Principles of Medication Administration

When you give medications, regardless of the type of medication, there are some basic principles that you will always follow. The basic principles that you will always follow are:

- Talk with the individual and **explain** what you are doing before you give medications. Answer any questions that the individual has.
- **Help** the individual to be as involved as possible in the process.
- **Provide privacy** for the individual.
- Give medication administration your **complete attention**.
  - Give medications in a quiet area, free from distractions.
  - Never leave medications unattended, even for a moment!
- **Wash your hands!** You must wash your hands before giving medications and then again after you have given medication to each individual.

Remember: if you have a question or a concern, you should **always** 

and call for help!

Principles of Infection Control: Handwashing

The single most important thing you can do to safeguard the health of others and yourself is wash your hands---and do it a lot!

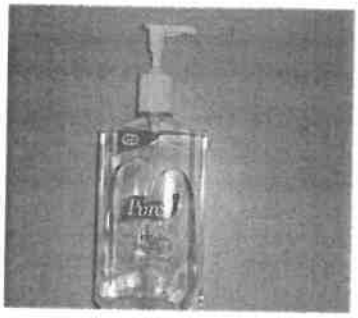
How many times per day do you and the individuals that you support need to wash your hands?

We all need to wash our hands:

- When we arrive at work
- After going to the bathroom
- Before, during and after meal preparation
- Before eating
- After blowing our nose, sneezing or coughing
- After providing personal care
- After gardening, housework
- Whenever hands are visibly dirty
- Before and after administering medications to an individual
- First thing in the morning and last thing at night

Effective handwashing is proven to decrease spread of colds and flu and to reduce overall infection rates. Handwashing with soap and water is the most sensible way to make sure that your hands are clean

You may also use an **alcohol-based hand rub** in place of soap and water.



Source: www.health.sa.gov.au/pehs/ images/clean-hands.jpg

When you are giving some types of medications, it is necessary to wear gloves.

Change your gloves as soon as you have finished administering medications to the individual. Never re-use gloves for more than one individual and always wash your hands again after you take off your gloves.

Wearing gloves does not take away the need for handwashing: Always wash your hands as soon as you take your gloves off. And, only wear a pair of gloves to complete a specific task for a specific individual. Never wear the same pair of gloves for another task or with another individual.

Six Rights Of Medication Administration

The Six Rights
When you are giving medication, regardless of the type of medication, you must always follow the six rights.

Each time you administer a medication, you need to be sure to have the:

1. **Right individual**
2. **Right medication**
3. **Right dose**
4. **Right time**
5. **Right route**
6. **Right documentation**

Each time you give a medication, you must systematically and conscientiously check your procedure against these six rights.

This is essential **every time** you administer **any** medication – including medications that an individual has been taking for a long time.

You must check for all six rights every time you administer any drug to any individual.

Each time that you give a medication, you also need to remember to do the "Three Checks". This means that you are going to do a **"triple-check"** to make sure that the six rights are present each time that you give a medication. You must:

1. Remove the medication from the locked area and check the prescription label against the medication log to make sure that they match: **this is the 1st check.**

2. Before pouring the medication, check the prescription label against the medication order to make sure that they match: **this is the 2nd check.**

3. After you pour the medication, but before you give it, check the prescription label against the medication log entry again to make sure that they match: **this is the 3rd check.**

Right Individual

In order to make sure that you are about to administer medications to the right individual, you have to know the individual.

Even when you know the individual well, mistakes can happen. Sometimes, when medications are being administered to more than one individual in a setting, or if you prepare medications for more than one individual at a time, you can be distracted and give the medications to the wrong individual.

You can avoid a serious mistake if you:

1. Prepare medication for one individual at a time.
2. Give the medication to the individual as soon as you prepare it.
3. Do not talk to others and ask them not to talk to you when you are giving medication.
4. Do not stop to do something else in the middle of giving medications.
5. Pay close attention at all times when you are giving medications.

You must also compare the individual's name on the prescription label, the medication order and the medication log. Make sure that they match.

If they do not match, or if there is any doubt about whether you are giving the medication to the right individual, 

!ASK QUESTIONS!

If you make a mistake, follow your agency's policy for reporting medication errors.

You may need to call the individual's physician, the Poison Control Center, and/or take the individual to the emergency room for evaluation.
THIS IS WHY WE DO THE TRIPLE CHECK.

Right Medication

In order to be sure that you are giving the right medication, you must:

Read the medication label carefully (remember that some medications have more than one name: a brand name and at least one generic name).

Check the spelling of the medication carefully. If there is **any** doubt about whether the medication name is correct, stop and call the nurse or the pharmacist **before** you give the medication.

Read the medication order carefully. Make sure that the medication name on the order matches the medication name on the label.

Read the medication log carefully. Make sure that the medication name on the label, the medication order and medication log match **before** giving the medication.

Look at the medication. If there is anything different about the size, shape or color of the medication, call the pharmacist **before** you give it. It could be that you have been given a different generic brand of the medication. But sometimes when a medication looks different it means that you have the wrong medication.

THIS IS WHY WE DO THE TRIPLE CHECK.

Compare the medication name on the prescription label, the medication order and the medication log.

If they do not match, or if there is any doubt that you are giving the right medication, 

! ASK QUESTIONS!

If you make a mistake, follow your agency's policy or procedure for reporting medication errors.

Right Dose

The right dose is **how much** of the medication you are supposed to give the individual at one time.

To determine the dose, you need to know the **strength** of each medication. In the case of liquid medications, you need to know the strength of the medication in each liquid measure.

The dose equals the strength of the medication multiplied by the amount.
Look at the sample label below.

RX #:828291

Town Pharmacy
100 Main Street
Pineville, MA 00000
(617) 000-0000

Jeff Smith

09/29/00

Valproic Acid 250mg
(I.C. Depakote)

Take 2 tabs by mouth twice a day

By Dr. B.J. Honeycutt

Lot #: PS 56721 Exp. Date: 9/29/01

Refills: 4

The **strength** of each Valproic acid pill is **250 mg.**
The **dose** is **500mg** twice daily.
Strength (250mg per pill) **X** Amount (2 tabs)= 500mg

Compare the dose on the prescription label, the medication order and the medication log.

If they do not match, or if there is any doubt that you are giving the right dose, 

! ASK QUESTIONS!
THIS IS WHY WE DO THE TRIPLE CHECK.
If you make a mistake follow your agency's policy or procedure for reporting medication errors.

ALERT! Always ask the pharmacist or the nurse about any order that requires administering more than 3 tablets or capsules of the same medication in one dose. This could be an over-dosage!

Right Time

Some medications must be administered only at very specific times of the day. For other medications, the time of day that you give the medication is less critical.

For example, some medications must be given before meals, one hour after meals or at bedtime in order to work best.

It is very important for medication to be given at the time of day that is written on the medication order. If no specific time is written on the medication order, ask the nurse or pharmacist about the best time of day to give the medication. Write this down on the medication log.

Compare the time on the prescription label, the medication order and the medication log.

If they do not match, or if there is any doubt about whether you are giving the medication at the right time, 

!ASK QUESTIONS!

THIS IS WHY WE DO THE TRIPLE CHECK.

If you make a mistake, follow your agency's policy or procedure for reporting medication errors.

Medications must be given within a ½ hour of the time that is listed on the medication log. This means that you have ½ hour before the medication is due, and ½ hour after it is due to administer the medication in order to be on time with medication administration.

The ½ hour timeframe does not apply to PRN medications.

For example: If you have a PRN medication order and PRN protocol for Tylenol to be given every 4 hours as needed, you cannot give it until 4 hours have passed since the last dose.

What if a prescribing practitioner writes a medication order for "am," "pm," or "hs?"

Sometimes because of a particular individual's life, it is more useful to have a "freer" interpretation of time than the 1/2hr window. **If the prescribing practitioner does not have specific times in mind,** then **the Nurse Trainer may choose** to be more natural in our supports of allowing a time variance.

In that case the 1st box of the time space on the med log says AM and under it in the 2nd box is written the word "Time" and then in the 3rd box down is written either PM or HS and in the 4th box the word "Time" again. Next to "Time" on each day of administration, **the provider initials and then below it documents the actual time of administration.**

A discussion between the provider and nurse trainer must occur at the onset for acceptable time frames but this mechanism allows a much wider "window" - maybe some days the individual has to get up particularly early for work or stay out late for community events or school and on the weekend likes to sleep in. Without changing the prescribing practitioner's order, we allow safe flexibility within the expected guidelines.

YOU MUST SPEAK WITH THE NURSE TRAINER BEFORE ADMINISTERING MEDICATIONS IF A THE PRESCRIPTION STATES AM, PM, OR HS

Right Route

The route means how and where the medication goes into the body.

Most medication is taken into the mouth and swallowed, but others enter the body through the skin, rectum, vagina, eyes, ears, nose, and lungs, through a g-tube or by injection.

The most common way (or route) for medications to enter the body is by mouth.

Compare the route on the prescription label, the medication order and the medication log.

If they do not match, or if there is any doubt about whether you are giving the medication by the right route, 

! ASK QUESTIONS!

THIS IS WHY WE DO THE TRIPLE CHECK

If you make a mistake follow your agency's policy or procedure for reporting medication occurrences.

Sometimes mistakes happen when you are giving several medications by different routes at the same scheduled time.

For example, you may be giving an eye drop and an eardrop to the same individual at the same time. If you become distracted, you could accidentally put the eardrops in the individual's eye. This would be a very serious mistake.

THIS IS WHY WE DO THE TRIPLE CHECK

Avoid this type of mistake by giving the eye drops first, and then put away the eye drops. After you have put the eye drops away, give the ear drops.

Right Documentation

Your responsibilities are not yet complete!

Each time a medication is administered, it must be documented.

Your documentation of medication administration must be done at the time that you give the medication.

You must complete all of the documentation that is required on the medication log.

- Documentation should be done in blue or black ink.
- No pencil or white out can be used.
- Never cross out or write over documentation.
- If you make a mistake when you are documenting on the medication log, circle your mistake and write a note on the log to explain what happened.

Double check your documentation as soon as you have finished giving medications and again at the end of the day.

If there is someone else that can double-check your documentation for you, ask him or her to go over your medication log documentation to make sure that it is complete.

All documentation must be done at the time that the medication is administered.

If there is any question about documentation on the medication log, 

! ASK QUESTIONS!

If you make a mistake, follow your agency's policy or procedure for reporting medication occurrences.

I have read and understand the 6 rights of medication administration for field trips at West Liberty-Salem.

Signature_____

Name_____

Date_____

EMERGENCY MEDICAL FORM FOR STAFF or CHAPERONES AT WEST LIBERTY-SALEM LOCAL SCHOOLS

EMPLOYEE/CHAPERONE NAME

_____

ADDRESS

_____

PHONE

_____

IN CASE OF AN ACCIDENT, INJURY OR SICKNESS NOTIFY THE FOLLOWING:

NAME (RELATIONSHIP) PHONE#

_____ _____

NAME (RELATIONSHIP) PHONE#

_____ _____

LIST BELOW PREFERRED HOSPITAL, PCP (PRIMARY CARE PROVIDER) AND DENTIST

HOSPITAL (MAY NOT APPLY DEPENDING ON LOCATION OF FIELD TRIP)

_____

PCP (PRIMARY CARE PROVIDER)

_____

DENTIST

_____

LIST ANY MEDICAL CONDITIONS, DIAGNOSIS, ALLERGIES OR MEDICATIONS THAT SHOULD BE SHARED:

_____

EXPLAIN ANY SPECIAL INSTRUCTIONS OR PREFERENCES REGARDING YOUR HEALTH CARE IN CASE OF AN EMERGENCY

_____

_____

DO YOU CONSENT TO EMERGENCY TRANSPORT & MEDICAL TREATMENT IF NEEDED _____YES _____NO

NAME DATE

_____ _____

AUTHORIZATION FOR PRESCRIBED MEDICATION/DRUG OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Name of Student _____ Address _____

School _____ Grade _____

A. I am requesting permission for my child named above to: (Check all that apply)

_____ use or receive prescribed medication

_____ receive prescribed treatment

_____ self-administer prescribed medication(s) in my presence or that of an authorized staff member

_____ for student with diabetes only: self-administer diabetes care in accordance with Policy 5336

in accordance with the Doctor's prescription.

B. I will assume responsibility for safe delivery of the medication/drug to school, except for diabetes medication student is permitted to posses pursuant to Policy 5336.

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment, or if I wish to revoke this authorization.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly from this authorization.

Signature of Parent _____ Date _____

Home Telephone _____ Work Telephone _____

Dosage, instructions, or precautions (including possible side effects): _____

_____

_____

_____

I have prescribed the following treatment _____

_____

_____

_____

_____

_____

Beginning Date _____ Ending Date _____

For student with diabetes only:

_____ I authorize the student to attend to his or her diabetes care and management, in accordance with my order, during regular school hours and school sponsored activities. have determined that the student is capable of performing diabetes care tasks.

_____ I do not authorize the student to attend to his or her diabetes care and management during regular school hours and school sponsored activities.

Prescriber's Signature _____ Telephone _____

Printed/Typed Name _____ Date _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s)/treatment(s):

_____

_____

_____
Principal

8/14/06
11/18/14

AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALER/OTHER EMERGENCY MEDICATION(S)

Student Name: _____ Date: _____

Address: _____

Authorization is hereby given for the student named above to:

[ ] receive the prescribed medication indicated from the designated school personnel.
[ ] keep emergency medication in his/her possession.
[ ] self-administer the prescribed medication as permitted by law.

Medication Name: _____

Dosage: _____

Date the administration is to begin: _____
Date the administration is to cease: _____

Adverse reactions that should be reported to the prescriber: _____

_____

Adverse reactions for unauthorized user: _____

_____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack or other condition requiring emergency medication: _____

_____

_____

Other special instructions: _____

_____

Prescriber and parent/guardian names, signature, and emergency phone numbers are required.

Prescriber name: _____ Phone: _____

Signature: _____ Date: _____

Parent/guardian name: _____ Phone: (Home) _____
(Work) _____
(Other) _____

Signature: _____ Date: _____

Copies must be provided to Principal and to the School Nurse if one is assigned to the student's building.
10/03
11/05

AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT
(ELEMENTARY VERSION)

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NONPRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Name of Student _____ Address _____

School _____ Grade _____

A. I am requesting permission for my child named above to: (Check one or both)

_____ use or receive the following over-the-counter medication(s)

Medication: _____

Dosage: _____

Medication: _____

Dosage: _____

_____ self-administer such medication(s) in the presence of an authorized staff member.

B. I will assume responsibility for safe delivery of the medication to school.

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent _____ Date _____

Home Telephone _____ Work Telephone _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-nonprescribed medication(s)/treatment(s): _____

_____

Principal _____

AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT
(ELEMENTARY VERSION)

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NONPRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Name of Student _____ Address _____

School _____ Grade _____

A. I am requesting permission for my child named above to: (Check one or both)

_____ use or receive the following over-the-counter medication(s)

Medication: _____

Dosage: _____

Medication: _____

Dosage: _____

_____ self-administer such medication(s) in the presence of an authorized staff member.

B. I will assume responsibility for safe delivery of the medication to school.

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent _____ Date _____

Home Telephone _____ Work Telephone _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-nonprescribed medication(s)/treatment(s): _____

_____

Principal _____

AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT
(SECONDARY VERSION)

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NONPRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Name of Student _____ Address _____

School _____ Class/Grade _____

A. I am requesting permission for my child named above to: (Check one or both)

[ ] use or receive the following over-the-counter medication(s).

Medication: _____

Dosage: _____

Check Option 1 or 2 below.

[ ] self-administer such medication(s) in the presence of an authorized staff member.

~~[ ] keep the medication(s) in his/her possession and self-administer the medication(s) as needed.~~

B. I will assume responsibility for safe delivery of the medication to school.

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent _____ Date _____

Home Telephone _____ Work Telephone _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-nonprescribed medication(s)/treatment(s):

_____

_____

Principal _____

MEDICATION ADMINISTRATION DAILY LOG

(To be completed for each medication)

School Year _____

Name of Student _____ Date of Birth _____ Sex _____ Grade or Homeroom (or) Teacher(s) _____

Name of School _____

Name and Dosage of Medication _____ Route(s) _____ Given in School _____

Directions: Initial with time of administration; a complete signature and initials of each person administering mediations should be included below.

	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
SEPTEMBER																															
OCTOBER																															
NOVEMBER																															
DECEMBER																															
JANUARY																															
FEBRUARY																															
MARCH																															
APRIL																															
MAY																															
JUNE																															

INITIAL (of person administering medication)

	INITIAL	SIGNATURE		INITIAL	SIGNATURE
1.	_____	_____	5.	_____	_____
2.	_____	_____	6.	_____	_____
3.	_____	_____	7.	_____	_____
4.	_____	_____	8.	_____	_____

CODES

(A) Absent

(E) Early Dismissal

(F) Field Trip

(N) No Medication Available

(O) No Show

(W) Dosage Withheld

(X) No School (i.e. Holiday, weekend, snow days, etc.)

Use reverse side for reporting significant information (e.g. Observation of medication's effectiveness, adverse reactions, reason for omission, plan to prevent future "no shows".)

MEDICATION ADMINISTRATION DAILY LOG

(To be completed for each medication)

School Year _____

Name of Student _____ Date of Birth_____ Sex_____ Grade or Homeroom (or) Teacher(s)_____

Name of School_____

Name and Dosage of Medication_____ Route(s)_____ Given in School_____

Directions: Initial with time of administration; a complete signature and initials of each person administering mediations should be included below.

	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
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FEBRUARY																															
MARCH																															
APRIL																															
MAY																															
JUNE																															

INITIAL (of person administering medication)

	SIGNATURE		SIGNATURE
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

CODES

(A) Absent

(E) Early Dismissal

(F) Field Trip

(N) No Medication Available

(O) No Show

(W) Dosage Withheld

(X) No School (i.e. Holiday, weekend, snow days, etc.)

Use reverse side for reporting significant information (e.g. Observation of medication's effectiveness, adverse reactions, reason for omission, plan to prevent future "no shows".)