15.4: Checklist for Oral Medication Administration

Use the checklist below to review the steps for completion of “Oral Medication Administration.”[1]

Steps

Disclaimer: Always review and follow agency policy regarding this specific skill.

Special Considerations:

• Plan medication administration to avoid disruption.
• Dispense medication in a quiet area.
• Avoid conversation with others.
• Follow agency’s no-interruption zone policy.
• Perform hand hygiene prior to medication preparation.
• Prepare medications for ONE patient at a time.

1. Gather supplies: MAR/eMAR.

2. Know the actions, special nursing considerations, safe dose ranges, purpose of administration, and potential adverse effects of the medications to be administered. Consider the appropriateness of the medication for this patient at this time.

3. Read the eMAR/MAR and select the proper medication from the medication supply system or the patient’s medication drawer. Perform the first of three checks of the six rights of medication administration plus two (allergies and expiration dates). Perform necessary calculations to verify correct dosage.
   - The right patient: Check that you have the correct patient using two patient identifiers (e.g., name and date of birth).
The right medication (drug): Check that you have the correct medication and that it is appropriate for the patient in the current context.

The right dose: Check that the dose is safe for the age, size, and condition of the patient. Different dosages may be indicated for different conditions.

The right route: Check that the route is appropriate for the patient’s current condition.

The right time: Adhere to the prescribed dose and schedule.

The right documentation: Always verify any unclear or inaccurate documentation prior to administering medications.

4. The medication label must be checked for name, dose, and route, and compared with the MAR at least three different times:
   - When the medication is taken out of the drawer.
   - When the medication is being prepared.
   - At the bedside, prior to medication administration to the patient.

5. Prepare the required medications:
   - Unit dose packages: Do not open the wrapper until you are at the patient’s bedside. Keep opioids and medications that require special nursing assessments separate from other medication packages.
   - Multi-dose containers: When removing tablets or capsules from a multi-dose bottle, pour the necessary number into the bottle cap and then place the tablets or capsules in a medication cup. Cut scored tablets, if necessary, to obtain the proper dosage. If it is necessary to touch the tablets, wear gloves.
   - Liquid medication in a multi-dose bottle: When pouring liquid medications out of a multi-dose bottle, hold the bottle so the label is against the palm to avoid dripping on the label. Use an appropriate measuring device when pouring liquids, and read the amount of medication at the bottom of the meniscus at eye level. Wipe the lip of the bottle with a paper towel.

6. Depending on agency policy, the third check of the label may occur at this point. If so, after all medications for one patient have been prepared, recheck the medication labels against the eMAR/MAR before taking the medications to the patient. However, many agencies require the third check to be performed at the bedside after obtaining two patient identifiers and scanning the barcode of the patient.

7. Replace any multi-dose containers in the patient’s drawer or medication supply system. Lock the medication supply system before leaving it.

8. Transport the medications to the patient’s bedside carefully, and keep the medications in sight at all times.

9. Perform safety steps:
   - Perform hand hygiene.
   - Check the room for transmission-based precautions.
   - Introduce yourself, your role, the purpose of your visit, and an estimate of the time it will take.
   - Confirm patient ID using two patient identifiers (e.g., name and date of birth).
   - Explain the process to the patient and ask if they have any questions.
   - Be organized and systematic.
   - Use appropriate listening and questioning skills.
   - Listen and attend to patient cues.
   - Ensure the patient’s privacy and dignity.
   - Assess ABCs.

10. When identifying the patient, compare the information with the eMAR/MAR. The patient should be identified using
at least two of the following methods:

◦ Check the name on the patient’s identification band.
◦ Check the identification number on the patient’s identification band.
◦ Check the birth date on the patient’s identification band.
◦ Ask the patient to state his or her name and birth date, based on facility policy.
◦ If a patient is unable to verbalize their name and date of birth and patient identification bands are not used, use alternative methods of identification such as a second staff member and/or a patient picture in the MAR.

11. Complete all necessary assessments before administering the medications. Check the patient’s allergy bracelet or ask the patient about allergies. Explain the purpose and action of each medication to the patient.

12. Based on facility policy, the third check of the medication label typically occurs at this point. If so, recheck the label with the eMAR/MAR before administering the medications to the patient. Scan the patient’s bar code on the identification band, if bar scanning is used. If an error occurs during bar code scanning, obtain assistance before administering the medication. Most error messages are intended to warn the nurse of a potential medication error.

13. Assist the patient to an upright (or a side-lying) position if they are unable to be positioned upright:

◦ Offer water or other permitted fluids with pills, capsules, tablets, and some liquid medications.
◦ Ask if the patient prefers to take the medications by hand or in a cup and if they prefer all medications at once or individually.

14. Remain with the patient until each medication is swallowed. Never leave medication at the patient’s bedside.

◦ Note: If the patient is confused or has been known to hoard pills, have the patient open their mouth and check under the tongue.

15. Assist the patient to a comfortable position, ask if they have any questions, and thank them for their time.

16. Ensure safety measures when leaving the room:

◦ CALL LIGHT: Within reach
◦ BED: Low and locked (in lowest position and brakes on)
◦ SIDE RAILS: Secured
◦ TABLE: Within reach
◦ ROOM: Risk-free for falls (scan room and clear any obstacles)

17. Perform hand hygiene.

18. Document medication administration and related assessment findings. Report any concerns according to agency policy.

19. Evaluate the patient’s response to the medication within the appropriate time frame. Note: Most sublingual medications act in 15 minutes, and most oral medications act in 30 minutes. If patient presents with any adverse effects:

◦ Withhold further doses.
◦ Assess vital signs.
◦ Notify prescriber.
◦ Notify pharmacy.
◦ Document as per agency policy.