CHAPTER 2

LESSON TWO

PREPARING FOR SAFE ADMINISTRATION OF MEDICATIONS

OBJECTIVES

2.1 Identify principles of maintaining aseptic conditions.

2.2 Recognize emergencies and other health-threatening conditions and respond accordingly.

2.3 Identify basic concepts of communication with the cognitively impaired client.

2.4 Measure and record vital signs.

2.5 Demonstrate understanding of the use of the International (Military) Time.

2.6 Identify the Five “Rights” of Medication Administration.

PERFORMANCE OBJECTIVES

Upon completion of Chapter Two, student will demonstrate an understanding of the principles of selected topics to prepare for safe administration of medications by completing a written quiz with a minimum score of 80%.

RETURN DEMONSTRATIONS

Perform proper hand washing under the instructor's supervision.

Measure and record oral temperature.

Measure and record an apical pulse.

Measure and record respirations.

Measure and record blood pressure using a sphygmomanometer (BP cuff).

KEY TERMS

- Alzheimer's disease
- Cognitive impairment
- Anxiety
- Communicable disease
- Aphasia
- Communication barrier
- Aseptic
- Contraindicate
- Biohazardous waste
- Cueing
- Blood-borne pathogen
- CVA

- Delirium
- Dementia
- Depression
- Directing
- Disinfect
- Disoriented
- Hypothermia
- ISP
- Pathogen
- Perseveration
- Redirecting
- Standard Precautions

2.1 Identify Principles of Maintaining Aseptic Conditions

INTRODUCTION: A Virginia Board of Nursing prerequisite for becoming a Medication Aide is successful completion of an approved nurse aide program or the forty-hour direct care staff training provided by the Department of Social Services. Therefore, students should have a background in each of the objectives in this chapter and the information should serve as a review.

This review is presented with a focus on issues related to medication administration.

TOPICAL OUTLINE

A.. The Occupational Safety and Health Administration.

1. Known as OSHA, is a government agency responsible for the safety of workers.
2. Has set standards for equipment use when working in facilities.
3. Standard Precautions is one of the OSHA safety guidelines.

a. Pathogens are organisms which cause disease.
b. Standard Precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where healthcare is delivered. These practices are designed to both protect HCP and prevent HCP from spreading infections among patients. Standard Precautions include:

1) hand hygiene,
2) use of personal protective equipment (e.g., gloves, gowns, masks),
3) safe injection practices,
4) safe handling of potentially contaminated equipment or surfaces in the patient environment, and
5) respiratory hygiene/cough etiquette.

(http://www.cdc.gov/HAI/settings/outpatient/outpatient-care-gl- standared-precautions.html)

(Include a handout for students that describes standard precautions)

Standard precautions reduce the chance of contracting disease caused by blood-borne pathogens, which are microorganisms that are found in human blood and cause disease. Blood-borne pathogens are transmitted either through direct contact with blood or indirect contact with something such as needles, blood glucose meters, or other surfaces that blood is on.

The three most common blood-borne pathogens are:

- Hepatitis B virus,
- Hepatitis C virus, and
- HIV (human immunodeficiency virus)

Links:

US Department of Labor OSHA Healthcare Wide Hazards (Lack of) Universal Precautions
http://www.osha.gov/SLTC/etools/hospital/hazards/univprec/univ.html

VDH Standard & Transmission-based Precautions
http://www.vdh.virginia.gov/epidemiology/surveillance/hai/documents/pd

f/StandardTransmissionBasedPrecautionsSign.pdf

4. Residents in assisted living facilities can get an infection from blood-borne pathogens by sharing contaminated needles, sharing contaminated finger-stick devices, or contact with blood from an infected person.

You can get an infection from blood-borne pathogens from accidental puncture wounds from contaminated sharps, devices used to puncture the skin such as needles or finger-stick devices or used to shave a resident, or contact with blood from an infected person.

B. Procedure for Standard Precautions

1. Always wear gloves when in contact with body fluids, or when a possibility of contact with body fluids exist, such as:

- Blood
- Vomit
- Vaginal secretions
- Sputum
- Feces
- Semen
- Urine
- Tears
- Open skin areas

2. Perform appropriate hand hygiene before and after all procedures. When hands are visibly contaminated, wash the hands with soap and water and pat dry. If not visibly contaminated, an alcohol-based hand-rub may be used.

3. If skin is contaminated with blood or body fluid, wash immediately with soap and water. Rinse and pat dry.

4. If assisting a client with insulin injections or blood glucose monitoring, place used needles and lancets into a rigid sharps container.

Never reuse, recap, bend or break needles or lancets.

5. Discard body waste directly into the toilet. Discard waste containing blood into plastic bags, making sure no leaks occur.
6. Discard used gloves into plastic bags for disposal in designated containers.

7. Spills of blood, or body fluid visibly stained with blood, should be cleaned with chlorine bleach or a spill kit and left for several minutes, in accordance with the facilities exposure control plan. Wearing gloves, remove bleach treated spill with disposable wipes. Place in plastic bag. Wash area with detergent and water.

C. Personal Protective Equipment (PPE)

1. Included in Standard Precautions.

2. PPE means Personal Protective Equipment (body protection) to be worn when there is danger of contact with blood or body fluids.

3. Danger is not routine/frequent in assisted living but it is important that staff be aware of the requirements for when PPE should be worn and that staff know where the equipment is stored and how it is used.

4. PPE includes:

a. Masks

b. Gloves

c. Gowns

d. Goggles

D. Employee precautions

1. All employees must have access to protective gloves. For those who are allergic to latex, the employer must provide another type of protective gloves. (vinyl, powder free, hypoallengenic)
2. Should a needle stick occur, follow facility policy to protect employee's & client's health. An incident report must be completed.

In accordance with OSHA regulations, the employee has the right to receive an evaluation and follow-up to assess the need for appropriate post exposure prophylaxis, in addition to other recommended precautions, depending on the situation.

Links:

E. Cleaning and disinfecting storage areas

1. Aseptic means free from disease-causing organisms.

2. It is important to use proper cleaning and disinfecting procedures to maintain aseptic conditions which means free from pathogens.

3.Cleaning removes germs, dirt, and other impurities from surfaces or objects using soap or detergent and water to physically remove germs from surfaces. This does not mean that germs are killed, but rather, by removing them, the amount of germs on a surface are decreased, lowing the risk of spreading infection.

4. Disinfecting kills germs on surfaces or objects by using chemicals that actually kill the germs. Disinfection does not necessarily clean dirty surfaces or remove germs, but by killing germs on a surface after cleaning, it can further lower the risk of spreading infection.

4. Materials, products and supplies used to clean and disinfect storage area, cart, etc. includes:

- Lysol
- Bleach solution (1/4 cup per gallon of water)
- Alcohol
- EPA approved industrial Solution(s)

5. Steps to follow in cleaning and disinfecting storage area, cart, etc. This is important to prevent the spread of disease from surfaces or equipment in the storage area to yourself or patients. Always use approved cleaners and follow label directions on cleaning products and disinfectants.

a. All surfaces, equipment, and other objects should be routinely cleaned and disinfected.

b. Proper PPE should ALWAYS be worn when processing dirty equipment

c. Follow your facility's procedures.

F. Disposing of infectious waste according to Virginia Law

1. Infectious waste is any waste capable of producing an infectious disease in humans or any waste contaminated by an organism capable of producing disease in humans.

2. Items likely to be found at the facility which are considered infectious waste

a. Blood and blood products may be found on:

- Catheters
- Enema tips
- Vials for taking blood (be VERY careful if glass should break).

b. Needles and syringes and blood-testing lancing devices.

c. Bedding-related wastes such as disposal pads.
d. Residue or contaminated water or debris resulting from the cleanup or spill of infectious waste.

G. How infectious waste is packaged and labeled for disposal

1. Infectious wastes should be contained in red, leak-proof plastic bags.

2. Bags are labeled, sealed, and disposed of according to facility procedure.

3. Needles and syringes must be placed in special rigid containers that are leak- proof and puncture-resistant and disposed of according to Virginia law.

4. Do NOT use glass or plastic beverage containers to dispose of needles and syringes.

I. Special considerations for Medication Aides

1. Do not come to work when ill, especially with symptoms of fever, vomiting, diarrhea, cough, sore throat, jaundice (yellow eyes or skin), or other flu-like symptoms. For open skin areas or draining wounds, ensure they are covered and do not perform tasks that could put others at risk.

2. Ensure that you are up to date on all recommended and required immunizations.
3. Residents of ALFs are a vulnerable population and at a higher risk for infection.

4. Symptoms that can put others at risk of becoming infected are:

- common cold symptoms
- diarrhea
- fever / flu
- jaundice (yellow eyes or skin)
- open skin areas
- productive cough or sputum
- sore throat
- vomiting

2.2 Recognize Emergencies and Other Health-Threatening Conditions and Respond Accordingly

INTRODUCTION: Observation of the client is an important step in the cycle of medication administration. Health Care Providers often depend on the observations of direct care staff when evaluating their clients. They also depend on Medication Aides to observe clients for both desired and undesired effects of medication. To insure safe care, the Medication Aide must be taught how to observe and report changes in the patient physically and/or mentally.

She/he must know what to report, to whom it should be reported, and when and how to report observations.

TOPICAL OUTLINE

A. Types of health-threatening conditions which should be reported

1. Life Threatening Emergencies
2. Non-Emergency, but health-threatening, conditions
3. Other significant changes in physical condition or behavior

B. **Causes for emergencies**

1. Injuries
2. Illnesses
3. Complications related to illness or injury
4. Unwanted effects of medication

C. Common emergency conditions

1. Excessive, uncontrollable bleeding (HCP not relieved by prn NTG if needed)
2. Accidents involving severe injury
3. Failure or obstruction of the respiratory system

4. Uncontrollable behavior which is a danger to the client or others
5. Loss of consciousness unrelated to predictable seizure activity

D. Appropriate responses to emergencies

1. When more than one staff member is involved:

a. Call emergency service—911.

b. Check designated emergency number(s).

c. Notify staff member as designated by facility policy.

d. Designated staff member must take charge and give directions.

e. Collect client's medical record for HCP.

f. Return to client to assist as needed.

2. When only one staff member is involved.

a. Call emergency service—911.

b. Provide assistance to client until help arrives.

c. Collect client's medical records for HCP.

d. Appropriate follow-up to emergencies

1. When emergency is under control, inform medical supervisor about the emergency condition.

2. Follow oral report with a written report.

F. Examples of non-emergency, but health-threatening conditions

1. Fever not reduced by normal procedures.
2. Atypical episodes of angry or aggressive behavior.
3. Diarrhea not affected by approved OTC medications.
4. Rash that lasts for several days or appears to get worse.
5. Persistent sore throat.
6. Severe seizure for client with history of mild seizures.

7. Increase in seizure activity.
8. Atypical, withdrawn behavior.
9. Confusion in clients who are not normally confused.
10. Lack of coordination.

G. Appropriate responses to non-emergency but health-threatening conditions

1. Report condition as soon as possible after it is observed.
2. Report condition to HCP.
3. Follow oral report with written report.
4. Continue to observe client for further changes.

H. Other significant changes in client's physical condition or behavior

1. Changes in sleeping patterns.
2. Colds, low fevers, mild diarrhea.
3. Unexplained minor bruises.
4. Slight rash.

I. Appropriate responses to significant changes

1. Report the change as soon as possible after it is observed. 2 Write a description of observation using a facility form. Submit to designate staff member. 3. Continue to observe client.

2.3 Identify Basic Principles of Communicating with the Cognitively Impaired Client

INTRODUCTION: Many clients living in assisted living facilities are cognitively impaired.

The impairment may be a temporary condition or it may be the result of permanent damage to an area of the brain.

While there are general guidelines that apply in all types of communication, there are special skills required for certain kinds of cognitive impairment.

Often a client's willingness to take medication is determined by the approach or attitude of the person offering it.

TOPICAL OUTLINE

A. Basic communication skills

1. Communication happens when there is:

a. a message

b. a sender

c. a receiver

2. If any one of these is missing, communication fails.

3. How to be a good listener

a. Face the client and maintain good eye contact.

b. Give the client your full attention.

While the patient is talking, listen, do not spend the time thinking about what you are going to say or do next.

c. Consider ideas of the client.

d. Use signs and body language to indicate that you are listening.

e. Do NOT assume that the client cannot understand and therefore it is not necessary to make the effort to communicate! This is one of the leading causes of aggressive behavior in the cognitively impaired client.

B. Communication barriers

1. Caregiver barriers

a. Failure to listen (not receiving the client's message).

b. Doing something else while client is trying to communicate.

c. Assuming that the client has nothing of value to say because of cognitive impairment.

2. Cognitive impairment

a. Cognitive impairment is the inability to think, to reason, and/or to remember.

b. This inability is severe enough to interfere with the ability to function.

c. It may be temporary or permanent, depending on the cause.

3. Causes of cognitive impairment - The three "D's"

a. Delirium

- A temporary state of confusion.
- Caused by disease, substances or medications.
- Subsides when cause is removed.

b. Depression

- A prolonged, sad mood state.
- May be caused by chemical imbalance in the brain.
- May be triggered by situation or event.
- Generally subsides or is alleviated with treatment.

c. Dementia-impairment resulting from brain cell destruction caused by:

- Multiple infarct (“mini” strokes)
- Injury
- Alzheimer’s disease: a neurodegenerative disease
- Usually not reversible

4. Other causes of cognitive impairment

a. Physical conditions

- CVA – cerebral vascular accident (brain stroke)
- Brain injury/closed head injuries

b. Mental illness

- Bi-polar disorder
- Obsessive-compulsive disorder

- Schizophrenia

c. Mental Retardation

- Down’s syndrome
- Birth trauma
- Injury

d. Substance abuse

- Alcohol
- Prescription drugs
- Illegal drugs

C. Communicating with the confused and/or disoriented client

1. Do the following:

a. Identify yourself to the client when you greet him.

b. Maintain eye contact.

c. Speak slowly, softly, simply.

d. Use touch if you are sure that it does not upset the client.

e. Repeat as needed.

f. Break tasks into simple steps.

g. Announce when you are leaving the room, twice.

2. Follow the plan of action regarding communication techniques that are effective for each client. This may be called the ISP (Individualized Service Plan) or, in some facilities, the “Action Plan”.
3. Remember that what works for one client may not work for another, be flexible.

D. Communicating with the client with Alzheimer's and other types of dementia

1. Behaviors associated with disease such as Alzheimer' include:

a. Agitation – restless or excited behavior.

b. Anxiety – apprehension, worry, uneasiness. Often characterized by fear.

c. Catastrophic reactions – an abrupt outburst related to a stimulus or trigger.

d. Clinging – holding onto others.

e. Combativeness – attacking others in some way.

f. Inappropriate sexual behavior – disrobing, touching others or themselves inappropriately.

g. Delusions / hallucinations – believing things that are not true / seeing things that are not there.

h. preservation- continuance of activity after stimulus is removed.

2. Communication techniques which minimize behavior problems:
   a. Know your client!! (Likes, dislikes, fears, etc.)
   b. Speak with the “3 S’s” – slowly, softly, simply.
   c. Be sure the client is looking at you when you are speaking.

d. Avoid asking questions.

e. Limit choices.

f. Don’t demand or order.

g. Mirror the desired behavior for the client or use pictures.

h. Cueing – giving the client a verbal or physical message to act (such as moving the hand, with fork, to the mouth to signal and beginning eating. Gentle touch is often effective (after you know it doesn't upset the client).

j. Don't try to reason with the confused client. Go along with the client (this is called validation).

E. Communicating with the mentally ill client

1. Do the following:

a. Identify yourself to the client when you greet him.

b. Respect the client's space.

c. Speak in your normal tone of voice.

d. Keep the message clear and direct (avoid metaphors, sarcasm, etc.).

e. Touch should be use with caution or not at all.

2. Follow the plan of action regarding communication techniques for the individual client.

F. Communication with the aphasic client

1. Aphasia is the inability to speak. Try to:

a. Stand where client can see you.

b. Look at the client the entire time.

c. DO NOT SHOUT (clients who cannot speak are not necessarily hearing- impaired and shouting may cause aggressive behavior).

e. Speak clearly and enunciate carefully.

f. Do not rush the client.

g. Use writing pads, chalk boards or a communication board.

G. Managing behavior problems

1. The best way to manage difficult behavior is to prevent it by following sound behavior management principles.

2. Knowing the client is a good way to avoid difficult behavior. Consistency of caregivers is important in this group of patients.
3. To effectively manage challenging behavior we must:

a. Identify the behavior and the cause using the ABC's of behavior management:

- Antecedent – what happens before the behavior?
- Behavior – what IS the behavior? (identify accurately)

- Consequence – what happens as a result of the behavior?

4. Tools for managing behavior

a. Directing and redirecting

1. When the client is not doing what we want to do we DIRECT them using such actions as cueing or mirroring.

2. When the client is doing something inappropriate or of danger to self or others, we REDIRECT them to another action.

b. Ignore the behavior when appropriate.

c. Increase your tolerance for the behavior, especially with the dementia client.

H. Actions for managing the angry client

1. Agitation

a. Listen closely and try to determine what triggered the behavior.

b. Watch the client's body language for signs of escalating anger such as:

- loss of eye contact
- repetitive movement, wringing of the hands, clenched fists
- increase in motor activity, such as frequent changes in position or pacing.
- change in tone of voice, repetitive sounds, crying, complaining.

c. Remain calm. Think before you speak.

d. Leave the client alone if appropriate and allow him to calm down.

2. Physical aggression

a. Avoid actions and issues that cause the client to become combative.

b. Call for assistance if the client loses control.

c. Back off when it is appropriate and allow the client time to settle down.

d. Keep yourself and others at a safe distance. Protect yourself and the patient.

e. Stay calm.
Don’t threaten.
NEVER HIT BACK!

f. When anger passes, talk with the client to try to understand and comfort them.

2.4 Measure and Record Vital Signs

INTRODUCTION : Medication administration will require the Medication Aide to measure the vital signs of clients who are taking particular drugs. This instructions should be a review since measuring vital signs is included in both the nurse aide training and the Direct Care Staff training curricula.

However, each student should demonstrate competency in measuring and recording vital signs, especially pulse and blood pressure. Devices for measuring vital signs vary..

Some facilities use manual blood pressure cuffs, others use electronic devices.

It is important that students understand what measurements are within normal range and when to report the measurements.

Emphasis should be placed on the importance of monitoring pulse and blood pressure when certain drugs are administered

PERFORMANCE OBJECTIVE

Given the equipment for measuring vital signs, measure and record temperature, pulse, respirations and blood pressure.

Procedures must be performed under supervision.

Blood pressure readings must be within +/- 2mm of mercury of a simultaneous reading by the instructor.

TOPICAL OUTLINE

A. When to measure vital signs

1 When ordered by HCP.

2. If required by facility policy and procedure on a routine basis.

3. When monitoring the client's response to certain drugs.

4. When the client shows signs of physical distress.

B. Determining baseline or “normal” vital signs for the individual client

1. Baseline temperature range
2. Baseline pulse rate
3. Baseline respiration (breathing) rate
4. Baseline or acceptable blood pressure rate.

C. Procedure for measuring and recording vital signs

1. Review step-by step procedure for measuring vital signs
    a. Temperature
        - oral 97.6 – 99.6
        - rectal A degree higher
        - axillary A degree lower
        - ear same as oral, less accurate than rectal

Most literature supports the belief that many (not all) older adults (85 and younger) tend to run “low normal” temperatures

Older adults often have a diminished ability to regulate body temperature.

They are at a higher risk for hypothermia, so need to include caution at both ends of the spectrum. If a facility is all geriatric, with a large percentage over 75 years old, they should have facility specific policies on when to begin to monitor.

b. Pulse

- normal range is 60 to 90 beats per minute
- measure and record:

o rate – number of beats/minute o rhythm - regular or irregular o quality – soft or bounding

c. Respirations

- normal range is 12 to 20 breaths per minute
- measure and record:
  - rate – one full rise and one full fall of the chest
  - rhythm – regular or irregular
  - quality – normal or labored

d. Blood pressure

- measurement of the pressure exerted against the walls of the arteries as the blood moves through the body

- most literature defines normal range as 110/60 to 130/80 (may vary per individual)

2. Review procedure for recording the measurements
    a. Use correct abbreviations.
    b. Follow facility documentation procedures.
3. Assisting the client to decide to administer medication
    a. Report measurements of vital signs to client.
    b. Contact appropriate HCP or designated staff member, regarding abnormal measurements.
    c. Follow facility procedure for assisting client to administer medication.

d. Document the measurements in the client's record. Document who was notified of abnormal readings and what action was taken.

e. Report abnormal readings.

Causes of Inaccurate Blood Pressure Readings

1. The cuff is too small or too large.
2. The cuff is not wrapped correctly.
3. Incorrect arm positioning.
4. Not using the same arm for all readings.
5. Not having the gauge at eye level.
6. Deflating the cuff too slowly.

7. Not waiting a sufficient amount of time between readings (repeating the process too quickly to recheck original reading).

2.5 Demonstrate Understanding of the Use of the International (Military) Time

INTRODUCTION : The method of representing time varies with different organizations or facilities. Many work settings use International Time to distinguish between AM and PM time. We sometimes refer to this a “Military Time” because the Armed Forces use this method to indicate time.

Because there is little chance of misreading the hour, it is the safest measure of time when it comes to medical procedures and medication administration.

PERFORMANCE OBJECTIVE

Given examples of Standard Time, indicate the correct International Time with 100% accuracy.

TOPICAL OUTLINE

A. Define International Time

1. International time is counted from the first hour of the day, (number 1), to the last hour of the day, (number 24).

B. Reading International Time

Tip: After the noon hour, add 12 to the ordinary time number.

1:am = 0100	9:am = 0900	5:pm = 5:pm + 12 = 1700
2:am = 0200	10:am = 1000	6:pm = 6:pm + 12 = 1800
3:am = 0300	11:am = 1100	7:pm = 7:pm + 12 = 1900
4:am = 0400	12:pm = 1200	Noon 8:pm = 8:pm + 12 = 2000
5:am = 0500	1:pm = 1:pm + 12 = 1300	9:pm = 9:pm + 12 = 2100
6:am = 0600	2:pm = 2:pm + 12 = 1400	10:pm = 10:pm + 12 = 2200
7:am = 0700	3:pm = 3:pm + 12 = 1500	11:pm = 11:pm + 12 = 2300
8:am = 0800	4:pm = 4:pm + 12 = 1600	12:mn = 12:mn + 12 = 2400

2.6 Identify the Five Rights of Medication Administration

INTRODUCTION : The rules for giving medications are universal. We call these rules the “Five Rights” of Medication Administration. These rules apply to every medicine, every client and every HCP at all times. Failure to follow the “Five Rights” could have serious, even fatal consequence. This objective is perhaps the most important one in this curriculum, a point which should be emphasized frequently.

PERFORMANCE OBJECTIVE

On a written quiz, demonstrate an understanding of the five rights of medication administration with 100 % accuracy.

A. The Five Rights

1. Right Client
2. Right Drug
3. Right Dose
4. Right Route
5. Right Time

B. The importance of observing the Five Rights each time a medication is administered

1. To achieve therapeutic goal
2. To prevent harm to the client
3. To avoid ethical and/or legal complications

C. Procedures for ensuring the rights

1. Know the client
2. Check and re-check HCP orders
3. Measure and count carefully

4. Follow specific administration instructions
5. Adhere to time schedule for the facility
6. Use the Medication Administration Record (MAR) correctly

7. When in doubt about any of the 5-Rights....DO NOT give the drug!!

D. Documentation

1. Documentation is often referred to as the ‘6th Right’ and will be discussed in

Students must earn a grade of at least 80% on the Chapter 2 test as well as perform return demonstrations for selected objectives.

Presentation & Discussion

D Present all material contained in Topical Outline for each objective. Elaborate and use examples as appropriate for the group or client population.

1. Free of disease-causing organisms means.

a. aseptic
b. contaminated
c. dirty
d. clean

Aseptic

2. A disease-causing organism that is carried in the blood is called a *blood-borne pathogen*.

a. True
b. False

True

3. Condition in which the use of a certain drug is dangerous or inadvisable is *contraindicated*.

a. True
b. False

True

4. Contraindicated means that a drug is supposed to be given right away.

a. True
b. False

False

5. Wearing gloves when handling body fluids, wearing personnel protective equipment and disposing of biohazardous waste is called:

a. standard precautions
b. optional practice
c. policy of the facility
d. experimental

Standard precautions

6. Delirium is permanent mental confusion.

a. True
b. False

False

7. Directing is a behavioral management tool that means to indicate the desired action (verbal or non-verbal.

a. True
b. False

True

8. Cueing is a behavioral management tool that means to give signs or signals to indicate desired action (usually non-verbal).

a. True
b. False

True

9. Perseveration means a one-time activity.

a. True

b. False

False

10. Aphasia means loss of the power of expression by speech, writing or signs due to injury or disease of the brain.

a. True
b. False

True

11. A Medication Aide observes that a resident's wrist is in an unusual position after a fall. The aide should:

a. document the observation and report at the change of shift.
b. call the HCP as soon as possible
c. call 911
d. both b & c

both b & c

12. When only one staff member is present during an emergency, the FIRST thing a Medication Aide should do is to:

a. call emergency service –911 immediately.
b. provide assistance to client until help arrives.
c. collect client's medical records for HCP.
d. all of the above

Call emergency service –911 immediately.

13. *Blood pressure* is the measurement of:

a. the number of times the heart beats per minute.
b. the pressure exerted on the walls of the arteries.
c. the beating of the veins.
d. the beating of the arteries.

The pressure exerted on the walls of the arteries.

14. Communication is MOST effective when:

a. there is a sender and a listener
b. there is a message
c. there is a sender, a receiver and a message
d. there is a message and a receiver

There is a sender, a receiver and a message

15. When a client becomes aggressive the BEST action for the Medication Aide would be to:

a. call for assistance if the client loses control
b. administer a antipsychotic medication immediately
c. back off, if appropriate, and allow the client time to calm down
d. both a and c

Both A and C

16. With the ABCs of behavior management, the *ABC* stands for:

a. appetite, belief, confusion
b. aftermath, behavior, confusion
c. antecedent , behavior, consequences
d. airway, breathing, circulation

Antecedent , Behavior, Consequences

17. Which of the following items can **NOT** cause an inaccurate blood pressure reading.

a. the cuff is too large or too small.
b. incorrect arm positioning.
c. the cuff is not wrapped correctly.
d. using the same arm for all readings.

Using the same arm for all readings.

18. In an emergency, the medication aide should call 911.

a. True
b. False

True

19. In a non-emergency but health threatening situation, the medication aide should call the HCP as soon as possible.

a. True
b. False

a. True

20. The five most important considerations of medication administration include all of the following *except*:

a. the right client.
b. the right drug.
c. the right dose.
d. the right room.
e. the right time.

The right room.

21. What important step in medication management is sometimes considered the "*6th Right*?"

a. Route of Administration
b. Right room
c. Documentation
d. Right date

Documentation

22. Normal pulse range is 60-90 beats per minute.

a. True
b. False

False

24.1400 is the international time for 4 p.m.

a. True
b. False

False

25. The elderly person is at an increased risk of hypothermia due to decreased ability to regulate body temperature.

a. True
b. False

True