



# Medication Administration Guide

## **Dear Omnicare Customer,**

This booklet will assist in maintaining ongoing regulatory compliance with the medication pass process. This booklet can be utilized to promote current Standards of Practice, and maintain an optimal skill set during this process.

This booklet was designed to assist the long term care facility with step- by-step instructions for a medication pass that is compliant with current guidelines. A review of the pharmacy F-Tags, medication preparation, skills checklists, observation tools as well as a sample Quality Assurance (QA) schedule have been provided.

This resource should be used in conjunction with state and federal regulations, facility policies and any accrediting body guidance that may apply. The most stringent rule typically takes precedence.

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## Medication Storage

Proper medication storage is a standard of practice. The pharmacy fills medications using specially packaged administration systems designed to assist facilities in reducing medication errors. Examples of specialized packaging include blister packaging, unit dose systems, and multidose packaging. Although there are no federal or state regulations specifying particular forms of medication packaging, facilities must have a system in place to organize medications and reduce medication errors.



### Proper drug storage includes the following:

- Store drugs in their original container or packaging and adhere to any auxiliary labeling
- Date and initial drugs with accelerated expiration dates or multi-dose vials when opened and check expiration dates
- Keep internal/externals separated

### Medication Room Guidance

- Medication Rooms should be locked when not in use
- Cabinets used for medication storage outside of a medication room should be locked
- Pharmacy totes should be stored in a locked area
- Only licensed individuals may have access to a medication room
- Maintenance department and housekeeping should not have a key or unescorted access
- Medication storage areas should always be clean and orderly
- Personal items are not stored in the medication room (e.g., drinks, phones, purses, coats)
- Maintain the appropriate temperature (59-77°F) and monitor humidity per federal regulations
- Expired and/or discontinued medications should be stored separately from other medications, and returned or disposed of in a timely manner

### Refrigerated Medications

- Medications requiring refrigeration must be locked or stored in a locked room. Controlled medications needing refrigeration must be double locked.
- Temperature is maintained between 36-46°F. Daily temperature logs must be maintained and visible.
  - If vaccines are stored, the temperature is documented twice daily
- All refrigerators should be clean and free from spills
- Freezers should be frost-free
- Only food designated for residents during medication pass should be stored in the refrigerator
- Food and supplements should be covered and dated when opened. Follow manufacturer's recommendation for "use by" date.
- Medication pass food and medications should be stored separately (e.g., on separate shelves/compartments)
- Lab specimens should not be stored in medication refrigerator
- Expired and/or discontinued medications should not be stored in medication refrigerators
- **Unopened** insulin vials/pens should be stored in the refrigerator

## Medication Carts

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- Medication carts and cabinets should be locked when unattended
- Medication carts are clean, stocked, and organized
- Pill crusher must be cleaned after each use
- Alcohol based hand gel must be stored properly (no resident access), and not expired
- Spoons are stored with the handle side up
- Personal items are not stored in/on the cart (e.g., drinks, phones)
- Pre-set/pre-prepared medications are not permitted (unless allowed by state regulation)
- Medications are properly labeled with resident name, lot #, and expiration date
- Over-the-counter medications for individual residents should have the resident's name and expiration date noted on the medication (follow state regulations)
- Medication is available for all active resident orders
- Discontinued and/or expired medications should be removed from medication carts
- Medications are reordered timely (when 3-5 days of medication supply is remaining)
- Storage containers should not be taken into resident rooms (e.g., eye drop, inhaler boxes)
- No writing on prescription labels (Utilize "Directions Changed" stickers)
- Medication dating (follow manufacturer recommendation)
  - **Insulins.** Label with date when opened. Expire in 28 days, unless the manufacturer specifies otherwise
  - **Eye Drops.** Eye medication bottles/tubes with accelerated expiration dates must be dated/initialed upon opening. Follow manufacturer instructions, or facility policy.(e.g., Latanoprost - 42 days)
  - **Inhalers.** Label with date when opened. Follow manufacturer recommendations.
- Medications should be stored separately according to route of administration:
  - **External medications:** includes transdermal patches, shampoos, creams, treatments, and other medications applied to the skin
  - **Internal medications:** includes oral medications, injectables, oral inhalers, ophthalmics, otics, and medications intended for instillation into an orifice
    - Further separate routes in medication carts (e.g., oral, injectables, liquids, eyes, ears, nose, inhalers)

## Security

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- It is the designated staff member's responsibility to maintain the possession of the keys and security of the medication cart. The medication cart always needs to be securely locked when it is out of the nurse's visual sight.
- Controlled medications must be counted with another designated staff member when there's an exchange of keys

## Pharmacy Associated F-Tags

Omnicare Pharmacy is committed to assist our customer facilities with the tools they need to promote compliance with the State and Federal Survey Process and Best Standards of Practice for Medication Administration. For your review, listed are the Federal Tags and Guidelines associated with medication administration.

F Tag	Interpretive Guideline
<b>F 550</b> <b>Resident Rights/Exercise of Rights</b>	<p>The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. If a resident can understand the situation and express a preference, the resident should be informed, and his/her wishes respected to the degree practicable.</p>
<b>F 583</b> <b>Personal Privacy/ Confidentiality of Records</b>	<p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p>
<b>F 554</b> <b>Resident Self-Admin Medications-Clinically Appropriate</b>	<p>If a resident requests to self-administer medication(s), it is the responsibility of the interdisciplinary team to determine that it is safe before the resident exercises that right.</p>
<b>F 605</b> <b>Right to be Free from Chemical Restraints</b>	<p>The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p>
<b>F 658</b> <b>Services Provided Meet Professional Standards</b>	<p>The services provided or arranged by the facility must meet professional standards of quality. Professional standards of quality means services that are provided according to accepted standards of clinical practice.</p>
<b>F 684</b> <b>Quality of Care</b>	<p>Facility must identify and provide needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's highest practicable physical, mental, and psychosocial needs.</p>
<b>F 694</b> <b>Parenteral/IV Fluids</b>	<p>The facility must ensure that residents receive proper treatment and care for injections and parenteral and enteral fluids.</p>
<b>F 757</b> <b>Drug Regimen is Free from Unnecessary Drugs</b>	<p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p>
<b>F 759</b> <b>Free of Medication Error Rates of 5% or More</b>	<p>The facility must ensure that it is free of medication error rates of 5 percent or greater.</p>

F Tag	Interpretive Guideline
<b>F 760</b> <b>Residents Are Free of Significant Medication Errors</b>	<p>The facility must ensure that the residents are free of significant medication errors.</p>
<b>F 755</b> <b>Pharmacy Services/ Procedures/Pharmacist/ Records</b>	<p>The facility must provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement described in §483.75(h) of the Code of Federal Regulations. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs, and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility; establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p>
<b>F 756</b> <b>Drug Regimen Review, Report</b>	<p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The Pharmacist must report any irregularities to the attending physician, and the Director of Nursing, and these reports must be acted upon.</p>
<b>F 761</b> <b>Label/Store Drugs &amp; Biologicals</b>	<p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments, under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II in the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>
<b>F 880</b> <b>Infection Prevention &amp; Control</b>	<p>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.</p>



## Medication Cart Setup\*

### Do you have...

- Medication Administration Record Book or laptop
- Keys
- Pen
- Pitcher of water/juice
- Cups
- Spoons
- Food Medium (e.g., applesauce, pudding)
- Pill Crusher
- Medication cups
- Tissues
- Alcohol/foam hand cleanser
- Germicidal Wipes
- BP Cuff
- Stethoscope
- Pulse Oximeter
- Watch
- Syringes/Safety Needles
- Trash bag
- Gloves
- “Should not crush” List
- Pad of paper

### \* CHECK MARs FOR ANY SPECIAL REQUIREMENTS

(e.g., glucometer, oral syringes)

## Preparing for Medication Administration

### Supplies

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Prior to beginning a medication administration pass, ensure that the medication cart is well stocked with the required supplies. This will prevent unnecessary disruptions and minimize the potential for medication errors.

- Pill crusher is clean
- Vital sign equipment is cleaned before and after each resident use
- Use syringe when measurements are not labeled on medication cup

### Handling of Food/Beverage for Medication Cart

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Only food and beverage items that will be used with the medication pass should be on the medication cart. They should be labeled with appropriate date and time and should be in closed containers. Once the medication pass is completed, any food and beverage items used during the medication pass should be refrigerated, per facility policy. Food and medication items should be stored separately.

- Medication, bowl of spoon, inside of medication cup, water cup, and straw should not be touched
- Food and fluid items are covered and dated
- “Take with food” medications are given with 3-4 ounces of semi-solid food

### Allowed Time Schedules

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To ensure timeliness of medication administration, the resident must receive the medication within one hour prior to or one hour after the designated administration time. Always review the MARs at the beginning of shift to be aware of any medications that may not be scheduled during the routine medication pass or those that may have specific administration requirements provided by the manufacturer.

- Medication pass starts and ends on time (per facility policy)
- Administer medications before meals (AC) and after meals (PC) as ordered
- Some medications must be administered at specific times (e.g., antibiotics, pain medications, Sinemet®)
- “Empty stomach” is defined as 1 hour before or 2 hours after meal

## Hand Hygiene

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- Ensure supplies necessary for adherence to hand hygiene are readily accessible in all areas where resident care is being delivered
- Prior to beginning the medication pass, perform hand hygiene using alcohol-based hand rub (ABHR) or by washing hands for at least 20 seconds with soap and water
- ABHR (60-95% alcohol) is preferred for use in most situations and is an effective method of cleaning hands
- Use soap and water when hands are visibly soiled, before eating, and after using the restroom
- During the medication pass, perform hand hygiene and use gloves
  - when administering eye drops, ear drops, nose drops, nasal sprays, or inhalers
  - when applying or removing transdermal products such as patches or semi-solid gels delivered via metered-dose pump
- Perform hand hygiene
  - after administering medications to each resident
  - immediately before touching a resident
  - before performing an aseptic task or handling and invasive medical device such as an indwelling catheter
  - before moving from work on a soiled body site to a clean body site on the same resident
  - after touching a resident or the resident's immediate environment
  - after contact with blood, body fluids, or contaminated surfaces
  - immediately after glove removal

## 10 Rights Related to Administration of Medication

1. **RIGHT** resident
2. **RIGHT** assessment/reason
3. **RIGHT** education
4. **RIGHT** to refuse
5. **RIGHT** medication
6. **RIGHT** dose/dosage form
7. **RIGHT** time
8. **RIGHT** route
9. **RIGHT** response
10. **RIGHT** documentation

## Medication Administration Practice Recommendations

- As each medication is prepared for administration, compare the medication to the MAR and to the label (3-way-check).
- Medication carts are clean, stocked, and clear of trash
- Medications should not come into contact with any surface except for the medication cup
- Appropriate hand hygiene is performed before and after direct resident contact (alcohol-based hand rub or soap and water)
- Alcohol based hand rub is not appropriate when caring for residents with *Clostridioides difficile* (*C. diff*) or Norovirus. Hand hygiene must be performed with soap and water.
- Resident is identified (e.g., picture, armband, name)
- Resident is properly positioned for ease of administration
- Nurse or qualified staff should be able to explain medication use and side effects
- Drug label, Medication Administration Record (MAR) and prescriber's order are identical
- Resident's rights and privacy are maintained. MAR is protected.
- "Take with food" medications are given with 3-4 ounces of semi-solid food
- Only crush medications that manufacturer states are crushable
- Use syringe when measurements are not labeled on medication cup
- Suspensions must be shaken well, and over-pours discarded
- Nurse or qualified staff should stay with resident until medications have been taken
- Withheld or refused medications are documented per policy
- Reason for PRN medication request is documented, and effectiveness is assessed and documented
- Exercise caution when handling medications labeled as "hazardous" or "cytotoxic"

## Specific Preparation of Varying Medication Forms

### Tablets and Capsules

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- **Always have gloves available on the medication cart if needed to handle a tablet or capsule.**
- **Never** touch the tablet or capsule with your fingers. Always wear gloves when handling medications.
- Place a “Should Not Crush” list on Medication Cart for quick reference
  - Examples of medications that should not be crushed are enteric coated tablets and extended-release dosage forms.
  - If the resident cannot swallow, contact the doctor and the pharmacist for discussion of alternate preparations.
- Exceptions to “Should Not Crush”:
  - If the prescriber orders a drug to be crushed which the manufacturer states should not be crushed, the prescriber or the pharmacist must document in the clinical record why crushing the medication will not adversely affect the resident. The pharmacist should inform the facility staff to observe for pertinent adverse effects.
- When crushing, use a commercial pill crusher and crusher pouch and/or medication cup
- Clean pill crusher immediately after each use
- Medications that are to be given within specific parameters should be crushed separately (e.g., Digoxin is dependent on apical pulse). Follow facility policy.
- Sublingual or buccal tablets should not be swallowed. If the resident persists with swallowing a sublingual or buccal tablet (e.g., nitroglycerin) despite all efforts to train otherwise, the facility should contact the physician and pharmacy to seek an alternative dosage form for this medication.

### Liquids

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- Liquid medications are measured at eye level and on a flat surface
- Pour liquids away from the label into a graduated medication cup
- Wipe away from the label to prevent drips or sticky residue from accumulating around the top of the bottle.
- Never pour excess liquid medication back into the bottle.
- If the medication cannot be precisely measured in the cup, use a different type of measuring device appropriate for small or fractioned doses (e.g., syringe).
- Shake oral suspensions well prior to pouring to disperse active ingredient(s) and achieve the correct medication dose for delivery
- Insulins should be mixed gently to avoid air bubbles.



**Never** touch the tablet or capsule with your fingers. Keep gloves handy to handle the pill if necessary.

## Eye Drops

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**Wash hands with soap and water immediately before and after administration of eye drops.**

- A prescriber's order is required for resident to self-administer and/or store medication at bedside
- Wash hands and don gloves before eye drop administration
- Place bottle lid, threads up, on clean barrier such as a tissue or a paper towel
- When administering multiple medications to the same eye, wait 3-5 minutes between medications
- When instilling more than one drop into the same eye, of the same medication, wait one minute to allow the medication to absorb
- Instill drops first and then ointments
- Separate eye ointments by 10 minutes; eye closed 1-2 mins after. Start placement at the corner of the eye nearest the nose and move to outer edge of eye. Instruct resident to gently close their eyelid, roll their eye around and stay seated for approximately 10 minutes after administration.
- Do not allow dispenser to touch lash or lid
- Suspension eye drops should be stored upright
- Provide a separate tissue for each eye
- Follow manufacturer's recommendations for administration of all eye drop medications

## Enteral Medication Administration

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- Verify the resident has a signed order for enteral medication administration and an order to crush medication
- Check the "Should Not Crush" list prior to crushing any medication
- Crush each medication individually, mix with water as appropriate and administer separately
- A prescriber's order must be obtained for each resident to combine multiple crushed medications for the same administration. If there's no order to combine, medications must be administered one at a time.
- Wash hands before and after procedure
- Provide resident privacy. Ensure this procedure is performed outside the view of others.
- Elevate head of bed to 30-45 degrees
- Confirm placement per facility policy
- Flush tube with at least 15 mL of room temperature or warm water prior to and following procedure, per prescriber's order and facility policy
- Assemble supplies, equipment, and medications; use a clean barrier
- To protect resident's skin integrity, comfort, and sense of dignity, cover exposed areas with a sheet or towel
- Use gloves per facility policy

## Nasal Medication Administration

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- Wash hands and don gloves prior to medication administration
- Residents should sit upright for nasal spray administration
- Instruct the resident to blow their nose prior to medication administration
- Place the applicator cap on a clean barrier when not in use
- Gently press the side of the nostril which is not receiving the medication
- Hold the container upright and point tip to the back, outer side of the nasal passage
- Instill the correct number of sprays while the resident inhales deeply through the nose
- Ensure the applicator tip is clean before reapplying cap
- For nasal drop administration, instill according to manufacturer's instructions

## Transdermal Patches

- Always remove old patch before applying new. Do not touch the medication side of the patch with bare hands.
- Destroy patch appropriately per facility policy
- Cleanse skin with clear water only and allow to dry completely
- Ensure that the patch sites are rotated. Document sites.
- Label the patch with the date, time, and your initials before affixing the patch to the resident
- Patches that are cut/divided or damaged in any way should not be used

## Injections

- **Never** recap needles
- Use **ONLY** safety engineered needles (In accordance with the Needlestick Safety and Prevention Act, 2000)
- Have sharps disposal container close at hand for immediate discard of used needles
- Dispose of sharps containers when three-fourths full
- For multi-dose vials, affix a label to the vial with resident identifiers, date opened and expiration date
- See manufacturer's recommendations for expiration of multi-dose vials

## Storage of Medication

- Medication drawers should be divided in such a way that various types of medication preparations (internals and topicals) are physically separated by a washable surface.
- Powdered preparations (such as protein powders) should not be stored with the scoop inside of the container. Use a spoon or tongue blade to pour powder in the graduated medication cup. The available scoop may be kept in a zip lock bag.
- **Medications should NEVER** be left on top of the cart.
- Medications must be stored at the appropriate temperature, humidity and protected from light and excessive humidity.
- Store unopened insulin in the refrigerator
- Store MDIs upright (or per manufacturer's recommendations)

## Insulin Storage Parameters

Storage of VIALS at room temperature (59°F–86°F). Discard after:		
<b>28 Days</b>		
Admelog	Insulin Aspart	Lyumjev
Apidra	Insulin Lispro	Novolog, Novolog Mix
Humalog, Humalog Mix	Insulin Glargine	Semglee
Fiasp	Lantus	
<b>31 Days</b>		
Humulin R (U-100)	Humulin N	Humulin 70/30
<b>40 Days</b>		
Humulin R (U-500)		
<b>42 Days</b>		
Levemir	Novolin R,N, 70/30 (up to 77°)	
<b>56 Days</b>		
Tresiba		

## Insulin Storage Parameters, cont.

Storage of PENS & CARTRIDGES at room temperature (59° F–86° F). Discard after:		
<b>10 Days</b>		
Humalog Mix 50/50 and 75/25	Humulin 70/30	Insulin Protamine/Insulin Lispro 75/25
<b>14 Days</b>		
Humulin N	Novolog Mix 70/30	Insulin Protamine/Insulin Aspart 70/30
<b>28 Days</b>		
Admelog	Insulin Lispro	
Apidra	Insulin Glargine	
Basaglar	Lantus	
Fiasp	Lyumjev (U-100)	
Humalog (U-100)	Lyumjev (U-200)	
Humalog (U-200)	Novolin (R, N, 70/30)	
Humulin R (U-500)	Novolog	
Insulin Aspart	Semglee	
<b>42 Days</b>		
Levemir		
<b>56 Days</b>		
Toujeo (U-300)	Toujeo Max (U-300)	Tresiba (U-100)
		Tresiba (U-200)

Storage of related non-insulin injectable medication at room temperature (59° F–86° F)	
Date when opened	Discard after
Bydureon	28 days
Ozempic	56 days
Soliqua	28 days
Trulicity (single-dose)	14 days
Victoza	30 days

## Commonly Expired Medications and Supplies

Refrigerated (36° F-46° F). Discard after:
<b>28 Days</b>
Afluria Quadrivalent Influenza vaccine – must remain refrigerated at all times
<b>30 Days</b>
Aplisol, Tubersol (tuberculin PPD testing solution) – must remain refrigerated at all times
<b>90 Days</b>
Ativan Oral Concentrate (lorazepam intensol)

**Note: PRN medications may expire due to non-use. Do not freeze. Discard product if previously frozen.**

## Ophthalmic Solutions Storage Parameters

### Ophthalmic Solutions – not specifically mentioned elsewhere

Eye medication bottles/tubes with accelerated expiration dates must be dated/initialed upon opening. Follow manufacturer instructions, or facility policy. (e.g., Latanoprost - 42 days)

#### Most common examples include:

- Artificial Tears
- Tears Naturale
- TheraTears
- Isopto Atropine (atropine)
- Betoptic S (betaxolol)
- Combigan (brimonidine/timolol)
- Alphagan (brimonidine)
- Lumigan (bimatoprost)
- Trusopt (dorzolamide)
- Cosopt (dorzolamide-timolol)
- Zatorid (ketotifen)

### Xalatan Ophthalmic Solution (Latanoprost)

Store in refrigerator until opened, date when opened and discard unused portion after 6 weeks

## Inhaler Storage Parameters

<b>Pulmicort Respules (budesonide inhalation suspension)</b>	Date when foil envelope is open and discard after 2 weeks
<b>DuoNeb (ipratropium-albuterol)</b>	Protect from light. Must remain stored in foil pouch at all times. If stored outside of pouch, discard after 14 days
<b>Advair Diskus (fluticasone-salmeterol)</b>	Date the Diskus when removed from the foil pouch and discard 1 month after removal
<b>AirDuo RespiClick (fluticasone-propionate and salmeterol)</b>	Date the Diskus when removed from the foil pouch and discard 1 month after removal
<b>Wixela Inhub (fluticasone propionate and salmeterol)</b>	Date after opening the foil pouch and discard after 1 month
<b>Calcitonin Salmon Nasal Spray</b>	Store upright after opening. Discard the open 2ml product after 14 doses or 30 days, whichever comes first  Discard the open 3.7ml product after 30 doses or 35 days, whichever comes first
<b>Anoro Ellipta (umeclidinium bromide/vilanterol)</b>	Date the inhaler when removed from the foil pouch and discard after 6 weeks
<b>Breo Ellipta (fluticasone/vilanterol)</b>	Date when opening foil tray and discard after 6 weeks
<b>Incruse Ellipta Inhalation Powder (umeclidinium)</b>	Date when removed from the foil tray and discard after 6 weeks
<b>Serevent Diskus (salmeterol)</b>	Date after opening the foil pouch and discard after 6 weeks
<b>Trelegy Ellipta (fluticasone furoate, umeclidinium, and vilanterol)</b>	Date after opening the foil pouch and discard after 6 weeks
<b>Flovent Diskus (fluticasone)</b>	Date the Diskus when removed from the foil pouch and discard 6 weeks (for 50mcg strength) or 2 months (for 100mcg or 250mcg strengths) after removal from foil pouch

Combivent Respimat (ipratropium bromide, and albuterol)	Discard inhaler after 3 months
Symbicort Inhalation Aerosol (budesonide-formoterol)	Date after opening the foil pouch and discard after 3 months
Ventolin HFA (albuterol sulfate)	Date after opening the foil pouch and discard after 12 months
Proair Respiclick (albuterol sulfate)	Date after opening the foil pouch and discard after 13 months

## Documentation of Medication Administration

### Medications Administered

Initial appropriate box of the MAR **immediately AFTER** administration of the medication.

### Medication Availability

- If a medication is not administered because the medication is not available, make every effort to locate the medication. If the medication cannot be located, check the interim or emergency kit for the medication so that the medication pass can be completed.
- Document unavailable medications appropriately per facility policy
- Contact the pharmacy and arrange for delivery of the medication.

### Medications Refused

- Document refused medications appropriately per facility policy
- Notify the prescriber when the refused medication is one of the narrow therapeutic index medications and efficacy is dependent on blood levels (e.g., digoxin, phenytoin, warfarin)
- Notify the prescriber if the resident routinely refuses a medication per prescriber's order and/or facility policy

## PRN Medications

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- Initial the entry on the MAR when a PRN medication is given.
- Document the date, time, and reason the medication was given.
- Documentation of the effectiveness of the medication is required within the recommended timeframe (e.g., 30-60 minutes following the administration of pain medication).
- Communicate administered PRN medications on the shift report for appropriate follow-up.

## Controlled Substances

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- Controlled medications are under double lock
- Controlled medication record is signed prior to administration to reflect declining count
- When performing shift count, both parties visualize medication and documentation; resident's name, medication name, dose, and quantity remaining are verbalized
- The controlled medication counts must be witnessed and signed each time the keys change possession
- Do not use symbols. Use numbers or write out the number.
- Two signatures required for wasted doses, page transfers, voided pages, or any error correction that affects the quantity remaining

## Completion of Medication Pass

- Return medication cart to designated area
- Ensure that cart is secured, and no resident information is visible
- Discard food items or return to refrigerator as appropriate
- Clean and re-stock the cart in preparation for next medication pass
- Perform hand hygiene

## Quality Assurance/Performance Improvement (QAPI)

### **Nursing Facility Quality Assurance/Performance Improvement for Medication Safety §483.75(f)(4)**

The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

**Scope of Care:** Resident Safety

**Aspect of Care:** Medication Safety

### Sample Resident-Centered Quality Indicators for Medication Safety

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#### **Medication Administration Accuracy**

- Percentage of self-reported medication administration errors per doses administered by the same staff on the same medication pass.
- Percentage of observed medication administration errors per 20 doses administered.
- Percentage of self-reported medication errors causing resident harm.
- Percentage of medication administration errors caused by facility staff data entry errors in electronic health records.
- Prevalence of adverse drug events related to medication administration errors.
- Prevalence of self-reported insulin medication errors.
- Prevalence of self-reported medication administration errors involving medications removed from emergency medication supplies.
- Prevalence of resident change in status due to adverse medication events.
- Prevalence of undocumented administration of medications.
- Percentage of medications administered without regard for prescribing parameters (undocumented, observed, self-reported).

#### **Unnecessary Drugs**

- Prevalence of PRN hypnotics administered per nurse.
- Percentage of PRN psychotropic drugs administered to manage behaviors in residents with dementia.
- Prevalence of antibiotics ordered without resident assessment (Loeb, McGeer, etc.).
- Prevalence of resident complaint of pain in the presence of orders for pain management.
- Incidence of falls related to adverse drug reactions.
- Prevalence of PRN psychotropic medication orders not evaluated by the prescriber every 14 days.
- Prevalence residents with PRN medication orders not used in 30 days.
- Prevalence of sliding scale insulin used longer than 30 days.

If the facility has a real or potential challenge that may pose a risk to resident safety due to medication administration errors and/or adverse consequences due to the inappropriate use of medications without diagnosis or assessment, the Quality Assurance/Performance Improvement Committee may consider a QAPI program to reduce the risk. Before beginning the program, inform all departments for buy-in. Communicate the issue, the need for action, create stakeholders and participants. Assign leaders, data collectors, staff to analyze and trend data, and include all departments in the action plans. Set meeting schedules, agendas, and adhere to them without fail.

<b>Step 1</b>	Identify the risk or performance measure using data collection, trending, and analysis. Utilize the best available evidence to define and measure indicators of medication safety and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents.
<b>Step 2</b>	Track and measure performance to identify and prioritize any real or potential deficiencies in medication safety.
<b>Step 3</b>	Establish resident safety goals or acceptable thresholds to be a measure of performance.
<b>Step 4</b>	Routinely (daily, weekly, monthly, quarterly, etc.) and systematically analyze the root cause causes of medication deficiencies.
<b>Step 5</b>	Develop, communicate, and implement corrective actions
<b>Step 6</b>	Monitor and evaluate the effectiveness of corrective action/performance improvement activities and revising as needed.

# Medication Storage Inspection Report

Facility	#	Station	Date
Fax machine is in working order			
Medications are destroyed in accordance with facility policy, state, and federal regulations			
<b>Method used to order or reorder medications</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>
Fax (Staff able to verbalize system)			
Omniview (Staff able to verbalize system)			
eMAR System (Staff able to verbalize system)			
Pharmacy hours of operation, cut off times and emergency numbers are posted			
<b>Medication storage</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>
<b>Storage room</b>			
Door locked			
No expired medications present			
<b>Refrigerator</b>			
Appropriate refrigerator is used for vaccine storage (per facility policy)			
Freezer free from frost (if applicable)			
All vials labeled with open date (open date on packaging not sufficient) per facility policy			
Medications are separated by route of administration			
Any food present has a prescriber's order (must be separated from meds)			
Temperature log documented on all dates of current month			
Temperature 36°– 46°F at time of observation			
If vaccines are present, temperature log reflects twice daily entries (if not electronically monitored)			
No expired medications present			
<b>Emergency Kits Storage</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>
<b>E-kit(s) are properly locked</b>			
<b>E-Kit</b> (Check "No" if items are expired)			
Controlled Substance not expired			
IV Solutions not expired			
IV Supplies not expired			
Refrigerator Controlled not expired			
Refrigerator Insulin not expired			
Contingency not expired			

Completed by

Date

# Quality Assurance/Performance Improvement Action Plan

Topic Reviewed/Discussed

Identified risk	
Goals	
Actions to be taken	
Staff responsible	
Date	

# Medication Administration Observation

<b>Facility Name</b>	<b>Date/Time</b>	<b>Unit/Floor</b>
<b>Nurse Observed</b>	<b>Auditor</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Nurse wearing badge?</b>

	YES	NO	N/A
<b>1. INFECTION CONTROL</b>			
A. Proper handwashing technique			
B. Proper alcohol gel technique			
C. Spoons stored with handles in upright position			
D. Unused medication cups stored upside down			
E. Straws opened from middle			
F. Medications not touched by fingers; spoon used as needed			
G. Double cup crushing technique used, tablet crushers cleaned			
H. Bottles wiped clean after use			
I. Fluid / food items covered and dated			
<b>2. MEDICATION CART AND DRUG SECURITY</b>			
A. Cart prepared with supplies prior to medication pass			
B. Cart is clean and organized			
C. Only medication administration supplies on cart			
D. No preset medications are found in / on cart			
E. Drug security maintained; cart always visible to Nurse or locked			
F. Medications stored properly when not attended			
G. Medication keys are retained by Nurse at all times			
H. Medications are locked and stored according to facility policy			
I. Bedside medications are locked and stored according to facility policy			
J. Sharps container is no more than 3/4 full			
K. Medication cart is cleaned and locked after medication pass			
<b>3. PRIVACY AND SECURITY</b>			
A. MAR covered when not attended			
B. Knock/Announce self prior to room entry			
C. Curtain closed for invasive techniques/privacy provided			
D. Medication not administered in bathroom / hallway / dining room			
E. Nurse discards depleted medication card without resident information			
<b>4. DOCUMENTATION STANDARDS</b>			
A. Routine medication doses properly documented			
B. PRN medication doses properly documented			
C. Bedside medications properly documented			
1. Assessment completed			
2. Physician order present			
3. MAR indicates which medications are self-administered			
D. Refused medications properly documented			
1. Prescribing physician notified			
E. Controlled substance records maintained			
1. Controlled medications are signed out at time of removal			
F. Controlled substance shift count sheet signed each shift			
<b>4. NURSING ADMINISTRATION TECHNIQUE</b>			
A. Handwashing / Alcohol gel utilized			
B. Resident identified			
C. Medications verified by MAR and label			
D. Nurse checks expiration date prior to administration			
E. Required vital signs taken prior to medications being given per facility policy			

F. Resident positioned properly			
G. Crush order from Prescriber present			
H. Only medications suitable for crushing are crushed			
I. Crushed medications are administered properly			
J. Patches rotated and dated properly			
K. Resident monitored daily for patch and presence documented			
L. Liquid medications are measured at eye level on flat surface			
M. Concentrates diluted properly			
N. Medications administered with meal when appropriate			
O. Nurse observed and ensured medication was taken			
P. Manufacturer specifications are observed			
1. Liquid suspensions and emulsions shaken well			
2. Adequate fluid offered with medication when specified			
3. Appropriate medications administered with food or antacid			
Q. AC / PC medications administered at appropriate times			
R. Medication pass not interrupted			
S. Nurse encouraged resident when medication refused			
T. Nurse can explain use of medication to resident			
<b>6. IV MEDICATIONS AND FLUIDS</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>
A. Handwashing before and after procedure with appropriate glove usage			
B. Resident identified			
C. Medications and fluids verified by MAR and label			
D. Nurse checks expiration date prior to administration			
E. Required vital signs taken prior to medications given per facility policy			
F. Resident positioned properly			
G. IV Site checked before fluids / medications started			
H. Injection ports cleansed with alcohol before use			
I. Asepsis maintained while preparing and administering medications			
J. Correct rate of administration maintained			
K. Catheter flushed within 15 minutes after infusion of intermittent medications			
L. Tip of IV tubing covered aseptically when not in use			
M. Needles disposed of properly			
<b>7. INHALED MEDICATIONS</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>
A. Handwashing / Alcohol gel utilized			
B. Resident identified			
C. Medications verified by MAR and label			
D. Nurse checks expiration date prior to administration			
E. Required vital signs taken prior to medications given per facility policy			
F. Resident positioned properly			
G. Resident instructed of procedure			
H. Inhaler shaken well prior to each puff			
I. Inhaler properly positioned prior to each puff			
J. Dropper bottle / lid placed on barrier			
K. Waited one minute between each puff or per manufacturers' guidelines			
L. Mouth rinsed after steroid inhaler			
M. Nebulized medications properly prepared for administration			
<b>8. G TUBE MEDICATIONS</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>
A. Handwashing before and after procedure with appropriate glove usage			
B. Resident identified			
C. Medications verified by MAR and label			
D. Nurse checks expiration date prior to administration			
E. Required vital signs taken prior to medications given per facility policy			
F. Resident positioned properly - HOB elevated 35-40 degrees			
G. Door / Curtain closed to provide privacy			

H. Clean barrier used for syringe, supplies, etc.			
I. Tube checked for placement			
J. Tube flushed with 30ml of water			
1. Before/after medications per facility policy and procedure			
K. Medications administered via gravity			
L. Medications flushed with 5cc's of water between medications			
M. Tube feeding turned off at least 1 hour before and after Dilantin administered or per facility policy and procedure			
<b>9. EYE DROPS</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>
A. Handwashing before and after procedure with appropriate glove usage			
B. Resident identified			
C. Medications verified by MAR and label			
D. Nurse checks expiration date prior to administration			
E. Required vital signs taken prior to medications given per facility policy			
F. Resident positioned properly			
G. Door / Curtain closed to provide privacy			
H. Eye drops stored and properly dated when opened, if applicable			
I. Pulls lower lid down to form a pouch			
1. Instructs resident to look upwards prior to instilling the drop			
2. Instills medication into lower lid			
3. Instructs resident to close eye for 3 minutes			
4. Or place pressure on bridge of nose for 1 minute			
J. Eye dropper does not come in contact with eye			
K. Eye drops administered at least 3 minutes apart or per manufacturers' guidelines			
L. Different medications administered at least 3-5 minutes apart or per manufacturers' guidelines			
M. Separate tissues offered for each eye and different medications			
N. Dropper bottle/lid placed on barrier in room			
<b>10. INJECTIONS</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>
A. Handwashing before and after procedure with appropriate glove usage			
B. Resident identified			
C. Medications verified by MAR and label			
D. Nurse checks expiration date prior to administration			
E. Required vital signs taken prior to medications given per facility policy			
F. Resident positioned properly			
G. Door / Curtain closed to provide privacy			
H. Appropriate site chosen; cleanse with alcohol and allow to dry			
I. OSHA approved syringes used; needles not recapped			
J. Injection site rotated and documented			
K. Needles disposed of properly in sharps container			
L. Injection site inspected for redness, swelling or lesion			
M. All multi dose vials are dated when opened			
N. Insulin is rolled not shaken			
O. Mixed insulins are drawn up appropriately (Short acting first, then longer acting)			
P. Blood glucose monitoring results are documented			
<b>11. OTHER STANDARDS OF PRACTICE</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>
A. Missing medications handled correctly			
B. Residents who have not been assessed do not administer own medications			
C. Medication pass began and ended on time			
D. Medications that are not to be crushed are not unless:			
1. Appropriate documentation is available for those medications crushed which manufacturer states "Do Not Crush"			
2. The Prescriber or Pharmacist has documented in the medical record why crushing will not adversely affect the resident			
3. Resident is monitored for pertinent side effects			
4. Literature is available to justify why crushing will not adversely harm the resident			
E. Refused medication doses are properly disposed of according to facility policy			

**Summary/Comments**

# of Errors \_\_\_\_ ÷ by # of Medications Observed \_\_\_\_ = Error Rate \_\_\_\_ X 100 = \_\_\_\_% Error Rate

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**Completed by**

**Date**

THIS CONFIDENTIAL DOCUMENT IS THE WORK PRODUCT OF THE FACILITY'S QUALITY ASSURANCE PROCESS.

**White Copy: Facility    Yellow Copy: Pharmacy**

## Skills Checklist 1: Oral Medication Administration

Nurse Name:	Date:
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This activity was performed in a:  clinical setting  classroom setting

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
<b>1</b>	Prepare supplies: a. Clean medication cart/workspace b. EMAR/MAR c. Water and/or other liquids (date items) d. Food medium (e.g., applesauce, pudding) dated when opened e. Paper/plastic medication cups stored down f. Spoons stored handle side up g. Clean pill crusher h. Tissues i. Gloves j. Hand sanitizer k. Drug reference, "Should Not Crush" list and storage parameters		
<b>2</b>	Assess for contraindications to receiving medications (e.g., NPO, hypotension, PT/INR, heart rate, allergies, etc.)		
<b>3</b>	Check <i>Medication Record</i> for order. a. Verify that the medication name and dose are correct when compared to the medication order on the medication administration record b. Do not administer a medication if the medication or prescription label is missing or illegible c. Administer medications within time specified by physician's order, facility policy or manufacturer's information d. Follow manufacturer medication administration guidelines (e.g., providing medication with fluids or food, shaking medications prior to pouring, etc.) e. Crush oral medications only with physician's order and in accordance with pharmacy guidelines and/or facility policy.		
<b>4</b>	Check expiration date of medications Enter the date opened on the label of medications with shortened expiration dates (e.g., liquid protein drinks, inhalers, etc.)		
<b>5</b>	Perform hand hygiene		

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
6	<p>Prepare medications for one resident at a time in a quiet area conducive to focusing on the task</p> <p>Verify each time a medication is administered that it is the: (update to 10 rights)</p> <ol style="list-style-type: none"> <li>right resident,</li> <li>right time,</li> <li>right drug,</li> <li>right dose,</li> <li>right dosage form,</li> <li>right route,</li> <li>right documentation.</li> </ol>		
7	<p>Do not touch the medications:</p> <ol style="list-style-type: none"> <li>When removing tablets or capsules from a multi-dose bottle, pour the necessary number into the bottle cap and then place the tablets or capsules in a medication cup. If it is necessary to touch the tablets, wear clean gloves.</li> <li>Do not split tablets. The pharmacy should be contacted to provide the correct dose.</li> <li>In an emergency, if a licensed nurse must split a tablet, the nurse should wear clean gloves and break only scored tablets.</li> <li>When pouring liquid medications out of a multi-dose bottle, hold the bottle so the label is against the palm to avoid dripping on the label. Use an appropriate measuring device when pouring liquids and read the amount of medication at eye level on a flat surface. Wipe the lip of the bottle with a tissue.</li> </ol>		
8	<p>Document the administration of controlled substances immediately and in accordance with facility policy.</p>		
9	<p>Replace any multi-dose containers and medication cards back in the medication cart and lock before leaving it. Do not leave medications or chemicals unattended.</p> <p>Follow HIPAA compliance and facility policy to protect and secure Protected Health Information (e.g., computer monitors, written resident vital signs and data, etc.)</p>		
10	<p>Check the resident's room for transmission-based precautions prior to entering the room</p>		

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
<b>11</b>	<p>During medication administration:</p> <ul style="list-style-type: none"> <li>a. Identify the resident per facility policy</li> <li>b. Position the resident properly, if necessary</li> <li>c. Observe each resident's privacy and rights in accordance with facility policy (e.g., knocking before entering the room, pulling privacy curtains, etc.)</li> <li>d. Explain purpose, action, and side effect of each medication to the resident</li> </ul>		
<b>12</b>	<p>Provide the resident with any necessary instructions:</p> <ul style="list-style-type: none"> <li>a. For orally disintegrating formulations: Removed the medication from the packet just before using by peeling back the foil. Do not push the tablet through the foil. Place the medication on top of the resident's tongue. Caution resident against chewing the medication.</li> <li>b. For buccally administered medications: place the medication in the mouth against the mucous membranes of the cheek and gums until it dissolves.</li> <li>c. For sublingually administered medications: place the medication under the tongue and allow it to dissolve completely. Cautioned resident against chewing or swallowing the tablet or lozenges.</li> <li>d. For powdered medications: mix with adequate fluid as specified by the manufacturer and physician's order.</li> <li>e. If the resident is unable to hold medication cup, place the cup to their lips, gently and slowly introduce each drug into the mouth, one at a time. Do not rush or force medication administration. If necessary, use a spoon to place medication directly into the resident's mouth.</li> </ul>		
<b>13</b>	<p>Remain with the resident until each medication is swallowed. Never leave medication at the resident's bedside.</p>		
<b>14</b>	<p>Ensure safety measures when leaving the room (e.g., call light and bedside table are within reach, bed is in lowest position and locked, floor is free of obstacles, etc.)</p>		
<b>15</b>	<p>Perform hand hygiene</p>		

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
16	After medication administration: a. Document medication administration information (e.g., when medications are given, if medications are refused, PRN medications, etc.) according to facility policy and procedure b. Dispose of unused medication portions and supplies in accordance with facility policy c. Clean any reusable equipment or supplies d. Ensure that medication carts are always locked when out of sight or unattended.		
17	Monitor for side effects.		

Nurse Signature

Evaluator Signature

## Skills Checklist 2: Administration of Ophthalmic Medications

Nurse Name:	Date:
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This activity was performed in a:  clinical setting  classroom setting

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
1	Check medication record for order Make certain medication is labeled for ophthalmic use (assures sterility and compatibility for use in the eye)		
2	Check expiration date of medication. Eye medication bottles/tubes with accelerated expiration dates must be dated/initialed upon opening. Follow manufacturer instructions, or facility policy. (e.g., Latanoprost - 42 days)		
3	Verify resident's identity		
4	Perform hand hygiene		
5	Put on gloves		
6	Explain procedure to resident: a. Ask resident to lie supine or sit. Head should be tilted back and toward side of the affected eye. b. Instruct resident to look up and away to minimize risk of touching cornea with dropper, particularly if resident blinks. Gently pull-down lower lid to expose conjunctival sac.		
7	For eye drop administration: a. Shake suspensions well b. Place bottle lid, threads up, on clean barrier such as a tissue or a paper towel c. Hold dropper in dominant hand above conjunctival sac. Do not touch dropper to eye. Gently pull lower lid and instill one drop at a time. d. Instruct resident to close their eyes slowly to allow for even distribution over surface of eye e. Apply gentle pressure to tear duct for one minute after administration or instruct resident to close eye for three minutes		

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
<b>7 cont.</b>	f. When instilling more than one drop into the same eye, of the same medication, wait one minute to allow the medication to absorb g. Wipe off tears or excess solution with clean tissue. Two different tissues should be used, one for each eye, to prevent cross contamination. h. When administering multiple medications to the same eye, wait 3-5 minutes between medications i. Instill drops first and then ointments		
<b>8</b>	Tilt residents head slightly back		
<b>9</b>	If administering medication to <b>both</b> eyes in resident with suspected or active eye infection, perform hand hygiene and change gloves between each eye administration or per facility protocol.		
<b>10</b>	Recap bottle or tube		
<b>11</b>	Discard barrier. Remove and dispose of gloves.		
<b>12</b>	Perform hand hygiene		
<b>13</b>	Replace medication into clean labeled box/ bag and return to storage area. Suspension eye drops should be stored upright.		
<b>14</b>	Document medication administration		
<b>15</b>	Monitor for side effects		

Nurse Signature

Evaluator Signature

## Skills Checklist 3: Blood Glucose Monitoring Procedure

Nurse Name:	Date:
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This activity was performed in a:  clinical setting  classroom setting

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
1	Check Medication Record for order		
2	Identify facility protocol for quality control testing and documentation policy Check meter code and test strip bottle for open date and expiration		
3	Perform hand hygiene		
4	Provide clean field for glucometer and equipment		
5	Verify resident's identity		
6	Put on gloves		
7	Insert unused/new reagent strip into glucometer and place on clean field		
8	Explain procedure to resident		
9	Choose a puncture site on the lateral side of finger. Avoid central tip of finger, which has more dense nerve supply		
10	Hold finger to be punctured in dependent position while gently massaging finger towards puncture site		
11	Clean the site with an antiseptic wipe, and allow it to dry completely		
12	Engage lancet per manufacturer's instructions		
13	Place lancet firmly against side of finger and push release button, causing needle to pierce skin.		
14	Wipe away first droplet of blood per facility policy and manufacturer's instructions		
15	Lightly squeeze puncture site (without touching) until large droplet of blood has formed		

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
16	<p>Hold reagent strip test pad to drop of blood, and lightly transfer droplet to test pad. Do not smear blood</p> <p>Re-puncturing may be necessary if large enough droplet does not form to ensure accurate test</p>		
17	Immediately press timer, if applicable, on glucose meter (follow manufacturer's guidelines)		
18	Apply pressure to skin puncture site with antiseptic wipe		
19	Dispose of supplies appropriately		
20	Remove gloves; perform hand hygiene		
21	<p>Disinfect glucometers before and after use per manufacturer's recommendations and facility policy. Follow recommended "wet"/"kill" time for each disinfectant product.</p> <p>Keep glucometer wrapped and wet for the manufacturer's recommended amount of time.</p>		
22	Notify physician according to ordered parameters for hypoglycemia or hyperglycemia		
23	Documents results and implement ordered treatment/medication		

Nurse Signature

Evaluator Signature

## Skills Checklist 4: Nasal Medication Administration

Nurse Name:	Date:
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This activity was performed in a:  clinical setting  classroom setting

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
<b>1</b>	Check <i>Medication Record</i> for order		
<b>2</b>	Check expiration date of medication. Be sure adequate number of doses remains.		
<b>3</b>	Verify resident's identity		
<b>4</b>	Perform hand hygiene		
<b>5</b>	Put on gloves		
<b>6</b>	Explain procedure to resident		
<b>7</b>	Shake suspensions well if indicated. Check package insert.		
<b>8</b>	Remove cap/cover and place it upright on a clean barrier		
<b>9</b>	If necessary, (check package insert) prime nasal inhaler device by holding bottle upright and away from face while spraying into air		
<b>10</b>	If possible, ask resident to gently blow nose to remove excess mucous		
<b>11</b>	If the nurse hands the resident the nasal medication and the opens or takes the cap off the medication and completes the administration process themselves, this may be considered self-administration.  A prescriber's order is required for resident to self-administer and/or store medication at bedside.		
<b>12</b>	For nose drop administration: a. Position resident in supine position. Instruct resident to breathe through the mouth. Push up tip of resident's nose. Position dropper just above nostril and direct tip toward midline of nose. b. Watch dropper to count drops. c. Ask resident to keep head tilted back for 5 minutes and breathe through the mouth.		

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
<b>12 cont.</b>	<ul style="list-style-type: none"> <li>d. Keep emesis basin handy for resident to expectorate medication which flows into mouth cavity</li> <li>e. Clean dropper by separating plunger and pipette. Flush with warm water. Allow to dry then replace.</li> </ul>		
<b>13</b>	<p>For nasal spray/atomizer:</p> <ul style="list-style-type: none"> <li>a. Position resident sitting upright with head tilted back slightly.</li> <li>b. Occlude one nostril with finger.</li> <li>c. Insert atomizer tip into open nostril. Instruct resident to inhale and squeeze atomizer once, quickly, and firmly. Repeat if ordered.</li> <li>d. Instruct resident to keep head tilted back for several minutes and breathe slowly through nose</li> <li>e. 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 recommendations; then repeat procedure above</li> </ul>		
<b>14</b>	<p>For nasal aerosols:</p> <ul style="list-style-type: none"> <li>a. Shake aerosol well immediately before use. See manufacturer's directions.</li> <li>b. Position resident upright with head tilted back.</li> <li>c. Insert adapter tip into nostril while occluding the other nostril with finger.</li> <li>d. Press adapter and cartridge together to release one measured dose of medicine.</li> <li>e. 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 recommendations; then repeat procedure above</li> </ul>		
<b>15</b>	Replace cap/cover; Discard barrier		
<b>16</b>	Remove and dispose of gloves		
<b>17</b>	Perform hand hygiene.		
<b>18</b>	If necessary, clean tip and/or device according to manufacturer's guidelines and/or facility policy and procedure.		

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
<b>19</b>	Replace medication into clean labeled box/ bag and return to storage area. Store upright if indicated.		

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**Nurse Signature**

**Evaluator Signature**

## Skills Checklist 5: Metered Dose Inhaler Administration

Nurse Name:	Date:
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This activity was performed in a:  clinical setting  classroom setting

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
1	Check <i>Medication Record</i> for order		
2	Check expiration date of medication. When Metered Dose Inhalers are opened it should be dated and discarded per the manufacturer guidelines. Ensure 'use by' dates on the inhalers have not been exceeded.		
3	Verify resident's identity		
4	Perform hand hygiene		
5	Apply gloves		
6	Explain steps for administering inhaled dose of medication (demonstrate steps when possible)		
7	If the nurse hands the resident the inhaler and the resident completes the administration process themselves, this may be considered self-administration. A prescriber's order is required for resident to self-administer and/or store medication at bedside.		
8	Shake well per manufacturer's recommendations		
9	Remove mouthpiece cover from metered dose inhaler Prime the inhaler device, if required Prime the inhaler device by holding bottle upright and away from face while spraying into air		
10	Place inhaler in mouth with opening toward back of throat, asking the resident to close lips tightly around it		
11	With inhaler properly positioned, have resident hold inhaler with thumb at the mouthpiece and the index finger and middle finger at the top		

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
12	Instruct the resident to depress the canister while inhaling SLOWLY and DEEPLY through the device		
13	Remove the device from the mouth Ask the resident to hold the breath for as long as is comfortable then gently breathe out		
14	If additional inhalations (puffs) are needed, wait 60 seconds between inhalations or per manufacturer's recommendation		
15	Rinse mouthpiece after each dose and store the device per facility policy		
16	<p>Spacer devices are used to attach to oral inhaler. When using a spacer:</p> <ol style="list-style-type: none"> <li>a. Remove mouthpiece cover from metered dose inhaler and mouthpiece of spacer device</li> <li>b. Insert MDI into end of spacer device</li> <li>c. Shake inhaler well for 2-5 seconds (five or six shakes)</li> <li>d. Place spacer device mouthpiece in mouth and close lips. Do not insert beyond raised lip on mouthpiece. Avoid covering small exhalation slots with the lips.</li> <li>e. Breathe normally through spacer device mouthpiece</li> <li>f. Depress medication canister, spraying one puff into spacer device</li> <li>g. Breathe in fully and slowly (for 5 seconds)</li> <li>h. Hold full breath for 10 seconds</li> <li>i. Instruct resident to wait 20-30 seconds between inhalations (if it is the same medication), or 2-5 minutes between inhalations if the medications are different.</li> <li>j. When finished, remove spacer, rinse the inhaler and cap and spacer with warm running water, and ensure the inhaler is completely dry before reuse.</li> <li>k. When using spacers, clean the spacer once per week with lukewarm water and mild detergent air-dry. Spacers should be replaced per facility policy or at least every 6-12 months.</li> </ol>		
17	If 2 or more inhalers are prescribed at the same time, ask physician or pharmacist which should be administered first		

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
<b>18</b>	Gargling or rinsing mouth after spraying will reduce drug absorption from the oral mucosa. Rinsing the mouth is recommended with long term steroid use.		
<b>19</b>	Remove and dispose of gloves.		
<b>20</b>	Perform hand hygiene.		
<b>21</b>	Replace medication into clean labeled box/ bag and return to storage area		
<b>22</b>	Document medication administration		
<b>23</b>	Monitor for side effects		

Nurse Signature

Evaluator Signature

## Skills Checklist 6: Enteral Tube Medication Administration

Nurse Name:	Date:
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This activity was performed in a:  clinical setting  classroom setting

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
<b>1</b>	Check <i>Medication Record</i> for order for enteral medication administration and an order to crush medication		
<b>2</b>	Prepare clean barrier for syringe and supplies Syringe and supplies should be dated and replaced every 24 hours or per facility policy		
<b>3</b>	Prepare medications: a. Liquid medications are the preferred dosage form. b. Check the “Should Not Crush” list prior to crushing any medication. Avoid oral dosage forms which should not be crushed c. Avoid medications which will clog tubes or interact with tube feedings. d. Crush tablets into a fine powder or open capsules with clean, gloved hands and reconstitute with 10-15 mls of water. e. Crush each medication individually and mix well.		
<b>4</b>	Maintain privacy by pulling the curtain and closing the door		
<b>5</b>	Elevate HOB 30 - 45 degrees		
<b>6</b>	Verify resident’s identity		
<b>7</b>	Perform hand hygiene		
<b>8</b>	Apply gloves		
<b>9</b>	Explain procedure to resident		
<b>10</b>	Place clean barrier around g-tube. Do not lay any apparatus on resident’s bed or unclean surface. To protect resident’s skin integrity, comfort, and sense of dignity, cover exposed areas with a sheet or towel.		

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
11	Shut off pump, clamp tube, and flush tube with at least 15 ml water. Medications should not be added directly to feeding.		
12	Confirm feeding tube for placement per facility policy		
13	Administration of medications: a. Insert medication syringe in appropriate port and pour each medication through the syringe b. Medications are prepared and given separately. Never mix medications together in a medication syringe. c. Allow the drug to flow in by gravity. d. If the medications will not flow easily, reposition resident, “milk” enteral tube or give gentle boosts with the plunger. Do not forcibly push medications through tube. e. Flush with at least 15 ml of water after each individual medication is given. f. Administer liquid medications first, then follow with medications that need to be diluted. Reserve administering thick medications (i.e., antacids, etc.) until last. g. Continue until all medications are administered as ordered. h. Flush with at least 15 ml warm water after the final dose is administered		
14	For a resident who requires fluid regulation, the physician’s order should include the amount of water to be used for the flushing and administration of medications		
15	Restart the enteral feeding as ordered		
16	Adjust head of bed as necessary		
17	Rinse out syringe, separate plunger from barrel and place back in clean storage bag to air dry.		
18	Perform hand hygiene.		
19	Document medication administration, water used and oral intake per facility policy		
20	Monitor for side effects		

Nurse Signature

Evaluator Signature

## Skills Checklist 7: Small Volume Nebulizer Administration

Nurse Name:	Date:
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This activity was performed in a:  clinical setting  classroom setting

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
<b>1</b>	Check <i>Medication Record</i> for order		
<b>2</b>	Check expiration date of medication		
<b>3</b>	Verify resident's identity		
<b>4</b>	Perform hand hygiene		
<b>5</b>	Apply gloves		
<b>6</b>	Assess pulse, respirations, breath sounds before beginning treatment		
<b>7</b>	Explain steps for administering nebulizer medication (demonstrate steps when possible)		
<b>8</b>	Assemble nebulizer equipment per manufacturer's directions		
<b>9</b>	Add prescribed medication and diluent as ordered to nebulizer cup.		
<b>10</b>	Have resident hold mouthpiece between lips with gentle pressure. a. If resident is fatigued, or who cannot follow instructions, use a facemask. b. Use special adapters for resident with a tracheostomy.		
<b>11</b>	Have resident take a deep breath, slowly, to a volume slightly greater than normal. Encourage a brief, end-respiratory pause. Then have the resident exhale slowly. If resident is dyspneic, encourage client to hold every fourth or fifth breath for 5 – 10 seconds.		
<b>12</b>	Turn on the small volume nebulizer machine and ensure that a sufficient mist is formed. a. Tap the nebulizer cup occasionally during treatment and at the end of treatment. b. Remind the resident to repeat the breathing pattern described in step 11 until the drug is completely nebulized.		

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
<b>12 cont.</b>	<ul style="list-style-type: none"> <li>c. Some practitioners set a timed limit as the length of the treatment rather than waiting for the medication to completely nebulize.</li> <li>d. Monitor resident's pulse during procedure, especially if beta-adrenergic blockers are used.</li> <li>e. Stay with resident during entire medication administration per facility policy or physician's order to self-administer.</li> </ul>		
<b>13</b>	<p>When medication is completely nebulized, turn off and store tubing assembly per facility policy.</p> <ul style="list-style-type: none"> <li>a. Shake the nebulizer bottle, attempting to remove all remaining solution.</li> <li>b. Rinse per facility policy; do not use tap water.</li> </ul>		
<b>14</b>	<p>If steroids are nebulized, ask the resident to rinse their mouth or gargle with warm water and spit out after nebulizer treatment.</p>		
<b>15</b>	<p>After medication administration, assess and record residents' pulse, respirations, and breath sounds.</p>		
<b>16</b>	<p>Perform hand hygiene.</p>		
<b>17</b>	<p>Document medication administration and time per facility policy.</p>		
<b>18</b>	<p>Monitor for side effects</p>		

Nurse Signature

Evaluator Signature

## Skills Checklist 8: Insulin Medication Administration

Nurse Name:	Date:
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This activity was performed in a:  clinical setting  classroom setting

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
<b>1</b>	Prepare supplies: a. Clean medication cart/workspace b. EMAR/MAR c. Tissues d. Gauze pads e. Clean gloves f. Hand sanitizer g. Alcohol pads h. Paper towel for clean barrier i. Sharps container		
<b>2</b>	If removing medication from the refrigerator for the first time, label pen or vial with date removed from refrigerator and the date the medication expires once opened.  Ensure a resident specific label is affixed to the vial or pen and is legible per facility policy. Only one insulin vial or pen is used for each resident.		
<b>3</b>	Verify capillary blood glucose monitoring (CBG) has been performed and results documented per facility policy		
<b>4</b>	Verify medication order on EMAR/MAR; check against physician order		
<b>5</b>	Check documentation of previous subcutaneous administration; injection sites are rotated per facility policy		
<b>6</b>	Assess for contraindications to receiving medication; if medication is to be administered prior to or during mealtime, ensure resident is prepared and medication is administered at the appropriate time, per order and facility policy.		
<b>7</b>	Inspect integrity of medication vial/pen; check insulin storage reference to ensure medication is not expired		

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
<b>8</b>	<p><b>If insulin vial is ordered</b></p> <ul style="list-style-type: none"> <li>a. When opening a new vial, remove cap</li> <li>b. Scrub rubber septum/stopper vigorously with alcohol swab before each use; allow to dry completely</li> <li>c. Gently roll insulin to mix, per manufacturer's instructions; do not shake</li> <li>d. Select the appropriate safety syringe, per manufacturer's instructions and facility policy</li> <li>e. After determining the appropriate number of units, draw up an equivalent amount of air into the empty syringe. Pierce the rubber septum/stopper with the needle, inject the air into the vial and draw up prescribed dose of insulin.</li> <li>f. Inspect the syringe to ensure no air bubbles are present</li> </ul> <p><b>If insulin pen is ordered</b></p> <ul style="list-style-type: none"> <li>a. Scrub rubber septum/stopper vigorously with alcohol swab before each use; allow to dry completely</li> <li>b. Attach safety needle to pen</li> <li>c. Dial up 2 units of insulin (or per manufacturer's recommendations); hold pen upright and perform an air shot to prime the pen. Repeat priming procedure if insulin not visualized.</li> <li>d. Turn dial to the prescribed number of units</li> </ul>		
<b>9</b>	Prepare to administer short-acting insulin first, then long-acting, if applicable		
<b>10</b>	Verify resident's identity		
<b>11</b>	Perform hand hygiene and don gloves		
<b>12</b>	Select an appropriate injection site, free from edema, induration, tenderness, or skin irritation		
<b>13</b>	Cleanse site with alcohol swab beginning at center of site and rotating outward approximately 2 inches. Allow skin to dry completely; do not fan or blow on site.		
<b>14</b>	With non-dominant hand, spread skin across injection site or pinch skin around injection site		
<b>15</b>	If an insulin vial is ordered, position needle with bevel up in dominant hand. Hold as if syringe were dart or pencil.		

Skill #	Critical Behaviors	Performs Satisfactorily	Needs Improvement/Comments
16	Inform resident he/she will feel a slight pinch, pressure, or stinging sensation as the insulin is injected		
17	When using a syringe, insert needle in a quick motion at a 45° or 90° angle to skin surface. When using a pen, the injection should be administered at a 90° angle.		
18	<b>During injection with a syringe</b> , hold needle in place for 5 seconds or per manufacturer's instructions.  <b>During injection with a pen</b> , push the plunger and slowly inject the insulin; hold the pen in place for 5-10 seconds per manufacturer's instructions.		
19	Remove needle quickly and gently, while placing gauze pad just above injection site; press gently on injection site		
20	Assess for bleeding or bruising at the injection site		
21	Dispose of syringe or pen needle into sharps container		
22	Remove gloves and perform hand hygiene		
23	Document medication administration and site of injection		
24	Insulin vials and pens should be stored per facility policy		

Nurse Signature

Evaluator Signature

## References

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