Administering Medication—(General Medication Administration Process)

- Oral Medication—Solid Form (including buccal and sublingual)
- Oral Medication—Liquid Form
- Eye (Ophthalmic) Drop
- Ear (Otic) Drop
- Nasal Drop
- Nasal Spray
- MDI (without and with spacer)
- MDI (automated or breath-activated)
- Nebulizer
- Topical (creams, ointments, and powder)
- Transdermal Patch (removal/application)
- Nitroglycerin Ointment
- Rectal
- Vaginal (cream, foam, gel, suppository with applicator)
- Vaginal (without applicator)

The South Dakota Board of Nursing Unlicensed Medication Aide Skills Performance Evaluation Checklist and Mosby's Textbook for Medication Assistants (2nd edition) were utilized as resources in creating this handout.

Please note that your facility policies and procedures, medication storage system, and documentation system will impact the skill steps you use in your job.

These skill steps are meant for general education only, illustrating the importance of the Six Rights of Medication Administration, the three safety checks, infection prevention, resident privacy, resident dignity, resident safety and your safety as a med aide.

The actual steps related to factors above and/or order of the steps could vary.

Consult a facility nurse with any questions.

Administering Medication—(General Medication Administration Process)

Prior to Medication Administration

1. Hand hygiene.
2. Check Medication Administration Record (MAR) and review for completeness, accuracy, known allergies. (Check each drug on the MAR.)
3. Check medication resources and references as needed.
4. Clarify questions with the nurse.
5. Wash hands.
6. Collect needed items.

During Medication Administration

1. Select the right medication (from the person's med drawer, or med cart, etc.)
2. Apply gloves and/or appropriate PPE.
3. Check label against MAR **(1st Check)** using 5 of the 6 Rights. (Individual, Drug, Dose, Time, Route)
    - Check for allergies
    - Check expiration date of med container
    - If previously opened, is 'open date' recorded on label (if no date, record date per facility policy)
8. Prepare medication for administration **(2nd Check)** using 5 of the 6 Rights.
9. Ensure med container is closed, clean, ready for next use.
10. Check label against MAR **(3rd Check)** using 5 of the 6 Rights., before returning medication to med storage location or plan to leave area to administer medication as appropriate.
11. Ensure all med storage/location is locked and/or within direct eye view at all times.
12. Hand hygiene, as appropriate. Apply gloves.
13. Identify person according to agency policy. Use at least two resident identifiers.
14. Provide privacy as appropriate.
15. Use barrier under all med containers.
16. Explain medication procedure to person.
17. Obtain and document required measurements.
18. Position person appropriately to administer drug.
19. Administer medication, as appropriate.
20. Remove gloves. Dispose of barriers and used supplies as appropriate.

Following Medication Administration

1. Use appropriate infection control procedures, according to agency policy.
2. Handle person carefully and respectfully. Provide position of comfort. Provide privacy. Scan the room for safety. Is call light within reach?
3. Hand hygiene.
4. Record the right documentation on the MAR, the 6th Right of Medication Administration.
5. Report to nurse and record resident observations/concerns.

Administering Oral Medication—Solid Form (including buccal and sublingual)

1. Utilize 'General' medication administration process, including 5 of the 6 Rights and 3 safety checks.
2. Check and record vital signs, if ordered. Notify nurse of results, to determine whether medication is to be administered.
3. Perform hand hygiene. Apply gloves.
4. Remove medication cap and place cap upside down on barrier.
5. Pour drug into med container lid. The lid should not touch the container. Return extras to the med container.
6. Pour the drug from the lid to the souffle cup.
    - It may be helpful to place sublingual or buccal med into a plastic med cup, squeezing the sides together to make a trough, allowing med to easily slide out of med cup OR use a spoon to administer the med.
    - Place buccal or sublingual meds in their own separate med cups. Regular oral tablets also in their own med cup.
7. Replace med container cap.
8. Position person in sitting position, Fowler's position, or in position directed by the nurse, care plan, and MAR.
9. With solid form, oral tablets let the person drink a small amount of water. Give the person the drugs.
    - For sublingual route, place tablet under tongue.
    - For buccal drug, place tablet between upper molar and the cheek.
    - **For sublingual and buccal drugs, do not give the person anything to drink,** *until medication is dissolved.* If other oral tablet or capsule, provide water as appropriate.
    - Check and record vital signs, if ordered. Notify nurse of results, to determine further action. Repeat dose, if ordered.
7. Stay with the person to make sure he or she swallows all of the drugs.
8. Remove and discard gloves and used supplies.
9. Hand hygiene.
10. Document, the 6th Right of Medication Administration.
11. Notify nurse of any concerns.

Administering Oral Medication—Liquid Form

1. Utilize 'General' medication administration process, including 5 of the 6 Rights and 3 safety checks.
2. Hand hygiene. Apply gloves.
3. Shake the bottle or container only if instructed to do so on the label.
4. Open the container. Place the lid on a barrier (paper towel) on the drug cart so that the outside of the lid is facing down and the inside of lid is facing up.
5. Hold the bottle so that the label is in the palm of your hand. This prevents smearing the label with bottle contents while pouring.
6. For a medicine cup: Locate scale to be used on the medicine cup. Locate the exact place where the liquid drug should be measured. Place cup on hard surface.
7. Pour the prescribed dose in the cup at eye level. Measure dose at the meniscus, lowest point of liquid in the cup.
8. For a syringe, pull back on the plunger to withdraw the drug form the medicine cup.
9. Set the syringe on a barrier/paper towel.
10. Wipe off any liquid from the bottle top and close the bottle.
11. Return bottle to storage, as appropriate.
12. Enter person's room appropriately. Provide privacy. Identify person using at least 2 identifiers. Obtain required measurements on MAR. Position person in sitting or Fowler's position as directed by nurse, care plan, or MAR.
13. Give person medicine cup. Observe person take the drug.
14. Remove and discard gloves and used supplies.
15. Hand hygiene.
16. Document, the 6th Right of Medication Administration.
17. Notify nurse of any concerns.

Administering Eye (Ophthalmic) Drop Medication

1. Utilize 'General' medication administration process, including 5 of the 6 Rights and 3 safety checks.
2. Hand hygiene. Apply gloves.
3. Use barrier under medication container. Give eye drops at room temperature. Remove medication cap and place cap upside down or on its side on barrier.
4. Provide privacy.
5. Position person supine, sitting, or fowler's position with head tipped back slightly.
6. Observe sclera of eye/related eye structures; notify nurse of any concerns.
7. Remove and discard gloves.
8. Hand hygiene. Apply gloves.
9. Clean eye secretions, as needed, from inner aspect of the eye (near the nose) out.
10. Remove and discard gloves.
11. Hand hygiene.
12. Apply gloves.
13. Use only the dropper supplied by manufacturer. Do not allow tip of dropper or med container tip to touch eye or other body part.
14. Apply eye drops/eye ointment into conjunctival. Do not apply drug directly to eyeball.
15. Have person close their eye gently. Provide tissue to dab excess at the inner corner of eye near nose. Do not rub or wipe eye area. NOTE: if person is dabbing their own eye, have them provide hand hygiene first.
16. Close med container.
17. Remove and discard gloves and used supplies.
18. Hand hygiene.
19. Return medication to storage.
20. Document, the 6th Right of Medication Administration.
21. Notify nurse of any concerns.

NOTE:

For eye ointment: squeeze the ointment into a thin strip into and along conjunctival sac, starting at inner aspect of eye near nose. Release lower lid. Have person close their eye gently; provide tissue. NOTE: if person is dabbing their own eye, have them provide hand hygiene first; have them move the eye(s) with the lids closed.

Administering Ear (Otic) Drop Medication

1. Utilize 'General' medication administration process, including 5 of the 6 Rights and 3 safety checks.
2. Hand hygiene. Apply gloves.
3. Use barrier under medication container. Give ear drops at room temperature.
4. Provide privacy.
5. Position person in side-lying position.
6. Observe ear. If wax is noted, wash with warm washcloth only. Notify nurse of any concerns.
7. Remove and discard gloves.
8. Hand hygiene. Apply gloves.
9. Prepare medication by drawing med into the dropper. Apply ear drops. (Age 3 and older, pull ear upward and back. Less than 3, pull ear downward and back.) Return dropper to med container.
10. Insert a cotton ball loosely in ear if ordered/authorized by the nurse.
11. Have person remain side-lying for 5 to 10 minutes or as directed by nurse. Notify nurse if any concerns.
12. Repeat dose into other ear, if ordered.
13. Remove and discard gloves and used supplies.
14. Hand hygiene.
15. Return medication to storage.
16. Document, the 6th Right of Medication Administration.
17. Notify nurse of any concerns.

Administering Nasal Drop Medication

1. Utilize 'General' medication administration process, including 5 of the 6 Rights and 3 safety checks.
2. Hand hygiene. Apply gloves.
3. Use barrier under medication container.
4. Provide privacy.
5. Provide tissues and assist or have person gently blow nose (unless recent nasal surgery—check with nurse.) Notify nurse of any concerns.
6. Position person supine position, looking up towards ceiling.
7. Remove and discard gloves.
8. Hand hygiene. Apply gloves.
9. Draw medication up into dropper, hold dropper close to nose (do not touch dropper to nose), drop ordered number of drops into nose. Return dropper to med container. Repeat into other nostril, if ordered.
10. Have person remain in position for 5 minutes, or as directed by nurse.
11. Remove and discard gloves and used supplies.
12. Hand hygiene.
13. Return medication to storage.
14. Document, the 6th Right of Medication Administration.
15. Notify nurse of any concerns.

Administering Nasal Spray Medication

1. Utilize ‘General’ medication administration process, including 5 of the 6 Rights and 3 safety checks.
2. Hand hygiene. Apply gloves.
3. Use barrier under medication container.
4. Provide privacy.
5. Position person in sitting or fowler’s position.
6. Provide tissues and assist or have person gently blow nose (unless recent nasal surgery—check with nurse.) Notify nurse of any concerns.
7. Remove and discard gloves.
8. Hand hygiene. Apply gloves.
9. Shake the container/bottle. Remove med container tip cover and place on barrier, making sure not to contaminate cover.
10. Hold medication spray container upright.
11. Block opposite nostril. Insert bottle tip into the nostril to be administered.
12. Squeeze a puff of spray into the nostril as the person is taking a deep breath through the nose.
13. Wipe bottle tip with tissue. Repeat into opposite nostril if ordered.
14. Replace medication tip cover.
15. Remove and discard gloves and used supplies.
16. Hand hygiene.
17. Return medication to storage.
18. Document, the 6th Right of Medication Administration.
19. Notify nurse of any concerns.

Administering MDI Medication

1. Utilize 'General' medication administration process, including 5 of the 6 Rights and 3 safety checks.
2. Hand hygiene. Apply gloves.
3. Use barrier under medication container. Remove medication cap and place cap upside down or on its side on barrier (if applicable.)
4. Provide privacy.
5. Position person in sitting or Fowler's position.
6. Observe oral cavity, as appropriate. Notify nurse of any concerns.
7. Remove and discard gloves.
8. Hand hygiene. Apply gloves.
9. Use inhaler as instructed.
10. Replace cap of inhaler, as appropriate.
11. Clean spacer (if used) per manufacturer instructions/facility policy.
12. Remove and discard gloves and used supplies.
13. Hand hygiene.
14. Return medication to storage.
15. Document, the 6th Right of Medication Administration.
16. Notify nurse of any concerns.

MDI without spacer:

1. Shake inhaler multiple times (approximately 10.)
2. Ask person to exhale.
3. Place inhaler 1-2 inches in front of mouth or, have person place inhaler in mouth, close mouth around inhaler, and tilt head back slightly.
4. Push down or squeeze the dispensing valve.
5. Have person inhale deeply and slowly for 3-5 seconds and hold breath for as long as possible—up to 10 seconds.
6. Ask person to exhale slowly through their mouth.
7. Repeat puffs as ordered (wait 1—3 minutes between doses.) Shake inhaler again, prior to repeating puffs.

MDI with spacer:

1. Shake inhaler multiple times (approximately 10.)
2. Insert inhaler into spacer.
3. Ask person to open their mouth and tilt their head back slightly.
4. Ask person to exhale.
5. Place mouthpiece of spacer into their mouth, close mouth around mouthpiece of spacer.
6. Push down or squeeze the dispensing valve.
7. Have person inhale deeply and slowly for 3-5 seconds and hold breath for as long as possible—up to 10 seconds.
8. Ask person to exhale slowly through their mouth.
9. Repeat puffs as ordered (wait 1—3 minutes between doses.) Shake inhaler again, prior to repeating puffs.

Administering MDI Medication

Follow facility policy and manufacturer instructions to activate applicable medication container.

1. Utilize 'General' medication administration process, including 5 of the 6 Rights and 3 safety checks.
2. Hand hygiene. Apply gloves.
3. Use barrier under medication container. Remove medication cap and place cap upside down or on its side on barrier (if applicable.)
4. Provide privacy.
5. Position person in sitting or Fowler's position.
6. Observe oral cavity, as appropriate. Notify nurse of any concerns.
7. Remove and discard gloves.
8. Hand hygiene. Apply gloves.
9. Use inhaler as instructed.
10. Replace cap of inhaler, as appropriate.
11. Clean spacer per manufacturer instructions/facility policy.
12. Remove and discard gloves and used supplies.
13. Hand hygiene.
14. Return medication to storage.
15. Document, the 6th Right of Medication Administration.
16. Notify nurse of any concerns.

Automated or breath-activated MDI

1. Remove cap over mouthpiece.
2. Ask person to exhale.
3. Ask person to place mouthpiece into their mouth and close mouth around mouthpiece.
4. Ask person to inhale deeply through mouth with moderate force (you may hear a click and/or feel a mist when the medication is activated.)
5. Ask person to hold breath for as long as possible—up to 10 seconds.
6. Ask person to exhale slowly through their mouth.
7. Repeat puffs as ordered (wait 1 - 3 minutes between doses.) Shake inhaler again, prior to repeating puffs.

Administering Med Via Nebulizer Device

Follow facility policy and manufacturer instructions.

1. Utilize 'General' medication administration process, including 5 of the 6 Rights and 3 safety checks.
2. Hand hygiene. Apply gloves.
3. Use barrier under medication container, as appropriate.
4. Provide privacy.
5. Position person in sitting or Fowler's position.
6. Remove and discard gloves.
7. Hand hygiene. Notify nurse of any concerns.
8. Apply gloves.
9. Connect together, all pieces of nebulizer cup.
10. Fill medicine cup with the ordered medication. NOTE: check and determine which nebulized medicines can be mixed.
11. Attach the other end of the tubing to the mouthpiece/medicine cup. NOTE: If person is unable to hold hand-held neb device, use specific mask that attaches to nebulizer medicine cup.
12. Turn on nebulizer machine.
13. Place mouthpiece in mouth, or apply nebulizer mask over the mouth and nose.
14. Ask person to breathe through the mouth until all medicine is used. Check medicine cup intermittently and gently shake nebulizer cup to ensure all liquid has been used. NOTE: nebulized medicines must be directly monitored.
15. Turn off the machine when done.
16. Clean medicine cup and mouthpiece per manufacturer instructions and/or facility policy. Return to storage.
17. Remove and discard gloves and used supplies.
18. Hand hygiene.
19. Return medication, as appropriate, to storage.
20. Document, the 6th Right of Medication Administration.
21. Notify nurse of any concerns.

Topical Drug Medication Administration

Administering Creams, Ointments, and Powder

1. Utilize 'General' medication administration process, including 5 of the 6 Rights and 3 safety checks.
2. Hand hygiene.
3. Provide privacy.
4. Position person to expose skin site. Drape with towel or the like, if needed.
5. Hand hygiene. Apply gloves.
6. Clean and gently dry skin site, as ordered.
7. Observe skin surface intended to be medicated.
8. Remove and discard gloves. Hand hygiene.
9. Report observation findings to nurse.
10. Consider application device (sterile cotton-tip applicator, sterile tongue blade, glove).
11. Consider post-procedure equipment (open to air, gauze dressing, etc.)
12. Consider comfort. (Is pain med needed prior to application?)
13. Hand hygiene. Apply gloves.
14. Use barrier under medication container. Remove medication cap and place cap upside down cap or on its side on barrier.
15. Remove and discard gloves.
16. Hand hygiene. Apply gloves.
17. Complete application of topical medication (do not re-dip into med container – use new application device if additional med is needed).
18. Replace med container cap.
19. Remove and discard gloves and used supplies.
20. Hand hygiene.
21. Return medication to storage.
22. Document, the 6th Right of Medication Administration.
23. Notify nurse of any concerns.

NOTE:

Lotion: Hold bottle on non-dominant hand, palm label, pour lotion onto gauze or glove; dab lotion to intended skin area.

Cream/ointment: Transfer cream/ointment from tongue blade or cotton-tip applicator to gloved hand, apply thin layer to intended skin area in direction of hair growth.

Powder: Apply thin, even layer with gloved hand.

Application/Removal of Transdermal Patch

1. Utilize 'General' medication administration process., including 5 of the 6 Rights and 3 safety checks.
2. Hand hygiene.
3. Use barrier under medication container and/or patch.
4. Provide privacy.
5. Position person to expose skin site. Drape with towel or the like, if needed. Notify nurse of any concerns.
6. Hand hygiene. Apply gloves.
7. Remove old patch (as appropriate) by folding in half. Properly dispose of patch and document removal, per facility policy and state regulation.
8. Clean/gently dry skin site of old application site, as ordered.
9. Remove and discard gloves.
10. Hand hygiene. Apply gloves.
11. Determine location for new patch (avoid skin with cuts, sores, or creases, gets sweaty, gets rubbed a lot, lots of hair, recently shaved, may be covered by belt/clothing seam).
    - Do not overlap patches; rotate application locations on the skin, as appropriate.
    - Make sure patch remains secure.
    - If edge of patch becomes loose, use tape/sticky adhesive film to secure loose edge. If the patch falls off completely, notify nurse to determine next action.
    - Check with nurse if person is able to get patch wet. Generally, a person may shower as usual. However, don't keep patch under water for long periods of time.
12. Clean/gently dry skin of new application site, as ordered.
13. Remove and discard gloves.
14. Hand hygiene. Apply gloves.
15. Remove backing of the new patch. Skin should be clean, dry, non-irritated. Do not touch sticky side patch. If patch's protective liner contains two parts, first peel off one part of liner. Apply exposed sticky part of patch to the skin and press down. Next, peel back second part of liner and press entire patch down. Use gloved fingers to press along the edges of patch. Patch should be smooth, with no bumps or folds. (Note: some organizational policy states to add a date/initials/time using Sharpie or other method when patch is applied.
16. Remove and discard gloves and used supplies.
17. Hand hygiene.
18. Document, the 6th Right of Medication Administration.
19. Notify nurse of any concerns.

Application of Nitroglycerin Ointment

1. Utilize 'General' medication administration process., including 5 of the 6 Rights and 3 safety checks.
2. Hand hygiene.
3. Use barrier under medication container. Remove medication cap and place cap upside down or on its side on barrier.
4. Provide privacy.
5. Position person to expose skin site. Drape with towel or the like, if needed. Notify nurse of any concerns.
6. Hand hygiene. Apply gloves.
7. Remove old dose/measuring paper by folding in half. Properly dispose dose/paper and document removal, per facility policy and state regulation.
8. Clean/gently dry skin site of old application site, as ordered.
9. Remove and discard gloves.
10. Hand hygiene. Apply gloves.
11. Determine location for new dose/paper (avoid skin with cuts, sores, or creases, gets sweaty, gets rubbed a lot, lots of hair, recently shaved, may be covered by belt/clothing seam).
    - Rotate application locations on the skin, as appropriate.
    - Make sure dose/paper remains secure—recheck location in use, as appropriate. If the dose/paper falls off completely, notify nurse to determine next action.
    - Do not get dose/paper wet with bathing.
12. Clean/gently dry skin of new application site, as ordered/if necessary.
13. Remove and discard gloves.
14. Hand hygiene. Apply gloves.
15. Use dose-measuring paper (print side down), squeeze a ribbon of ointment on the paper for the amount ordered.
16. Apply the dose/paper, ointment side down, to application site. Use the paper to spread a thick, uniform layer of ointment under the paper (but do not rub into the skin).
17. Cover dose/paper with clear-see through dressing (per facility policy).
18. Close med container.
19. Remove and discard gloves and used supplies.
20. Hand hygiene.
21. Return medication to storage.
22. Document, the 6th Right of Medication Administration.
23. Notify nurse of any concerns.

Administering Rectal Medication

1. Utilize ‘General’ medication administration process, including 5 of the 6 Rights and 3 safety checks.
2. Hand hygiene. Apply gloves.
3. Use barrier under medication container as appropriate.
4. Provide privacy.
5. Position person in Left Sim’s or side-lying position.
6. Remove and discard gloves.
7. Hand hygiene. Apply gloves.
8. Open and remove wrapper containing suppository.
9. Again explain procedure to person.
10. Lubricate the suppository and place suppository on barrier (paper towel.)
11. Lubricate the index finger of the glove which will insert the suppository.
12. Expose and observe rectal area. Notify nurse of any concerns.
13. Insert the suppository. With gloved hand raise the upper buttock and expose the anus. Ask person to take a deep breath. With lubricated, gloved index finger, place the rounded tip of the suppository into the anus/rectum at least 1 inch or more to be beyond the rectal sphincter along the rectal wall. Wipe the anus with toilet tissue. Ask person to remain in side-lying position for 15 to 20 minutes or per nurse direction.
14. Remove and discard gloves, used supplies.
15. Hand hygiene.
16. Return medication container to storage.
17. Document, the 6th Right of Medication Administration.
18. Notify nurse of any concerns.

1. Utilize 'General' medication administration process, including 5 of the 6 Rights and 3 safety checks.
2. Have person void/urinate before the procedure.
3. Complete pericare with proper hand hygiene, supply use, procedure, use of gloves.
4. Hand hygiene. Apply gloves.
5. Use barrier under medication container as appropriate.
6. Provide privacy.
7. Position person in dorsal recumbent position. Place drape.
8. Remove and discard gloves.
9. Hand hygiene.
10. Apply gloves.
11. Observe the perineum and vaginal opening. Notify nurse of any concerns.
12. Prepare and administer the drug (after med preparation, remove gloves, apply new gloves when medication is to be actually administered)

CREAM, FOAM, GEL, SUPPOSITORY with APPLICATOR

- Remove medication cap and place cap upside down or on its side on barrier
- Attach applicator and squeeze the medication into the applicator
- Lubricate the applicator and place on barrier (paper towel)
- Again explain the procedure to the resident
- Spread labia to expose the vagina using your non-dominant hand
- Insert the applicator as far as possible into the vagina
- Push the plunger to deposit the medication and remove applicator
- Apply a perineal pad or panty shield
- Remove and discard gloves and used supplies
- Hand hygiene.
- Assist woman into supine position for 5 to 10 minutes.
- Hand hygiene. Apply gloves.
- Clean & store applicator per manufacturer instructions OR, dispose of applicator if one-time use.
- Remove and discard gloves and used supplies, hand hygiene, return med container to storage.
- Document, the 6th Right of Medication Administration.
- Notify nurse of any concerns.

1. Utilize 'General' medication administration process, including 5 of the 6 Rights and 3 safety checks.
2. Have person void/urinate before the procedure.
3. Complete pericare with proper hand hygiene, supply use, procedure, use of gloves.
4. Hand hygiene. Apply gloves.
5. Use barrier under medication container as appropriate.
6. Provide privacy.
7. Position person in dorsal recumbent position. Place drape.
8. Remove and discard gloves.
9. Hand hygiene.
10. Apply gloves.
11. Observe the perineum and vaginal opening. Notify nurse of any concerns.
12. Prepare and administer the drug (after med preparation, remove gloves, apply new gloves when medication is to be actually administered)

SUPPOSITORY without APPLICATOR

- Open and remove wrapper containing suppository.
- Again explain the procedure to the person.
- Lubricate gloved finger and suppository.
- Spread the labia to expose the vagina using your non-dominant gloved hand.
- Using your gloved, lubricated finger, insert the suppository as far as possible into the vagina.
- Apply a perineal pad or panty shield.
- Remove and discard gloves and supplies.
- Hand hygiene.
- Assist person into supine position for 5 to 10 minutes.
- Hand hygiene, return med container to storage.
- Document, the 6th Right of Medication Administration.
- Notify nurse of any concerns.