-four hours of receipt of the prescription;

(i) Failure to promptly refill current medications, resulting in one or more missed doses of medication;

(j) Administration or assistance with self-administration of an expired or improperly labeled medication; and

(k) Failure to conduct an accurate medication count for controlled medications.

(2) **Immediately following a medication error, the medication assistance provider or facility administrator must take the following steps:**

(a) Notify any supervisory personnel;
(b) In the case of administration of a wrong medication or a wrong dosage, observe the client closely for a minimum period of 20 minutes after the medication was administered or self-administered, immediately report any observed changes in the client's condition to the prescribing health care practitioner, and call 911 to request emergency services if the client exhibits respiratory difficulty or other potentially life-threatening symptoms;

(c) Notify the client's prescribing health care practitioner of the error, request that the practitioner prepare and fax a medication directive addressing the error to the client's home, facility, or pharmacy, and document the client's health care practitioner's response; and

(d) Fully document all observations and contacts made regarding a medication error in a "Medication Error Report," APD Form 65G7-05 (3/30/08) incorporated herein by reference, and place a copy of the Report in the client's file. A copy of the form may be obtained by writing or calling the Agency for Persons with Disabilities, at 4030 Esplanade Way, Suite 380, Tallahassee, FL 32399-0950; main phone number (850) 488-4257. An electronic copy of the form is available at http://apd.myflorida.com/medication/forms.

(3) If a medication error occurs in a facility, the medication assistance provider must submit copies of the Report to the facility administrator and to the Agency area office within 24 hours of discovering the error.

(4) If a medication error occurs in a client's home and the medication assistance provider committed the error, the provider must submit a Medication Error Report to the Agency area office within 24 hours of the discovering the error and maintain a copy of the report in the client's file or other location easily accessible for review.

(5) Following a medication count, the medication assistance provider must report a discrepancy in the accounting of controlled substances by 5:00 p.m. of the next business day following discovery of the error to the Area office and, if applicable, to the facility supervisor.

(6) If the Agency Medical Case Manager determines that a medication assistance provider's medication error justifies corrective action, including additional training, the Area Office will notify the provider in writing of the necessary corrective action plan, including a specific and reasonable timeframe for completion of the corrective action plan. If the medication assistance provider fails to comply with the corrective action plan, the Agency will revoke the medication assistance provider's validation, subject to the provisions of Chapter 120, F.S.

Importance of Medication Administration and Resident's Rights

Inform the resident/ patient about the procedure before performing the procedure.

Answer resident/ patient's questions about the medication

Respect the resident/patient (address him/ her with respect)

Do not interrupt the resident/ patient while eating for the administration of medications, such as oral inhalers and eye drops

Do not administer medications outside the resident's room that require privacy and removal of clothing, for example dressing treatment and dressing changes, vaginal and rectal administrations.

Do not administer injection outside resident/ patient's room (provide privacy).

Do not awaken resident/ patient to administer medications that should be scheduled or could be administered at other times.

Do not use restraint for staff convenience.

Do not administer medications when he resident/ patient is receiving personal care or in bathroom.

Never force a resident/ patient to take a medication.

Refusal of medications (resident/patient s have the right to refuse medications).

Follow the facility's policy and procedure when a resident refuses medications (policy and procedure; update the physician in a timely manner based on resident's/patient's condition and the medication.

Always knock on closed doors before entering

Provide privacy for the resident/ patient.

Medication Allergy

Some medications are not allowed to be used or they are contraindicated for some patients. Therefore, the medication should not be given to the patient. Other medications may only be used with some patients when they are used with extreme caution and with frequent monitoring.

A very common contraindication is an allergy or sensitivity to the medication. Always check the patient's medical record for allergies and ask the patient before you assist. Sometimes you will observe NKA on the patient's medical record /chart; this indicates that the patient has no known allergies. Sometimes you may observe NKDA- this means no known drug allergies.

ALLERGY

Allergy involves hypersensitivity or an exaggerated response of the immune system, often to common substances such as medication, pollen or foods. A rash or a life threatening reaction such as Anaphylaxis can occur if the patient takes a medication that he/ she is allergic to.

Some types of Allergies are:

- Food allergies e.g. peanuts, peanut butter, shellfish
- Drug allergies
- Latex allergies e.g. latex gloves
- Seasonal allergies
- Animal allergy

Some signs of Allergic reactions include:

- Itching , Hives
- Redness of the skin
- Dyspnea, Shortness of Breath (SOB)
- Problems with breathing
- Throat swelling
- Loss of consciousness
- Irregular heart beat /rhythm
  Decrease in the blood pressure (BP)
  Abdominal discomfort / cramps
- Nausea and / or vomiting
- Death

Anaphylaxis

Anaphylaxis is a severe, whole-body *allergic reaction* to a chemical or substance that has become an allergen. An allergen is a substance that can cause an allergic reaction. Some drugs such as, Penicillin, aspirin, x-ray dye, morphine and others may cause an anaphylactic-like reaction when the patient is first exposed to them. Anaphylaxis is an emergency that requires medical attention immediately. Call 911 immediately.

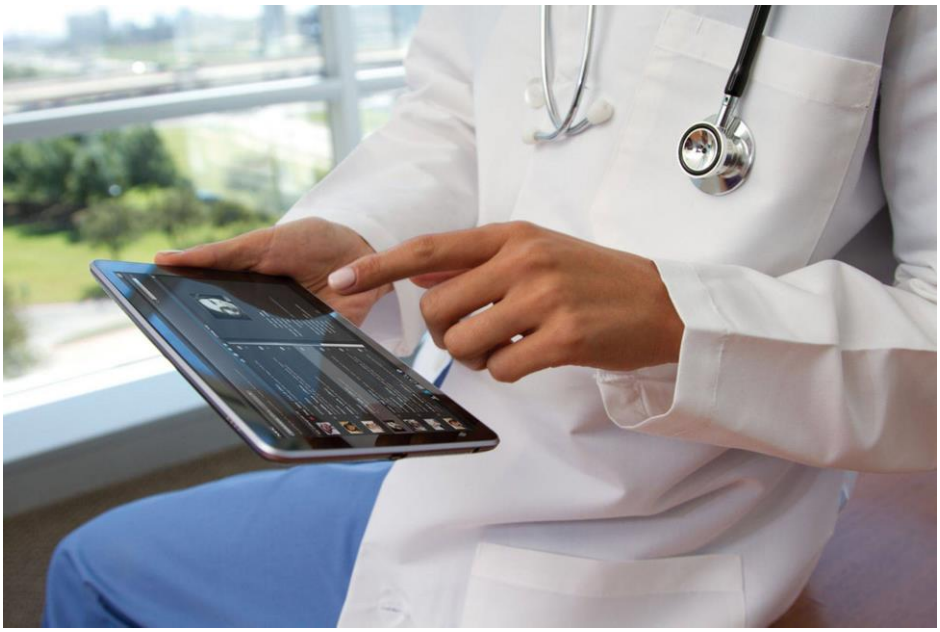
Symptoms will develop very quickly, often within seconds or minutes. They may include:

- Difficulty breathing
- Facial swelling
- Redness of the skin
- Itchy /hives
- Light headed / dizziness
- Loss of consciousness
- Swelling of the face and eyes
- Chest tightness/ discomfort
- Palpitations
- High pitched abnormal breathing sounds
- Wheezing
- Coughing
- Speech becomes slurred
- Difficulty swallowing
- Swelling of the tongue
- Restlessness / anxiety
- Diarrhea
- Abdominal pain
- Nausea or vomiting
- Death

ALERT !!

Upon admission, document ALL known allergies and if there are no known Allergies, this also must be documented.

All information on allergies should be reported to the pharmacy and to the physician and this information must be recorded in the resident's record.



Recognizing and Reporting Side Effects

ADVERSE REACTIONS / SIDE EFFECTS

Side effects

A side effect is also known as an adverse effect, adverse event, or undesirable secondary effect when a medication or treatment goes beyond the desired effect and causes or leads to a problem (an undesirable secondary effect). Some side effects are not life threatening but others can be life threatening.

Side effects vary for each patient, and depend on different factors such as;

- the patient's general health,
- age,
- the stage of their disease,
- weight and
- Gender.

Adverse drug reactions

Adverse drug reactions are serious and they can also lead to death. Some medications also have toxic effects. Learn about the possible adverse drug reactions, side effects and the toxic effects of all the medications that your patient is taking so that you can report them.

DOSAGES/ DOSES

All medications have prescribed amount or dosage ranges for the adults and for children. Older patients are at greater risk for adverse drug events because of the metabolic changes and decreased medication clearance that is associated with the aging process. Some adult dosages may be lowered for the older patient because they are more susceptible to adverse medication reactions, side effects, over dose and even toxicity. Adolescents can take the adult dosages. Children are given medications with a dose that is based on their body weight.

Toxicity

Toxicity is the degree to which a substance “a toxin” can cause harm to humans or animals. Acute toxicity involves the harmful effects in an individual or organism through short-term exposure. Subchronic toxicity is the ability of a toxic substance to cause effects for more than one year but less than the lifetime of the exposed organism. Chronic toxicity is the ability of a mixture of substances or a substance to cause harmful effects over an extended time period, usually upon continuous or repeated exposure, that can sometimes last for the entire lifetime of the exposed organism/ individual.

Residents /patients may experience various side effects from taking certain medications. Always monitor for, report and document side effects.

Side effects may include:

- Changes in alertness
- Changes in behavior
- Changes in appetite/ eating
- Changes in swallowing
- Changes in mobility

- Skin rashes
- and others side effects not listed here.

When there is a change in the resident/ patient, ALWAYS follow the facility's policy regarding what to do and who to contact, which may include:

- Notifying the supervisor, health care professional / physician.

Medication interactions

Some medications may interact with other medications, various herbs, foods, supplements and drink for example; alcohol. Medication interactions can cause the medication that the patient is taking, to be less effective, or cause unexpected side effects, or cause an increase action of a particular medication. Some drugs interaction can be very harmful to the patient. Always read the medication label for every prescription and nonprescription medications.

Take the time to learn about the medication interactions. You will reduce the risk of potentially harmful medication interactions and / or side effects.

Medication interactions fall into three categories:

Drug to drug interactions

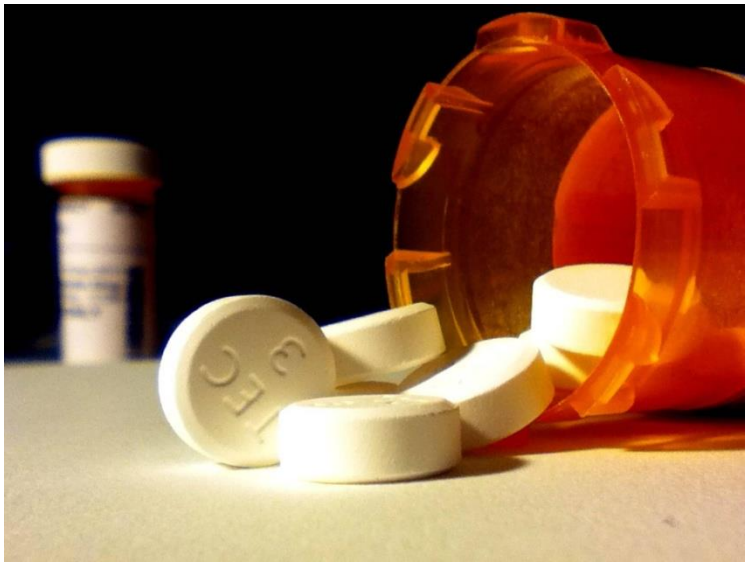
Drug to drug interaction occur whenever two or more medications react with each other. This drug-drug interaction may cause the resident /patient to experience an undesired side effect or reaction, for example, resident/ patient who takes a blood thinner e.g. Coumadin and then takes aspirin for a headache will increase the risk of bleeding.

Drug to food/beverage interactions

Drug to food / beverage interactions result from medications reacting with the food or drink. For example, having alcohol with some medications may cause the patient to feel sleepy or slow his/ her reaction.

Drug to condition interactions

Drug to condition interactions may occur when the patient has an existing medical condition / disease that makes some medications potentially harmful. For example, residents /patients with high blood pressure may experience an undesired reaction if he/she takes a cough or decongestant medication.



Section 2

Medication Orders

The Written Physician Order
A prescription (Rx) is the written order to the pharmacist listing the name and quantities of drugs or ingredients to be mixed and/or dispensed to a specific patient or resident including the directions for use. A Physician/ Doctor or another qualified individual, such as a nurse practitioner (ARNP), must write a complete Order. The order has to be legible/ clear – able to read and complete for the medication before it can be administered or taken.

A complete order must have the:

- The Name of the patient
- The name of the medication,
- Strength/ Dose of the medication,
- The form of the medication,
- Quantity of drug,
- The route of administration,
- time the medication should be given
- or frequency that the medication should be taken,
- The date and time of the order
- signature of the MD or nurse practitioner who order the medication

For example:

Date ordered	PHYSICIAN'S ORDER
04/21/2015	Patient: Felicia Br **Amoxicillin** *500mg* **TAB # 21** Take **one** Tablet by **mouth** ***three times daily*** *with food*
	Signature of Physician: *Dr. Michel Conry* *Date: 04/21/2017* Time: *10am*

There are various formats of Physician's order but they all have to include the factors that are listed above to ensure that the order is complete.

TIPS REGARDING MEDICATION ORDERS

- An order is NEEDED to administer, to change or to discontinue medications and treatments
- KNOW the components of a medication order
- Contact the Physician / prescribing health care provider if the order is not clear or legible (you cannot guess)
- If the medication order is not complete or if the medication order is not clear on how to administer the medication, you need to contact the supervisor or physician.

Form Used to Transcribe Medication Orders

Medication Administration Record (MAR)

Medication administration record - the form onto which medication orders are transferred.

Every resident /Patient has a medication administration record (MAR)

This has a record of all medications to be administered

This has a record of all staff who administered medications

This has a record of all medications not administered and the reason.

Transcription of orders onto the MAR

To transcribe the order means to write down the order or copy medication or treatment orders onto the Medication administration record (MAR).

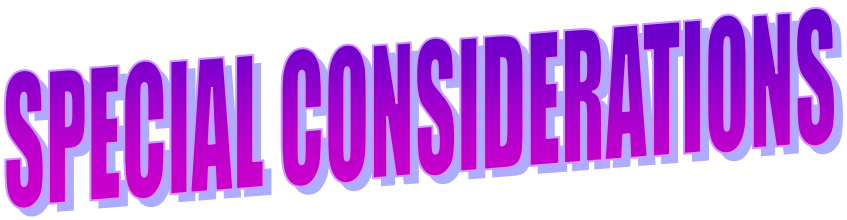
Medication orders are transcribed copied onto the Medication administration record (MAR) when the order is received or written.

Transcribe or write out completely, all the components of the medication order.

Sign or Initial and date orders written on the Medication administration record (MAR).

Always count the number of dosages to be administered; **NOT the number of days** when you are calculating **stop dates** for medication orders that have been prescribed for a specific time period.

Do not schedule PRN orders for administration at specific times (PRN orders are only administered when resident /patient needs the medication for a specific circumstance for example, Administer PRN fever (therefore administer when resident /patient has fever – and stay within the specific hour requirement for example every 4-6hr).



Discontinuation of an order

To stop or discontinue a medication a discontinue order must be obtained unless the physician or prescribing practitioner has already specified the number of days or dosages to be administered.

ACTIVITY: Medication Label

Look at a medication label provided by a pharmacy.

LOCATE the following information on the label:

Prescription number

Name of the Medication

Medication strength

Expiration date

Date Dispensed

Quantity /amount dispensed

Directions for use

Name of Pharmacy that dispensed the medication

Equivalency statement - this is included when the brand or medication name dispensed is different than the brand or the medication name that is prescribed.

Directions on medication label & MAR

ALWAYS CHECK THE DIRECTIONS ON MEDICATION LABEL from the pharmacy against the MAR.

(If not the same information or there is a difference between the information on the MAR and the medication label, check the order in the resident's /patient's record.

Section 3

Medication Administration

Gather the appropriate equipment and supplies

The equipment and supplies that you will need will depend on medication that needs to be administered.

Some equipment and supplies that are used during administration of medication includes:

- MAR for each resident /patient
- Medication cart
- Blood pressure cuff
- Stethoscope
- Blood glucose meter
- Water cups
- Water for resident to drink when taking PO medications
- Food (pudding, applesauce - to use when administering crushed medications)
- Calibrated plastic cups,
- oral syringes
- Droppers for oral liquid medications
- Soufflé cups for oral medications in pill or capsule form
- Alcohol wipes for cleansing with injections, or to clean equipment stethoscope or for accu checks etc
- Sharps container
- Lubricant for use with suppositories
- Insulin syringes (for insulin administration- licensed personnel)
- Band-Aids (use with injections)
- Gloves (use when coming into contact with body fluids /blood such as administering injections, contact with mucus membranes; administering vaginal /rectal suppositories
- Paper towels, soap or alcohol based hand rubs to use before preparing medications or before administering medication to each resident/patient and after administration of medication to each resident/patient.

Keep supplies and equipment clean (medication carts, pill crusher…).

Infection Control

Infection control refers to guidelines / regulations that are designed for educating, reporting, monitoring, managing and isolating healthcare related and/or community acquired infections. Therefore, infection control measures are important to control, eliminate or minimize employee exposure to bloodborne pathogens and communicable diseases.

During Administration of Medication, Infection Control guidelines include:

Always use sanitary technique when preparing or pouring medications into the container

Avoid contaminating the medication;

NEVER touch medications (contaminate), ALWAYS pour the medication from the original medication container into the appropriate medication container and give the medication to the resident/ patient in the container.

DO NOT use your hands to administer the medication

DO NOT pour medication in the resident/ patient's hand.

Observe Standard Precautions

Perform hand hygiene; always wash hands with soap and water or use an alcohol-based hand rub if hands are not visibly soiled.

Wear gloves whenever there may be exposure to mucus membranes or to bodily fluids for example, inside of the nose, eyes etc

ALWAYS wash your hands before and after removing gloves

Wear gloves when you need to administer transdermal products such as Duragesic patches or Nitroglycerin patches (when you apply or remove these patches)

Licensed personnel –

- Use 70% alcohol to clean the tops of medication vials before inserting a needle into the vial
- Never administer medications from the same syringe to multiple residents/ patients (even after the needle has been changed).
- NEVER reuse a syringe to enter a medication vial.
- DO NOT recap or break needles.
- NEVER administer medications from single-use vials, bags, ampules, or bottles to more than one patient /resident.
- Immediately dispose of used needles and syringes in a sharps container that is puncture-resistant, and leak-proof.

Hand Hygiene /hand washing

Use adequate soap, make a lather and continue rubbing for ***15-20 seconds***. To wash for the correct time, sing -Happy Birthday to You (two times).

If soap and water are not available, you can use an alcohol based hand rub to clean your hands.

TIPS - to prevent the spread of infection

Keep the fingernails clean and short,

AVOID wearing fake nails or nail extensions (they can hide germs under fingernails)

Remove jewelry/ rings (germs can adhere to jewelry).

Wearing Gloves

Gloves come in different sizes.

Wear appropriate size gloves (should be comfortable; not too loose and not too tight).

Wear gloves when the possibility of contact transmission may occur, when hand contact with body fluids or blood is anticipated, or when handling items that are contaminated.

Wear gloves when possibility of contact with mucus membranes, Inside of the mouth, nose.

Wear gloves when possibility of contact with non-intact skin such as cuts or sores.

Wear gloves when providing/assisting with perineal care; genitals and buttocks.

Wear gloves when performing a finger stick for blood sugar check.

Wear gloves if you have open cut on your hands.

Gloves are worn once; then discard of in the appropriate receptacle

If gloves become dirty or torn, change them

Gloves are made of different materials, such as latex or vinyl

If resident/ patient is allergic to latex; wear non-latex gloves

When wearing gloves, work from a clean area, before touching

contaminated area.

Always remove gloves carefully; avoid touching your skin or clothing with the dirty (contaminated) sides of the gloves

Do not touch anything with dirty gloves (this contaminates the object and some else might touch the same object without gloves).

Change gloves between each patient procedure

Identify Residents/ Patients Before Administering Medications

Common methods used for identifying residents/Patients before administering medications include:

- ID Band/bracelet
- Photographs of residents /patients in the medication administration record
- Photographs need to be kept updated (needs to have the name of the resident/patient on it).

The medication administration record (MAR) and the Medication Label

The medication administration record (MAR) is designed to promote safe medication administration.

The medication administration record (MAR) is designed to promote accurate medication administration.

The information on the medication administration record (MAR) and the medication label should match (sometimes the MD may order changes in directions).

The information on the medication administration record (MAR) must be written clearly.

The information on the medication administration record (MAR) must be promptly updated when there are changes in medication orders (changes in directions).

NOTE

Use the medication administration record (MAR) every time you prepare and administer medications.

Do Not rely on your memory, when administering medications (use MAR).

Compare the medication label to the medication administration record three times to make sure the medication is labeled for the resident /patient.

Check, check & check…

The 3 checks:

1. Complete the 1st check when you remove the medication container from where it is stored

2. Complete the 2nd check just before or after opening the medication and preparing it for the patient /resident.

3. Complete the 3rd check after pouring the medication and before the medication is administered to the patient /resident.

ALERT!!

ALWAYS compare the medication name on the prescription label, the medication order and the medication log (if they do not match –ALERT!! something is wrong).

Timing of Medication Administration

As mentioned earlier timing of medication administration is very important.

Some medications are ordered to be administered on an empty stomach.

Some medications are ordered with timing that relates to meals:

Administer before meals (generally administered within 30 minutes before the patient / resident eats a meal).

Some medications are ordered to be administered with meals (generally administered when the patient /resident is eating meal or immediately after finishing the meal.

Some medications are ordered to be administered after meals (administered after the patient /resident has finished eating meals up to 30 minutes after meal).

Medications should **NEVER be omitted** without contacting the supervisor, charge nurse, physician or the prescribing practitioner.

With the medication pass, patients /residents should receive their medications ***within one hour before and one hour after*** the scheduled administration time that is on the medication administration record (MAR), **EXCEPT** in cases where the medication is prescribed for administration in relation to the meal and also for Insulin and other medication ordered for specific time of administration.

If you are not sure about administering a medication because it is outside the designated time frame:

ASK the supervisor, charge nurse regarding administration of the patient's /resident's medication; then determine if the physician or the prescribing practitioner should be called.

Documentation of Medication Administration

According to Florida Administrative code 65G-7.008 regarding Documentation and Record Keeping:

(1) An up-to-date MAR shall be maintained for each client requiring assistance with medication administration, except when the client is off-site. The medication assistance provider must document the administration of medication or supervision of self-administered medication immediately on the MAR, using either APD Form 65G7-00 (3/30/08), incorporated by reference at subsection 65G-7.001(12), F.A.C., or on an alternative MAR form that includes the following information:

(a) The client's name;
(b) Any client food or medication allergies;
(c) The name of each medication prescribed for the client;
(d) The medication strength (i.e., 5mg/ tsp);

(e) The prescribing health care practitioner for each medication;

(f) The date that the medication was ordered and any date the medication was changed (including D/C date);

(g) Prescribed dosage for each medication;

(h) Scheduled time of administration for each medication;

(i) Prescribed route of administration for each medication;

(j) Prescribed instructions for crushing, mixing or diluting of specific medications, if applicable;

(k) The dates each medication was administered;

(l) The initials and signature of the medication assistance provider who assisted with medication administration;

(m) A record of any medication dosage refused or missed, documented by the medication assistance provider responsible for administering the scheduled dosage, by drawing a circle around the appropriate space on the MAR form and initialing it; and

(n) The reasons for not administering a medication, annotated and initialed by the medication assistance provider in the comments section on the MAR form using the following system, or a comparable numbering and coding system containing the same information: 1 – home, 2 – work, 3 – ER/hospital, 4 – refused, 5 – medication not available (explain on back of MAR form), 6 – held by MD (explain on back of MAR), 7 – other (explain on back of MAR).

(2) Each client record must contain the following medication documentation readily available to the medication assistance provider and for Agency review upon request:

(a) Completed MAR forms;

(b) A list of potential side effects, adverse reactions, and drug interactions for each medication;

(c) A record of drug counts for each controlled medication;

(d) Written determination by the client's physician that the client requires assistance with the administration of his or her medications; and

(e) The original Informed Consent form permitting a medication assistance provider to assist with the administration of medication.

(3) The validated medication assistance provider or the provider's employer must maintain documentation that the medication assistance provider has completed an approved medication administration course and is currently validated as competent to assist with the administration of medication. *Specific Authority 393.501 FS. Law Implemented 393.506 FS. History–New 3-30-08.*

Documentation of Medication Administration

ALWAYS sign / document on the Medication Administration Record (MAR), only ***after*** watching /observing the resident/patient take the medication.

The Medication Administration Record (MAR) has a space where the Medication administration personnel needs to document his /her initials that a dose has been given under the correct day and time.

The Medication Administration Record (MAR) is signed or initialed immediately after the medications are administered and before the administration of the next resident's medications

NEVER erase or cover up errors; If you made an error in the documentation on the Medication Administration Record (MAR), follow the facility's policy to correctly document medication errors.

Pre-charting is NEVER allowed (never sign the MAR before medications has been administered)

Signature and Initials:

Document using an equivalent signature to correspond with the initials that is used on the Medication Administration Record (MAR).

PRN ("pro re nata") means the administration of medication on an as-needed basis rather than according to a prescribed schedule. Administer PRN medications when the residents/ patients need the medication but you CANNOT administer the medication more frequently than the physician has ordered.

When documenting PRN medications include:

The amount of the medication administered,

The time of administration

The reason for the medication administration (the reason a PRN medication is to be administered has to be on the physician's order).

The effectiveness of the medication.

Change of shift

Monitor the effectiveness of the medication (follow up with resident /patient – if it is change of shift, another staff may need to record the effectiveness of the medication).

If a resident/patient is requesting administration of a PRN medication on a regular basis or frequently or more often than ordered, contact the supervisor /report this to the physician.

Documentation in Resident's/Patient's Record

ALWAYS document any contact with the supervisor, physician/ the prescribing practitioner or health care provider regarding a resident/patient in the resident's /patient's record.

Prior to Administration of Medications – Vital Signs

Sometimes vital signs are required prior to administering a medication.

Assess /check the vital signs before preparing the medication for administration.

Document vital signs.

Sometimes the medication needs to be held due to ***vital sign parameters*** set by the physician or prescribing provider, for example, ***Hold Digoxin for HR less than 60bpm*** (update physician and document orders and interventions).

Crushing Medications and Mixing in Food

When you are crushing medications and mixing the medication in food items;

Make sure there is an order that specifies that the medication may be crushed and mix in food.

NEVER crush medications until immediately before the medication is to be administered.

Gather the device used for crushing medications. Make sure the device is thoroughly clean and has no residue from another resident's/ patient's medication (avoid cross-contamination).

Different methods used to crush medications

There are different methods used to crush medications such as:

Using a pill crusher and crushing the medications using 2 medication soufflé cups.

A mortar and pestle can also be used (clean thoroughly before crushing another resident's medications)

Medications that are unit dose may be crushed in the unit dose package and empty into a medication cup (follow your facility's policy).

MEDICATION PILL CRUSHER

Medication Soufflé Cups

DO NOT CRUSH LIST

Review the DO NOT CRUSH LIST.

A DO NOT CRUSH list is available from the **Institute for Safe Medication Practice** at:

www.ismp.org/tools/DoNotCrush.pdf

Administering Oral Medications

Administration of oral Medications in Solid Form

Make sure patient is in appropriate position - **elevation of head.**

Administer the powdered medications for example bulk laxatives, with the amount of fluids indicated

Place tablets or capsules in medication cup / soufflé cup for administration

Offer sufficient fluids following the administration of oral medications

Observe the resident taking the medication to assure the medication is swallowed before documenting the administration of the medications.

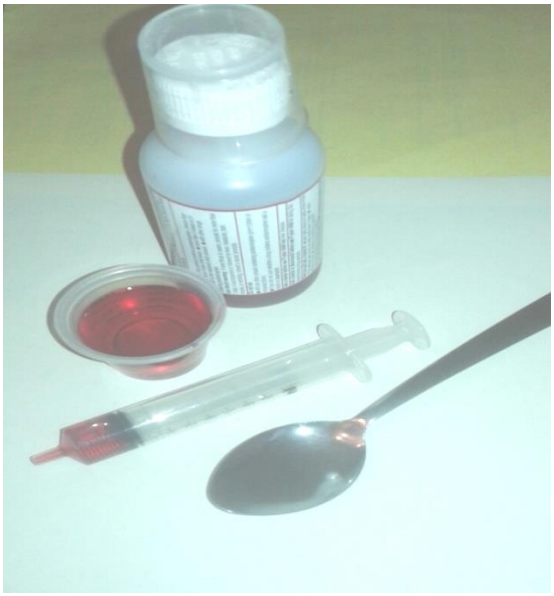
Liquids

When administering liquids, never approximate the amount of medication to be administered.

The amount of liquid ordered, has to be the amount administered.

When measuring liquids, place the medication cup on a flat surface and measured at eye level to ensure accuracy.

NEVER mix liquid medications together.



Use the calibrated syringe for measuring liquids medicine in amounts less than 5 ml and unequal amounts.

Measure liquid medications in a calibrated medication cup / calibrated device **BUT never use eating utensils** or other household devices for administering medications.

Increments marked off in mg or ml

Some medications have special measuring devices for administering the medication. The measuring devices have increments that are marked off in mg instead of ml and will often have the name of the medication on the measuring device.

POURING LIQUID MEDICINE

When pouring liquids, hold the medication container so that the medicine flows from the side opposite the label so the liquid does not run down the container and hide or stain the label.

Administration requirements

Liquids may have specific administration requirements for example,

Shake Well before administration.

Mix with sufficient fluids (to decrease side effects)

Requires Dilution before administration.

Some liquids are in suspension; therefore, the suspension needs to be shaken thoroughly to mix the medication. If not shaken thoroughly the medication will settle and gives inconsistent dosing.

Sublingual Medications

When administering sublingual medications:

Instruct the resident NOT to chew the medication and NOT to swallow the medication

Place the medication under the resident's tongue

Do NOT give with liquid after (might cause the sublingual tablet to be swallowed).

Oral Inhalers

The Physician or practitioner may order the sequence of administration if multiple inhalers are ordered.

Wait at least one minute between puffs for multiple inhalations

The pharmacy may provide instruction on the medication label or the Medication Administration Record.

Proper sequence (spacing) of the different inhalers is important for the effectiveness of the medication.

Administering Ear Drops

Otic (Ear) Drops

Always identify the patient (Right Patient), gather supplies, wash hands
Gloves are to be worn as indicated

Confirm / verify that it is the right medication and it is not expired

Make sure the ear drops is warm/ body temperature
For appropriate position - instruct the patient to lie on the side
Make sure that the ***ear that requires the medicine is upward***
Pull gently on the ear lobe up and back to straighten the ear canal
While you continue to hold the ear, put the drops against the side of the inner ear.
Continue to hold the ear lobe in place until you do not see any more medicine in the ear.
Tell the patient to keep the head to the side for at least 10 minutes (to allow medication to Penetrate).

Wash hands after administration of medication.

Administering Eye Drops and Ointment

Ophthalmic (Eye) Drops and Ointments

Always identify the RIGHT resident /patient, gather supplies, wash hands
Confirm / verify that it is the right medication and it is not expired
Put on gloves as indicated - always wear gloves when there is redness, drainage or possibility of infection

For appropriate positioning - assist the resident/ patient to a sitting position or into a supine position.

Tell the resident /patient to tilt the head back
Tell the resident/ patient to look up and away
Pull down the lower eye lid
Put the ordered number of drops into the space under the lower eye lid
If it is an eye ointment, pull down the lower lid
squeeze the tube, place the medicine on the inside of the lower eye lid, (from the inside near the nose to the outer part of the inside of the lid).
Do not touch the eye with the **tip of the tube (**dropper or medication container).
Ask the patient to close the eye.
Clean off the excess with a tissue
Wash hands after administration of eye drops and ointments.

NOTE!!

Whenever the resident/ patient has two or more eye medications to be administered, the medications should be scheduled / administered **at least 5-10 minutes apart (see the directions for that particular medication).** The patient's vision may be blurry after the application. Instruct / teach the resident / patient to remain seated until his/ her vision clears up.

Administering Nose Drops and Nasal Sprays/Inhalants

For Nose drops

Always identify the resident /patient, gather supplies, wash hands (supplies e.g. Nose drop medication with label, gloves, cotton balls or tissues). Gloves are to be worn as indicated.

If the nasal medication requires refrigeration, store in refrigerator and monitor temperature with a daily log.

Always confirm / verify that it is the right medication and it is not expired.

Identify the nostril (left, right or both) to receive the medication

If nose drops are suspension, then you need to shake well.

For proper positioning – Resident/patient should lie down on his/her back with head tilted and turn the head so that the affected nose is facing up.

If bottle serves as the dropper, remove the cap and place it upright on a barrier or on a clean, dry surface.

If nose drops, instill the prescribed number of drops into nostril or both nostrils. Do not let tip of the dropper touch the nose or any other surface. Recap the container.

(Instruct resident/ patient to remain in the position for about 2 minutes; this allows sufficient contact of medication with nasal tissue).

Wash hands/ perform hand hygiene, after procedure.

For Nasal Sprays

Always identify the resident /patient, gather supplies, wash hands

Confirm / verify that it is the right medication and it is not expired

Prime the nasal inhaler device by holding the bottle upright and away from face while spraying into air.

For proper positioning – Have the resident/ patient sit up if possible. Instruct resident/ patient to hold head upright.

Identify the nostril (left, right or both) to receive the medication.

Gently press side of nostril that is not receiving drug using finger of other hand.

Keep bottle upright and insert spray tip into nostril (no more than 1/4 inch). Point the tip to the back outer side of nose. Ask the resident/ patient to breathe out through the mouth

(Instill the prescribed number of sprays into one or both nostrils as prescribed. Instruct resident/ patient to breathe in through nose and out mouth).

Instruct resident/ patient to tilt head back to help penetration of the medication into the nasal cavity (as indicated).

Instruct patient to remain in same position for about five minutes with affected nostril upwards. Wipe off any excess drainage with clean tissue and gently place a cotton ball in the external nostril to prevent leakage.

Instruct patient to avoid blowing nose for at least 15 minutes.

If another dose of the same or different nasal medication is required in the same nostril, ***wait the amount of time recommended*** by the manufacturer (see package insert) or as prescribed. Repeat dose in either nostril as prescribed.

Clean spray tip and device according to manufacturer's guidelines or institution policy and recap container.

Wash hands/ perform hand hygiene, after procedure.

NOTE:

Replace medication into labeled box/bag and return medication to proper storage area.

Inhalation Medications

Metered-dose inhalers and Turbo inhalers:

Metered-dose inhalers

Always identify the resident /patient, gather supplies, wash hands

Confirm / verify that it is the right medication and it is not expired

Shake the Metered-dose inhaler bottle and remove the cap

Instruct the patient to breathe out

Instruct the patient to keep the chin up

Instruct the patient to place his/her lips around the mouthpiece and start to breathe in slowly, press down on the canister one time

Keep breathing in slowly to completely fill your lungs

Have the patient hold his/her breath for 10 seconds and then slowly breathe out Count to 10 slowly will assist patient. (holding breath allows the medicine to reach the airways of the lungs)

Repeat puffs for amount of times ordered by physician.

Wait about 1 minute in between puffs.

Instruct the patient to rinse his/her mouth with water and spit it out

Replace the cap on the Metered-dose inhaler when finished.

Turbo inhalers

Always identify the resident/ patient, gather supplies, wash hands

Confirm / verify that it is the right medication and it is not expired

Slide the sleeve away from mouthpiece

To unscrew, turn the mouthpiece counter-clockwise

Place the medication into the stem of the mouthpiece

Rescrew the inhaler

Slide the sleeve all the way down to make a hole into the capsule

For proper positioning – Have the resident/ patient sit up if possible. Instruct resident/ patient to tilt the head back

Instruct patient to blow out all the air in the lungs and then breathe in deeply and hold it for 10 seconds while the mouthpiece is in their mouth

Repeat until all of the medication has been used

When medicine is finished instruct the patient to rinse the mouth.

NOTE:

Rinsing the mouth and gargle with water helps remove any medication left in the mouth and throat. It also reduces the urge to cough. Rinsing and gargling may also help prevent a mouth infection.

Rinse the mouthpiece with warm water. Dry the turbo-inhaler completely before putting it away.

After Procedure:

- Remove and dispose of gloves, discard any barriers used
- Wash hands thoroughly
- Monitor for side effects or adverse effects
- Return the medications to the proper storage area
- Record the administration in the MAR
- Always document the administration of a PRN -as needed medication and the patients' ***response.***

REMINDER!!!

ALWAYS check manufacturer instructions before using inhalers because some require priming prior to administration.

Administering Topical Medications

Topical (Skin Surface) medications are available in creams, lotions, ointments, patches, sprays.

NOTE !!

Perform hand hygiene / wash hands

Wear gloves

Use tongue blade, cotton tipped applicator or gauze to apply the medication

ALWAYS use a new applicator each time you remove medication from the container to prevent contamination.

Topical medications are applied to the skin and absorbed by the skin.

Do NOT use Topical medications on skin that is ***not intact*** unless the medicine is being used to treat the broken skin.

PROCEDURE:

Always identify the resident /patient, gather supplies, wash hands

Provide privacy

Confirm/ verify that it is the right medication and it is not expired

Open the container or tube

Place the top upside down to keep it clean

Put on gloves to protect the skin- the medication will have an effect on your skin as well as the patient.

You may put the medicine on a tongue depressor. Use a cotton tip applicator or sterile gauze for the face. Apply the topical medicine in long strokes, if hair growth is present, apply the medicine in the direction of hair growth.

Always follow your institution policy and procedures.

Do not cover with a bandage unless directed by the physician.

NOTE !!

Do not dispose of gloves and supplies in area that is accessible to residents/ patients (medication is on the supplies).

Administering Medications Using Transdermal Products/Patches

NOTE !!

These medication Patches are applied to the skin and the medication is absorbed by the skin.

Transdermal Products

PROCEDURE:

Always identify the resident /patient, gather supplies, wash hands

Confirm / verify that it is the right medication and it is not expired

Ensure patient is in a comfortable position.

Put on gloves

If patient has an old patch, remove it

Wash the new site with soap and water

Locate a site that has no hair growth (e.g. upper arm, chest)

Alternate the application sites to avoid skin irritation. Notify the health care provider of irritation at site.

Dry the new site

Put the dose on the patch or strip.

Do not let it medicine touch your skin.

With the medicine down against the skin, move the patch /strip gently over about 2-3 inch area to spread the medicine out but do not rub.

Cover it with a plastic wrap or special dressing; tape it in place so that it will stay on skin without falling off.

Write on the patch/dressing; the time, date, and your initials

Always follow your institution policy and procedures.

Transdermal – Some are already made with the medication

Always identify the resident/ patient, gather supplies, wash hands

Confirm / verify that it is the right medication and it is not expired

Put on gloves

Open the package and remove the patch

Date, time and initial the patch

Remove the backing from the patch

Apply the patch to a dry, hairless site on the body, follow package instructions

Check for and remove the old patch

Alternate the application sites to avoid skin irritation. Notify the physician of irritation

Dispose of the supplies and wash hands immediately to avoid absorbing the medication yourself.

NOTE !!

When the patch is ordered to be worn for ***less than 24 hours***, document on the medication administration record (MAR) that the patch was removed and document the time it was removed.

It is very important to rotate the application sites for transdermal patches. This is done to prevent irritation to the skin. Therefore, document the application sites on the MAR.

After you have removed the patch, clean the area to remove the residual medication from the skin (If medication remains on the skin – the effects from the medication will continue).

After patch is removed, remove gloves and wash hands.

Administering Injections

ALERT!!! – INJECTION ADMINISTERED BY Licensed Personnel (see your facility's policy).

Injection safety:

DO NOT recap syringes

DO NOT place syringes in pocket

Disposed of used syringes immediately (in sharps containers).

Some Commonly used Medications

Some medical indications and purposes for commonly used medications, their common side effects, and symptoms of adverse reactions:

Warfarin (Coumadin)

Lasix

Aspirin

Digoxin

MEDICATION	INDICATION/PURPOSE	COMMON SIDE EFFECTS/ SYMPTOMS OF ADVERSE REACTIONS
Warfarin (Coumadin) **Classification** Therapeutic: anticoagulants	**Indications** Prophylaxis and treatment of: Venous thrombosis (blood clot), Pulmonary embolism, Atrial fibrillation (A-fib) with embolization. Management of myocardial infarction (MI): Decreases risk of death, decreases risk of subsequent myocardial infarction (MI), reduces risk of future thromboembolic events. Prevention of thrombus (clot) formation and embolization after prosthetic valve placement. **Action** Interferes with hepatic synthesis of vitamin K-dependent clotting factors (II, VII, IX, and	Bleeding (can be life threatening) Gastrointestinal: cramps, nausea. Dermal: dermal necrosis. **MONITOR/CHECK PATIENT**: - for signs of bleeding and hemorrhage (bleeding gums; nosebleed; unusual bruising; tarry, black stools; hematuria; Drop in hematocrit or blood pressure; positive guaiac (stools, urine, or nasogastric aspirate).

	X). **Therapeutic Effects:** Prevention of thromboembolic events.	
Furosemide (Lasix) ***Classification*** Therapeutic: diuretics	**Indications** Edema due to heart failure, hepatic impairment or renal disease. Hypertension. **Action** Inhibits the reabsorption of sodium and chloride from the loop of Henle and distal renal tubule. Increases renal excretion of water, sodium, chloride, magnesium, potassium, and calcium. **Therapeutic Effects:** Diuresis, mobilization of excess fluid (swelling /edema, pleural effusions). Decreased blood pressure.	**Central Nervous System:** blurred vision, dizziness, headache, vertigo. **Cardiovascular:** hypotension. **ENT:** hearing loss, tinnitus. **Gastrointestinal:** anorexia, constipation, diarrhea, dry mouth, dyspepsia, nausea, pancreatitis, vomiting. **Genitourin:** excessive urination. **Derm:** photosensitivity, pruritis, rash. **Endocrin:** hyperglycemia, hyperuricemia. dehydration, hypocalcemia, hypochloremia, hypokalemia, hypomagnesemia, hypona tremia, hypovolemia, metabolic alkalosis. **Hematology:** APLASTIC ANEMIA (can be life threating), AGRANULOCYTOSIS (can be life threating), hemolytic anemia, leukopenia, thrombocytopenia. **Muscular Skel:** muscle cramps. **Neurological:** paresthesia. **Misc:** fever, increased BUN **MONITOR /CHECK PATIENT:** - fluid status, Monitor daily weight, intake and output ratios, amount and location of edema, lung sounds, skin turgor, mucous membranes. **Notify MD or other health care professional if** thirst, dry mouth, lethargy, weakness, hypotension, or oliguria occurs. Monitor blood pressure and pulse before and during administration.
Acetylsalicylic acid (Aspirin)	**Indications** Inflammatory disorders such as: Rheumatoid arthritis, Osteoarthritis. Mild to moderate pain. Fever Prophylaxis of transient ischemic attacks (TIA) and MI.	**Gastrointestinal:** GI Bleeding, dyspepsia, epigastric distress, nausea, abdominal pain, anorexia, hepatotoxicity, vomiting. **Hematology:** anemia, hemolysis. **Derm:** rash, urticaria. **ENT:** tinnitus. Other: Allergic reactions such as: anaphylaxis and laryngeal edema.

	ACTION: Produce analgesia and reduce inflammation and fever by **inhibiting the production of prostaglandins**. Decreases platelet aggregation. Therapeutic Effects: Analgesia. Reduction of inflammation. Reduction of fever. Reduce incidence of transient ischemic attacks (TIA) and MI.	**MONITOR/ CHECK PATIENT:** **- for Toxicity and Overdose:** Monitor for the onset of tinnitus, headache, hyperventilation, agitation, mental confusion, lethargy, diarrhea, and sweating. If these symptoms appear, withhold medication and notify MD or other health care professional immediately.
Digoxin (Lanoxin) ***Classification*** Therapeutic: antiarrhythmic, inotropic	**Indications** Heart failure, Atrial fibrillation (A-fib), Atrial flutter (slows ventricular rate). Paroxysmal atrial tachycardia. **Action** Increases the force of myocardial contraction Prolongs refractory period of the AV node. Decreases conduction through the SA and AV nodes. **Therapeutic Effects:** Increased cardiac output (positive inotropic effect) and slowing of the heart rate (negative chronotropic effect).	**Central Nervous System: headache,** fatigue, weakness. **ENT:** blurred vision, green or yellow vision. **Cardiovascular:** Arrhythmias (can be life threatening), bradycardia, EKG changes, AV block, SA block. **Gastrointestinal:** anorexia, nausea, vomiting, diarrhea. **Hematology:** thrombocytopenia. **Metabolic:** electrolyte imbalances with acute digoxin toxicity. **MONITOR /CHECK PATIENT:** Monitor apical pulse for **1 full min** before you give to resident/patient. **Withhold dose and notify physician if pulse rate is <60 bpm in an adult, <70 bpm in a child, or <90 bpm in an infant**. Also notify MD/ health care professional quickly of any significant changes in rate, rhythm, or quality of pulse.

ACTIVITY: Medication Resources or References

1. LOOK UP <u>Synthroid</u> COMMONLY USED MEDICATION

USE medication resources, reference books, manuals and/or pharmacy information sheet

2a. Write medical indications /purposes,

2b. common side effects, and symptoms of adverse reactions

MEDICATION	medical indications /purposes	common side effects, and symptoms of adverse reactions
<u>Synthroid</u>		

Section 4 – Ordering, Storage and Disposal of Medications

It is important to avoid medication errors that result due to medication is not available on hand. Make sure you are aware of the facility's policy and procedures; there has to be a system in place for timely reordering and delivery of residents /patients medications.

Ordering Medications

Be aware of the facility's policy and procedures regarding:

When and how to refill medications

Receiving medications when they are delivered from the pharmacy

Emergency pharmaceutical services availability.

ALERT!!

Medications have to be monitored on a regular basis.

Medications have to be reordered on a regular basis.

When a medication is not available (this is critical) extreme effort has to be made to obtain the medication and this has to be documented. Update the pharmacy, supervisor, physician and family, regarding any medication not being available, as needed. Follow your facility's policy.

Proper Storage of Medications

Medication storage location such as medication room, medication cart, need to be clean and neat (clutter free) so that medications can be found easily.

There are specific directions for stating the appropriate temperature at which medications shall be stored. Research has shown that the storage at a higher or a lower temperature have produced undesirable results.

The Pharmacopeia;
book containing an official list of medicinal drugs together with articles on their preparation, formulas, dosage, use etc. may be accessed at United States Pharmacopeia (USP) / www.usp.org/.

The United States Pharmacopeia and The National Formulary (USP–NF) is a book of public pharmacopeial standards. It contains standards for (chemical and biological drug substances, dosage forms, and compounded preparations), medical devices, and dietary supplements.

Storage definitions, as defined in the General Notices section of the USP-NF, for recommended conditions commonly specified on product labels as follows:

Freezer: The temperature is maintained thermostatically between -20 C and -10 C (-4 F and 14 F).
Cold: Any temperature not exceeding 8 C (46 F).
A refrigerator is a cold place in which the temperature is maintained thermostatically between 2 C and 8 C (36- 46 F).
Cool: Any temperature between 8 C and 15 C (46-59 F). A substance that requires cool storage, alternatively may be stored in a refrigerator, unless otherwise specified by the individual USP monograph.
Room Temperature: The temperature prevailing in a working area.
Controlled Room Temperature: A temperature maintained thermostatically that encompasses the usual and customary working environment of 20 C to 25 C (68-77 F) that allows for brief deviations between 15 C and 30 C (59-86 F) that are experienced in pharmacies, hospitals, and warehouses.
Warm: Any temperature between 30 C and 40 C (86-104 F).
Excessive Heat: Any temperature above 40 C (104 F).

Protection from Freezing: freezing may cause a substance to lose its potency or strength, or alters its characteristics. The container label must have appropriate instructions to protect the substance from freezing.

Safe Medication Storage

Keep all medications out of reach of children.
Keep medications out of the reach of anyone who might abuse/ misuse them.
Be careful if medication looks like water or drink.
Make sure that medications that need to be in the refrigeration are not stored in an area where they will freeze.
Make sure the medications are kept separate from food items.
A good idea is to place them in a container that separates them.
Always Store the medication in its original container.
Do not mix different medications together in one container. This will make it difficult to identify during an emergency
Store all medicines in one designated location together. The location should be a dry and cool place. Properly dispose of any medication that has expired or that the physician has discontinued.

LOCKED AREA

Medications must be stored in a locked area, unless medications are under the direct supervision of Staff (direct supervision means the cart is in sight).

ALWAYS lock medication room, medication cart and medication cabinet when not in use (unless the medication storage area is under direct supervision of staff).

External and Internal Medications

External and internal medications must be stored in separate designated areas

Refrigeration

As mentioned earlier, store medications that require refrigeration at 36 degrees F to 46 degrees F (2 degrees C to 8 degrees C).

Controlled Substances

Prescription medications are categorized through the controlled substance act into five classes or schedules:

SCHEDULE 1 (CLASS I) DRUGS are illegal because they have high abuse potential, no medical use, and severe safety concerns; for example, narcotics such as LSD, Heroin, and cocaine. Marijuana is also included as a Class 1 drug; now it is legal in some states and some states are using it as a medicinal drug.

SCHEDULE 2 DRUGS (CLASS 2) DRUGS have a high potential for abuse and dependence and abuse, an accepted medical use, and the potential for severe addiction. These drugs include opiods based on high dose Fentanyl, codeine, Oxycodone also Methamphetamine and Barbiturates; also included are such drugs as opium, morphine. The main difference between a Schedule, or Class, 1 and 2 is whether or not the drug is deemed to have a valid medical application.

SCHEDULE 3 (CLASS 3) DRUGS have a lower potential for abuse than drugs in the first two categories, accepted medical use, and mild to moderate possible addiction. These medications include Codeine (low dose), steroids, and Hydrocodone-based opiods.

SCHEDULE 4 (CLASS 4) DRUGS have a lower abuse potential than Schedule 3 Drugs with limited potential for addiction and accepted medical use. These include many of the anti-anxiety medications like the Benzodiazepines, sleeping agents, Sedatives, and the mildest of the opiod type medications like Darvon.

SCHEDULE 5 (CLASS 5) DRUGS have a low potential for abuse, accepted medical use, and very limited potential for addiction. Such as; medications with limited amount of narcotics or stimulant medicines for cough, or pain.

Lock up controlled substances

All controlled substances or controlled medications must be kept locked.

LOCKED LOCATION:

Locked at special location in medication room.

Locked in drawer in the medication cart.

MEDICATION COUNT

Medication count needs to be ACCURATE.

Check the number or amount of medication listed on the controlled substance log **BEFORE** removing any medications for the patient/ resident.

Every time a controlled medication is removed/administered, the amount that was removed has to be documented and the amount that remains has to be counted and documented.

There has to be ACCURATE record of all controlled substances.

Every facility is required to:

Document the receipt of controlled substances.

Document the administration of controlled substances.

Document the disposition of controlled substances.

NOTE

Discrepancies discovered needs to be reported.

Disposal of Medications

Some of the reasons for disposal of medications include:

- Medication is expired.
- Dosage of medication was opened and prepared for administration and was not administered promptly for various reasons.
- Medication was prepared but the resident/patient refused the medication.
- Medication is contaminated such as touches your hand during medication pass.

- Physician or prescribing practitioner has discontinued the medication.
- Medication is contaminated such as fell to the floor during medication pass.

FOLLOW FACILITY'S POLICY

All medications that is discontinued or medications that are expired should be destroyed or return to pharmacy in accordance with policy of the facility.

Proper Disposal of Medications

Federal Guidelines

Discontinued or Unused portions of medications must be disposed of properly to avoid harm. Never flush prescription medications down the sink / drain, or the toilet unless the label or instructions tells you to. The U.S. Food and Drug Administration (FDA) website is an excellent recourse for information regarding proper disposal of medications.

FDA and the White House Office of National Drug Control Policy developed Federal guidelines that are summarized below:

- Follow any specific disposal instructions on the prescription drug labeling or patient information that accompanies the medicine. Do not flush medicines down the sink or toilet unless this information specifically instructs you to do so.
- Take advantage of community drug take-back programs that allow the public to bring unused drugs to a central location for proper disposal. Call your city or county government's household trash and recycling service (check the phone book) to see if a take-back program is available in your community. The U.S. Drug Enforcement Administration, working with state and local law enforcement agencies, periodically sponsors National Prescription Drug Take Back Days.
- If no disposal instructions are given on the prescription drug labeling and no take-back program is available in your area, throw the drugs in the household trash following these steps.

  1. Remove them from their original containers and mix them with an undesirable substance, such as used coffee grounds or kitty litter (this makes the drug less

appealing to children and pets, and unrecognizable to people who may intentionally go through the trash seeking drugs).

2. Place the mixture in a sealable bag, empty can, or other container to prevent the drug from leaking or breaking out of a garbage bag.

Over 600,000 pounds of unneeded, unwanted, or expired prescription medications were properly disposed of during the final Drug Enforcement Administration (DEA) National Prescription Drug Take-Back Day, held September 27, 2014.

Procedural arrangements for clients who require medication offsite

According to Florida Administrative code 65G-7.009 regarding Off-site Medication Administration:

(1) If a client will be away from a licensed residential facility or supported living home and requires during that time administration of medication by persons other than the medication assistance provider, the medication assistance provider must comply with the following requirements to assure that the client has appropriate medications during his or her absence:

(a) Provide an adequate amount of medication for administration of all dosages the client requires while away;

(b) Perform a count of the medication amounts provided to the client for administration during the absence and a second count of the medication amounts received upon the client's return;

(c) Record both medication counts in an "Off-site Medication Form," APD Form 65G7-08 (3/30/08), incorporated herein by reference. A copy of the form may be obtained by writing or calling the Agency for Persons with

Disabilities, at 4030 Esplanade Way, Suite 380, Tallahassee, FL 32399-0950; main phone number (850) 488-4257.

(2) Medication ***may not*** be transferred from its original container to a weekly pill organizer or otherwise co-mingled unless the client's primary care provider determines that the client is able to self-administer that medication without supervision; in that case, only the client, the client's family member, or a legal guardian may transfer the medications from the original container.

(3) The medication assistance provider must provide the name and telephone number of a contact person and the name and telephone number of the client's prescribing practitioner to the person who will assist the client with medication administration while the client is offsite.

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