

MEDICATION ADMINISTRATION PROCEDURES

PROCEDURE FOR ADMINISTERING ORAL MEDICATIONS

1. Wash your hands.
2. Gather needed supplies.
3. Remove the person's medication(s) from the medication storage area.
4. Check the label on the bottle or card and select the medication to be administered.
5. Compare the medication administration record with the label to make sure they correlate. If there is a discrepancy, call the nurse before giving the medication.
6. Observe the person to see if there is anything that needs to be reported to the nurse or doctor before giving the medication.
7. Do not touch the medications with your hands.
8. Follow the instruction listed below for each type of oral medication to be given.

To give tablets or pills:

- Check the label. Pour the correct number of pills or tablets into the lid of the medication container, pour the pills into the medication cup and put the cap back on the bottle.
- When removing medication from a blister pack, hold the medication cup under the correct blister and punch the medication directly into the cup. Document date, time and initials next to the blister that the medication was removed from.
- Check the label.
- Identify the person and give the medication with a full glass of water (unless another liquid is specified).
- Watch the person swallow the medication.

If more than one oral medication is to be given to the person:

- Read the label and select the other medication to be given.
- Compare the label against the medication administration record.
- Check the label and pour the correct number of pills into the lid of the medication container, then into a med cup and put the cap back on the bottle.
- When removing medication from a blister pack, hold the medication cup under the correct blister and punch the medication directly into the cup. Document date, time and initials next to the blister that the medication was removed from.
- Check the label.
- Repeat this procedure for each oral medication to be administered to the person.
- Identify the person and give the medication with a full glass of water or other liquid.
- Watch the person swallow the medication.

To give Lozenges:

- Check the label and unwrap the lozenge (if necessary) and put it in a medication cup.
- Identify the person and tell the person to place the lozenge on their tongue.
- Tell the person to keep the lozenge in their mouth until it is completely dissolved.
- Do not give water with lozenges or immediately after.

To give Sublingual tablets:

- Check the label and pour the correct number of tablets into the lid of the medication bottle, then pour the tablets into a medication cup and replace the lid on the bottle.
- When removing medication from a blister pack, hold the medication cup under the correct blister and punch the medication directly into the cup. Document date, time and initials next to the blister that the medication was removed from.
- Check the label.
- Identify the person and tell them what you are going to do.
- Using a glove, place the tablet under the person's tongue to dissolve.
- Tell the person not to chew the tablet.
- Do not give water with sublingual medications.

To give liquid medication:

- Check the label on the bottle, and then turn the label away from you.
- At eye level, carefully pour the correct amount of the liquid medication into a graduated plastic med cup or into a medication spoon.
- Check the label and put the cap back on the bottle.
- Give the liquid medication.
- Water is not given with some liquid medications. Check directions on the bottle.
- If a medication spoon has been used, wash it with soap and warm water.

9. Throw away used disposable supplies.
10. Put the person's medications back in the medication storage area.
11. Make sure the storage area is secure.
12. Wash your hands.
13. Chart the medication administered on the medication administration record.

PROCEDURE FOR ADMINISTERING SKIN MEDICATIONS

1. Wash your hands.
2. Gather needed supplies.
3. Check the label and remove the medication from the medication storage area.
4. Compare the label with the medication administration record to make sure they correlate. If there is a discrepancy, contact the nurse before giving the medication.
5. Identify the person and explain what is to be done.
6. Position the person as indicated.
7. Check the area to which medication is to be applied to see if the condition has changed. If there are concerns, call the nurse or doctor before giving the medication.
8. When indicated, wash the area to which medication is to be applied with soap and warm water. Dry the area if indicated.
9. Check the label and apply the medication to a Q-tip, tongue blade, gauze square or to disposable gloves, whichever is most appropriate. Never use the bare hands to apply topical medications.
10. Close the medication container and put back in the person's medication supply.
11. Apply the medication.
12. Throw away used disposable supplies.
13. Put back other supplies.
14. Return supplies to the medication storage area and make sure it is secure.
15. Wash your hands.
16. Chart the medication on the medication administration record.

PROCEDURE FOR ADMINISTERING EYE DROPS

1. Wash your hands.
2. Gather needed supplies.
3. Check the label and remove the medication from the storage area.
4. Compare the label with the medication administration record to make sure they correlate. If there is a discrepancy, contact the nurse before giving the medication.
5. Identify the person and explain what is to be done.
6. Have the person sit or lie down.
7. Observe affected eye(s) for any unusual condition, which should be reported to the nurse or doctor prior to medication instillation.
8. Position the person with head back and looking up.
9. Put on gloves.
10. When indicated, cleanse eye with clean tissue, wiping from inner corner outward once. If drops are to be instilled into both eyes, a clean tissue is used for each eye.
11. Check the label and open the bottle.
12. To administer the eye drops:
 - Separate lids by raising upper lid with forefinger and lower lid with thumb.
 - Approach the eye with the dropper from below the eye, outside of the person's field of vision.
 - Do not allow the dropper to touch the eye.
 - Apply drop(s) gently near the center of the lower lid, not allowing drop(s) to fall more than one inch before striking eye.
 - Ask the person to keep eyes gently closed for a few minutes.
13. Close the medication container.
14. Wipe off excess medication from the eye with a clean tissue, using a separate clean tissue for each eye if the medication is administered to both eyes.
15. Throw away disposable supplies.
16. Return medication to the storage area and make sure the area is secure.
17. Wash your hands.
18. Chart the medication on the medication administration record.

PROCEDURE FOR ADMINISTERING EYE OINTMENT

1. Wash your hands.
2. Gather needed supplies.
3. Check the label and remove the medication from the storage area.
4. Compare the label with the medication administration record to make sure they correlate. If there is a discrepancy, contact the nurse before giving the medication.
5. Identify the person and explain what is to be done.
6. Have the person sit or lie down.
7. Observe affected eye(s) for any unusual condition which should be reported to the nurse or doctor prior to medication application.
8. Position the person with head back and looking upward.
9. Put on gloves.
10. When indicated, cleanse the eye with clean tissue, wiping from inner corner outward once. If ointment is to be applied to both eyes, a clean tissue is used for each eye.
11. Check the label and remove the cap.
 - Retract lower lid.
 - Approach the eye from below, outside the person's field of vision.
 - Apply ointment in a thin layer along the inside of the lower lid.
 - Do not allow the medication container to touch the eye.
12. Position the person comfortably and ask him/her to keep eyes closed gently for a few minutes.
13. Replace the cap on the medication and put it back in the storage area.
14. Throw away disposable supplies.
15. Make sure the storage area is secure.
16. Wash your hands.
17. Chart the medication on the medication administration record.

PROCEDURE FOR ADMINISTERING EAR DROPS

1. Wash your hands.
2. Gather needed supplies.
3. Check the label and remove the medication from the storage area.
4. Compare the label with the medication administration record to make sure they correlate. If there is a discrepancy, contact the nurse before giving the medication.
5. Identify the person and explain what is to be done.
6. Position the person:
 - if lying in bed, put bed flat and turn head to opposite side.
 - if sitting in chair, tilt head sideways until ear is as horizontal as possible.
7. Put on gloves when drainage is present.
8. Clean entry to ear canal with a clean tissue or cotton ball when indicated.
9. Observe the affected ear for any unusual condition which should be reported to the nurse or doctor prior to ear drop instillation.
10. Check the label and draw up the ordered amount of medication into the dropper, if applicable.
11. Administer the ear drops by pulling the ear gently backward and upward and instilling the number of drops ordered into the ear canal. Do not contaminate the dropper by touching any part of the ear.
12. Have the person remain in the required position for five minutes.
13. If drops are ordered for both ears, wait at least five minutes before putting drops in the second ear, repeating the procedure.
14. Replace cap and put the medication back in the storage area.
15. Make sure the storage area is secure.
16. Throw away used disposable supplies.
17. Wash your hands.
18. Chart the medication on the medication administration record.

PROCEDURE FOR ADMINISTERING RECTAL MEDICATIONS

1. Wash your hands.
2. Gather needed supplies.
3. Check the label and remove the medication from the storage area.
4. Compare the label with the medication administration record to make sure they correlate. If there is a discrepancy, contact the nurse before giving the medication.
5. Check the label and return remaining supply of medication to the storage area.
6. Make sure storage area is secure.
7. Ensure privacy when administering the medication.
8. Identify the person and explain what is to be done.
9. Position the person on their left side.
10. Put on disposable glove.
11. Remove suppository from the wrapper or foil, if applicable.
12. Lubricate tip of the suppository with a water-soluble lubricant (such as K-Y jelly).
13. Insert suppository into the rectum beyond the sphincter, pushing it in gently with gloved finger.
14. Encourage relaxation by instructing the person to breathe slowly through their mouth.
15. Withdraw finger, press tissue against anus until the urge to expel subsides.
16. Throw away used disposable supplies.
17. Wash your hands.
18. Chart the medication on the medication administration record and document effectiveness of the medication in the progress notes.

PROCEDURE FOR ADMINISTERING VAGINAL MEDICATIONS

1. Wash your hands and gather needed supplies.
2. Check the label and remove the medication from the storage area.
3. Compare the label with the medication administration record to make sure they correlate. If there is a discrepancy, contact the nurse before giving the medication.
4. Check the label, and place the prescribed medication dose in the applicator. To make insertion easier, the suppository or applicator tip may be lubricated with water or water-soluble lubricating jelly (such as K-Y jelly).
5. Return remaining medication to the storage area and secure the area.
6. Identify the person and explain what is to be done. Ask the person to urinate before beginning procedure.
7. Put on gloves.
8. Ensure privacy and position the person properly on her bed, lying on her back with knees flexed and legs apart.
9. If discharge is noted:
 - Soak several cotton balls in warm soapy water.
 - Separate the labia with one hand and working from front to back clean the left side of the labia, using a downward stroke. Discard cotton ball.
 - Using a fresh cotton ball, repeat the procedure for the right side of the labia and then the center of the labia.
 - Be sure to use a clean cotton ball for each stroke.
10. Separate the labia with one hand. Insert the applicator into the vagina with your other hand. Advance the applicator about 2 inches, angling slightly toward the back.
11. Push the plunger to insert the medication. Remove the applicator.
12. Encourage the person to remain lying down for about 30 minutes so the medication can be absorbed.
13. If applicator is not disposable, wash it with soap and warm water.
14. Discard used disposable supplies. Replace any other supplies and make sure medication storage area is secure.
15. Wash your hands.
16. Chart the medication on the medication administration record

PROCEDURE FOR ADMINISTERING TRANSDERMAL OINTMENT OR PATCH

1. Wash your hands. Gather needed supplies.
2. Check the label and remove the medication from the storage area.
3. Check the label. Compare the label with the medication administration record to make sure they correlate. If there is a discrepancy, call the nurse or doctor before giving the medication.
4. Identify the person and explain what is to be done.
5. Provide for privacy.
6. Put on gloves.
7. As needed, remove any previously applied strips or disks. Dispose as directed.
8. Ointment
 - Check the label.
 - Place the prescribed amount of ointment on the application strip or measuring paper, taking care not to get any on your skin.
 - Apply the strip to any dry, hairless area of the body. Don't rub the ointment into the skin.
 - Tape the application strip and ointment to the skin.
 - If desired, cover the application strip with plastic wrap; and tape the wrap in place.

Patch

- Check the label.
 - Open the package and remove the disk.
 - Without touching the adhesive surface, remove the clear plastic backing.
 - Apply the disk to a dry, hairless area of the body as directed.
9. If possible, mark the patch with date and time applied.
 10. Remove your gloves. Wash your hands.
 11. Chart the medication on the medication administration record.

Special considerations for Transdermal Medications.

- Apply transdermal medications at the same time every day to ensure a continuous effect.
- Alternate application sites to avoid skin irritation.
- Do not apply below the elbow or knee.
- Do not get the patch wet. If the patch falls off, discard it, clean the site with soap and water, and contact nurse for directions.
- Do not apply to broken or irritated skin.

PROCEDURE FOR ADMINISTRATION OF INSULIN USING THE INSULIN PEN

1. Wash your hands and put on gloves.
2. Assemble this equipment in a clean area:
 - Insulin Pen with correct dose dialed and second staff person has compared the label on the syringe to the medication administration record to make sure they correlate. If there is a discrepancy the nurse or physician must be called before giving the injection.
 - Alcohol swabs or wipes (or rubbing alcohol and cotton balls).
3. Provide privacy.
4. Select an appropriate injection site. Refer to the guide your nurse gave you, showing you how to rotate injection sites correctly. Keep a record of which sites you used and when you used them.
5. Pull the skin taut; then, using a circular motion, clean the skin with an alcohol swab or wipe.
6. Check the label. Remove the needle cover. Do not touch the needle. Touch only the barrel.
7. Using your thumb and forefinger, pinch the skin at the injection site.
8. Quickly push the needle (up to its hub) into the subcutaneous tissue at a 90-degree angle. Inject the insulin by using your thumb to push in the injection button completely.
9. Keep pressing and continue to hold the injection button firmly while counting slowly to 5.
10. Place an alcohol swab or cotton ball over the injection site; then press down on it lightly as you withdraw the needle. Do not rub the injection site when withdrawing the needle.
11. When the injection is done, an “o” or an arrow must be seen at the end of the pen. This means the full dose has been delivered. **If you do not see the “o” or an arrow at the end of the pen a full dose was not administered.** Call the nurse.
12. Holding only the insulin pen, carefully replace the outer needle shield by sliding the needle into the outer shield.
13. Remove the capped needle by turning it counterclockwise. Place the used needle in a sharps container.
14. Replace the cap on the Pen.
15. Throw gloves and other used disposable supplies in the garbage. Replace other supplies.
16. Wash your hands and make sure the medication area is secure.
17. Chart the medication.

PROCEDURE FOR SUBCUTANEOUS INSULIN INJECTIONS

1. Wash your hands and put on gloves.
2. Assemble this equipment in a clean area:
 - A sterile syringe and needle pre-filled with insulin. Check the label.
 - Alcohol swabs or wipes (or rubbing alcohol and cotton balls).
3. Compare the label on the syringe to the medication administration record to make sure they correlate. If there is a discrepancy, call the nurse or doctor before giving the insulin.
4. Check the label and return remaining supply of syringes to the medication storage area and make sure the area is secure.
5. Identify the person and explain what is to be done.
6. Ensure privacy when administering the medication.
7. Select an appropriate injection site. Refer to the guide your nurse gave you, showing you how to rotate injection sites correctly. Keep a record of which sites you use and when you used them.
8. Pull the skin taut; then, using a circular motion, clean the skin with an alcohol swab or wipe or a cotton ball soaked in alcohol.
9. Remove the needle cover. Do not touch the needle. Touch only the barrel and plunger of the syringe.
10. Using your thumb and forefinger, pinch the skin at the injection site.
11. Quickly plunge the needle (up to its hub) into the subcutaneous tissue at a 90-degree angle. Inject the insulin.
12. Place an alcohol swab or cotton ball over the injection site; then press down on it lightly as you withdraw the needle. Do not rub the injection site when withdrawing the needle.
13. Do not recap the needle. Dispose of the needle and syringe in a puncture resistant plastic container.
14. Throw gloves and other used disposable supplies in the garbage.
15. Wash your hands.
16. Chart the insulin.

GUIDELINES FOR DEVELOPING A SELF ADMINISTRATION PROGRAM

1. Obtain a physician's order for a person to be on a self medication program.
2. To qualify for a self medication program, the person should meet the following criteria:
 - Can physically grasp and handle medications;
 - Is physically able to fill a glass of water and drink (if necessary);
 - Is able to follow verbal instructions;
 - Is able to remember instructions from beginning to end;
 - Is able to make accurate time determinations for taking medications;
 - Is responsible for his/her own possessions;
 - Is able to report to an appropriate individual when he/she is having difficulty in taking medications or is having a change in state of well being;
 - Is able to identify medication on sight;
 - Knows the reason for taking medications;
 - Is able to identify and take correct dosage; and
 - Indicates willingness to take medications.
3. Teaching to the person in the following areas should occur as indicated:
 - The necessity for taking each particular drug;
 - The hours of the day each drug is taken;
 - Proper storage and security of the drug;
 - Proper reading or understanding of drug labels and prescribed dosage amounts;
 - Demonstration of the procedure by staff and correct return demonstration by the person; and
 - Where, when and how to obtain refills
4. If medisets or envelopes are used, they must be labeled.
5. Medication programming should be done in stages.
 - The individual must have successful performance in each stage before moving on to the next stage.
 - Each stage will increase the individual's responsibility.
 - Safe storage of medication must be addressed at each stage.
 - Each stage must have a method of evaluating the person's performance
 - Medication documentation is required until the person successfully completes the program and is totally independent in self medication administration.
6. The nurse may provide consultation for the development of a self-medication program to help ensure the program meets guidelines for safety and documentation requirements.