65G-7 MEDICATION ADMINISTRATION TRAINER TRAINING

Agency for Persons with Disabilities

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Medication Administration Trainer Training Objectives

To familiarize participants with Florida Administrative Rule Chapter 65G-7 Medication Administration:

1. Understand the rules and requirements for unlicensed staff to give medications
2. Understand the requirements for Trainers and Validation Trainers
3. Demonstrate the ability to accurately complete all forms required
4. Understand the requirements for Validation
5. Understand the types of medication errors and the steps to take if an error is made
6. Understand the requirements for giving PRN (as needed) medications
7. Understand the rules for storage of different medication types, including prescription, controlled, over the counter
8. Understand the steps to follow when medications go off-site with the client
9. Understand the process for teaching the Basic Medication Administration Training curriculum and the Prescribed Enteral Formula Administration Training curriculum

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About Basic Medication Administration Training

- Designed to train unlicensed staff who work with clients of the Agency for Persons with Disabilities (APD) to safely assist clients with their medications.
  - To familiarize participants with the procedural aspects of Florida Administrative Rule Chapter 65G-7
  - To teach participants how to safely administer medications and supervise the self-administration of medications
- Must be taught by an APD approved trainer using the APD provided training.
- Only licensed nurses – LPNs, RNs, APRNs – will be approved to teach this training.

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Administrative Rule Chapter 65G-7 Medication Administration

- Rule Chapter 65G-7 includes 12 different rules
- These rules describe the requirements licensed nurses must meet in order to offer training in Medication Administration to unlicensed individuals who wish to assist clients of APD by:
  - Supervising the client's self-administration of medication
  - Administering medication to clients
- This training course is one of the requirements

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How do I become Medication Administration Training Trainer?

Steps to becoming a Trainer:

1. Have a valid license to practice nursing in the State of Florida – APRN, RN, or LPN. Interstate compact licenses are fine
2. Fill out APD Form 65G-7.003 A "Medication Administration Trainer Application Form"
3. Attend this class, and pass the test
4. Receive your materials and Trainer number

Annual Requirements:

1. Take the 65G-7 Medication Administration Trainer Training Annual Update provided by your Regional MCMs, pass the test
2. Make sure to update license and contact information within 30 days of any change

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To complete this course you must:

- Be present the entire time the course is being taught.
  - No texting, browsing, or reading on electronic devices!

- Obtain a score of 90% or above on the exam on TRAIN Florida
  - You will receive an access code for the exam at the end of this course
  - You must have a TRAIN Florida account to take the exam – you received instructions on how to get one when you were scheduled for this class

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First, we will take a brief look at F.S. 393.506.

Then, we will take a longer, and more in depth look at Rule Chapter 65G-7 Medication Administration.

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Florida Statute 393.506

Last amended in 2018. Includes the following components:

1. An unlicensed direct service provider may administer or supervise the self administration of medication by specified routes if they meet the requirements of the Statute.

2. To meet the requirements the unlicensed direct service provider must satisfactorily complete an initial training course conducted by an agency-approved trainer of not less than 6 hours in medication administration. They must also be found competent to supervise the self-administration of medication by a client, and to administer medication to a client in a safe and sanitary manner.

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F.S. 393.506, continued

3. Competency in the otic, transdermal, and topical routes must be assessed and validated using simulation during the initial training course. These routes do not have to be revalidated annually.

4. Competency must be validated originally and revalidated annually for the oral, enteral, ophthalmic, rectal, and inhaled routes, and these assessments must be done onsite with an actual client using the client's actual medications. During this assessment, the validating trainer must observe the direct service provider administering medications by all routes validated and supervising the self-administration of medication by all routes validated.

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F.S. 393.506, continued

5. An unlicensed direct service provider who completes the initial training course and is validated in the oral or enteral route doesn't have to take the training course again unless they fail to maintain their validation on the oral or enteral route.

6. An unlicensed direct service provider who has already completed a training course of 4 hours and been validated as competent for oral or enteral routes before July 1, 2018 doesn't have to take the 6-hour training, if they maintain their validation for the oral or enteral routes.

F.S. 393.506, continued

7. An unlicensed direct service provider must attend and pass a 2-hour APD-developed update training annually before attempting to re-validate their skills.

8. Training, determination of competency, and initial and annual validations must be performed by APRNs, RNs, or LPNs. Additionally, MDs or DOs may validate.

9. Directs APD to establish rule standards and procedures to carry out the intent of the statute, and lists what must be addressed in rule, as well as establishing methods of enforcement to ensure compliance.

Rule Chapter 65G-7, F.A.C.

This Rule Chapter was first adopted on March 30, 2008. There were no revisions to the Rule as initially written until July 1, 2019, when the current revision was adopted.

Rule Chapter 65G-7 contains 12 separate Rules, starting with 65G-7.001, and ending with 65G-7.009.

We will take a look at each of them today.

65G-7.001 Definitions

There are 53 definitions in this Rule – most
are very straightforward, while others are
more complex.

We'll look at some of the more complex
ones.

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65G-7.001 Definitions, continued

7.001(2) Defines administration routes. 7.001(2)(a) "Enteral" which
means medication or prescribed enteral formula is delivered by
gastrostomy, jejunostomy tube, or gastrostomy-jejunostomy tube

7.001(2)(j) Defines the vaginal route as being inserted into the
vagina. It specifically states that this route does not include
medications applied to the skin external to the vagina (note that the
vaginal route is not an approved route for MAPs)

7.001(7), (10), and (11) all discuss orders and prescriptions – what a
current order is, the expiration date of a prescription, the expiration
date of a medication

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65G-7.001 Definitions, continued

7.001(20) "Medication Assistance Provider" or "MAP" – this is the job
you will be training your students to perform. The MAP is an
unlicensed direct service provider who has completed the course you
will be teaching, and who has been validated.

7.001(29) "Primary route of medication administration" or "primary
route" means the oral route, or the enteral route for a MAP that
primarily administers medication by that route. The primary route is
used to determine the annual validation date of a specific MAP for
the purpose of requiring retraining and validation if a lapse in
validation occurs.

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65G-7.002 Authorization for Medication Administration and Informed Consent Requirements

An Agency client's need for assistance with medication administration, or their ability to self-administer without supervision must be documented by their physician, PA, or APRN on an "Authorization for Medication Administration" form. This form must be available for review in the client's current place of residence, and must be renewed and updated annually – *and upon any change in the client's medical condition or self-sufficiency that would affect the client's ability to self-administer medication or tolerate particular administration routes.*

Any provider (including a MAP) who is with a client when the healthcare provider changes an Authorization form is responsible for notifying the Waiver Support Coordinator of the new form.

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Determining the Need for Assistance:

Authorization for Medication Administration

APD Form 65G-7.002 A

Different clients need different levels of help with their medications.

How do you, the MAP, know how much help to give?

The Authorization form tells you!

This must be filled out by the client's MD (or DO), physician assistant (PA), or advanced practice registered nurse (APRN) annually or with any change to the client's medical condition or self-sufficiency.

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Different levels of need: what do they mean?

There are 5 different levels of need on the Authorization. We will discuss each of these over the next few slides.

1. **Fully capable of self-administering his/her medications without supervision.**
   - Take their own medications by themselves, without any supervision.
   - No Medication Administration Record (MAR) is kept, because a MAP can only document what he or she actually does, and they are not giving or supervising the medications for these clients.
   - Client may be reminded that it is time to take medications, and the client's medications may be brought to them if they are centrally stored.
   - They may need assistance to re-order their medications, or to get them from the pharmacy.
   - May use a 'pill-minder' to store medications – but the MAP may not help them to fill it.
   - If living in a group-home or multi-person supported living environment, must keep their medications in a locked storage area in their room. Under certain circumstances, they must keep their medications in central storage (where all of the other medications are stored).

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Levels of need – continued

2. Requires supervision while self-administering their medications
- Needs the assistance of a MAP or licensed healthcare professional to take their medications. The MAR is used for documentation of assistance.
- Assistance will not be the same for every client, as each client needs to be encouraged towards independence. Some things the MAP may need to assist with are:
  - Prompt the client, observe taking the medication
  - Confirm that the client is taking the correct dose
  - Check the label on the medication against the MAR and the order
  - Open the medication if the client is not able to do so
  - Discuss the medication with the client – make sure they understand what they are taking, and why
- Medications must be centrally stored.
- Supervision of self-administration includes instructions or any other assistance necessary to ensure the correct self-administration of medications:
  - A client may be able to self-administer some routes, but need to have others administered
  - May be able to apply topicals and patches to easy-to-reach areas, but need it applied for them on others

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Levels of need - continued

3. Requires Medication Administration
- MAP must prepare and give all their medications.
- MAP documents the medications on the MAR immediately after they give them.
- Goal is still to help clients become more independent with their medications. The MAP can do this by:
  - Helping the client to rub a topical medication in by themselves
  - Tell the client the name of each medication, and the reason the client takes it
  - Ask the client to help count out their medications, or work on learning how many of each medication they take, or how often
  - Let the client pop the pills out, or take them out of the bottle if they can safely do so
- Medications must be centrally stored.

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Levels of need, continued…

The final two levels of need are very similar:
Requires Medication Administration, with the following exceptions which the client is fully capable of self-administering without supervision (specify route(s))
and,
Requires Supervision of self-administration of medication, with the following exceptions which the client is fully capable of self-administering without supervision (specify route(s))
Each of these requires either administration or supervision of medication – but the healthcare professional makes an exception for a route the client can be independent in. This can be anything from topical medications they apply often, to inhalers, or premeasured insulin injections they give themselves each morning.

These medications are treated just like the medications of a client who administers medication without supervision – you don't document them on the MAR, the medications are not required to be centrally stored (but they can be), and you may retrieve the medications for the client and remind them that it is time to take them.

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Fill out an Authorization for Medication Administration

You will each receive information on a client from the instructor – fill out the Authorization to reflect that information

Share what you have written with the rest of the class

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65G-7.002 Authorization for Medication Administration and Informed Consent Requirements

This Rule also deals with the Informed Consent form, which is also mentioned in F.S. 393.506. It must be updated annually, and with any change of residential provider or other provider agency.

7.002(4) lists who the Rule Chapter does not apply to. Take special note of the requirements for healthcare practitioners at 7.002(4)(a). It states that nurses (and other healthcare providers that give medication) *must* document on APD forms – and it gives a list of the forms.

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65G-7.0025 Self-Administration of Medication Without Supervision

This Rule concerns clients who are authorized to self-administer their medications without supervision.

A provider may help the client by making the medication available and reminding the client to take the medications at the appropriate time.

This Rule also discusses pill-minders. A client who self administers medication without supervision may use one, but a MAP may not help them fill it in any way, including coaching.

This client may store their medication in a locked container in their room. If this is not possible, the medication may be stored with other client's medications and provided to the client when needed.

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65G-7.003 – Medication Administration Trainer Requirements

This Rule is ALL about YOU!!!

All of the requirements for Medication Administration Training providers can be found here.

We will go thru it step-by-step.

65G-7.003 – Medication Administration Trainer Requirements

(1) RNs or LPNs must be approved by APD before providing *or offering to provide* either Basic Medication Administration Training or Prescribed Enteral Formula Administration (PEFA) Training.

(2) To be eligible to provide either course, you must:

a) Be licensed to practice nursing in Florida

b) Apply on the Medication Administration Trainer Application Form – filling in ALL the required information, and indicating if you will also provide PEFA training

c) Complete this training. The application for training is not considered complete until the MCM providing this training indicates on the Application Form that the applicant has successfully completed the course.

(3) If APD denies your application, we will tell you why, in writing.

65G-7.003 – Medication Administration Trainer Requirements, continued

(4) **Approved Trainers Shall:**

a) Only provide those courses they have been approved to train

b) Use the curriculums provided by the Agency for both Basic Medication Administration and PEFA training.

c) *Failure to teach the curriculum to the Agency standard and requirements set forth in 65G-7.0033 subjects the trainer's approval to disciplinary action, including revocation of approval.*

65G-7.003 – Medication Administration Trainer Requirements, continued

(4) Approved Trainers Shall:

c) Submit proof of nursing license renewal within 30 days of renewal

d) Inform the APD Regional Office within 30 days of revocation of license or loss of authority to practice nursing in Florida

e) Notify the Regional office within 30 days of any change to contact information

f) Provide a schedule of their training course to the local Regional Office MCMs, or the MCMs of any other Region where they provide courses. The schedule must include all courses, with place, date, and time.

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65G-7.003 – Medication Administration Trainer Requirements, continued

(4) Approved Trainers Shall:

g) Make provisions for Agency employees to observe their training upon request. This also applies to providers of web-based distance learning courses. The Agency may attend courses randomly, or as a result of specific complaints.

h) Maintain a copy of a training roster for each course provided, including a list of students, and a list of students who passed the course. These rosters must be kept for at least 2 years.

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65G-7.003 – Medication Administration Trainer Requirements, continued

(5) All Trainers must attend:

a) An Initial Training providing an overview of Chapter 65G-7, F.A.C. provided by a Regional Office MCM before the application to provide medication administration training is approved.

b) An Annual Update Training course provided by a Regional Office MCM, due no later than December 31st each year. Trainers approved within 6 months prior to December 31st don't have to take the Update until the following year.

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65G-7.003 – Medication Administration Trainer Requirements, continued

(6) The Agency assigns a Trainer Number to each approved Trainer

a) This number must be displayed on all materials used in teaching the courses

b) Anyone who has obtained a Trainer number is authorized to teach the Basic Medication Administration Course, the Prescribed Enteral Formula Administration Course, or both, throughout the State of Florida

(7) Any approved Trainer who received a Trainer number prior to the current rule revision may continue to provide training

a) They must use the most current curriculum provided by APD

b) The Trainer is not required to attend this Initial training, but is required to attend the Annual Updates

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65G-7.003 – Medication Administration Trainer Requirements, continued

(8) The Agency can deny a Trainer's application for not complying with the application or eligibility requirements, or for:

a) Trying to gain approval through fraud, deceit, false statements, or misrepresentation of facts, whether made knowingly or negligently

b) Not providing complete or accurate information on the initial application or in any information requested by APD during the application process

c) Not notifying the Agency within 30 days of a change in information required for approval, including address and contact information

d) Failing to provide information regarding the applicant's eligibility requirements or providing information indicating that the applicant does not meet eligibility requirements. Nursing licenses or authorizations in current but inactive status must be updated to active status before an approval may be provided.

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65G-7.003 – Medication Administration Trainer Requirements, continued

(9) Failure to comply with Chapter 393.506, F.S., or any provision of Chapter 65G-7, F.A.C., shall subject the Trainer's approval to disciplinary action, including use of a corrective action plan, suspension, or revocation of the Trainer's approval. If revoked, the Trainer shall not subsequently be approved to provide medication administration training or prescribed enteral formula administration training. The Agency shall take action against a Trainer's approval if the Trainer fails to comply with Chapter 393.506, F.S., or Chapter 65G-7, F.A.C., including any of the following actions or omissions:

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65G-7.003(9) – Medication Administration Trainer Requirements, continued

a) Obtaining or trying to obtain approval by not being truthful – whether you do this knowingly, or negligently;

b) Not providing complete, accurate information in the application, or in any notification of change in information, including contact information;

c) Not notifying the Agency within 30 days of changes in the information required for approval to train;

d) Falsifying any records about the course;

e) Not attending the required Annual Update review through a Regional Office;

f) Not maintaining required records about the course – attendance, hours of training, date of course, name of course, and any other persons assisting the Trainer

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65G-7.003(9) – Medication Administration Trainer Requirements, continued

g) Not maintaining the course curriculum in the format and content provided by the Agency (a Trainer developing a web-based curriculum may make minor alterations);

h) Allowing Trainers who are not licensed or authorized to practice nursing by the State of Florida to provide training;

i) Allowing individuals who have not been approved by the Agency to provide training;

j) Not notifying the Agency of individuals who are providing training that the Trainer knows are not approved by the Agency;

k) Allowing individuals to train who have previously had their approval revoked;

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65G-7.003(9) – Medication Administration Trainer Requirements, continued

l) Providing training while not licensed or authorized to practice nursing by the State of Florida, or after the license or authorization has been revoked or otherwise acted upon by the State of Florida;

m) Not notifying the local Regional Office in a region where their course is provided of all scheduled courses, including place, date, and time;

n) Sharing the course exams with anyone not participating in the course in any form, including on the internet, or to a student prior to the student taking the exam;

o) Giving training that doesn't meet the standards in Rule 65G-7.0033;

p) Failure to provide validation by simulation of otic, transdermal, and topical routes during the course, unless the course is web-based, and the Validating Trainer will provide the validation.

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65G-7.003 – Medication Administration Trainer Requirements, continued

(10) Training Certificates – describes the certificates Trainers will receive when they finish this training course or the Annual Update Training, including issuing a Trainer Number. Trainers must maintain these certificates for Agency review, on request.

This section also describes the training and validation certificates Trainers will issue to MAP applicants, and the certificate for MAPs who complete PEFA training successfully.

For both of these, if the Trainer fills the forms out *completely*, they will meet the requirements.

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65G-7.0033 – Medication Administration Training Course Curriculum Requirements

The Agency provides the Training Curriculum for the Basic Medication Administration Course and for the Prescribed Enteral Formula Administration Course.

Basic Medication Administration Courses shall:
1. Not be less than 6-hours in length;
2. Have no more than 20 students per class;
3. Use the exams provided by the Agency.

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65G-7.0033 – Medication Administration Training Course Curriculum Requirements

The Basic Medication Administration Course Curriculum covers:
1. Safe storage, handling, and disposal of medications;
2. Understanding medication instructions;
3. Medical indications and purposes of commonly used medications;
4. Common side effects;
5. Symptoms of adverse reactions;
6. Proper administration of medications, including all of the routes listed here

a. Oral;
b. Enteral (medications ONLY – not feeding);
c. Transdermal; ***
d. Ophthalmic;
e. Otic; ***
f. Rectal;
g. Inhaled (nasal, nebulizers, inhalers); and
h. Topical ***

*** includes validation by simulation

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65G-7.0033 – Medication Administration Training Course Curriculum Requirements

The Basic Medication Administration Course Curriculum covers:

7. Safety and sanitation while giving medications;
8. Documentation and recordkeeping of medication administration;
9. Medication errors and error reporting;
10. Other documentation requirements, including Authorizations and Consents;
11. Off-site medication procedures; and
12. Validation requirements.

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65G-7.0033 – Medication Administration Training Course Curriculum Requirements

Web based course requirements – There are extra requirements for providing the course via web-based distance learning – please review 65G-7.0033(c).

These requirements concern interactivity between Trainer and student, monitoring student comprehension, verifying course hours spent by student, monitoring enrollment, participation and completion – and several other items.

Any Trainer wishing to provide the course in a web-based format should contact their Regional MCM for a full discussion of what is required.

**Web-based training may not be used for Prescribed Enteral Formula Administration training.

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65G-7.0033 – Medication Administration Training Course Curriculum Requirements

Prescribed Enteral Formula Administration (PEFA) Training must:

1. Be not less than 2 hours in length, and include lecture, demonstration and return-demonstration

2. Be limited to 6 participants per class

3. Utilize the curriculum and the tests provided by the Agency

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65G-7.0035 – Validation Trainer Requirements

1) Must be approved by APD as a Validation Trainer – must indicate whether they will validate for PEFA

2) Must be an APRN, RN, LPN, or physician licensed or authorized to practice in FL

3) Apply on the "Validation Trainer Application Form" and complete the Validation Requirements Overview with the Regional Office MCM. The application is not complete until the MCM indicates on the form that the overview has been successfully completed

4) Approved Medication Administration Trainers may provide Validation Training without attending the overview – but they must abide by all other requirements of the Rule.

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Validation by Simulation

• Validation for simulated routes (otic, transdermal, topical) never expires (with *one* exception).

   • Any MAP validated by simulation does not have to seek revalidation for those routes – it is a permanent validation (with one exception).

   • Any MAP who has a current validation for otic, transdermal, and topical does not have to seek revalidation for those routes (with one exception).

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More on Validation:

The exception to permanent validation of otic, transdermal, and topical routes:

If the MAP loses validation for their *Primary Route* (either oral or enteral) then they lose ALL of their validations, even the permanent ones achieved by simulation, or those not expired.

This usually happens when the MAP is not revalidated by their 'validation effective date,' although a MAP might lose validation via a corrective action of some sort.

The 'Validation Effective Date' is the date a MAP first validates for their ***primary route***. This date is used to determine if a lapse in validation has occurred. The validation will expire annually on that date if not revalidated for the primary route.

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More on Validation

Validations for all other non-primary, non-simulated routes expire one year from the date they were last validated.

These routes are inhaled (nasal, inhalers, nebulizers), rectal, ophthalmic, and *either* oral or enteral – whichever is NOT the primary route.

If validation for one of these routes expires, the MAP may not give medications by that route until successfully revalidated.

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Routes of Medication Administration – a Summary

Route	How Validated	When Validated *unless Primary Route lapses
Oral **	Actual client/actual medication	Annually, by validation effective date (if primary route)
Enteral (gastric tube) **	Actual client/actual medication	One year from date last validated* (if not primary route)
Otic (ear)	Simulation	Once, by simulation*
Ophthalmic (eye)	Actual client/actual medication	One year from date last validated*
Topical (skin)	Simulation	Once, by simulation*
Transdermal (patches)	Simulation	Once, by simulation*
Inhaled (nose drops/sprays, inhalers, nebulizers)	Actual client/actual medication	One year from date last validated*
Rectal	Actual client/actual medication	One year from date last validated*

** **Either** one of these may be the primary route, but not **both.**

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Here is the top section of the Basic Medication Administration Validation Certificate

write in: Date of Annual Update: (if applicable)

The **blue** arrow points to the Primary Route box, and the Oral route is circled. The **Validation Trainer** will initial and date each route as it is validated.

The **green** arrow points to the One-time validation by simulation box, for the otic, transdermal, and topical routes. The **Basic Medication Administration Trainer** initials/dates these spaces after the MAP successfully validates by simulation during the class **and passes the class**.

Note that the one-time, simulated routes may have been validated outside of a class – this is ok. If the person is already validated for a one-time route, the date may be 'brought forward' from the previous validation certificate.

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An Explanation of Dates on the Validation Certificate

Primary Route Validation Date = the date the *current* Primary Route Validation takes place. "Today."

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An Explanation of Dates on the Validation Certificate

Validation Effective Date = the date that the MAP *first* validated for their primary route. ★★

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An Explanation of Dates on the Validation Certificate

Validation Expiration Date = the same day and month as the Validation Effective Date, *next year*.

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This is most of the lower section of the Basic Medication Administration Validation Certificate

The Validation Trainer that validates the Primary Route initially **and** annually must also validate the skills in this box.

Subsequent route validations may be needed from trainers that are not the trainer that signed in the spot at the top of the certificate. Rows have been provided in this box at the bottom of the page for these trainers.

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Filling out the Validation Certificate

You will be filling out much of this certificate for each student who passes your training course

Fill out the top of the certificate for a fictional student. Pretend that you are the Medication Administration Trainer only, and fill in the appropriate parts

Then, once the MCM has checked your work, fill out the rest of the form, assuming the student's primary route is oral, and they also validate on inhalers and ophthalmic on the same day.

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65G-7.004 – Medication Assistance Provider Training and Validation Requirements

An unlicensed direct service provider shall not give medications or supervise self-administration of medications - unless they have successfully completed the Basic Medication Administration Training Course and obtained validation for any routes by which they give medications.

The same is true of administering Prescribed Enteral Formulas – they must take the training course and obtain validation.

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How do I become Medication Assistance Provider (MAP)?

Steps to becoming a MAP:

1. Take the Basic Medication Administration Training (this course), including passing validation for otic, transdermal, topical by simulation
2. Take the test, and pass – receive certificate
3. In an on-site setting with actual clients and their medications, successfully demonstrate your skills with a Validation Trainer – receive certificate

Annual Requirements:

1. Take the Basic Medication Administration Annual Update, pass, get certificate – on-line, or in Update provided by APD Regional Office
2. Revalidate with a Validation Trainer – receive certificate

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65G-7.004(7) – MAP Training and Validation Requirements – *Temporary Validation*

• Temporary Validation – allows for a 30-day validation for a MAP under certain circumstances, to make sure a client's new medication is started timely

• May be provided by anyone who *could* provide validation, but has not signed up with APD and received training from an MCM

• May NOT be used to validate Prescribed Enteral Formula Administration

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Temporary Validations are *time and route limited*
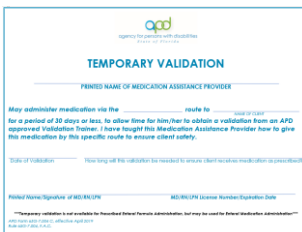
• MAP must seek validation from an APD approved trainer as soon as possible
• Temporary Validation may not be used for Prescribed Enteral Formula Administration
• Temporary Validation is only good for:
  – One route
  – One client
  – No longer than 30 days

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65G-7.005 – Medication Administration Procedures

This Rule is covered in the Basic Medication Administration Training Course, and in the PEFA training course. It covers what MAPs and licensed healthcare practitioners must do when administering medications, and also what they may not do.

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65G-7.005 – Medication Administration Procedures

There are several items to discuss briefly – you will need to be prepared to explain these to students:
- It is ok to use stock bottles of OTC medications for common medications used by clients, but MAPs may not give OTC medications unless they have an order to do so.
- New, or changed orders for a specific medication override the current order for that medication – an order to discontinue the previous order isn't necessary. Example – dose changes, number of times given per day
- Time-limited orders don't need a d/c order at the end of the time allotted
- Prepare medications for one client at a time, at the time the medication is given (NO pre-pouring of medications)

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65G-7.005 – Medication Administration Procedures

More items to discuss briefly:
- When a client returns from an inpatient stay, the client's PCP must be called *within 24 hours* to reconcile the client's medications with any ordered with discharge from the inpatient stay. Document the call, and the response, or lack of response, and all subsequent attempts to contact. Remember that if no licensed person is there to take a telephone order, the PCP must fax or send electronically
- Always check to make sure a client actually swallowed their oral medication before leaving the client and documenting on the MAR
- The back of the MAR is used to document the reason medications are not given, and the reason PRNs are given, as well as the *result* of the PRN

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65G-7.005 – Medication Administration Procedures

More items to discuss briefly:
- EpiPens may be used by MAPs in an emergency. They are briefly covered in the curriculum, and there is a poster on their use in the appendix to the written curriculum
- A MAP that is not validated for the rectal route may give a rectal gel for seizures in an emergency
- MAPs may not give insulin, but they may test blood sugar if the test is not associated with the administration of insulin
- MAPs may not insert vaginal medications. Topical medications may be applied to the skin external to the vagina
- MAPs may not give medications into a tracheostomy, irrigate or dress full thickness wounds, or debride necrotic tissue

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65G-7.005 – Medication Administration Procedures

More items to discuss briefly:
- If it is easier for a client to swallow whole pills when they are given in a thicker substance like applesauce, ice cream, or pudding it is fine for the MAP to give them that way – no order needed
- If the client needs the medications crushed or dissolved in some other substance in order to take them, an order is needed from the doctor
- MAPs may break *scored* pills if needed, and put the remaining half back in the pill bottle or blister for later use
- MAPs may not assist a client to fill a pill organizer (pill minder, pill box), give medications or supervise self-administration of medications from a pill organizer

62

PRN Medications Require *Parameters*

Parameters = a set of facts which describe and limit how something should be done

The health care practitioner must give written parameters for PRN medications – a prescription or order which has the following information:
- The name of the medication
- The exact prescribed dose (not "give 1-2 tablets" or "give 2-3 puffs")
- The specific time intervals for giving the medication (not "every 4-6 hours")
- Which administration route the medication is given by
- Specific directions for use, including:
  – The medical reason (symptoms) for the medication
  – The maximum number of doses per day
  – The maximum number of days the medication should be given
  – Any conditions under which the prescriber should be notified

63

65G-7.006 – Medication Errors

Medication Errors are extensively covered in the Basic Medication Administration Training Course.

When teaching Medications Errors, it is important to thoroughly discuss:

- What constitutes a medication error
- What to do immediately following a medication error
- How to document a medication error

BUT – most important is PREVENTION of medication errors!!

64

The APD Medication Error Report

65

Filling out the Medication Error Report – Page 1

1. Discovery type: If a MAP or their supervisor is writing, check "Provider Reported." This is what you will use, unless APD or some other agency discovers your error after-the-fact.
2. Indicate the date you write the report.
3. Enter the Agency/Provider name (ABC Group Home) and address and check what type of provider you are.
4. Enter your name and title, and sign.

Fill out this form completely. Don't leave blanks. If something doesn't apply, write "N/A."

66

Filling out the Medication Error Report – Page 1

5. Add the names of ALL staff involved, their title, and check whether they were validated or not.

6. If the error was made by an RN or an LPN, you must check 'yes' and enter the name of the nurse. Otherwise, check 'no.'

7. Enter the date the error happened

8. Give name of medication, dose, time given, and how many total doses were involved.

9. Check if any of these were controlled substances.

Name of all Staff Members Involved (use additional pages if needed):
Name: _____ Title: _____ Medication Validated? Yes ☐ No ☐ **5**
Name: _____ Title: _____ Medication Validated? Yes ☐ No ☐
Name: _____ Title: _____ Medication Validated? Yes ☐ No ☐
Error Made by RN or LPN? Yes ☐ No ☐ IF Yes, Name of Nurse _____ **6**

ALL MEDICATIONS INVOLVED IN ERROR MUST BE LISTED. USE ADDITIONAL PAGES IF NEEDED.
Describe all errors involving times in description of incident.

DATE OF ERROR: _____ **7**

Name of Medication: _____ Dose: ____ Time Given: ____ **Total doses involved:** ____
Name of Medication: _____ Dose: ____ Time Given: ____ **Total doses involved:** ____ **8**
Name of Medication: _____ Dose: ____ Time Given: ____ **Total doses involved:** ____

ARE ANY OF THE MEDICATIONS LISTED CONTROLLED SUBSTANCES: YES ☐ NO ☐ **9**

If the error was made over more than one day, enter the range, for example: 7/14/19 - 8/5/19.
If there are more than 3 staff involved, attach a sheet with their names, titles, and validation status listed.
If there are more than 3 medications involved, attach a sheet with a list of the medications, doses, times given, and total doses for each medication.

67

Filling out the Medication Error Report – Page 1

10 ☐ **Wrong Medication Given***
☐ Administration of medication for any symptom, illness, or reason For which it was not prescribed (wrong reason = wrong medication)
☐ Administration of medication for which there is no current prescription or MD order

☐ **Wrong Dose of Medication Given***
☐ Administration of an incorrect dose of medication
☐ Administration of more than one dose of the same medication in a scheduled time period

☐ **Medication Given to the Wrong Person*** (Administration of medication prescribed for someone else)

☐ **Medication Not Given at the Right Time***

☐ **Wrong Route***

☐ **Medication Administration Record Not Immediately and Accurately Documented**

☐ **Medication given by staff not validated per 65G–7.004** **11**

Type of Medication Error Involved: Please select the option that best fits the type of error. If you select "Other", please explain

☐ Shift to Shift Count on Controlled Medication Not Accurate
☐ **Other error** (except not given)
☐ Administration of expired or improperly labeled Medication

☐ **Medication Not Given*** (select reason not given below)
☐ Client refused medication ☐ Legal Rep. refused for client
☐ Failed to give
☐ Medication not available (select reason not available below)
☐ New order not initiated within 24 hours
☐ Refill not ordered timely
☐ Insurance Issue
☐ Pharmacy Issue
☐ Family Error (Explain)
☐ Other not given reason (Explain)

* Error type starred above must be reported to healthcare practitioner

10. Type of medication error – select the option that best fits. Many of the options have boxes underneath to further narrow down what type of error it is. If you choose 'other,' you must explain on page 2.

11. Note the black *'s – they remind you what must be reported to the healthcare practitioner.

68

Filling out the Medication Error Report – Page 2

Did medication error result in MD or ER Visit or Hospitalization? Yes ☐ No ☐ IF Yes, include explanation in description below
Description of Incident and Immediate Action or Intervention (Include any medical care required): **WHO WHAT WHEN WHY HOW**
_____ **10**

If medical care required, please describe care and current status of individual
_____ **11**

Notification: **12**
☐ Physician, PA, or APRN Name: _____ (Must be notified for errors starred above)
☐ Family/Legal Rep. ☐ Support Coordinator Name: _____ (Must be notified)
☐ Abuse Registry ☐ Agency for Persons with Disabilities ☐ Other-List: _____

10. If the client was taken to the healthcare practitioner or had to go to the ER or was hospitalized, check yes, and include an explanation in the "Description of Incident." Also explain any 'other' entries from page 1 in this box.

11. If the client received more medical care, describe here. Also describe the current condition of individual.

12. Check who you notified.

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23

Filling out the Medication Error Report – Page 2

This section is completed by your supervisor.

It tells APD what the supervisor did, or plans to do, to prevent an error like this from happening again.

This is one of the most important parts of Medication Error reporting. Understanding the causes of errors, and fixing those causes, is the key to preventing future errors.

70

Filling out the Medication Error Report – Page 3

The last page of the report is filled out by the APD Medical Case Manager.

Here, the MCM indicates what follow-up they require – it may be different than what the supervisor wanted to do.

The MCM will write down who is expected to be trained, and by what time the training should be completed. They will list any other actions they want the supervisor to take.

The form is then sent back to the supervisor, with the expectation that the recommendations will be carried out, and the MCM notified when they are done.

71

65G-7.007 – Storage Requirements

A residential facility or supported living client who self-administers medications without supervision may store his or her medications in a secure, locked place in his or her room.

This client's medications may also be centrally stored and retrieved by staff if needed. There are several reasons for this listed in this Rule, all have health and safety implications.

- The keys to locked medication storage must be kept securely by either MAPs or nurses
- Controlled medications are double locked separately from other medications and counted each shift
- Each client's medications are kept separate from other client's medications
- Medications must be kept in their original packages that are provided by the pharmacy, or purchased, in the case of OTC medications
- Sample medications must be labelled by the health care practitioner that gives them to the client (a bag with multiple packs of the same medication labelled on the outside is sufficient)

72

24

This is the Controlled Medication Count form.

When a controlled medication is received, the top of the form is filled out, including the initial number received, and the initials of the MAP(s) or nurse(s) who verify the amount is correct.

Each supply of a controlled medication gets a new count sheet.

Each time medication is used, a line is filled out on the sheet. At the end of the shift, two MAPs (or nurses) count and initial to verify the accuracy of the last entry in the highlighted "number remaining" column.

MAPs (and nurses) sign and initial at the bottom to identify their initials in the columns above.

Remember! ALL controlled medications present must be counted! This includes medications that have been discontinued, but are still stored in the facility awaiting destruction, or a new monthly supply that has not been put in use yet.

All controlled medications must be double-locked, whether they are in use or not.

73

How to use the Controlled Medication Count

When medication is first received – fill out the top of the sheet and verify the count.

Each time medication is given, fill in one line to identify who administered, number on hand, number given, number remaining.

At the end of each shift (or daily count for facilities without shifts or only one MAP), the medication is counted to verify that the amount in the "number remaining" column is correct. In a facility with shifts, one MAP or nurse from each shift initials together that they have verified the count (if a daily count, one MAP or nurse initials), and enters the date and time of the count. **NOTE** that the yellow box is not filled out each time the medication is given – but when the medication is counted.

74

Practice documenting on the Controlled Medication Count

Enter a medication that you would give several times a day – document each dose and the count at the end of the shift

Show how you would document on the Controlled Medication Count if you did not have a change of shifts, and were the only MAP or licensed professional available to count

75

65G-7.008 – Documentation and Record Keeping

This Rule covers the Medication Administration Record – the MAR, as it is commonly known. It describes how the MAR should be filled out, in detail.

It also tells us that each client record must have certain medication documentation that is recorded in a way that effectively communicates to Agency staff and other health care providers, and that the documentation must be *readily available* to the MAP or health care practitioner and for Agency review, on request.

65G-7.008 – Documentation and Record Keeping

The next set of slides is from the Medication Administration Training course you will be teaching.

It is important that you, the Trainer, understand how the MAR is to be filled out, as there are two different class activities in the curriculum that have your students using MARs. This is practice for the MAR section of the exam, which will have two MAR questions to answer on two MAR forms.

When teaching the course, bring a sufficient supply of MAR documents for student practice.
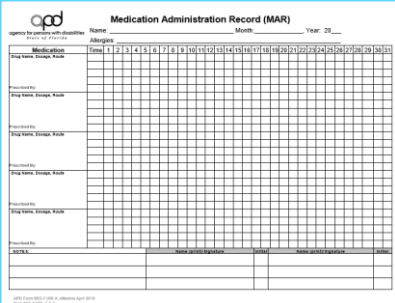
Medication Administration Record (MAR)

This is the front of the APD MAR.

Often, you will use a different MAR provided by a pharmacy, or perhaps you will use a MAR that is provided electronically, on a computer. All MARs used for APD clients must contain the same elements as the APD MAR.

No matter which MAR you use, the goal is to accurately document the medications you give.

Documentation on the MAR

Required information:
1. Client's name (on both sides, if MAR has more than one side).
2. Allergies to food or medication.
3. Name of each medication prescribed for the client.
4. Prescribed dose for each medication – for example, 30mg, or 2000 units.
5. Strength of the medication – for example, 15mg per 5ml, or 360mg per tablet.
6. The name of the health care practitioner who prescribed the medication.
7. The date the medication was ordered, changed, or discontinued.
8. Scheduled time of administration for each medication.
9. Route by which the medication is to be given.
10. Prescribed instructions for crushing, mixing, or diluting the medication, if needed.
11. Date each medication was given.
12. Initials and signature of each MAP (or licensed health care professional) that gave or supervised the client's self-administration of medication at the bottom, with initials in the square for the date, time, and medication given.

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Medication Administration Record (MAR)

This is the back of the APD MAR.

Be sure to write the name of the client at the top!

On this side of the MAR, you will document scheduled medications that are not given, and information about PRN (as needed) medications – why they were given, what the response was to them.

It is acceptable to attach more than one 'back' of the MAR to one front.

80

Documentation on the MAR

A record of any *missed* medications is also required. The MAP must:
1. Initial and circle the correct square on the MAR for each missed medication.
2. Write the reason the medication was not taken on the back of the MAR. These might include:
   * Refused – when the client won't take the medication.
   * At work, or ADT – the client is at their regular day-time activity.
   * Home with family.
   * ER/Hospital – client is in a medical facility
   * Not given – requires an explanation: Not available -- **why**? Held by MD -- **explain**. Problem with pharmacy -- **what was the problem?** Refill not ordered timely -- **explain.**
   There are many other reasons a medication might not be given – write what it was in the space provided.

81

Documentation on the MAR

And finally – also on the back of the MAR, the MAP must:

1. Indicate why any PRN (as needed) medications were given, and if they helped:
   1) What symptoms did the client have? Fever? Cough? Anxiety?
   2) Remember that you may only give PRNs for the reason they are prescribed.
   3) Come back later (30 minutes to 1 hour) and document the client's response to the medication. Was the fever reduced, what is their temperature now? Still coughing, or not? Anxiety relieved?

2. Document the client's response to a new medication, including PRN medication:
   1) For the first 3 doses of a new medication, observe the client after giving it for at least 20 minutes to detect potential side effects. The documentation must include any adverse reactions, but also must include the lack of adverse reactions.

3. Document anything else concerning a client and their medication administration that is out-of-the-ordinary.

82

Changing an order on the MAR

1. When a client's medication order is changed or discontinued, you DO NOT change the original entry on the MAR. The original entry is marked 'changed' or 'discontinued' with date and time, initialed, and highlighted in yellow over the entire row. The new order is written on a new line. This is demonstrated on the next slide.

2. In the examples shown in the next slide, the new medication order takes a medication (Warfarin) that was originally ordered at 2.5mg by mouth daily, and changes it to reorder Warfarin at 2.5mg by mouth each morning on Monday, Wednesday, Friday and Sunday, and at 5mg by mouth each morning on Tuesday, Thursday, and Saturday.

3. Another order discontinues the client's Metoprolol completely.

4. Notice how the parts of the grid that will not be used are dealt with. You do not want to obscure the grid, but you must make it clear which days each dose is given. This particular medication is often ordered this way, but there are others that are given every other day, or once a week that you would treat similarly.

83

Medication changed on 7/15/19, after AM dose given. Row highlighted in yellow, 'changed,' date, initials written across days medication won't be given.

Medication discontinued on 7/24/19, after AM dose given. Row highlighted in yellow, 'discontinued,' date and initials written across days medication won't be given.

New order, with different doses on different days of the week entered, beginning on the 16th. Arrow drawn across earlier cells to indicate not started. Horizontal line drawn across each day the medication is not to be given.

84

28

Time-limited orders on the MAR

- Many medications are given for only a short time – the most common of these is antibiotics, but there are others as well.
- A time-limited order does NOT need another order to discontinue the medication. The order to discontinue is contained in the original order.
- You might see orders like these, demonstrated on the next slide:
  - Amoxicillin 250mg by mouth 3 times daily for seven days for bronchitis.
  - Vitamin D 50,000 units by mouth once weekly for 4 weeks.
  - Sulfamethoxazole and Trimethoprim Oral Suspension, 200mg:40mg/5ml, 20ml every 12 hours by mouth for 14 days for urinary tract infection.
  - Ciprodex ear drops 3 drops to the right ear daily for five days for middle ear infection.

85

These are all examples of medications ordered for only a limited time.

Note that none of the spaces on the MAR are blocked out so that they cannot be seen.

You should use black ink on the MAR – the arrows were drawn in blue for emphasis.

If an error is made, line through, write "error" and initial.
Never use white-out or completely blacken any part of the MAR!

86

This is what the back of the previous MAR should look like. Only the first two medications are shown, but similar documentation would be done for the other two.

You can see that the entire back of the MAR might quickly get filled, especially if there were also some PRN medications.

This is when you would staple another 'back' onto the MAR, stapling it only to one end so that you can flip back to previous sheets for information.

87

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Medications that are documented on BOTH sides of the MAR

PRN medication orders must include the name of the medication, the prescribed dose, specific directions for use - reason, how often to give, maximum doses in a specified time period, and what conditions to call the doctor for. Documentation includes why the medication was given, and the response to the medication

Missed doses of medication require documentation on both sides of the MAR. On the front, the space is initialed as usual, and then circled

Initial, then circle to indicate a missed dose.

PRN medications

88

This is part of the back of the MAR we just looked at.

The time MUST be documented on the back – it is optional on the front.

Note how the PRN medication comments say *why* the medication was given, and then tell us what the *result* of taking the medication was. These comments are required. If the medicine did not make the symptoms better, that also must be written down.

Medications that are not given must also have a comment that explains why the client did not take the medication. **These comments explain what is being done about the reason the medication was not taken. This is ideal.**

89

As a group, practice entering medications on the MAR, and documenting medication administration

Make up and enter orders for:
• Medications with limited time orders
• Changed orders for the same medication
• PRN orders
• Missed medications

Remember to document on the back of the MAR as appropriate, and sign and initial where needed

90

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65G-7.009 - Off-Site Custody of Medications

This is the Off-Site Custody of Medications form.

Fill it out completely, including the provider contact person and physician telephone numbers.

Go over the medications with the responsible party, count, and sign the form – make a copy for the person accompanying the client.

Count and sign again with the responsible party when the client returns.

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BREAK TIME

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Teaching the Basic Medication Administration Training Course

Basic Medication Administration Training

Ron DeSantis
Governor

Barbara Palmer
APD Director

93

This training provides guidelines:

For unlicensed direct care staff serving clients with

developmental disabilities in group homes, adult day

programs, foster and family homes, independent and

supported living, and any other place that clients receive

APD services.

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Guidelines include:

1. When supervision of self-administration of medication by unlicensed direct care staff is appropriate.
2. Rules and instructions for supervising the self-administration of medication.
3. When administration of medication by unlicensed direct care staff is appropriate.
4. Rules and instructions for administering medication.
5. How to safely administer medications by the oral, enteral, topical, transdermal, rectal, inhaled, ophthalmic, and otic routes of administration.
6. How to handle medications safely.
7. How to prevent medication errors.
8. When and how to report any concerns or errors.

95

Course Objectives

1. Understand the requirements for validation.

2. Demonstrate the ability to accurately complete and maintain all forms required.

3. Understand the rules for Authorization for Medication Administration and for Informed Consent for Medication Administration.

4. State, and demonstrate the 'rights' of medication administration.

5. Discuss and demonstrate correct supervision of self-administration of medications.

6. Demonstrate the ability to look up information on commonly used medications.

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Course Objectives, continued

7. Demonstrate understanding of medication instructions by:
   a. Reading and following instructions on a prescription label or health care practitioner's order
   b. Accurately transcribing prescriptions or orders to the MAR (medication administration record).
   c. Correctly documenting on the MAR when medications are given or missed.
8. Understand the requirements for giving PRN (as needed) medications.
9. Demonstrate understanding of safety and sanitation procedures.
10. Demonstrate understanding of proper positioning of clients for medication administration.

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Course Objectives, continued

11. Demonstrate the correct preparation and administration of medication by oral, enteral, topical, transdermal, ophthalmic, otic, rectal, and inhaled routes.
12. Understand the steps to take if a medication error is made.
13. Understand the rules for storage of different medication types, including prescription, controlled, over-the-counter.
14. Demonstrate the proper disposal of expired or discontinued medications.
15. Understand the steps to follow when medications go off-site with the client.
16. Validate medication administration skills by simulation for the otic, transdermal, and topical routes of medication administration.

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Elements of the Basic Medication Administration Training Course

When you successfully complete this course, your Regional MCM will supply you with the following items via e-mail:
1. Basic Medication Administration Training PowerPoint, consisting of 187 slides
2. Basic Medication Administration Training written curriculum – a Trainer version and a student version
   a. The Trainer version includes a supply list, and instructions for the class activities
   b. Both versions contain forms, sample medication orders, 65G-7 and F.S. 393.506
3. Two sets of MAR exams, and two different multiple-choice exams
4. Handout of the PowerPoint in notes format (3-to-a-page) to give students
5. Certificate of Completion, with APD watermark, and the Validation Certificate

99

Supplies and equipment needed to teach the Basic Medication Administration Training Course

A projector to project the presentation onto the screen or the wall. These come in many sizes and styles – some are not much bigger than your cell phone!

Usually you will use the wall to project on – if a suitable wall is not available, you may need to buy a screen at the office supply store, or borrow one
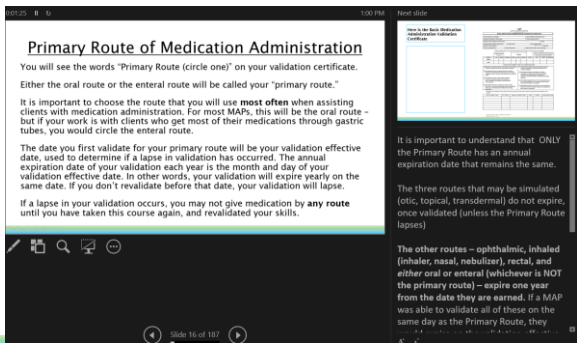

100

Using PowerPoint
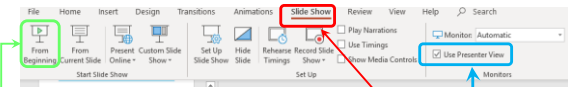
When you are ready to use the PowerPoint, click on the Slide Show tab at the top of your screen

Make sure that you click the box for Use Presenter View

Click From Beginning to start your presentation

101

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Using PowerPoint

The curriculum has some 'animations' in it.

What is happening now on the screen is an example of animations – used to concentrate on one idea at a time, keep students interested, and add a sense of movement to the presentation.

You will control this from the presenter screen, but it generally only takes a click to get it all moving along.

Why are they pointing at me?
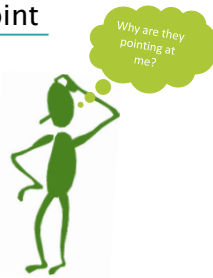
103
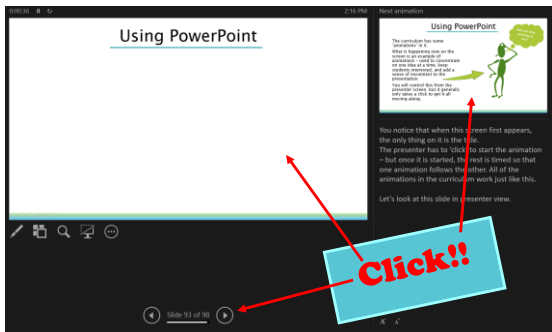
104

When the presenter clicks once, the first sentence shows up. After a wait of a few seconds, the rest of the words and pictures follow. With practice, you will learn to speak with the timing of the animations.
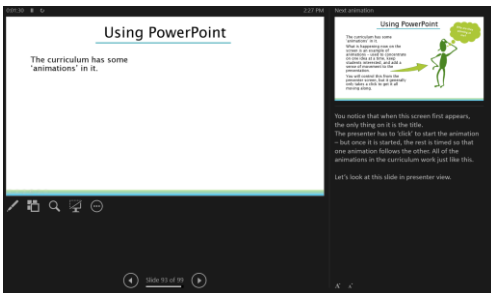
105

Here is the same slide when all the animations are finished. Notice that the upper right hand corner now shows the next slide, but the presenter notes for this slide are still here. A click will advance the slide.
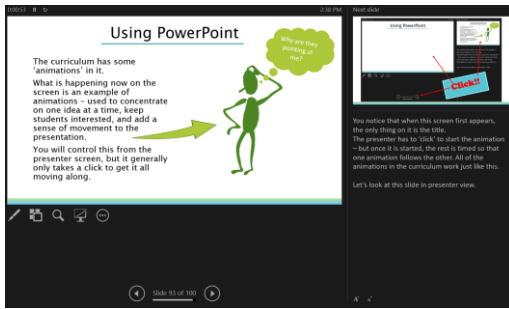
106

Metered Dose Inhalers -- Step-by-Step

If giving more than one type of inhaler, make sure you know the proper order to give them in!

1. Remove the cap from the mouthpiece.
2. Ensure the mouthpiece is clean.
3. Shake the inhaler.
4. Have client sit up straight and tilt their head back slightly.
5. Ask the client to breathe out.
6. Place the mouthpiece between lips and ask client to close their lips.
7. Spacers may be used if the client can't close their lips around the mouthpiece – open mouth technique should be last resort.
8. Ask the client to breathe in slowly as you push down on the inhaler canister.
9. Have the client hold their breath with their mouth closed for a few seconds as you remove the inhaler.
10. Then, ask the client to breathe out.
11. If a second puff is ordered, wait at least one minute – two minutes is better.
12. Rinse mouthpiece (or spacer), replace cap.
13. Ask the client to rinse their mouth.

107

What it looks like before any clicks

Notice that there are a lot of presenter notes not visible – you will have to scroll to see them all

108

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There are 5 Class Activities

Activities provide a good break from the PowerPoint, and help the students to reinforce what they've been learning

Each activity is provided in the student version of the printed curriculum, in Appendix 2. The Trainer version includes discussion points for each scenario

111

Class Activities

Activity One – MAP validation and training:
- Break class into small groups – there are 3 scenarios – depending on the size of your class, you may need to use a scenario for more than one group
- Assign each group a scenario, allow time for discussion
- One presenter for each group presents the scenario to the class – class should discuss

These scenarios discuss validation and training for MAPs, the use of temporary validations, MAP training, annual updates, and validation by simulation

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Class Activities

Activity Two – levels of assistance:
- Break class into small groups – there are 6 scenarios – depending on the size of your class, you may need to give groups more than one scenario
- Assign each group a scenario, allow time for discussion
- One presenter for each group presents the scenario to the class – class should discuss

These scenarios discuss the different levels of assistance clients may need and ask the students to decide which would be the most appropriate level for different situations. You did an activity like this earlier today.

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Class Activities

Activity Three – practicing medication administration:
- Pair up students and role play, with one person acting as the MAP, and the other as the client, and then switching places.
- Have MARs available, along with labelled medication containers and supplies.
- All regularly scheduled medications should be "given" and documented correctly.
- Also practice how the MAP should 'supervise' the same route of medication for clients who self administer with supervision.
- All PRNs should be 'given' and documented correctly.
- Students may have to decide when a medication starts and stops.
- We will go into more depth on MARs in the next section – this is a good spot to help students identify what they might not understand.
- You are encouraged to make up more scenarios to use if you wish.

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Class Activities

Activity Four – Practicing MAR documentation

• Remind students that they must get MARs 100% correct on the exam!

• Hand out MAR sheets (printed front and back), highlighters, and pens

• Have students work on documenting the different scenarios – this is an individual activity, and all students should try as many as there is time for

• There are some redacted real prescriptions of different types in the packets. There are several different 'looks' to these. Have students transfer some of these to the MAR. They should also check to be sure the prescription can be used as is. Do any of them need more information to be appropriate for use?

115

Class Activities

Activity Five – putting it all together

This is an activity designed to get students thinking about clients and medication administration on a more comprehensive level – to help them to see the whole picture

Discuss this one as a class, encourage students to come up with other situations that might happen with the client, and discuss what could be done

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Supplies for Training

The last page of the Trainer version of the written curriculum is a Suggested Supply list. Among the items on that list, you will find:

1. Sign-in sheets
2. Yellow highlighter for each student
3. Pens/Pencils
4. Student version of the written curriculum (includes the Statute and the Rule as well as most forms), and a copy of the PowerPoint printed in 3-per-page format for each student
5. Extra copies of MARs
6. Supplies for teaching the different routes of medication administration
7. Hand sanitizer
8. Basic Medication Administration Training and Validation Certificates

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Supplies for teaching Medication Routes

Medication Containers with Labels (no actual med contents)

For oral – liquids and pills in bottles, blister packs, unit doses
- Samples of tablets, caplets, capsules, gel caps, powders, syrups, etc – either pictures or actual OTC medications (not prescriptions). Examples of scored and enteric coated are helpful

Medication cups

Eye medications

Ear medications

Nose spray/drops

Dry powder inhaler

Metered dose inhaler (with spacer)

Nebulizer with sample vial of meds

Topical medications:
- Creams, lotions, ointments, powders, shampoos, sprays, etc.

Transdermal medication samples – either pictures or actual samples – including transdermal Nitro-bid (not the real medication) with paper applicators

Suppositories

Enema bottle (Fleet's type)

G-tube extension set, G/J tube, mickey button sample

60 cc catheter tip syringe

Large bottle to mimic stomach to practice G-tube medications

Water supply

Pill cutter, pill crusher

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Validation by Simulation

Watching the student give or apply the medication is only part of the validation!

The student must correctly complete the entire medication administration process:
- Compare label-MAR-order
- Know where to find information on the medication
- Hand hygiene before/after
- Gloves if needed
- Give or apply medication correctly
- Return to storage/lock
- Document on MAR – including reason for giving and result if PRN medication

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Validation by Simulation

- Students should perform the step-by-step instructions learned in the sections of the curriculum on otic, transdermal, and topical routes

- They must also perform all of the initial preparation steps and documentation common to all routes of medication administration

- For the otic route, it is not necessary to put drops or ointments in the ear – you may use an empty medication bottle and simulate dropping drops in

- For the transdermal and topical routes, use non-medicated lotions, creams, powders, or sprays – you may use adhesive bandages for transdermal, marked paper and tape for nitro-bid

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APD will provide…

- PowerPoint Curriculum
- Written Curriculum – Trainer and Student versions
- PDF of PowerPoint Handout version
- Class Completion Certificate
- Validation Certificate
- Exams

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The Basic Medication Administration Training Course Exam

- The exam consists of 2 parts
  - Medication Administration Record (MAR) exam – 100% correct required to pass
  - Multiple Choice Exam – 85% correct required to pass
- The exam must be completed within 3 calendar days of class completion.
- A student may retake the exam once, at the discretion of the Trainer – but it must be within the allotted 3 calendar days. The Trainer must give different versions of the exam at any re-take.
- There will be multiple exams, and multiple MAR exams provided randomly by APD.

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The Basic Medication Administration Training Course Exam

The multiple-choice exam has 60 questions. In order to pass this portion of the exam, the student must answer 51 questions (85%) correctly.

The MAR exam contains 2 questions and two MARs. The MARs are partially filled out – the student should make sure they are using the proper MAR for the question! Students should be encouraged to take the MARs slowly – start at the top of the question and work their way down. They should PAY ATTENTION to what has already been filled out – there may be 'clues'. They should remember to put written name, signature, and initials on each side of the MAR at the bottom.

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Basic Medication Administration Training Certificate

- This is the only acceptable certificate for this course.
  - The one online course will have a different certificate, but must include the same information
- Must include the training date.
- Must include the APD Approved Trainer number.
- Must be signed by the Trainer.
- Must include the Trainer's nursing license number and expiration date.

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Practice filling out the Certificate of Completion

Fill out the Certificate of Completion as you would if you had just taught the Medication Administration Training Course

Give it to your instructor to check

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Basic Medication Administration Training

State Law requires that this course be "no less than" 6 hours long.

It is fine if it takes longer than 6 hours.

It is ok to break it into more than one session, as long as the sessions total 6 hours or more.

You should let students know when they sign up whether you will offer them the opportunity to retake the exam one time, if needed, or not.

Remember to provide your Regional MCM with your training schedule!

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THANK YOU FOR TAKING THIS COURSE!

PLEASE CONTACT YOUR REGIONAL MCMs
FOR ANY QUESTIONS THAT YOU HAVE
ABOUT TEACHING THE BASIC MEDICATION
ADMINISTRATION COURSE OR THE
PRESCRIBED ENTERAL FEEDING
ADMINISTRATION COURSE.

apd

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