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The purpose of this alternate scenario is to offer additional exposure to the concepts of medication administration and practice in documentation. As a trainer, you may use the Alternate Scenario in its entirety or just those pieces with which your students are having difficulty. The structure of the Alternate Scenario parallels that of the scenario for the initial Classroom Presentation with different medications and situation. It is broken up in a way that you can present some activities and not others. You may modify the presentation of this material by just using what is needed.

Some of the material and slides such as those introducing the students to the course may not need to be used depending on how recently the students have completed the initial scenario. Trainers can present just the material on documentation for students needing additional instruction related to documentation. The Trainer-led Medication Administration Demonstration can be used for students having difficulty with administration skills. Trainers should present the materials that meet the needs for each group of students recognizing that not all students will have the same needs.

Keep in mind that all of the pieces of the Alternate Scenario that are presented must be presented as written. You may not modify the wording or examples.
CLASSROOM PRESENTATION
ALTERNATE SCENARIO
WELCOME AND COURSE ORIENTATION

[Put up SLIDE 1]

1. **Welcome** the students to the course.

2. **Introduce** yourself
   
   a. [Share some of your background and experience. You may include information about how long you have worked in the field, what positions you have held, and how long you have been administering medication and/or training medication administration.]
   
   b. [If the students don’t know each other, then have the students introduce themselves.]

3. **Class rules**: [Acquaint the students with your class rules and any typical housekeeping details that they may need to know such as where the restroom is, if there will be a break, etc.]

4. **Explain the purpose of the course**

   [Put up SLIDE 2 – Course Purpose]

   [Read the following to the students.]

   • The purpose of this course is to teach unlicensed staff to administer medication to people with the goal of improving their quality of life.

   • The course uses a standard method to teach medication administration so that it can be done in the most safe and accurate manner.

   • It is your job to administer medication correctly and to follow the steps you’ve been taught for accurate administration.
5. Completion criteria

[Put up SLIDE 3 – Course Completion Criteria]

[Read the following to the students.]

a. To finish the requirements for the course, we need to:

i. Complete the face to face classroom training

ii. Take the skill competency tests for handwashing and gloving

iii. Successfully complete the multiple choice and written documentation exams online, and

iv. Complete four observed medication administrations.

[Inform them of how you will be approaching these. E.g. two of the observations will be done today and the other two in your work environment in the next two to three weeks, etc.]

INTRODUCTION AND SCENARIO

[Put up SLIDE 4 — with the medication administration cycle]

Remember like when we did the initial scenario, this face to face part of the course serves to pull together the concepts that you learned in the lessons completed online and shows you how to apply them. It allows you additional practice for the skills that you will need to properly administer medication. In order to do this, we will again walk through the Medication Administration Cycle with an emphasis on the application of the principles of safe medication administration and the practical skills of actual administration and documentation of medication administration. To illustrate this, we will use a different scenario.

[Give each student a copy of the scenario which appears in Appendix 1.]
You are working with Alfred Nicolai who has recently been hospitalized for heart failure. He was admitted to the hospital when he had trouble breathing and was feeling his heart beat fast. You also noticed that he said that he felt more fatigued lately and wasn’t able to walk quite as far on his daily walks. In addition, his appetite had decreased. He started a new medication, digoxin, in the hospital and was put on a low dose because his kidneys don’t work well. He takes 0.125 mg of digoxin once a day. Alfred’s healthcare practitioner wants a measure of his heart rate prior to administering the digoxin. In addition to taking medication, he is to decrease how much salt he eats. On discharge from the hospital, he no longer has trouble breathing and has a normal heart beat. You are told to watch for signs of improvement or worsening of his heart failure and side effects of the medication which include nausea and vomiting, blurred vision, and headaches. You have instructions to bring him to see his healthcare practitioner in 2 weeks to report on his progress.

At 2 weeks, Alfred goes back to see his healthcare practitioner for a post-hospital follow-up visit. He hasn’t had much response to the medication, but hasn’t had side effects either. There are still symptoms of fatigue and he still hasn’t been able to walk as far as in the past. However, he has no problems taking the medication. The healthcare practitioner increases his dose of medication to 0.25 mg once a day with a follow-up visit in 6 weeks.

At the 6 week follow-up, you and Alfred note that there have been some changes. He is feeling more energetic and is now able to do his full daily walk. His appetite is better and he is really feeling well. He has no side effects and the healthcare practitioner decides to continue the medication at 0.25 mg per day with a re-evaluation in 4 weeks.

[Tell the students the following:]

Let’s look at your role as a medication administrator in this scenario. First, let’s review the five steps in the Medication Administration Cycle that you learned about in the online lessons. Safe medication administration and management in the treatment of health conditions requires following the steps in this cycle. It guides your role and responsibility in the healthcare of the people with whom you work. The steps include: Observation, Report changes, Communication and healthcare practitioner visit, Record and store, and Administration and documentation. Let’s start with your role and responsibility in observation.
Observation can be defined as the act of noticing or perceiving. We learned that observations are a combination of objective observations which are facts and subjective observations which are appraisals or perceptions from the person. Objective information is based on fact and often can be measured. It is something that you have first-hand knowledge of. You use your senses, vision, hearing, touch, and smell to gather objective information. Subjective observations rely on what the person tells you. Symptoms like ringing in the ears, blurred vision, and nausea or upset stomach must be told to you by the person. These can’t be measured or verified. Using both of these types of observations provides a more comprehensive picture of what is happening. This helps you better communicate that with others. Remember that observation does not include your thoughts about what is causing the observed symptoms. This is important because the healthcare practitioner will use your observations to help determine diagnosis and treatment. Inaccurate or incomplete information could result in inappropriate treatment for the person.

Activity 1

Let’s look back at the scenario and identify how observation was used.

[Ask the students to do the following, listing their answers on a flip chart or white board.]

Using the scenario, what were Alfred’s initial presenting symptoms that were observed?

[Students should include the following points:]

- Trouble breathing
- More fatigued
- Fast heart beat
- Decreased appetite
- Decreased exercise tolerance (not able to walk as far as usual)
[Tell the students:]

Now identify which type of observation, objective or subjective, each symptom represents.

[The answers are:]

- Trouble breathing—objective
- More fatigued—subjective
- Fast heart beat—subjective – This is subjective because Alfred said he was feeling a fast heart beat. If you had measured it as fast, then it would be objective.
- Decreased appetite—objective
- Decreased exercise tolerance (not able to walk as far as usual)—objective

In addition to the observations above that you took to the initial visit with the healthcare practitioner, other information was used to make the diagnosis of heart failure. In this instance, this included a hospitalization. Discharge planning included information about what you are told to watch for, both the signs of improvement or worsening of his heart failure, and those for side effects of the medication including nausea and vomiting, blurred vision, and headaches. You have instructions to bring him to see his healthcare practitioner in 2 weeks to report on his progress. Your observations based on what you saw and were told were communicated at the 2 week visit.

REPORT CHANGES

[Put up SLIDE 6 — with the medication administration cycle with report changes emphasized]

The next step in the Medication Administration Cycle is to report changes. Reporting changes is the communication of what you observe. The information that you have regarding your observations is important to many people who work with the person. As the staff member who spends the most time with the person, you are often the first person to observe a change. Without reporting your observations, changes in the person might be missed and a health condition could worsen or go untreated. Therefore, you are responsible for reporting what you observe. Remember to report everything that you observe no matter how insignificant you might think it is. Sometimes what you believe is least important, turns out to be the most important. You shouldn’t make judgments about the importance of what you have observed, just like you shouldn’t assign cause to what you observe. Next, we’ll talk about when to report.
The timing of reporting depends on the nature of the observation. Some situations require immediate responses, while others may be gathered and shared with the healthcare practitioner at a later date such as a follow-up visit. Timing generally falls under four categories: emergent, urgent, certain time and routine. Let’s look at timing related to the scenario about Alfred.

**Activity 2**

[Ask the students:]

Determine the type of timing related to the initial symptoms in the scenario.

[Give them time to reflect on the scenario and answer.]

[Tell the students the following:]

This is an example of urgent reporting since it is unexpected, requires attention, but is not life-threatening. It does need to be reported when it is discovered.

This is not routine reporting because while the symptoms developed over time, this represents a change in the person that needs to be evaluated soon and not at the next routine visit. It also requires an additional action which makes it different from a routine observation.

[Ask the students:]

Determine the type of timing related to the symptoms at the two week follow-up visit in the scenario.

[Give them time to reflect on the scenario and answer.]

[Tell the students the following:]

This is an example of certain time reporting since the timing of the reporting was established by the healthcare practitioner. The observations gathered prior to the two week visit should be documented daily in written form. That information should be put into a report to take to the visit.
Suppose that Alfred develops a red blotchy rash and trouble breathing three days after starting the medication. What would you do? What kind of reporting would this be?

Give them time to reflect on the scenario and answer.

Answer: Students should identify this as emergent reporting.

Tell the students the following:

This is an example of emergent reporting since the development of new, potentially life-threatening symptoms must be addressed immediately. These are the symptoms of an anaphylactic, allergic reaction. These symptoms might be a reaction to the new medication; however, it might be to some other substance. The determination of what caused this reaction should be made by a healthcare practitioner.

We’ve looked at the timing of reporting. Let’s move on to the methods used to report changes. You can report changes verbally, in writing, or using both verbal and written reports. It is probably best to report some kinds of changes using both methods as that not only passes the information on quickly, but also captures what was observed in a manner that can be reviewed later. You will almost never only report changes verbally since it is important for others who may not be present to have access to the information. Verbal reporting followed by written reporting depends on the nature of the changes and the timing. Most likely, routine observations will only be reported in a written document, while urgent, emergent, or certain time reports likely will require both verbal and written reporting.

Activity 3

Tell the students the following:

Write a note with the summary of the information to be taken to the healthcare practitioner at the 2 week follow-up visit using the information provided in the scenario.

Give the students time to complete the note.
Let’s review the elements that your note should contain. Look at your note as we review each one to make sure that element is present.

- Person’s name
- Date of the note
- Time the note was written
- Observations
  - The person is taking 0.125 mg Digoxin in the morning.
  - There are no changes in the existing symptoms observed over the last two weeks and no new symptoms.
  - The person has done well with taking the medication.
- Observer’s signature

Let’ move on and talk about communicating with the healthcare practitioner. Why is it important to have good communication with healthcare practitioners? Good communication between caregivers like yourself and healthcare practitioners promotes better healthcare for the person. It also uses your time and the healthcare practitioners’ time more efficiently and results in better satisfaction for everyone. Communication between you and the healthcare practitioner is a partnership and you both have a responsibility to communicate. This means asking questions, sharing information, and bringing up issues that you are concerned about. Doing this for and with the person that you support adds additional complexity. Therefore, it is critical for you to do a few things to promote good communication.
What is good communication and how do you achieve it? There are some tips to assist you in better communication with the healthcare practitioner. These include:

- Making sure that the healthcare practitioner knows your role and its limits. Know who makes medical decisions and signs consents for this person. Also, remember to promote the person’s interaction with the healthcare practitioner.
- Take information that summarizes the person’s situation and what has been happening from the vantage point of everyone working with the person. Symptoms, graphic data like blood pressures and weights, and other pertinent information should be written down.
- Respect the confidentiality of the person and the need to have the full attention of the healthcare practitioner by holding conversations in an appropriate place like the exam room and not in the hallway or waiting room.
- Recognize that not every situation presented will have an immediate or obvious answer and that the healthcare practitioner’s impression may not be what you expect.
- Be sure to write down what the healthcare practitioner tells you so that you can share that information with the rest of the team. Repeating back to the healthcare practitioner what you heard will help assure that you get the correct information.
- Ask about other resources and where you may learn about the condition and how to manage it.

**Activity 4**

[Tell the students:]

Using the scenario, identify the types of visits represented.

[Give them time to reflect on the scenario and answer.]

[Answer: The students should identify that there is an initial visit and two follow-up visits in the scenario. If they do not do this correctly, give them the correct answer.]

[Have the students do the following activity. You can accomplish this using class discussion or as a written activity either as a group or individually.]
[Tell the students:]

Identify the information that would be taken to the initial visit and each of the two follow-up visits as well as the information to bring back to the provider from the visits.

[The students should include the following in their answers/discussion.]

Initial Visit
- Information to take initial visit
  - Symptoms of changes in behavior: trouble breathing, more fatigued, fast heart beat, decreased appetite, decreased exercise tolerance (not able to walk as far as usual).
- Information to bring back from the hospitalization
  - Diagnosis of heart failure
  - Prescription for digoxin 0.125 mg, one tablet, taken once a day by mouth in the morning and that the pharmacy will deliver the medication to the home.
  - Diet should have less salt in it.
  - Follow-up visits at 2 weeks and 6 weeks for a check and medication follow-up respectively.

Two Week Visit
- Information to take to 2 week visit
  - Symptoms are improved: trouble breathing and fast heart beat.
  - Some symptoms are not changed and there are no new symptoms.
  - There are no problems with taking the medication.
- Information to bring back to the provider from the 2 week visit
  - The medication was increased to 0.25 mg because there was no response.
  - How the increased dose of medication will be accomplished. [Tell students how your provider approaches this situation.]
Six Week Visit

- Information to take to 6 week visit
  - Remaining symptoms are better
    - Appetite is better
    - Less fatigued
    - Better exercise tolerance
  - No new symptoms
- Information to bring back to the provider from the 6 week visit
  - No change in medication
  - Follow-up visit in 4 weeks

[Tell the students:]

One of the important parts of the visit to the healthcare practitioner with regards to medication administration is the medication prescription. In this example, the prescription was not written on paper, but sent electronically directly to the pharmacy. Depending on the healthcare practitioner’s electronic capabilities and the person’s insurance for medication, there are multiple ways to get a prescription filled. As well, providers approach getting medication for people in different ways. Let’s first review how we get medication for people at our provider.

Policy and Practice

[Review practically how your provider obtains medication.]

[Put up SLIDE 9 – with the 5 rights]

Now we’ll talk about the information from the prescription that you will use for medication administration. This information will also be on the pharmacy label. Remember that these are called the “5 Rights.”

Here is a pneumonic to help you remember the “5 Rights.”

I Must Do This Right.

- “I” for individual or the person
- “M” for medication
- “D” for dose
- “T” for time
- “R” for route
Activity 5

[Put up SLIDE 10 – Pharmacy Label and tell the students:]

Using the information from the scenario or the pharmacy label on the slide, identify the “5 Rights.”

[Have the students complete this either as a group discussion activity or individually as a written activity. The answers should include the information below. Review the correct responses with the students.]

- **Individual/Person:** Alfred Nicolai
- **Medication:** Digoxin is the name of the medication. While you may not know this, digoxin is the generic name for this drug. One of the brand names for it is Lanoxin.
- **Dose:** 1 tablet of 0.125 mg is the initial dose.
- **Time:** It is taken one time a day in the morning. The time or hour of administration requires an actual time. It is not acceptable to list am, pm, breakfast, etc. The time associated with “morning” is defined in our medication administration policies and procedures which we’ll take about in a minute.
- **Route:** The medication is taken by mouth or orally.

**Policy and Practice**

[Describe how the hour of administration is defined for your provider and the range of time that medication is considered to be administered on time, e.g. one hour before and one hour after.]
RECORD AND STORAGE

[Put up SLIDE 11 — with the medication administration cycle with recording and storage emphasized]

[Tell the students:]

The next step in the medication cycle is the recording and storage of medication. Recording involves taking the information from the pharmacy label and putting it onto the Medication Administration Record or MAR where the documentation of medication administrations will occur. Medication needs to be stored in a place where it’ll be safe. For those people who do not understand about poisonous substances or how medications are used, you will need to store medication so that they can’t get hold of it. Medication must be stored in a way to maintain its integrity. Remember, medication may be sensitive to heat or humidity. That effects where medication should be stored.

Next, we’ll look at recording or entering the medication information from the scenario onto an MAR as a new medication. Remember that even if the medication is already entered onto the MAR by the pharmacy, it is still your responsibility to make sure that the information on the MAR matches the information on the pharmacy label.

Before we enter that information, let’s review the MAR that you will be using.

Policy and Practice

[Review the parts of the MAR using your provider MAR so that the student knows where all of the information is located. If you use an electronic MAR, show the students both how to use the electronic MAR and the back-up paper version. This may be an appropriate time to show any formal information provided by the electronic MAR vendor including written instructions, videos, etc. Be sure that you cover the information listed below.]
[Put up SLIDE 12 — blank MAR or picture of provider specific MAR that is blank]

[Tell the students:]

Let’s look at the MAR.

- Find the following information:
  - The person’s name
  - The person’s diagnoses - this may be on the MAR or with the medication information
  - Healthcare practitioner(s)
  - Allergies
  - Identifying information such as where the person lives or a personal identifier like a number or a birth date.

- Show where the specific medication information like medication name, dose, etc. will go. What is this called? [Answer: description box].

- Identify the hour column.

- Point to where information about the diagnosis associated with medication goes. [This should be based on regulatory requirements and provider policy and practice.]

- Show the following:
  - Timeframe, month and year
  - Where you will sign your name and initial [If this is done on a central sheet, then show them that at this time.]

- Show where PRN or as needed medications will be documented including where the response to the medication can be put. [Either on the back of the MAR or in a note based on provider practice and policy.]

**Policy and Practice**

[For medication that requires additional monitoring such as blood pressure or blood sugar prior to administration, describe for students where to document that and remind them that they need to be trained how to perform the monitoring technique prior to administering that medication.]
Activity 6

[Put up SLIDE 13 — pharmacy label below]

[Tell the students:] Let’s now look at how to enter the information from a pharmacy label onto a blank MAR. Use the pharmacy label that you have a copy of and is also on the slide.

[Give the students time to complete the documentation.]

[Use the pharmacy label that appears below for this activity. A copy of this pharmacy label for student use appears in Appendix 2. Be sure to use your provider MAR for this activity, if possible. If it is not possible, then a blank MAR is also in Appendix 2.]

<table>
<thead>
<tr>
<th>PHARMACY LABEL</th>
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</thead>
<tbody>
<tr>
<td>Local Drugstore, Inc.</td>
</tr>
<tr>
<td>DEA#: 5553535</td>
</tr>
<tr>
<td>123 Main Street</td>
</tr>
<tr>
<td>Anytown, PA 16006</td>
</tr>
<tr>
<td>123-123-4567</td>
</tr>
<tr>
<td>PH: STV</td>
</tr>
<tr>
<td>Original script date: 04/25/2000</td>
</tr>
<tr>
<td>RX 1313 22 746</td>
</tr>
<tr>
<td>Date filled: 07/05/2004</td>
</tr>
<tr>
<td>Alfred Nicolai</td>
</tr>
<tr>
<td>234 Main Street</td>
</tr>
<tr>
<td>Anytown, PA 16006</td>
</tr>
<tr>
<td>123-234-2345</td>
</tr>
<tr>
<td>1 tablet by mouth one time a day in the morning for heart failure. Do not give if heart rate is below 60 beats per minute.</td>
</tr>
<tr>
<td>Digoxin 0.125 mg</td>
</tr>
<tr>
<td>QTY: 30</td>
</tr>
<tr>
<td>QRS Drugs, Inc.</td>
</tr>
<tr>
<td>Refills: 3</td>
</tr>
<tr>
<td>Burns, Thomas MD</td>
</tr>
<tr>
<td>Drug expiration: 10/15/2009</td>
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</table>
[Put up SLIDE 14 — MAR or other visual with the answers to the activity]

[Walk around and look at each student’s MAR to assure it’s done correctly. Then review the MAR entries with the students showing them where each entry goes on the MAR that they are using. “HERE” is used to indicate when to point out where the entry should go on the MAR.]

The entries on your MAR should look like this. Let’s go through each of the pieces.

- The individual/person is Alfred Nicolai and that belongs “HERE” on the MAR.
- The information belonging in the description box about the medication includes the medication name, dose, and route and this goes “HERE” on the MAR. Remember that the information in the description box MUST match the information on the pharmacy label exactly.
- The time goes in the hour of administration box which is “HERE” on the MAR. Remember that the time associated with “morning” is defined by policy.
- On the slide, the heart rate appears “HERE” under the time in the hour of administration box and would be documented in the date and time box under your initials for each administration.
- The diagnosis goes “HERE” on the MAR. It also may be present in the description box.
- The healthcare practitioners’ names go “HERE” on the MAR.

[If you are using your own MAR, then you will need to identify for the students the dates of administration for that MAR, allergies and any other identifying information for the person and where the information goes on the MAR. You also need to tell them where to document additional information like the heart rate if it is different from the example above.]
Activity 7

[Put up SLIDE 15 – pharmacy label]

[Use the pharmacy label that appears above for this activity. A copy of this pharmacy label for student use appears in Appendix 2.]

[Tell students:]
Let’s suppose that Alfred is also on verapamil which has a brand name of Catan, 80 mg and takes one tablet by mouth three times a day for high blood pressure. Use the information on the pharmacy label to enter the verapamil on the MAR with the digoxin including the times of administration.

[Provide students time to complete the documentation.]

[Walk around and look at each student’s MAR to assure it’s done correctly. Then review the MAR entries with the students showing them where each entry goes on the MAR that they are using.]

[Put up SLIDE 16 – completed MAR or other visual with the answers to the activity]

The entries on your MAR should look like this. Let’s go through each of the pieces.

- The individual/person is Alfred Nicolai and that is “HERE” on the MAR. This should already have been entered on the MAR for the previous medication.
- The information belonging in the description box about the medication includes the medication name, dose, and route and this goes “HERE” on the MAR. Remember that the information in the description box MUST match the information on the pharmacy label.
- The time goes in the hour of administration box which is “HERE” on the MAR. Remember that the times associated with three times a day are defined by policy.
- The diagnosis goes “HERE” on the MAR.
- The healthcare practitioners’ names go “HERE” on the MAR.
[Tell the students:]

Both digoxin and verapamil are medications that affect heart function, but neither of them is a controlled or countable substance. In order to practice the skills for a medication that is required to be counted, we will use the pain medication meperidine or Demerol. This is a Schedule II controlled substance and must be accounted for by counting at each change of shift or possession. This practice protects you and the provider as these medications are identified as having a higher potential for abuse by the Federal Drug Administration or FDA.

Activity 8

[Put up SLIDE 17 — countable substance form]

Policy and Practice

[Introduce the students to your provider controlled substance counting forms and the procedures and practices you use to count controlled substances. Also inform them of the procedure they should follow if the count is wrong including who to notify and how. A sample countable substance form appears below and in Appendix 3.]

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<tr>
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<th>MEDICATION AND DOSE</th>
<th>STARTING COUNT</th>
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<tbody>
<tr>
<td>Alfred Nicolai</td>
<td>Meperidine 50 mg 1 tablet every 4 hours as needed for pain</td>
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<td>N.R. Starr</td>
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<td>N.R. Starr</td>
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Continued
[Tell the students:]

Let’s practice documenting the count of a controlled substance on a counting form. Alfred takes 50 mg of meperidine every 4 hours as needed for pain. Suppose that it is the 5th of the month and Alfred gets 4 doses of meperidine each day, one in the morning and at noon and one in the evening and at bedtime. These times represent two shifts and two doses are given by the first shift and two by the second shift. If the medication container for meperidine originally had 60 doses in it, then show on the form what the count would be at the beginning and end of the first shift assuming that he took all four doses. Use the numbers on the form to document the next two counts. Assume that you are the person who is coming to work for the day shift and that you are relieving D.S. Collins who worked the night shift. For the afternoon shift you are being relieved by N.R. Starr.

[Provide students time to complete the documentation.]

[Put up SLIDE 18 — countable substance form with highlighted entries]

[Tell the students and show them where each element belongs on the count sheet.]

Your count sheet should look like this.

- Your name should appear twice on the count sheet. The first time when you relieve D.S. Collins from the night shift. The second time when N.R. Starr relieves you from the day shift.
- There were no doses given overnight so the morning count when D.S. Collins goes off shift and you come on is the same as the night count.
- There were two doses given during the day shift. When you leave and N.R. Starr comes on for the afternoon shift, the count should be two tablets less which is 42.
- Remember that you need to count with the person going off or coming on shift and both of you need to sign the count sheet.
Moving from recording to storage, the next step in the process of receiving medication is storing it. You learned about the principles of storage and the best kinds of places to put medication. Now, we’re going to talk about how we approach storage of medication as a provider.

**Policy and Practice**

*Show or describe to the students where medication is found, how it is secured, and other storage details that they will need to know.*

*Tell the students:*

Now that you know how we approach storage of medication, let’s talk briefly about the disposal of discontinued or out of date medication.
Policy and Practice

[Describe your provider’s approach to disposal of medication including whether or not you return it to the pharmacy; use community take-back programs; or destroy medication at the worksite. If you have staff destroy medication at the worksite, remember that there must be two staff present for the destruction and exactly what and who’s medication and how much was destroyed must be documented in a note. Both staff present must sign the note with the details of what was destroyed. Remember to caution staff never to flush discontinued medication down the toilet unless instructed otherwise. Look at the federal websites (e.g. Food and Drug Administration, Drug Enforcement Administration, etc.) or talk with the pharmacist about how to destroy a particular medication.]

ADMINISTRATION

[Put up SLIDE 19 — with the medication administration cycle with administration and documentation emphasized]

[Tell the students:]

Administration and documentation are the next pieces of the cycle. Documentation is an integral part of the medication administration process. There are a number of scenarios to learn about documentation and we will address those separately from the process of administration. We’ll begin with reviewing and practicing the process of administering medication using the most common type of documentation which is termed a typical administration.

First, there are some important, general rules that you should remember when administering medication. These rules help you know when you should stop medication administration because something is not right.

[Review these with the students by asking them what they would do in these situations. Read the first part of each example below and then ask the students what they would do. Have the students identify if they would continue the medication administration or stop it. If they would stop it, then ask them why and what they would do to fix the issue. If their answer is different from the one after the example, then provide that information to them.]
[Ask the students:]

What would you do…

1. If you are missing any piece of information like the route of administration?
   [Answer: Stop and find that piece of information]

2. If you cannot read the pharmacy label or the label is missing?
   [Answer: Stop and call the pharmacy. Follow your agency protocol for contacting the pharmacy.]

3. If you cannot read the label on an over the counter medication?
   [Answer: Stop, discard the medication because you don't know what it is. You will need to replace this medication.]

4. If the medication has been prepared by another staff member?
   [Answer: Stop. You should never give a medication prepared by someone else. You don't know what that medication is.]

5. If you don’t think that one of the rights is correct? For example, you’re not sure that you have the right individual or person.
   [Answer: Stop and double check that you have the right individual or person by looking at a picture or asking another staff person. Do not ask the individual or person as some people answer to any name.]

6. If the person has a change in their condition like becoming more sleepy?
   [Answer: Stop and call the healthcare practitioner. Follow your agency protocol for contacting the healthcare practitioner.]

7. If the person has more difficulty than usual taking the medication?
   [Answer: Stop and call the healthcare practitioner to tell him or her that the person is having trouble swallowing. Follow your agency protocol for contacting the healthcare practitioner.]

8. If the person is having trouble breathing, decreased awareness, unconscious, etc?
   [Answer: Stop. This person appears to have a health or life threatening condition. Call 911 and then follow your agency protocol for addressing an emergency.]
9. If the person refuses the medication?

   [Answer: Stop. Do not force them to take it. Try to identify whether this is a new problem or not. Use any behavioral strategies that the team has developed to work with this person around taking medication. Make sure that you are approaching administering the medication the way that the person prefers to take it.]

The Steps of Medication Administration

Medication administration can be broken down into three parts: preparation, administration, and completing the administration including documentation. Each of these parts has a number of steps. The pattern of steps to administer medication is the same regardless of the medication and how it is going to be administered. Some of the steps in preparation may be different depending on the form of the medication and the route to administer the medication. Remember that the basic patterns of the steps of administration are the same regardless of the route.

We will look at oral administration as this is the most common way that medication is administered. You will find that each place you work may be set up a little differently. Therefore, the preparation for medication administration, the first part, may occur in a slightly different order than we teach. It is important however, that you make sure that you include all of the steps. The steps for the second part, the actual administration of the medication, should occur in exactly the order learned. The tasks related to the completion of the process of medication administration should always follow the administration of the medication. The order of these may be varied depending on your work environment and how it is set up.

Next we will review the steps associated with part one of medication administration.
Part 1 – Preparation

[Put up SLIDE 20 — with the first five or preparation steps for medication administration - You should alter the order of these steps on the slide to match the set-up of your environment and/or add details as it relates to the provider procedures.]

[Tell the students:]

Starting with part one, let’s describe the steps in preparing to administer medication. These steps involve preparing the environment and yourself for the administration.

Step 1 is to identify the individual or person and the medications that you will give them. This requires reading the medication log or MAR in order to identify which medications this person is to receive at this time. Use this time to identify any special equipment that you might need in order to prepare the medication. For example, if the medication is a liquid to be given orally, you will need to make sure that you have a measuring device in order to give it. Depending on how your environment is arranged, you may have that person come with you while you prepare the medication or you may wait to bring the medication to them after you have finished preparing it.

Step 2 begins the preparation of the space that you will use to prepare the medication for administration. It is important to create a clear, clean place with enough space to put all of the tools that you will need. You should wash the surface prior to preparing the medications for administration.

Step 3 is to gather the equipment that you will need. This includes the MAR and whatever you will use to put the medication into. For pills, this might be a shallow dish or a small plate. For liquids, this might be a measured cup, dropper, measured spoon, dosing syringe, or other device to measure the medication dose. Don’t forget that you may need some water in a cup for the person to take their medication. You should also prepare that at this time.

Step 4 is to get the medication containers that you need from the locked storage area. Where you keep medications will affect how you do this step. If the preparation site and the locked medication storage area are in two different places, then you may want to take the medication with you when you go to prepare your workspace. You must always be careful to make sure that the medication is not accessible to the people that you serve if they are unable to avoid poisonous substances. You should not leave medications out in a public or unlocked area where other individuals might take them. Always be sure that you have not left the medication where anyone could touch them.
Step 5 is an important infection control measure. Before you prepare or handle the person’s medication, you should wash your hands as you learned in the online lesson about handwashing and gloving.

Part 2 – Administration

[Put up SLIDE 21 — with the second five or administration steps for medication administration – the order of these steps may not be modified]

[Tell the students:]

The second part of medication administration is the actual administration of the medication. This requires you to use the information that you learned about pharmacy labels, MARs and the five rights. There are five steps to the actual administration of medication. These must be done in order and must not be interrupted. If you are interrupted in the middle, then you should go back to the first step and make sure that you have done everything right. Now we’ll go through the steps for part 2.

Step 1 is the first check when you match the label on the medication container to the MAR or med log. First, remove the medication container that you need for this administration from the locked container. Some types of medication, especially inhalers, come in a box with the pharmacy label on it. You will need this box with the label to complete the next part of the process. Be sure that you keep any labeled boxes that come with the medication. You will also need the number on this box to refill the medication. In addition, you must always be careful to make sure that the medication is not accessible to the people that you serve if they are unable to avoid poisonous substances. You should not leave medications out in a public or unlocked area where other people might take them. Always be sure that you can assure that no one has touched the medications that you have prepared to administer.

The way that you do the first check is to compare the 5 rights between the pharmacy label on the medication container and the MAR. Compare the individual or person, medication, dose, time, and route. Make sure that they all match. After you are sure that you have the right medication container, then move to step 2. If you have any questions, stop and clarify them before proceeding.
**Step 2** is your second check. This time you pick up the bottle and again compare the label to the MAR. Make sure that the person, medication, dose, time, and route all match. If they all match, then open the container and put the correct dose into the bowl or saucer that you will administer it from. You can pour a pill, or the correct number that the label directs, from the container into the bowl, preferably without touching it with your hands. This is also possible to do by punching the pills from a blister pack.

Look at the medication in the bowl. Is the tablet whole or broken? If it is broken, then you should not use it, unless the dose requires tablets to be broken in half. Do not alter the medication by crushing or dissolving it in water unless the label instructs you to do so. If the medication is in a liquid form, then pour the correct dose into the measuring device at this time. Never give another person’s medication even if it is the same medication and dose.

**Step 3** is the third and last check before you give the medication. Once again compare the label and MAR or med log to make sure that the person, medication, dose, time, and route are correct. You may now close the container. Keep the container out, unless you must put it away for safety reasons. Putting it away is a step in Part 3, completing the administration. At this point in the process, some documentation that the medication has been poured can be helpful.

**Policy and Practice**

*Some providers use the strategy of putting a dot in the initial box on the MAR as they complete step 3 for each medication. There are other ways to accomplish this. Talk with the students about how your provider does this.*

*Tell the students:*  

**Step 4** is the actual administration of the medication. First, you must identify the right person. There are multiple ways to do this if you don’t know the person well. You can use a picture, ask a staff person who knows the person well, or ask your supervisor. Do not solely rely on asking the person themself as some people answer to other people’s names.
If you have the person with you as you are preparing, then you can just give them their medication now. If you will be giving the medication in another location, you will need to take the medication to that location remembering to secure the medication container in the preparation area. When you have the medication and the person in the same place, then you will give them the medication. Remember to use the skills that the person has in terms of taking the medication. If the person can pick up the pill and put it into their mouth, then he or she should do that. If the person can hold the cup to drink after he or she takes the medication, then allow him or her to do that. Use this opportunity to talk to the person about what the medication is and why he or she is taking it. That not only provides the person with information, but also reminds you.

**Step 5** includes observing the person after taking the medication for any problems. Observation is not something that occurs only after administration. However, you must remember that it is an important part of your job. Make sure that the person takes the medication without any difficulty. Stay with the person until the medication is swallowed. If you note that someone consistently has trouble swallowing pills, you should alert your supervisor and the healthcare practitioner. This may indicate a swallowing problem that needs to be addressed. You can also ask the pharmacist whether or not the medication that the person is on can be crushed to make it easier to swallow.

**Part 3 – Completion**

[Put up SLIDE 22 — with the third five or completion steps for medication administration - You should alter the order of step 4 on the slide to match the set-up of your environment and/or add details as it relates to the provider procedures.]

[Tell the students:]

The last part of medication administration is completing the process. This part is just as important as the others as it connects back into the medication cycle. It includes the documentation of what you have done so that others will know that this person got their medication as directed. Sometimes people feel that this part of the process is not as important as the others. However, it is crucial for you to document the administration so that it doesn't get administered twice by another person. This is particularly important for people who cannot reliably tell you that they got their medication and cannot self-administer it. Although it is important for everyone because even if people can remember in the short term, how many people remember that they took their medication a week ago.
**Step 1** is when you look again. You can consider this as a fourth check. It occurs when you come back to the room where you prepared the medication and once again verify the 5 Rights. As you are preparing to document the administration, look again for the five rights to make sure that you administered the medication correctly. This look comes when the administration is fresh in your mind and if something wasn’t right, then you are more likely to catch it now and perhaps prevent any problems from an error. If you identify a problem, then you must contact the designated person immediately.

**Policy and Practice**

*At this time tell staff who the designated person will be at the worksite—e.g. house manager, provider nurse, supervisor, etc.*]

**Step 2** is the documentation of the medication administration on the MAR or med log. This document contains all of the information including the details about the administration. Documentation of the administration is done by writing your initials in the box that corresponds to the medication administration date and time. You will always use ink to document as this is a permanent record. You will also document any observations in the place where your provider keeps notes. These may include side effects, good effects, or other observations.

**Policy and Practice**

*If you use an electronic MAR, you should teach both the paper process using this guidance and how to use the electronic system. You can mention that you use an electronic system here, but instructions for when to teach how to use the system appear under the documentation section and you should wait to teach the electronic MAR then.*

*Tell the students:*

**Step 3** is to return the medication and the MAR to their storage area. Don’t forget to lock the medications, if needed, so that they will be safe and no one can access them.

**Step 4** is handwashing. You should wash your hands after the administration of the medication. You may do this immediately following administration and prior to the administration of medication to another person or after documentation if this is your last administration for this time.
Step 5 is to observe the person for effects from the medication. These may be desired or unwanted effects. Remember that part of the medication cycle is to observe for side effects after administering medication. While you may not see these immediately, it is important to remember to look. This serves as your reminder about that.
TRAINER-LED DEMONSTRATION

The first part of this exercise will be a trainer-led demonstration. You will do a demonstration for the students with them repeating the steps after you do. You will need some things to use to simulate medication administration. As much as possible, make these items similar to those used at your provider worksites. You will need the following:

- Saucers, med cups, paper plate, bowls, etc. for the preparation of medication
- A mock medication container with a pharmacy label. You may copy the pharmacy label provided and tape it to an empty, clean bottle from the pharmacy. If you create your own, be sure to mark on the label that this is for demonstration purposes only so that no one will mistake it for real medication. Put some small candies or beans into the bottle to make the demonstration more real. Be sure that you have enough demonstration bottles for each student to use.
- Medication log or MAR of the type used by the provider or the one provided. If you are using one of the provider MARs, then you will need to add the appropriate information from the pharmacy label used for this demonstration.
- Medication storage boxes (could be as simple as a shoe box)
- Paper towels to clean preparation area
- Cups for water (these don’t have to be filled with water)

Begin with the preparation and move through administration and completion of the administration as illustrated below. You may want to show the PowerPoint with the parts of administration outlined during the demonstration.

PART 1 - PREPARATION

[Put up SLIDE 23 — with the first five or preparation steps for medication administration - You should alter the order of these steps on the slide to match the set-up of your environment and/or add details as it relates to the provider procedures.]

[Tell the Students:]

We are going to practice a medication administration. I will demonstrate a step and then you will repeat it after me.

Preparation is the first part. For this activity, we will be giving Alfred Nicolai his 8 am digoxin medication.
Step 1: Identify the person that you will be giving medication to. We are going to be looking at the information for Alfred. Since Alfred doesn't like to be in the room where we prepare medications, I will prepare his first and take it to him. I know that he likes to take his medication sitting at the kitchen table. So we will give it to him there. I am going to ask Alfred to sit at the kitchen table to wait for his medication. I will be with him in a minute.

Next, I will read Alfred’s medication log or the MAR and identify what medication he is supposed to take at 8 am. I look for the hour of administration on the med log to find the time of 8 am. Then I look in the description box to identify the medication that is supposed to be given at 8 am.

[Ask students:]

Using the MAR that you prepared in Activities 6 and 7, what medication do you see for 8 am?

[Answer: digoxin and verapamil]

[Tell the students:]

For the purposes of this administration, we will use only the digoxin.

Step 2: Clear and clean the area where you will be working. I need to move all of the books and papers out of the way and then will take a wet cloth and wash the surface of the desk. I also need to remember to let that dry before I start setting things on it. Now clear and clean your surface.

Step 3: Gather the equipment that you need to give medication. Alfred will get fluoxetine which is an oral medication in tablet form. Therefore, you need to have the med log, a place to pour the tablet, in this case we will use a ________ [fill this in with what you pour medication onto], and a cup of water for Alfred to use to take the medication. This could be set on the kitchen table where he will be taking his medication or you could ask him to get a cup of water himself as you are preparing the medication.

Step 4: Unlock the medication storage area. We keep medication in ________________ [fill this in with what you keep medication in] that sits in a locked cabinet. Get the ________________ [fill this in with what you keep medication in] out now and unlock it.

[Demonstrate getting the box out and unlocking it.]
[Tell students:]

You can now get your box out and unlock it at this time.

**Policy and Practice**

Describe what your agency uses and use that or something to simulate it. You could use shoe boxes or other kinds of containers for this part. Each box should have multiple containers in it so that the person can pull out the correct containers. The other containers can be labeled with the additional pharmacy labels provided. These can also be used later for additional practice.

[Tell the students:]

**Step 5:** Wash your hands. Remember how we learned to wash hands previously. We’ll practice that now. Since we don’t have running water, we will need to pretend that we do. Go ahead and “wash” your hands now.

**PART 2 - ADMINISTRATION**

[Put up SLIDE 24 — with the second five or administration steps for medication administration – the order of these steps may not be modified]

[Tell the students:]

**Step 1:** Read the med log and identify the medication that you are going to give. Look in the box for that medication. Once you have found that container, then you must do your first check and match the person, medication, dose, time and route on the med log to that on the pharmacy label on the bottle. This is check 1. Find the correct container in your box and perform check 1.

**Step 2:** Check again that you have the right person, medication, dose, time, and route by comparing the med log to the label on the container. This is check 2. If everything is right in check 2, then open the container and pour the dose onto the ____________ [fill this with what you pour medication onto]. Complete this now.
Step 3: Close the container and then do a third check to make sure that you have the right person, medication, dose, time, and route by comparing the med log to the label on the container. This is check 3, complete it now. Remember to ____________ [insert the procedure that your provider uses for this such as putting a dot in the date and time box.] Do not initial the MAR at this time.

Step 4: Now you will take the medication to Alfred to give it to him. If you are leaving the medication preparation room, then you need to make sure to secure that room by locking it after you leave or if you cannot lock the room you will need to put the medication back in the box and lock it. Before you give the medication to Alfred, you will take his pulse or heart rate to make sure that you can give the medication. Assume that his heart rate is 78.

Since Alfred can take the medication from the plate by himself, you will let him do that. At this point you would say to Alfred something like, this is your 8 am digoxin, take your pill and then drink some water to help you swallow it.

Step 5: Make sure that Alfred swallows the medication. You can even ask him if he did and praise him for participating.

PART 3 - COMPLETION

[Put up SLIDE 25 — with the last five or completion steps for medication administration - You should alter the order of step 4 on the slide to match the set-up of your environment and/or add details as it relates to the provider procedures.]

[Tell the students:]

Step 1: Now go back to the medication log and the container, unless you have had to relock the container to keep it secure. Read the medication log and the pharmacy label a fourth time to assure that what you gave is correct. This may seem like an unnecessary step, however, it is one in which you may catch an error even though everything seemed right with the other three checks. If you catch it now, then you are more likely to be able to prevent any adverse reaction by getting further instructions about what to do. Do the fourth check now.

Step 2: Document that you gave the medication on the MAR that we recorded the medication on previously. You will do this by writing your initials in the box by the time and today’s date and also put the pulse or heart rate in the box underneath. Find the time which is 8 am next to digoxin and put your initials in the box for July 1st and the heart rate in the box underneath. Do this now.
**Step 3:** Return the medication and the MAR to their storage areas. Put the medication in the box, lock it and put it back into the storage area if you have not already done so.

*Demonstrate this and tell students:*

Go ahead and return the medication and the MAR to their storage areas now.

**Step 4:** “Wash” your hands after the administration process as you learned to do. You may wash your hands now.

**Step 5:** Observe for effects. Remember that part of the medication cycle is to observe for side effects after administering medication. While you may not see them immediately, it is important to remember to look. This serves as your reminder about that.

**PARTNER PRACTICE**

*Now pair up the students so that each student has a partner. If you are working with one student, then you will be that student’s partner. If you have an uneven number of people, then have one group of three. For the group of three, have person 1 administer to person 2, person 2 administer to person 3, and person 3 administer to person 1. You will use the same materials as in the trainer-led demonstration (medication log/MAR, pharmacy containers and label, etc.). However, you should choose a different time and, therefore, a different medication for each person. These are provided and should be the other mock, labeled containers in the medication storage area. This should simulate a medication administration as closely as possible. You may choose to use candy for this exercise. This will allow the participants to eat it (if they are allowed) making the exercise more real to them.*

*Tell the students:*

You will go through the steps of a medication administration using your partner as the person who will be receiving medication. You should go through the process twice so that each person has a chance to be both medication administrator and consumer.

*If you have a group of three, then tell them how they will do it using the information above. As the students are working, walk around the room to make sure that they are following the steps and have correctly identified the medication that they are to be administering. If you find any errors or omissions that most groups are doing, you will want to stop everyone and remind them of that so that everyone benefits from that observation.*
ADMINISTRATION OF MULTIPLE MEDICATIONS

[Put up SLIDE 26 — listing the three parts of the administration]

[Tell the students:] Up to now we have concentrated on a single person getting a single medication. However, many people take more than one medication at a time and there will be times when you will need to give medication to more than one person at a time. Let’s look at the three parts of administration again, this time thinking about how to do it for multiple people and multiple medications.

Part 1 is the preparation of your workspace. You will only do this once regardless of how many medications will be given and how many people they are for. When you do Part 1 step 1, you will identify everyone who gets medication at that time and each of the medications that they will be getting. In the other preparation steps, you will also need to make sure that you have all of the special equipment that you might need for any of the medications. For step 5, if you do not prepare medication in the place where it is stored, then you need to bring all of the medication containers with you.

Policy and Practice
[Describe for students how this will work at their worksite.]

[Tell the students:] Part 2 is the administration of the medication and involves the three checks. When a person is receiving multiple medications at the same time, then you will perform the three checks, steps 1, 2, and 3, for each medication. You will do all three checks for one medication at a time putting each medication onto the plate or saucer as the third check is completed. After all of the medications have been checked three times and are on the plate, then you will move to steps 4 and 5; administration and observation of them taking the medication. They can all be administered at the same time or one at a time depending on the person’s ability to swallow them and preference.

Part 3, completing the administration will, like preparation, be completed only once for all of the medications. Each medication will be checked for the fourth time and documented individually, steps 1 and 2. Steps 3, 4, and 5 will then be done once for all of the medications. Observation for good effects and side effects is important for people taking multiple medications because they are at higher risk for adverse effects and interactions.
[If the students will be working with more than one person and people with more than one medication, it is recommended that the trainer use this opportunity to allow them to practice this skill. Trainers can use the examples provided in scenario (Alfred’s digoxin and verapamil), the additional examples, and/or create additional practice activities for this skill.]

**DOCUMENTATION**

[Put up SLIDE 27 — with the medication administration cycle with administration and documentation emphasized]

[Tell the students:]

Documentation of a medication administration is a crucial way to communicate to your co-workers and others involved in that person’s life that that the person’s medication was given. Diligent documentation will help avoid medication errors like duplicating a dose which could put the person at risk for adverse drug effects related to getting too much medication. We will be reviewing and practicing the kinds of documentation that you will be using as a medication administrator. You have seen how to do these in the online portion of the course. This is your opportunity to practice and learn these documentation skills so that you can use them in your everyday work.

[You will need to prepare MARs with the scenarios provided for the students to use to practice documentation. You should use your provider MARs and transfer the information onto these from the provided, sample MARs. If you use an electronic system, at this point you will need to teach the students each of these documentation activities using both the electronic system and the back-up paper system so that they know how to use both. The answer keys for these activities can be found in the text in the manual following the reference to the slide with the answer on it. The answers for those particular tasks are highlighted. For the initial typical administration, be sure to include a copy of a signature sheet or to show the students where their signature and initials go on the MAR.]
TYPICAL DOSE

[Tell the students:]

You have already practiced documentation of one typical administration when you learned the steps of administration. Let’s do another example to make sure that you know how to do this. This is the most common kind of documentation that you will be using and it is important to know this. In addition to documenting a typical administration, you will be adding your signature and initials to the signature area associated with that MAR.

Using the MAR from the scenario, Alfred takes two medications, digoxin and verapamil. Both are given at 8 am, but only the verapamil is given at 4 pm and 10 pm. Document the administration of verapamil, 80 mg, to Alfred at 4 pm on July 5th and sign and initial in the designated signature area.

[Give the students time to complete the documentation and note.]

[Put up SLIDE 28 — with the answer to the question]

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| MEDICATION | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
| Digoxin 0.125 mg | 8 am |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1 tablet by mouth, once a day in the morning for heart failure. Do not give if heart rate is below 60 beats per minute | Heart rate |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Verapamil 80 mg | 8 am |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1 tablet by mouth, three times a day for high blood pressure | 4 pm |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10 pm |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Places of administration from: 7-1-04 to 7-31-04 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PHYSICIAN(S): | Dr. Thomas Burns |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ALLERGIES: | UNKNOWN |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DIAGNOSES: | Heart failure, high blood pressure |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| NAME: | Alfred Nicolas |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DOB: | 12/2/78 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ID NUMBER: | 000-0000-00 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Initials | Signature | Initials | Signature |
| JJ | John Thomas |  |  |
```

[Verify that each student documented the administration correctly and that they signed and initialed in the appropriate place.]
MISSED DOSE

[Tell the students:]

Omissions or missed doses are the most common kind of medication error. While there are many reasons that these occur, often it is because people just forget to give the medication. Suppose that you are preparing Alfred’s 8 am medications and you notice that his 4 pm dose of verapamil from the day before, July 6th, is still in the container or that it is not signed for. From your analysis and evaluation, you determined that this dose was not given. Therefore, it was missed or omitted. The other way that you might find an omission with a controlled substance like meperidine is when you count at the time of shift change. You would have one more dose than expected. You could also count doses if you found an empty time box in order to identify whether or not that dose was in the container. Since it is too late to think about giving this dose, you will document it as a missed dose including writing a note and reporting the incident.

So let’s document this missed dose. Remember that when you document a missed dose, you put an “O”, the letter not a zero, into the date and time box for that missed dose. Remember that you do not put your initials inside the O. You then write a note about what happened and report the missed dose.

Policy and Practice

[You should tell the students here how the reporting of medication errors and issues occurs in your provider and who they should be reporting to.]

[Tell the students:]

Document Alfred’s missed dose of verapamil for July 6th at 4 pm and then write a note describing that.

[Give the students time to complete the documentation and note.]

[Put up SLIDE 29 — with answer to missed dose]
### Medication Administration Record (MAR)

| MEDICATION                | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---------------------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Digitoxin 0.125 mg       | 8 am |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 1 tablet by mouth,      | 4 pm |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| once a day in the        | 10 pm|   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| morning for heart        |      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| failure. Do not give if  |      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| heart rate is below 60  |      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| beats per minute.       |      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Verapamil 80 mg          | 8 am |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 1 tablet by mouth,      | 4 pm |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| three times a day for   |      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| high blood pressure.    |      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

Dates of administration from 7-1-04 to 7-31-04

**PHYSICIAN(S):** Dr. Thomas Burns  
**ALLERGIES:** UNKNOWN  
**DIAGNOSES:** Heart failure, high blood pressure  
**NAME:** Alfred Nicolai  
DOB: 12/1/78  
ID NUMBER: 000-0000-00

---

**Note**

**Alfred Nicolai**

**July 6, 2004**

**6 pm**

Alfred returned late from a visit with his family and missed his 4 pm dose of verapamil. Supervisor notified.

**John Thomas**

---

*Verify that each student documented the omission correctly and that the note written contains the required elements. Compare the students’ work to the answer key.*
LATE ADMINISTRATION

[Tell the students:]

Suppose instead that it is 6 pm on July 6th and you discover that you have not given Alfred his 4 pm dose of verapamil. Is this a problem?

[Give the students time to respond.]  

[Answer: Yes, this is a problem. It is an omission or missed dose that is found early enough that a late administration might be considered.]

Policy and Practice

[Use this opportunity to remind the students of the provider policy related to times of administration and what “on time” means in your provider e.g. usually a window for administration of 1 hour before to 1 hour after.]

[Tell the students:]

This is a missed dose and when you go and read the instructions from the healthcare provider, you find that you may give this dose as late as 7 pm. So now you give the dose, but it is late. Remember, with the late administration you need to add a second entry on the MAR for that medication with the time that you administered the late dose in the hour column. Block all of the date boxes prior to the current date with a single line. Document the administration by entering your initials in the date and time box corresponding to the administration. In the next date box enter a “/”, a diagonal slash line indicating that there will be no additional doses administered for that medication and time. In the box after that, block all of the date and time boxes to the end of the MAR row. Let’s document the late administration. Don’t forget to include a note about what occurred.

[Give the students time to complete the documentation and note.]
[Put up SLIDE 31 — with answer to late dose]

![Medication Administration Record (MAR)](image)

[Put up SLIDE 32 — with additional note version 1]

**Note Version 1**

*Alfred Nicolai*

*July 6, 2004*

*5:45 pm*

Alfred returned home late from a visit with his family and missed his 4 pm dose of verapamil. Supervisor notified and healthcare practitioner's instructions reviewed in the chart. Instructions state that if a dose is missed before 7 pm, then it can be given late.

*John Thomas*

*July 6, 2004*

*6 pm*

Late dose given at 6 pm.

*John Thomas*
[Put up **SLIDE 33** — with version 2 another option to use a single note for both activities]

**Note Version 2**

Alfred Nicolai  
July 6, 2004  
6 pm

Alfred returned home late from a visit with his family and missed his 4 pm dose of verapamil. Supervisor notified and healthcare practitioner's instructions reviewed in the chart. Instructions state that if a dose is missed before 7 pm, then it can be given late. Late dose given at 6 pm.

**John Thomas**

[Verify that each student documented the late dose correctly and that the note written contains the required elements. Compare the students' work to the answer key.]

[Tell the students:]

In this example, would it matter if it was 4:45 pm rather than 6 pm when you discovered that the dose had not been given?

[Give the students time to respond.]

[Tell the students:]

This would not be an omission because the medication can still be given until 5 pm and be on time. So you would give the medication and document it like a typical administration. When these kinds of situations arise and you are unsure what to do, you can always call your supervisor.

Let’s go back to the original omission scenario. It is 8 am on July 7th and you identify that the date and time box for Alfred’s verapamil for 4 pm on July 6th is not initialed. You look for the dose, but do not find a pill. In this case, you don’t know if the medication was given and not documented or if it was lost or something else happened. You would not document this as an omission, although you would document the discovery of the empty box and notify your supervisor.

**Policy and Practice**

[Discuss your provider process for addressing this situation at this time.]
REFUSED DOSE

[Tell the students:]

Next we will talk about how to document when a person refuses to take their medication. You learned many ways why this might occur in the online lesson. Let’s talk about how to document a refused dose. There are a couple of different issues to think about regarding refused doses. Any dose of medication that is refused does not become truly refused until its administration is late. So let’s look at Alfred again. This time he refuses to take his digoxin at 8 am on July 12th. Would you document this as a refusal at this time?

[Give the students time to respond.]

[Tell the students:]

The answer to this question is no because the dose isn’t late until after 9 am based on using an hour before and an hour after as acceptable times of administration.

Instead, you would work with him to take his medication. Let’s suppose that he continued to refuse to take his 8 am dose and it is now 9:20 am. This is now a refused dose and needs to be documented as such. To do this, identify the MAR for Alfred; the refused medication on the MAR; and the date and time of the refusal. Put a circle in the box corresponding to that time and date. Put an “R” in the circle to distinguish it from a missed dose. Do not initial the MAR for that date and time. Next, put a note into the record including the information about the refusal and how you approached it.

Policy and Practice

[Tell students where your provider puts these notes in the MAR or chart.]

[Tell the students:]

Remember that a refused dose has the same potential outcome as a missed dose, but it is not considered a medication error. Document Alfred’s refused dose of digoxin for July 12th at 8 am and then write a note describing that.

[Give the students time to complete the documentation and note.]
[Put up SLIDE 34 — with answer to refused dose]

![Medication Administration Record (MAR)](image)

[Put up SLIDE 35 — with the note for the refusal]

**Note**

Alfred Nicolai  
July 12, 2004  
9:30 am

When offered his digoxin at 8 am, Alfred refused to take it. He said that he didn’t feel like taking it this morning. Attempted to determine why he didn’t feel like taking it and continued to offer the dose to him until 9:20 am. Reviewed healthcare practitioner’s instructions and if one dose is missed or refused, then wait until the next dose is due and try again. Notified supervisor.

**John Thomas**

[Verify that each student documented the refusal correctly and that the note written contains the required elements. Compare the students’ work to the answer key.]
VACATION OR ABSENCE

Administration of medication becomes the responsibility of someone else during an absence such as hospitalization or vacation when the person is not present to receive medication. Even if that medication was not given while the person was visiting family, etc., this is not a medication error and shouldn’t be reported as such. However, you do need to document that the person was absent during that time. This documentation always occurs at the time the administration is due even in the case of a known period of absence. This way if the period of absence changes and the person returns sooner than thought, you will still be able to administer and document using the existing MAR without discontinuing and reentering the medication. Otherwise, you might have two documentations for the same date and time: the absence and the administration. This could lead to confusion about what actually happened.

To document an absence, you will enter an established code into the date and time box that reflects that absence. There are many options for this including “V” for vacation; “TL” for therapeutic leave; or “A” for absence.

Policy and Practice

Remember that you only document what you do when you are the person responsible for administering the medication. You will enter the code for an absence regardless of whether or not the person received the medication while on vacation or absent. Remember that you need to enter the code each time the medication would be due while the person is absent. Do not enter the code ahead of time in case the person comes back early. You also will write a note when the person leaves and another when the person returns. The note when the person returns is the place where you would document any information about the visit or absence including if none of the medication was gone from the container when it was returned.

Alfred is going on an overnight visit with a friend on July 14th to July 15th. He leaves at 6 pm and returns at 11 am on July 15th. He had a good visit and there were no issues with taking his medication while absent. Document his absence on the MAR and write the appropriate notes.
[Give the students time to complete the documentation and notes.]

[Put up SLIDE 36 — with answer to vacation dose]

![Medication Administration Record (MAR)]

[Put up SLIDE 37 — with both notes for the vacation]

**Note 1**

Alfred Nicolai  
July 14, 2004  
6 pm

Alfred left for a visit with his friend and took his 10 pm and 8 am medications with him. He is due back late morning.

*John Thomas*
Alfred Nicolai  
July 15, 2004  
11 am  

Alfred returned from his visit with his friend at 11 am. He said he took his medications without problems. He had a good visit.

John Thomas

[Verify that each student documented the absence correctly and that the notes written contain the required elements. Remember that there are multiple medications involved in this activity. There should also be two notes written. Compare the students’ work to the answer key.]

**PRN OR AS NEEDED**

[Tell the students:]

PRN medications are taken as they are needed to treat symptoms that occur periodically. Alfred is going to the dentist and he usually receives lorazepam to assist with the dental appointment. You look at his plan and note the dose that he can take for dental visits.

The documentation of a PRN medication may be done in a couple of different ways. If you document the administration of the PRN on the front of the MAR, then you have two options for writing a note. The first is to put the note in the chart and the second is to put the note regarding reason and response on the back of the MAR. The third option for documentation is to put all of the documentation including the initialing of the administration and the note with the reason and response on the back of the MAR. The option that you will use depends on the format of your provider MAR and where PRN information is documented.

**Policy and Practice**

[Describe the option that you use as a provider for documenting a PRN medication. An example of each of the options appears below.]
[Ask the students the following questions and review the answers using your provider policies and practices.]

- How would you report the need for dental medication? [Answer: provider policy and practice]
- What kind of reporting is this? [Answer: routine]
- What kind of observation is this? [Answer: objective]

[Put up SLIDE 38 — with the pharmacy label]

![Pharmacy Label]

[Tell the students:]

The healthcare practitioner has prescribed lorazepam 1 mg, 1 tablet 30 to 60 minutes prior to dental appointments. Alfred’s appointment is at 2:45 on July 16th. Document the administered dose of lorazepam on July 16th at 2 pm and complete the documentation. Include the information that Alfred was alert, but calm and relaxed after taking his medication.

[Give the students time to complete the documentation and note. If you are using the MAR in Appendix 2, you should have students complete the documentation using the back of the MAR which corresponds to slide 41.]
[Put up **SLIDE 39** — with answer to PRN dose with documentation on the front of the MAR]

### Medication Administration Record (MAR)

| MEDICATION                        | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|----------------------------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Digoxin 0.125 mg                 | 8 am |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Heart rate                       |      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Lorazepam 1 mg                   |      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 1 tablet by mouth 30 to 60 min   |      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| minutes prior to dental          |      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| appointments                     |      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Dates of administration from: 7/1-04 to 7/31-04 |      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

**PHYSICIAN(S):** Dr. Thomas Burns  
**ALLERGIES:** UNKNOWN  
**DIAGNOSES:** Heart failure, high blood pressure  
**NAME:** Alfred Nicolai  
**DOB:** 12/1/78  
**ID NUMBER:** 000-0000-00

[Put up **SLIDE 40** — with the note for the PRN documented on back of MAR or in a chart note]

**Note Option 1: Note in Chart**

Alfred Nicolai  
July 16, 2004  
2 pm

Alfred has a dental visit and receives lorazepam prior to those visits. He was given one dose of the medication and was calm and relaxed, but alert prior to the visit.

**John Thomas**

**Note Option 2: Note on back of MAR**

<table>
<thead>
<tr>
<th>Date</th>
<th>Reason</th>
<th>Response</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/16/2004</td>
<td>Gave one dose of lorazepam 45 minutes prior to dental exam.</td>
<td>Was calm and alert prior to leaving for dental appointment.</td>
<td>JD</td>
</tr>
</tbody>
</table>
[Put up SLIDE 41 — with documentation of a PRN medication on the back of the MAR only.]

<table>
<thead>
<tr>
<th>Date</th>
<th>Time Given</th>
<th>Medication &amp; Dose</th>
<th>Route</th>
<th>Reason</th>
<th>Response</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/16/2004</td>
<td>2 pm</td>
<td>Lorazepam 1 mg</td>
<td>By mouth</td>
<td>Gave one dose of medication 45 minutes prior to dental examination.</td>
<td>Was calm and alert prior to leaving for dental appointment.</td>
<td></td>
</tr>
</tbody>
</table>

[Verify that each student documented the PRN dose correctly and that the notes written contain the required elements. Compare the students’ work to the answer key.]

**DISCONTINUED MEDICATION**

[Tell the students:]

Medications often are changed based on poor response to the medication or finishing medication like an antibiotic used to treat a temporary condition. In order to communicate that the medication is no longer being given, you must document the discontinuation of the medication. In doing this, it is important that everything already documented for this medication is still readable in case anyone would need to return to review this information. So, we will be using single lines that clearly indicate the discontinuation without obliterating the information.

In the scenario, Alfred started with a dose of digoxin of 0.125 mg. When it was reported to the healthcare practitioner that this dose was not having its intended effect, the healthcare practitioner increased the dose to 0.25 mg. This occurred on July 19th after the 8 am dose was given. To document the discontinuation of the 0.125 mg of digoxin, you will line out all of the information in the description box with a single line.

**Policy and Practice**

[If your provider uses some method in the place of a single line such as highlighting or x-ing, to document a discontinuation, then substitute that method here for the students. Remember that highlighting does not photocopy. Also, whatever method you use, make sure that the underlying information is not rendered unreadable.]

[Tell the students:]
You will also put a single line through all of the times in the hour of administration column. Next, in the date box following the last initialed dose of the medication enter a “/”, a diagonal slash line indicating that there will be no additional doses administered for that medication and time. In the box after that, draw a single line through all of the date and time boxes to the end of the MAR row. On the line, write “discontinued”, your initials, and the date. Don’t forget to include a note about what occurred. If the medication is given multiple times in a day, then you will draw the slash and the line through the row for each time, but only need to write “discontinued” once. The container with the discontinued medication should be removed from the storage area and disposed of according to the provider policy when the medication is discontinued. Document the discontinuation of Alfred’s digoxin now.

[Give the students time to complete the documentation and note.]

[Put up SLIDE 42 — with answer to discontinued medication]
[Put up SLIDE 43 — with the note for the discontinued medication]

Note

Alfred Nicolai
July 19, 2004
2 pm

Returned home from a visit to review his digoxin dose with the healthcare practitioner. The current dose of 0.125 mg did not seem to have made a lot of difference and he was not showing any response to the dose. The dose was increased to 0.25 mg with the next dose which will begin tomorrow (7/20).

John Thomas

[Verify that each student documented the discontinuation correctly and that the note written contains the required elements. Compare the students’ work to the answer key.]

NEW ENTRY FOR CHANGE IN DOSE

[Put up SLIDE 44— with pharmacy label for new dose of digoxin]

<table>
<thead>
<tr>
<th>PHARMACY LABEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Drugstore, Inc.</td>
</tr>
<tr>
<td>123 Main Street</td>
</tr>
<tr>
<td>Anytown, PA 16006</td>
</tr>
<tr>
<td>123-123-4567</td>
</tr>
<tr>
<td>RX 1313 22 746</td>
</tr>
<tr>
<td>Alfred Nicolai</td>
</tr>
<tr>
<td>234 Main Street</td>
</tr>
<tr>
<td>Anytown, PA 16006</td>
</tr>
<tr>
<td>123-234-2345</td>
</tr>
</tbody>
</table>

1 tablet by mouth one time a day in the morning for heart failure. Do not give if heart rate is below 60 beats per minute.

| Digoxin 0.25 mg | QTY: 30 |
| QRS Drugs, Inc. | Refills: 3 |
| Burns, Thomas MD | Drug expiration: 10/15/2009 |
Tell the students:

Next, enter the new dose of the digoxin. Remember with a change in dose you need to add a new entry for that medication with the time that it will be administered in the hour column. Next, block all of the date boxes prior to the current date with a single line. You will document the first administration of this new dose by entering your initials in the date and time box after the line. In this case, the medication was started on July 20th. Use 8 am as the time of administration for the increased dose of digoxin. Document the increased dose of digoxin and the typical administration of the first dose on July 20th using the information on the pharmacy label.

Give the students time to complete the documentation.

Put up SLIDE 45 — with answer to new entry

[Verify that each student documented the new entry and first administration correctly. Compare the students’ work to the answer key.]
OBSERVATION

[Put up SLIDE 46 — with the medication administration cycle with observation emphasized]

[Tell the students:]

Now that Alfred’s digoxin has been increased, you must begin again to observe him for all of the possible effects: good effects, bad effects, and no effect. This takes the medication cycle full circle back to observation, then reporting, etc. It is a continual process for each medication that a person is on. Each step builds on the previous steps and none of the steps can be skipped.

[Put up SLIDE 47 – duplicate of SLIDE 3 with the next steps for the students.]

[Tell the students what the next steps are and how those will be accomplished.]

END OF TRAINER CLASSROOM PRESENTATION TO STUDENTS
APPENDICES

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APPENDIX 1

ALFRED NICOLAI
ALTERNATE SCENARIO
Alfred Nicolai Alternate Scenario

You are working with Alfred Nicolai who has recently been hospitalized for heart failure. He was admitted to the hospital when he had trouble breathing and was feeling his heart beat fast. You also noticed that he said that he felt more fatigued lately and wasn’t able to walk quite as far on his daily walks. In addition, his appetite had decreased. He started a new medication, digoxin, in the hospital and was put on a low dose because his kidneys don’t work well. He takes 0.125 mg of digoxin once a day. Alfred’s healthcare practitioner wants a measure of his heart rate prior to administering the digoxin. In addition to taking medication, he is to decrease how much salt he eats. On discharge from the hospital, he no longer has trouble breathing and has a normal heart beat. You are told to watch for signs of improvement or worsening of his heart failure and side effects of the medication which include nausea and vomiting, blurred vision, and headaches. You have instructions to bring him to see his healthcare practitioner in 2 weeks to report on his progress.

At 2 weeks, Alfred goes back to see his healthcare practitioner for a post-hospital follow-up visit. He hasn’t had much response to the medication, but hasn’t had side effects either. There are still symptoms of fatigue and he still hasn’t been able to walk as far as in the past. However, he has no problems taking the medication. The healthcare practitioner increases his dose of medication to 0.25 mg once a day with a follow-up visit in 6 weeks.

At the 6 week follow-up, you and Alfred note that there have been some changes. He is feeling more energetic and is now able to do his full daily walk. His appetite is better and he is really feeling well. He has no side effects and the healthcare practitioner decides to continue the medication at 0.25 mg per day with a re-evaluation in 4 weeks.
APPENDIX 2

PHARMACY LABELS AND MAR FOR ACTIVITY 6 ALTERNATE SCENARIO
Activity 6

Alternate Scenario

Pharmacy Label 1

<table>
<thead>
<tr>
<th>PHARMACY LABEL</th>
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<tbody>
<tr>
<td>Local Drugstore, Inc.</td>
</tr>
<tr>
<td>DEA #: 5553535</td>
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<tr>
<td>123 Main Street, Anytown, PA 16006</td>
</tr>
<tr>
<td>123-123-4567</td>
</tr>
<tr>
<td>PH: STV</td>
</tr>
<tr>
<td>Original script date: 04/25/2000</td>
</tr>
<tr>
<td>RX 1313 22 746</td>
</tr>
<tr>
<td>Alfred Nicolai, 234 Main Street, Anytown, PA 16006</td>
</tr>
<tr>
<td>Date filled: 07/05/2004</td>
</tr>
<tr>
<td>123-234-2345</td>
</tr>
</tbody>
</table>

1 tablet by mouth one time a day in the morning for heart failure. Do not give if heart rate is below 60 beats per minute.

Digoxin 0.125 mg |
QRS Drugs, Inc. |
Burns, Thomas MD |

QTY: 30 |
Refills: 3 |
Drug expiration: 10/15/2009 |
## Medication Administration Record (MAR)

| MEDICATION | HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

**Dates of administration from:** 7-1-04  
**to** 7-31-04

**PHYSICIAN(S):**

**ALLERGIES**

**DIAGNOSES:**

**NAME:**  
**DOB** 12/1/78  
**ID NUMBER:** 000-0000-00
## Medication Administration Record (MAR) - Back

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<th>REASON</th>
<th>RESPONSE</th>
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Activity 6

Alternate Scenario

Pharmacy Label 2

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<td>PH: STV</td>
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<tr>
<td>123 Main Street</td>
<td>Originals</td>
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<tr>
<td>Anytown, PA 16006</td>
<td>04/25/2000</td>
</tr>
<tr>
<td>123-123-4567</td>
<td>Date filled: 07/05/2004</td>
</tr>
<tr>
<td>RX 1313 22 746</td>
<td></td>
</tr>
<tr>
<td>Alfred Nicolai</td>
<td></td>
</tr>
<tr>
<td>234 Main Street</td>
<td>123-234-2345</td>
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<tr>
<td>Anytown, PA 16006</td>
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<tr>
<td>1 tablet by mouth three times a day for high blood pressure.</td>
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<td>Verapamil 80mg</td>
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<td>QRS Drugs, Inc.</td>
<td>Refills: 3</td>
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<td>Burns, Thomas MD</td>
<td>Drug expiration: 10/15/2009</td>
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APPENDIX 3

COUNTABLE SUBSTANCE SHEET FOR ACTIVITY 8 ALTERNATE SCENARIO
### Activity 8

**Alternate Scenario**

**Sample Countable Substance Sheet**

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<td>Meperidine 50 mg 1 tablet every 4 hours as needed for pain</td>
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<td>A.T. Greene</td>
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