Guidelines for Completing the Medication Administration Skills Validation Form

Section 1: Basic Medication Administration Information and Medical Terminology	**Section 1**: **The employee must be knowledgeable of at least:**
A. Match common medical abbreviations with their meaning	A. Refer to Handout D-3, page L-8, of *The Medication Administration: 10-Hour/15-Hour Training Course for Adult Care Homes.* The employee is to be familiar with them and be able to find a list when needed
B. List/Describe common dosage forms of medications and routes of administration	B. Refer to Handouts D-6 and D-7, pages L-11-12, of *The Medication Administration: 10-Hour/15-Hour Training Course for Adult Care Homes*. The employee is to be familiar with the common dosage forms. Medications are available as different dosage forms, e.g., tablets, capsules, liquids, suppositories, topicals, inhalants and injections. An order is to indicate the route of administration. Some medications may come in several dosage forms. An example is Phenergan. It is available in tablet, liquid, suppository and injectable.
C. List the 6 rights of medication administration	C. Six Rights of Medication Administration: 1.Right Resident 2.Right Medication 3.Right Dose 4.Right Route 5.Right Time 6.Right Documentation
D. Describe what constitutes a medication error and actions to take when a medication error is made or detected	D. A medication error occurs when a medication is not administered as prescribed. Examples of medication errors include: omissions; administration of a medication not prescribed by the prescribing practitioner; wrong dosage; wrong time, wrong route; crushing a medication that shouldn't be crushed; and documentation errors. The employee must be able to explain the facility's medication error policy and procedure or at least be knowledgeable of where to find it. The procedure is to include who to notify, i.e., supervisor and health professional and forms to complete. The employee is to be able to recognize medication errors. The employee needs to understand that recognizing medication errors and acting quickly to correct them help prevent more serious problems.
E. Describes resident's rights regarding medications, i.e., refusal, privacy, respect	E. Medication administration can effect a resident's rights which include, but not limited to, the following: 1. **Respect** – How the resident is addressed; The resident should not be interrupted while eating for the administration of medications such as oral inhalers and eye drops. The resident should not be awakened to administer a medication that could be scheduled or administered at other times; Explain to the resident the procedure that the employee is about to perform; Answer questions the resident may have about the medication. 2. **Refusal** – The resident has a right to refuse medications. A resident should never be forced to take a medication. The facility should have a policy and procedure to be followed when residents refuse medications. The policy and procedure is to ensure the physician is notified timely (based on the resident's condition, physically and mentally and the medication.) 3. **Privacy** – Knock on closed doors before entering; Do not administer medications when the resident is receiving personal care or in the bathroom; Administration of medications requiring privacy, e.g., vaginal and rectal administrations, dressing changes and treatments requiring removal of clothing. 4. **Chemical Restraint** Medications, especially psychotropics, are not to be administered for staff convenience.

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F. Define medication "allergy" and describe responsibility in relation to identified allergies and suspected allergic reactions	F. Medication Allergy: a reaction occurring as the result of an unusual sensitivity to a medication or other substance. The reaction may be mild or life-threatening situation. These may include rashes, swelling, itching, significant discomfort or an undesirable change in mental status, which should be reported to the physician. A severe rash or life-threatening breathing difficulties require immediate emergency care. The employee should understand that information on allergies should be reported to the pharmacy and physician and this information is recorded in the resident's record. Upon admission, it is important to document any known allergies. If there are no known allergies, this should be indicated also.
G. Demonstrate the use of medication resources or references	G. The employee should be familiar with medication resources or references, including the facility's policy and procedure manual, and be able to find information. Resources written for non-health professionals, including information sheets from the pharmacy, are recommended instead of references written for health professionals, such as the PDR.
Section 2: Medication Orders	**Section 2**
A. List/Recognize the components of a complete medication order	A. Components of a complete order: 1.Medication name; 2.Strength of medication (if one is required); 3.Dosage of medication to be administered; 4.Route of administration; 5.Specific directions for use, including frequency of administration; and, 6.PRN or "as needed" orders must also clearly state the reason for administration Orders for psychotropic medications prescribed for "PRN" administration must include symptoms that require the administration of the medication, exact dosage, exact time frame between dosages and maximum dosage to be administered in 24 hour period. Example: Ativan 0.5 mg. by mouth every 4 hours prn for pacing or agitation. Physician is to be contacted if more than 4 doses are needed in 24-hour period. **For items B. through E. of this section: If the employee has any responsibility for transcription of orders and processing admissions, the employee is to describe and demonstrate the procedures involved in these areas. If the employee does not have any responsibility for transcription or processing orders, the employee still needs to have general knowledge of the procedures and be able to screen orders to determine correctness.**

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B. Transcribe orders onto the MAR 1. Instructions written out completely 2. Calculate stop dates correctly 3. Transcribe PRN orders appropriately 4. Copy orders completely and legibly and/or checked computer sheets against orders and applied to the MAR 5. Discontinue orders properly	B. Transcription of orders onto the medication administration record is to include: 1. Orders are to be transcribed onto the medication administration record when obtained or written. The employee is to initial or sign and date orders written on the medication administration record. (Waiting until the medication arrives from the pharmacy before transcription of an order onto the medication administration record is not correct. The directions on the medication label from the pharmacy must be checked against the order on the medication administration record. If there is a discrepancy between the information on the medication administration record and the medication label, the order in the resident's record is to be checked. When there are discrepancies between the medication label and the order, the employee is to follow the facility's policy and procedure, which would address who to contact.) 2. Transcribe the order with instructions written out completely. The order is to be complete. 3. When calculating stop dates for medication orders such as antibiotics that have been prescribed for a specific time period, the number of dosages to be administered should be counted instead of the number of days. 4. PRN orders are not scheduled for administration at specific times. PRN medications are given when the resident "needs" the medication for a certain circumstance. 5. Review medication administration records monthly at the beginning of the cycle to assure accuracy and then update the medication administration records as needed. 6. A discontinue order has to be obtained for an order to be discontinued, unless the prescribing practitioner has specified the number of days or dosages to be administered or indicates that a dosage is to be changed. For example, a prescription with "No Refills" does not automatically mean the order is to be discontinued.
C. Describe responsibility in relation to telephone orders	C. Telephone or verbal orders may be accepted only by a licensed nurse, pharmacist or qualified staff responsible for medication administration. The order is to be dated and signed by the person receiving the order and signed by the prescribing practitioner within 15 days of when the order is received. It is important that the employee understands that a copy of an order, including a telephone order, is always kept in the resident's record.
D. Describe responsibility in relation to admission and readmission orders and FL2 forms	D. A FL2 form is required for new admissions. It is important that all the information on the FL-2 is reviewed for accuracy. If any clarification is needed, the prescribing practitioner is to be contacted. If the FL-2 has not been signed within 24 hours of admission, the orders are to be verified by the facility with the prescribing practitioner. Verification of orders may be by fax or telephone. There has to be documentation of this verification in the resident's record, e.g., a note in the progress notes or the orders may be rewritten as telephone orders and signed by the prescribing practitioner. The orders could also be faxed to the prescribing practitioner for review, signature and date. Readmission from the hospital requires a transfer form, discharge summary or FL-2 signed by the prescribing practitioner. Often, the facility may receive a discharge summary or transfer form and a FL-2. The employee must be able to describe the procedures for readmission, especially when two or more forms with orders are received. Orders are to be verified by facility staff with the prescribing practitioner if the orders have not been signed within 24 hours of admissions, if clarification is needed or if the prescribing practitioner has not signed the orders. If a prescribing practitioner does not sign orders, the orders are to be processed per facility policy and signed by the

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	prescribing practitioner. This may be by telephone or facsimile. Medication orders are to be reviewed and signed by the physician at least every 6 months. When the orders are renewed and there are changes without any reason, the physician or prescribing practitioner should be contacted for clarification. A medication could have been accidentally left off or the wrong dosage could have been written. Clarification is obtained whenever orders are unclear, incomplete or conflicting. New orders will need to be written as necessary for these clarifications. "Continue previous medications" or "Same Medications" are not complete medication orders and are not to be accepted for medication orders. An order has to be obtained for any medication administered, i.e., over–the–counter or prescription. The employee is to understand the difference between a prescription and an order. The facility needs an order to administer a medication. The prescription may be used for the signed order.
E. Describe or demonstrate the process for ordering medications and receiving medications from pharmacy	E. The employee should be knowledgeable of the facility's procedures on ordering medications, including refills, procedures for emergency pharmaceutical services and on receiving medications when delivered from the pharmacy. The facility is to be able to account for medications administered by staff; therefore, the facility is to have procedures to ensure that dispensing information, i.e., date, name, strength and quantity of medication, can be readily available. For situations such as admissions when the resident or responsible party brings medications into the facility, the name, strength and quantity of medication brought in should be documented.
F. Identify required information on the medication label	F. The employee has to be able to identify the following information on the label: medication name and strength; quantity dispensed and dispensing date; directions for use; the pharmacy that dispensed the medication and the prescription number; and expiration date. The employee should understand the difference between generic and brand names and know that an equivalency statement should be on the medication label when the brand dispensed is different than the brand prescribed. The employee should also know labeling requirements for over-the-counter (OTC) medications, according to the regulation 10A NCAC 13F/13G .1003.
Section 3 : Using appropriate technique to obtain and record the following: A. * Blood Pressure	**Section 3** A. Blood Pressure (B/P)– The employee is to know how to check a blood pressure by using the facility's blood pressure device. If electronic machines are used, the employee should understand that the device needs to be checked for accuracy according to the manufacturer's recommendations. The instructor needs to indicate on the checklist how the employee obtained the resident's blood pressure, i.e., electronically or manually with a stethoscope and blood pressure cuff. The employee should know that blood pressure cuffs that are too small or large for the resident's arm might result in an inaccurate reading. Ranges for high and low blood pressures that indicate the resident's blood pressure should be reported are to be established by the facility's policy or physician's order.

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B. * Temperature	B. Temperature (T or TEMP.)– The employee should know how to obtain the resident's temperature using the facility's thermometer: i.e., electronic, glass or tympanic. The employee should know the normal oral temperature and that temperature is measured using either the Fahrenheit or Celsius scale. Normal oral temperature is 36.5 – 37.5 degrees Celsius or 96.7 – 99.6 degrees Fahrenheit. The employee should know that activity, food, beverages and smoking all affect body temperature.
C. * Pulse	C. Pulse – Number of heartbeats counted in one full minute. The employee should know how to take a radial (heart rate measured at the thumb side of the inner wrist) and apical pulse (heart rate measured directly over the heart using a stethoscope). A pulse may be obtained by using an electronic device. Normal range is 60 to 100 beats/minute.
D. * Respirations	D. Respirations (R) – Number of breaths a person takes per minute. The normal range is 10 to 24 breaths per minute. One full breath is counted after the resident has inhaled and exhaled. The most accurate rate is taken when the resident is not aware that his/her respirations are being monitored.
E. Fingersticks/Glucose Monitoring **(Only required to be validated if the employee will be performing this task.)**	E. The employee is to know how to operate devices used for the collection and testing of fingerstick blood samples, such as glucose monitoring devices. Staff is to know about calibrating and cleaning the machine per manufacturer's instructions. The range of a monitoring device should be posted with the MARs or available for staff for reference. Ranges for devices, such as glucose monitoring machines, may vary. The facility should have procedures developed when a reading is obtained, especially if the reading is low or high. The employee is to be knowledgeable of the procedures and know where to locate the information if needed. The employee is to be knowledgeable of infection control measures, such as wearing gloves, disposal of lancets in sharps container and the cleaning of machines per manufacturer's instructions, for procedures with which bleeding occurs or the potential for bleeding exists.
Section 4: If medications are prepared in advance, procedures, including documentation, are in accordance with regulation 10A NCAC 13F/13G .1004. (only has to be completed if applicable to facility)	**Section 4** The containers must be prepared and labeled according to regulation 10A NCAC 13F/13G .1004. If the medications are not dispensed in sealed packages, the container has to be capped or sealed and each medication prepared is to be identified on the container. The MAR is to be used when prepouring or preparing medications. If the person who prepares the medication is not the same person to administer the medication, the person preparing the medication must document each medication prepared. (This is in addition to documentation by the person who actually administers the medications. The administration of medications is not to be documented until after the resident is observed to take the medications.)
Section 5: Administration of Medications	**Section 5**
A. Identify resident	A. The employee is to know the procedures for identifying residents. The most common method used is photographs of residents in the medication administration records. The photos should be kept updated and the photograph is to have the name of the resident on it. Relying on other staff to identify residents is not appropriate.

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B. Gathered appropriate equipment and keeps equipment clean	B. This will depend on the medications to be administered. Supplies/equipment to have for medication administration need to include at least the following: 1. Medication administration records 2. Medication cups for oral medications, i.e., liquids and tablets 3. Sufficient fluids available to administer medications 4. Food substance, i.e., applesauce or pudding, if needed. 5. If soap and water is not available for washing hands, an appropriate antiseptic is to be available for use. Supplies and equipment used in the process of administering medications is to be kept clean and orderly, i.e., medication carts, trays and pill crusher.
C. Medication administration records utilized when medications are prepared and administered. They are also used when medications are prepoured, if prepouring is allowed.	C. Employee is to use the medication administration record when administering medications.
D. Read the label 3 times. Check label against order on the medication administration record.	D. Reading the label - The employee should compare the label to the MAR 3 times: 1. when selecting the medication from the storage area 2. prior to pouring the medication 3. after pouring and prior to returning the medication to the storage area. The information on the MAR and the medication label should match, unless there has been a change in the directions. The employee is to be familiar with the facility's policy on direction changes. A medication label can only be changed or altered by the dispensing practitioner.
E. Use sanitary technique when pouring or preparing medications into the appropriate container	E. Medications are not to be touched or handled by the employee's hands. Medications are to be poured from the medication container into an appropriate medication container or cup and given to the resident. It is not acceptable for the employee to use his/her hands to administer the medications or for the resident to have to use his/her hands to receive the medications. (This is referring to the facility not having adequate or appropriate supplies or the employee not using the supplies to administer medications. This is not referring to residents pouring the medication, e.g., tablet, or wanting the medication poured into their hands.)
F. Offer sufficient fluids with medications	F. The resident should be offered sufficient fluids following the administration of medications even if the medication is administered in a food substance.
G. Observe resident taking medications and assures all medications have been swallowed.	G. The employee is to observe the resident taking the medication to assure the medication is swallowed. This must be before documenting the administration of the medications.

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Section 6: Utilized Special Administration/Monitoring Techniques as indicated (vital signs, crush medications. check blood sugar, mix with food or liquid)	**Section 6** The employee is to be knowledgeable of the facility's policy on crushing medications and mixing medications in food. A current list of medications that should not be crushed may be available for staff to use or facility policy should require that no medications be crushed prior to checking with the pharmacist. Medications are not crushed until immediately before the medications are administered to a resident. One of the objectives with crushing medications is to avoid cross-contamination. Facilities may use different devices to crush medications. The most common method is using a pill crusher and crushing the medications using two medication souffle cups. If the medications are unit dose, the employee may crush the medication in the unit dose package and empty into a medication cup. If the facility uses a device such as a mortar and pestle, and the residue from the medications is present, the device has to be cleaned thoroughly before crushing another resident's medications. When a vital sign, i.e., pulse or blood pressure, is to be obtained prior to the administration of a medication, the employee should have the results prior to preparing the medications for administration.
Section 7: **Administer medications at the appropriate time**	**Section 7:** The employee is to be knowledgeable of what "before meals", "after meals" and "with meals" mean. Medications prescribed before meals are generally to be administered about 30 minutes prior to the resident eating. When the medications are prescribed to be administered with or after meals, the medication is to be administered sometime after the resident has started eating up to 60 minutes after the resident has finished eating. The employee also has to be knowledgeable of the time period allowed by state regulations to administer medications, one hour prior to and one hour after the scheduled administration time. The employee must know that this does not apply to medications prescribed for administration in accordance with meals or for medications such as insulin.
Section 8: Describe methods used to monitor a resident's condition and reactions to medications and what to do when there appears to be a change in the resident's condition or health status	**Section 8** The employee should know that there are various side effects of medications. Side effects of medications include but not limited to the following: change in behavior, change in alertness, change in eating or swallowing, change in mobility and skin rashes. When there is a change in the resident, the employee is to follow the facility's policy on what to do which may include the following: using a medication reference and looking up possible side effects of a medication, asking the resident how they are feeling, observing the resident and notifying the supervisor or a health professional. The employee is to know that information regarding the resident's behavior and action taken should be documented.

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Section 9: Utilize appropriate hand-washing technique and infection control principles during medication pass	**Section 9** Infection control or prevention recommendations and precautions are to be implemented. This includes employees wearing gloves when there may be exposure to bodily fluids. The employee is to be knowledgeable of when to wear gloves and when to change gloves. Handwashing should be with soap and water. When soap and water is not readily available, an antiseptic gel or product must be used in place of soap and water. Handwashing should be frequent and is required when there has been contact with the resident's body or bodily fluids during the administration of medications. Gloves should be worn and handwashing must also be done when transdermal products, i.e., Nitroglycerin or Duragesic patches, are applied or removed.
Section 10 – Documentation of Medication Administration	**Section 10**
A. Initial the MAR immediately after the medications are administered and prior to the administration of medications to another resident. Equivalent signature for initials is documented.	A. The employee is to sign the MAR only after observing the resident take the medications. Precharting is not permitted and this includes signing the MAR anytime prior to the medications being administered. The MAR is to be signed immediately after the medications are administered and prior to the administration of the next resident's medications. The employee is also to document an equivalent signature to correspond with the initials used on the MAR.
B. Document medications that are refused, held or not administered, appropriately	B. The facility is to have procedures to ensure that there is a consistent method of documenting why a medication was not administered. The employee is to be knowledgeable of the facility's policy and procedures. If the facility uses abbreviations such as "R" or "H", there is to be documentation on the medication administration records of the abbreviations and what the abbreviations mean. The facility may have staff circle their initials and document the reason a medication was not administered on the back of the MAR. The employee is also to be knowledgeable of the facility's policy when a resident refuses medications, i.e., notifying the supervisor or physician. If the medications are not administered because the resident is out of the facility, i.e., leave of absence and workshops, there should also be documentation of the medications sent with the resident. (A medication release form is often used for leave of absence.)
C. Administer and document PRN medications appropriately	C. Documentation of PRN medications is to include the amount administered, the time of administration and the reason for administration. The reason a PRN medication is to be administered is to be indicated in the order. The effectiveness of the medication is to also be documented when determined. A different employee, depending on the time of administration and shift schedules may record the effectiveness of the medication. If a resident is requesting or requiring administration of a prn medication on a frequent or routine basis, the employee should report this to the supervisor or the physician. PRN medications are to be administered when a resident needs the medication but may not be administered more frequently than the physician has ordered. The need for medication may be based upon the resident's request for the medication or observation by staff, i.e., resident exhibiting pain but does not request medications or may not be able to request the medication.

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D. Record information on other facility forms as required	D. The forms to be completed would depend on the facility's policy and procedures. The employee is to be knowledgeable of forms to complete, i.e., administration of controlled substances and documentation of medications provided for leave of absence.
E. Write a note in the resident's record when indicated	E. Any contact with the prescribing practitioner is documented in the resident's record. The employee needs to be knowledgeable of how to write a note in the resident's record appropriately, i.e., date and employee's signature. The employee also must be knowledgeable of the facility's procedures for documenting information that needs to be communicated to other staff or health professionals. This may be in the resident's record or on some other document used to communicate with staff or health professionals.
Section 11: Completion of Medication Pass	**Section 11**
A. Store medications properly	A. External and internal medications are to be stored in separate designated areas. The employee should store refrigerated medications in the medication refrigerator or locked container. Medications requiring refrigeration are to be stored at 36 degrees F to 46 degrees F (2 degrees C to 8 degrees C). A resident's oral solid medications should be stored together and separated from other residents' medications. It may not be possible for other medications, i.e., liquids and topical medications, to be separated by dividers for each resident. Medication storage areas need to be orderly so medications may be found easily.
B. Dispose of contaminated or refused medications per policy	B. Dosages of medications that have been opened and prepared for administration and not administered for any reason should be disposed of promptly. The disposal of these medications should be in accordance with the facility's policy and procedures. Loose medications are not to be kept in the facility or returned to the pharmacy.
C. Recheck medication administration records to make sure all medications are administered and documented	C. When the medication pass is complete, the employee is to recheck the medication administration records to make sure all medications have been administered and documented appropriately. At the end of the medication pass if a medication is not signed off upon recheck of the medication administration record, and the employee is certain the medication was administered, it is acceptable for the employee to document the administration. This is acceptable when there are only a few, i.e., one or two, omissions. It is not acceptable for the employee to have omitted documentation of the administration of medications for multiple residents.
Section 12: Medication Storage	**Section 12**
A. Maintain security of medications during medication administration	A. Medications are to be stored in a locked area, unless the medications are under the direct supervision of staff. Direct supervision means the cart is in sight and the staff person can get to the cart quickly, if necessary.

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B. Store controlled substances appropriately and count and sign controlled substances per facility policy	B. The storage of controlled substances is to be in accordance with the facility's policy and procedures. Controlled substances may be stored in one location in the medication cart or medication room. When Schedule II medications are stored in one location together or with other controlled substances, the controlled substances are to be under double lock. When controlled substances, including Schedule II, are stored with the resident's other medications, only a single lock is required. There has to be a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. The employee is to be knowledgeable of any forms to be completed.
C. Assure medication room/cart/cabinet is locked when not in use	C. Medication room/cart/cabinet is locked when not in use. Unless the medication storage area is under the direct supervision of staff, the medication area including carts is to be locked. When the medication cart is not being used, it should be stored in a locked area or stored in an area where it is under the supervision of staff.
Section:13: Administer medication utilizing appropriate technique for dosage form/route and administer accurate amount	**Section 13** The employee is to actually perform or at least be able to demonstrate to the instructor the proper technique for administering the different dosage forms and routes of administration for A through J **prior** to the employee being assigned to administer medications in the adult care home. Routes of administration for K through P only have to be validated if the employee will be responsible for administering these medications or medications by these routes. **The information below does not provide step by step procedures for administering medications. It provides pertinent information on techniques and infection control that the employee is to know. Refer to the State Approved Medication Administration Courses for Adult Care Homes for step by step procedures.**
A. Oral tablets and capsules **B. Oral liquids**	**A. & B. Oral Medications** • Appropriate positioning of resident, elevation of head. • The amount of medication to be administered, such as liquids, is never to be approximated. The amount ordered is to be the amount administered; therefore, a calibrated syringe is often necessary for measuring liquids in amounts less than 5 ml. and unequal amounts. • Liquid medications must be measured in a calibrated medication cup/device. • Measuring devices used for administering medications are to be calibrated and designed for measuring medications. Eating utensils or other household devices are not to be used for administering medications. • When measuring liquids, the medication cup should be placed on a flat surface and measured at eye level to ensure accuracy. • For liquids, hold the medication container so that the medication flows from the side opposite the label so it doesn't run down the container and stain or obscure the label. • Powdered medications such as bulk laxatives need to be given with the amount of fluids indicated. • More than one capsule or tablet may be in the same medication cup, but liquid medications are not to be mixed together.

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	• Special measuring devices for certain medications should only be used for that medication. (These measuring devices have increments marked off in "mgs." instead of "mls" and usually have the name of the medication on the measuring device.) • Liquids may have administration requirements such as Shake Well and Requires Dilution prior to administration. Examples of these liquids are Dilantin Suspension, which must be shaken thoroughly because the medication settles after administration and gives inconsistent dosing; Liquid Potassium and bulk laxatives have to be mixed with sufficient fluids to decrease side effects. • Refer to Handouts I-2 and I-3 , pages L-26-27, of *The Medication Administration: 10-Hour/15-Hour Training Course for Adult Care Homes*.
C. Sublingual medications	**C. Sublingual** • The medication is to be placed under the resident's tongue. The resident should be instructed not to chew or swallow the medication. Do not follow with liquid, which might cause the tablet to be swallowed.
D. Oral Inhalers	**D. Oral Inhalers** • Refer to Handout I-4, page L-28, of *The Medication Administration: 10-Hour/15-Hour Training Course for Adult Care Homes*. • Spacing and proper sequence of the different inhalers is important for maximal drug effectiveness. • The prescribing practitioner may specifically order the sequence of administration if multiple inhalers are prescribed or the pharmacy may provide instruction on the medication label or MAR. • The use of spacer or other devices to aid with administration should be discussed with the employee. • Wait at least one minute between puffs for multiple inhalations
E. Eye drops and ointments	**E. Eye drops and ointments** • Hands are to be washed prior to and after administration of eye drops and ointments. Gloves are to be worn as indicated. Gloves are to always be worn when there is redness, drainage or possibility of infection. • When two or more different eye drops must be administered at the same time, a 3 to 5-minute period should be allowed between each. • Dropper or medication container should not touch the resident's eyes.
F. Ear drops	**F. Ear Drops** • Wash hands before and after administration of medication. Gloves are to be worn as indicated. • By gently pulling on the ear, straighten the ear canal • The employee should request the resident to remain in same position for 5 minutes to allow medication to penetrate. It may be necessary to gently plug the ear with cotton to prevent excessive leakage.
G. Nose drops **H. Nasal Sprays/Inhalers**	**G. & H. Nose Drops & Nasal Sprays/Inhalers** • Wash hands before and after. Gloves are to be worn as indicated. • For drops: Resident should lie down on his/her back with head tilted back and the employee should request the resident to remain in the position for about 2 minutes to allow sufficient contact of medication with nasal tissue. • For Sprays: Hold head erect and spray quickly and forcefully while resident "sniffs" quickly. It may be necessary

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	to have the resident tilt head back to aid penetration of the medication into the nasal cavity. • The dropper or spray should be at least wiped with a tissue before replacing the cap.
I. Transdermal medications/Patches	**I. Transdermal Products/Patches** • Application sites for transdermal patches should be rotated to prevent irritation. The application sites should be documented on the MAR. • If the patch is ordered to be worn for less than 24 hours, documentation on the medication administration record is to reflect that the patch was removed and the time it was removed. • Gloves should be worn and hands washed after the patch is applied or removed. • When a patch is removed, the area should be cleaned to remove residual medication on the skin.
J. Topical (creams and ointments; not dressing changes)	**J. Topical** • Wear gloves and use a tongue bade, gauze or cotton tipped applicator to apply the medication. • A new applicator should be used each time medication is removed from container to prevent contamination. • Privacy should be provided, as necessary. This would depend on the area to be treated. • The lid or cap of the container should be placed to prevent contamination of the inside surface. • Gloves and supplies used should not be discarded in areas accessible to residents.
	(Validation for items K. through P is only necessary if the employee will be performing the task. These are tasks under Licensed Health Professional Support. Refer to regulations 10A NCAC 13F/13G .0504; .0505 and .0903.)
K. *Clean dressings	**K. *Clean Dressing** • The employee is to be knowledgeable of techniques with dressing change to ensure there is no cross-contamination • Information under item J is also applicable to dressing changes.
L. *Nebulizers	**L. *Nebulizers** • Nebulizer equipment, tubing and mask, is to be cleaned and changed in accordance with the facility's policy.
M. * Suppositories **1. Rectal** **2. Vaginal** **N. * Enemas**	**M.&N. Suppositories & Enemas** • Wash hands before and after. Gloves are to be worn and properly disposed of. • Remove foil or wrapper from suppository. A small amount of lubricant applied to the suppository will aid with administration of rectal preparations. • Privacy is to be provided. • Reusable applicators are to be cleaned with soap and water and properly stored.
O. * Injections **1. Insulin**** 2. **Other subcutaneous medications**	**O. Injections** • Syringes are not to be recapped and must be disposed of in appropriate containers, i.e., Sharps. • **For insulin, the employee is to have also received training according to regulation 10A NCAC 13F/13G .0505. • The employee is to be knowledgeable of the facility's policy on storage of insulin.

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	• Employee is to be knowledgeable of technique for mixing different insulins. • Employee is to be knowledgeable of facility's policy and procedure of when insulin should be held and interventions for hypoglycemia and hyperglycemia reactions. • Wash hands before and after. Gloves are to be worn.
P. * Gastrostomy Tube	**P. Gastrostomy Tube** • Wash hands before and after. Gloves are to be worn. • Tube should be flushed with sufficient water prior to and after the administration of medications. The amount of water should be reflected in the physician's order or the facility's procedure. • Solid medications that are crushed or altered for administration should be dissolved well in water. Employee is to also check to check with the pharmacist to ensure medications may be crushed or altered.
Section 14: Other Tasks/Skills	**Section 14**
A. Self-Administration of medications by residents	A. The employee is to be knowledgeable of the facility's policy and procedure for self-administration. A physician's order is required for the resident to self-administer medications and be able to store medications in their rooms.
B. Received orientation to facility's policy and procedures for medication administration	B. The employee has been provided a copy of the facility's policy and procedures, knowledgeable of the facility's policy and procedures and able to locate the manual as a resource and reference.