

## PRINCIPLES OF MEDICATION ADMINISTRATION

As a trained medication passer, I understand and adhere to the following:

1. I always pass medications under the delegation and supervision of a licensed nurse.
2. Before preparing and administering medication I must have the:
  - Knowledge about the medication(s) to be administered. Being medication knowledgeable means knowing intended purpose, common side effects, life threatening effects, knowledge of what to do should a life threatening effect occur and proper route of administration.
  - Knowledge about the individual's general health and condition that is receiving the medication.
  - Skills necessary to administer medication(s).
  - Knowledge that "no drug is harmless."
  - Knowledge of my own limitations and the line of responsibility related to medication administration.
  - Knowledge and ability to practice ethical behavior relating to medication administration: to pass medications to one client at a time and to pass those medications that I set up. I realize that I must set a good example to my co-workers and that others will learn from my demonstration of administration techniques.
  - Skills to properly document the medication administration process.
  - Knowledge and ability to practice cleanliness skills including proper hand washing and infection control techniques.
  - Knowledge and ability to practice organizational skills including giving medications accurately and safely.
  - Knowledge to pass any medication only with a physician order.
  - Knowledge that some medication administration procedures are very individualized for a person.
  - Understanding that constant practice and continuing education about medications is important.
  - Knowledge that a medication passer may not give PRN medications without involving the assessment of a nurse.

Signature



Date

8-17-22

## OBSERVED SKILL ASSESSMENT

Name of staff member Monseral Hernandez

The staff member has successfully demonstrated the ability to administer medications by the following routes, according to facility procedures:

Route	Date	Nurse Signature
Oral	<u>8.17.22</u>	<u>J. Anderson RN</u>
Skin/topical	_____	_____
Ear drops	_____	_____
Eye drops	_____	_____
Buccal	<u>8.17.22</u>	<u>J. Anderson RN</u>
Sublingual	<u>8.17.22</u>	<u>J. Anderson RN</u>
Transdermal	_____	_____
Rectal	_____	_____
Vaginal	_____	_____
Inhaler	_____	_____
Nasal Spray	_____	_____
Gastrostomy	_____	_____
Subcutaneous Injection	_____	_____
Other	<u>Blood glucose 8.17.22</u>	<u>J. Anderson RN</u>
Other	_____	_____
Other	_____	_____

File in staff member's personnel file.

## Employee Training for the Insulin Pen Delivery System

EMPLOYEE NAME Morse Hernandez

DATE 8/31/22 LENGTH OF TRAINING 5

THE EMPLOYEE HAS RECEIVED THE FOLLOWING INFORMATION:

Yes No N/A

- |                                     |                          |                          |   |
|-------------------------------------|--------------------------|--------------------------|---|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Overview of insulin delivery system                  |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Equipment necessary for procedure                    |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Specific protocol                                    |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Consequences if procedure is not performed correctly |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Symptoms and signs requiring physician notification  |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Procedure for contacting nurse or doctor             |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Procedure for cleaning/replacing equipment           |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. Location of written procedure and protocol           |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. Purpose and effects of procedure                     |
| <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | 10. Other _____   |

**THE EMPLOYEE HAS SUCCESSFULLY DEMONSTRATED THEIR SKILL IN PERFORMING THIS PROCEDURE.**

1. I fully understand the above information and am willing to assume the responsibility for performing the procedure.
2. I will perform the procedure according to the written instructions.
3. I will notify the nurse or physician of problems or questions.

Morse Hernandez  
Employee Signature

J. Anderson RN  
Nurse Signature

## Employee Training for Blood Glucose Testing

EMPLOYEE NAME Monseral Hernandez

DATE 8-17-22 LENGTH OF TRAINING .5

THE EMPLOYEE HAS RECEIVED THE FOLLOWING INFORMATION:

Yes No N/A

- |                                     |                          |                          |   |
|-------------------------------------|--------------------------|--------------------------|---|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Overview of diabetes and diabetic medication         |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Equipment necessary for procedure                    |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Specific protocol                                    |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Consequences if procedure is not performed correctly |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Symptoms and signs requiring physician notification  |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Procedure for contacting nurse or doctor             |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Procedure for cleaning/replacing equipment           |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. Location of written procedure and protocol           |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. Purpose and effects of procedure                     |
| <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | 10. Other _____   |

**THE EMPLOYEE HAS SUCCESSFULLY  
DEMONSTRATED THEIR SKILL IN PERFORMING THIS  
PROCEDURE.**

1. I fully understand the above information and am willing to assume the responsibility for performing the procedure.
2. I will perform the procedure according to the written instructions.
3. I will notify the nurse or physician of problems or questions.

  
Employee Signature

  
Nurse Signature