Skills Procedural Guidelines for CMA Training Program

This document contains procedural guidelines to help guide the teaching and practice of some of the necessary CMA skills.

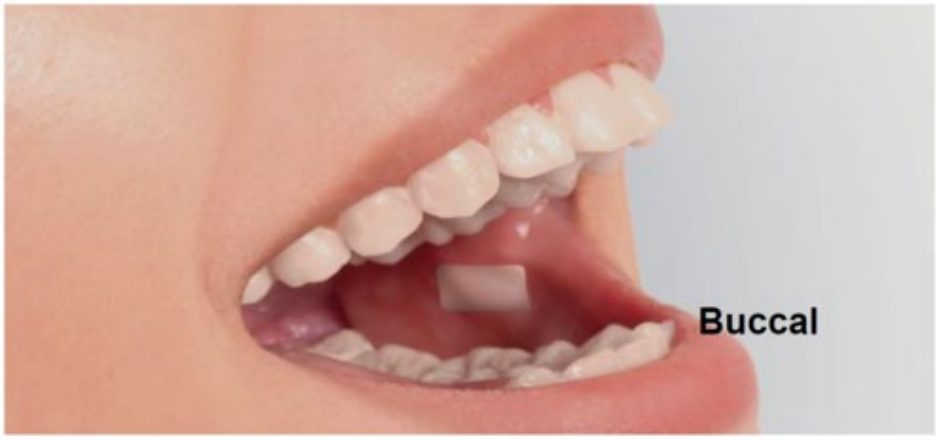
Contents

Procedure for Administering Oral Medications

1. Identify yourself by name. Identify the resident by name and date of birth. (or picture).
2. Wash your hands.
3. Explain the procedure to the resident. Speak clearly, slowly, and directly.
4. Provide for the resident's privacy with a curtain, screen, or door.
5. Put on gloves if required.
6. Raise the head of the bed. Make sure the resident is in an upright sitting position.
7. Help the resident to clean his or her hands, if they have not already done so.
8. Measure and document vital signs as ordered. If measurements are not within the appropriate range, report to your supervisor. Do not administer the medication.
9. Provide medications to the resident according to preference. Some residents may prefer to swallow several solid medications at one time. Others may need to take each medication separately.
10. Observe as the resident swallows each medication. DO NOT leave the room until all medications have been swallowed. If required, check the resident's mouth to make sure the medication was swallowed.
11. Make the resident comfortable. Remove privacy measures.
12. Clean and store reusable equipment. Discard any disposable items or trash.
13. Remove and discard gloves if used. Wash your hands.
14. Place the call light within the resident's reach.
15. Report any changes to the nurse.

Procedure for Administering Buccal and Sublingual Medications

1. Identify yourself by name. Identify the resident by name and date of birth (or picture).
2. Wash your hands.
3. Explain the procedure to the resident.
4. Provide for the resident's privacy with a curtain, screen, or door.
5. Put on gloves if required.
6. Raise the head of the bed. Make sure the resident is in an upright sitting position.
7. Help the resident clean her hands if he/she hasn't done so.
8. Measure and document vital signs as ordered. If measurements are not within the appropriate range, report to your supervisor and do not administer the medication.
9. Provide medication to the resident. For the buccal route, instruct the resident to place the medication between the cheek and gums. For the sublingual route, instruct the resident to place the medication under the tongue. If the resident needs help, use gloved hands to handle medications and place them properly.
10. Tell the resident to allow the medication to dissolve in place. Do not chew or swallow the medication.
11. Do NOT leave the resident's room until the medication has been placed and dissolved. Do not offer fluids or food until the medication has dissolved completely.
12. Make the resident comfortable. Remove privacy measures.
13. Clean and store reusable equipment. Discard any disposable items or trash.
14. Remove and discard gloves if used. Wash your hands.
15. Place the call light within the resident's reach.
16. Report any changes in the resident to the nurse.
17. Document administration of the medication on the MAR.



Procedure for Administering Medication by Metered Dose Inhaler

1. Identify yourself by name. Identify the resident by name and date of birth (or photo).
2. Wash your hands.
3. Explain the procedure to the resident. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
4. Provide for the resident's privacy with a curtain, screen, or door.
5. Raise the head of the bed. Make sure the resident is in an upright sitting position.
6. Measure and document vital signs as ordered. If measurements are not within the appropriate range, report to your supervisor and do not administer the medication.
7. Put on gloves if required.
8. Shake inhaler vigorously for approximately 5 seconds.
9. Remove the cap from the mouthpiece. Check the mouthpiece for any foreign object or dust.

If spacer is used:

10. Insert the inhaler mouthpiece into the spacer.
11. If the resident uses a mask with the spacer, place the spacer mask over their nose and mouth to form a tight seal. If they do not use a mask ask them to put the spacer mouthpiece between their teeth and form a seal around it with their lips. Hold the inhaler with your thumb underneath the plastic case and index finger on top of the medicine canister. As needed, support the spacer with your other hand, or ask the resident to hold it.
12. Press down firmly and quickly on the inhaler's medicine canister to release the medication into the spacer.
13. Encourage the resident to breathe in slowly through the mask or mouthpiece. Some spacers make a warning whistle when the user breathes in too quickly. If a whistle sounds, ask the resident to slow their breathing.

If spacer is not used:

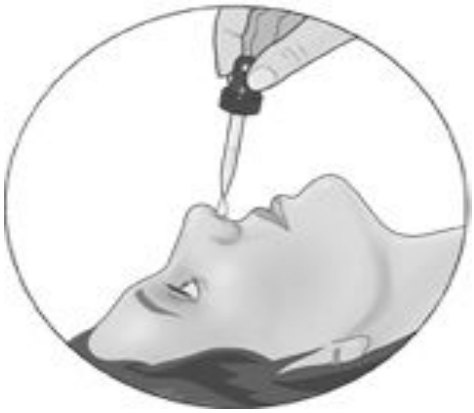
10. Hold the inhaler with a thumb underneath the plastic case and the index finger on the medicine canister.
11. Tell the resident that you are going to count to 3, and that on 3, you will activate the inhaler. Ask them to breathe in steadily when the medication is released.
12. Instruct the resident to breathe in and out. Place the inhaler between the teeth, sealing the lips around the mouthpiece.
13. Count to 3. On 3, press down firmly and quickly on the inhaler's medicine canister and encourage the resident to breathe in.

For both methods:

14. When the medication has been inhaled, ask the resident to hold their breath for 5 seconds (or as directed).
15. If more than one inhalation is ordered, wait approximately 1 minute before instructing the resident to perform the second inhalation. Shake the inhaler again before administering a second inhalation.
16. If the medication inhaled is a corticosteroid, ask the resident to rinse his mouth and then spit out the rinse water.
17. Replace cap(s) on the inhaler and spacer (if used).
18. Make the resident comfortable. Remove privacy measures.
19. Clean and store reusable equipment. Discard any disposable items or trash.
20. Remove and discard gloves if used. Wash your hands.
21. Place the call light within the resident's reach.
22. Report any change in the resident to the nurse.
23. Document administration of the medication on the MAR.

Procedure for Administering Nasal Medications

1. Identify yourself by name. Identify the resident by name and date of birth (or photo).
2. Wash your hands.
3. Explain the procedure to the resident. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
4. Provide for the resident's privacy with a curtain, screen, or door.
5. Put on gloves.
6. Give the resident a tissue and ask them to blow their nose gently.
7. Position the resident properly. If administering a nasal spray, raise the head of the bed. Make sure the resident is in an upright sitting position with the head tilted slightly forward. If administering nasal drops, lower the head of the bed. The resident should be lying flat on their back.
8. Administer the medication. For nasal spray, shake the medication, then place the nozzle into one nostril and squeeze to administer. Place the nozzle into the other nostril and squeeze to administer. Repeat if multiple sprays are ordered. For nasal drops, do not touch the dropper to the outside of the nose or the nostril. Squeeze the dropper and allow the ordered number of drops to fall into the resident's nostril, toward the septum (the wall dividing the nostrils).
9. Encourage the resident to wait at least a minute before wiping or blowing her nose.
10. Make the resident comfortable. Remove privacy measures.
11. Clean and store reusable equipment. Discard any disposable items or trash.
12. Remove and discard gloves. Wash your hands.
13. Place the call light within the resident's reach.
14. Report any changes in the resident to the nurse.
15. Report any changes in the resident to the nurse.
16. Document administration of the medication on the MAR.



Procedure for Administering Ophthalmic Medications

1. Identify yourself by name. Identify the resident by name and date of birth (or photo).
2. Wash your hands.
3. Explain the procedure to the resident. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
4. Provide for the resident's privacy with a curtain, screen, or door.
5. Put on gloves.
6. Use a tissue to gently wipe the resident's eye from the inside corner to the outside. If medication will be administered to both eyes, use a new tissue to wipe the other eye.
7. Position the resident properly, with the head tilted back. The resident can be sitting up or lying down.
8. Using a gloved finger, pull the lower eyelid down slightly, forming a pocket (gap) between the lower lid and the eye. Tell the resident to look up.

For eye drops:

9. Squeeze and release the bulb to fill the medicine dropper or point the tip of the bottle downward if it has a built-in dropper. Instill a drop of medication into the gap between the lid and the eye. Take care not to touch the eye with the dropper.
10. Direct the resident to close the eye, and press gently on the inner canthus for 1 minute. Repeat as needed if more than one drop is ordered, waiting 5 minutes for the medication to absorb before instilling the second drop. Repeat with second eye if ordered.

For ointment:

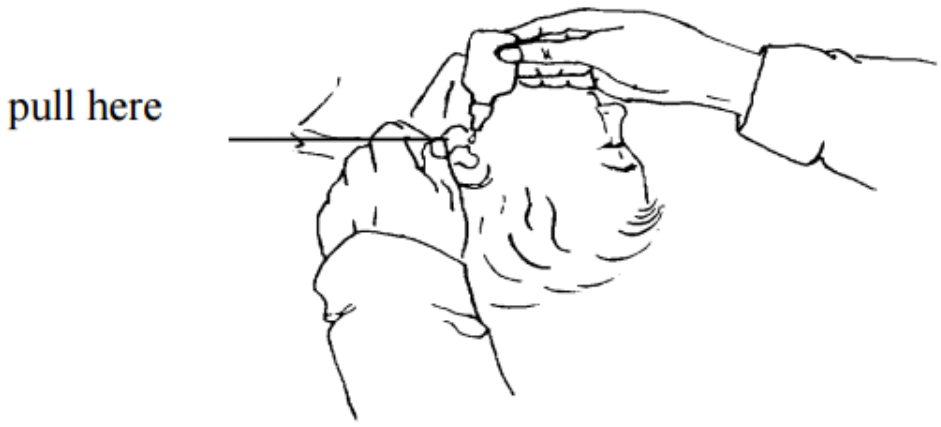
9. Carefully squeeze a line of ointment into the gap between the eye and the lower lid. Do not touch the tip of the tube to the eyelid or eye. Repeat with second eye if ordered.
10. Ask the resident to gently close their eyes and leave them closed for several minutes.

For both forms:

11. Use clean tissues to remove excess drops or ointment from around the resident eyes. Use a new tissue for each eye.
12. Make the resident comfortable. Remove privacy measures.
13. Clean and store reusable equipment. Discard any disposable items or trash.
14. Remove and discard gloves. Wash your hands.
15. Place the call light within the resident's reach.
16. Report any changes in the resident to the nurse.
17. Document administration of the medication on the MAR.

Procedure for Administering Otic Medications

1. Identify yourself by name. Identify the resident by name and date of birth (or photo).
2. Wash your hands.
3. Explain the procedure to the resident. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
4. Provide for the resident's privacy with a curtain, screen, or door.
5. Put on gloves if required.
6. Position the resident properly. Ideally, the resident should be lying down with their head turned to the side. The resident may also be seated with their head tilted back and to the side.
7. Use a cotton ball to wipe away any moisture or debris from the outer ear.
8. Straighten the ear canal by gently pulling up and back on the outside edge of the ear. Squeeze and release the bulb to fill the medicine dropper or point the tip of the bottle downward if it has a built-in dropper. Instill the ordered number of drops to the ear. Allow the liquid to run down the side of the ear canal (this helps prevent the formation of air bubbles).
9. Place a clean cotton ball over the ear canal (do not insert into the ear canal). Ask the resident to remain in the same position for 3-5 minutes. Repeat with the second ear if ordered.
10. Help the resident to a comfortable position. Remove privacy measures.
11. Clean and store reusable equipment. Discard any disposable items or trash.
12. Remove and discard gloves if used. Wash your hands.
13. Place the call light within the resident's reach.
14. Report any changes in the resident to the nurse.
15. Document administration of the medication on the MAR.

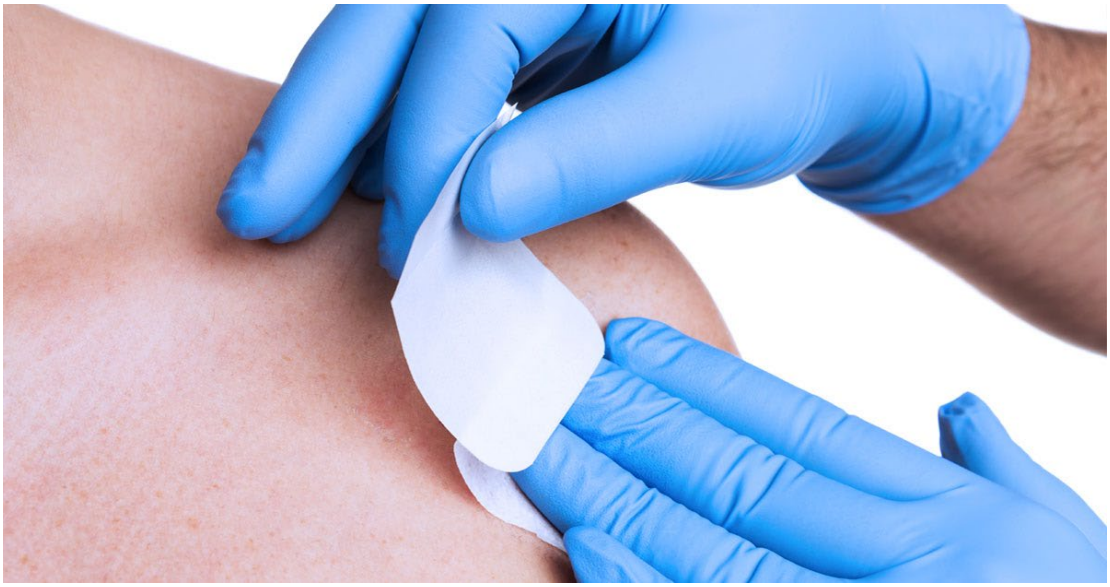


Procedure for Administering Topical Medications

1. Identify yourself by name. Identify the resident by name and date of birth (or photo).
2. Wash your hands.
3. Explain the procedure to the resident. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
4. Provide for the resident's privacy with a curtain, screen, or door.
5. Put on gloves if required.
6. Position the resident properly. Expose only the body part to which the medication will be applied.
7. Follow the medication order and manufacturer's instructions for application. Know whether the medication should be rubbed in or left on top of the skin.
8. Discard used application devices.
9. Make the resident comfortable. Remove privacy measures.
10. Clean and store reusable equipment. Discard any disposable items or trash.
11. Remove and discard gloves if used. Wash your hands.
12. Place the call light within the resident's reach.
13. Report any changes in the resident to the nurse.
14. Document the administration of the medication on the MAR.

Procedure for Administering Transdermal Medications

1. Identify yourself by name. Identify the resident by name and date of birth (or photo).
2. Wash your hands.
3. Explain the procedure to the resident. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
4. Provide for the resident's privacy with a curtain, screen, or door.
5. Put on gloves.
6. Position the resident properly. Expose only the body part to which the medication patch will be applied.
7. If a patch is already in place, remove it. Clean the site as directed.
8. Follow manufacturer instructions for discarding the used transdermal medication. Do not touch the patch with bare hands. Discard it so that no other person may accidentally touch it.
9. Remove and discard gloves. Wash hands and put on a new pair of gloves.
10. Write your initials, the date, and the time on the patch, if required.
11. Follow the medication order and the manufacturer's instructions for application of the transdermal patch.
12. Remove and discard gloves. Wash your hands.
13. Make the resident comfortable. Remove privacy measures.
14. Place the call light within the resident's reach.
15. Report any changes in the resident to the nurse.
16. Document administration on the MAR.



Procedure for Administering a Rectal Suppository

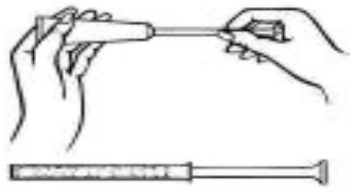
1. Identify yourself by name. Identify the resident by name and date of birth (or photo).
2. Wash your hands.
3. Explain the procedure to the resident. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
4. Provide for the resident's privacy with a curtain, screen, or door.
5. Adjust the bed to a safe level, usually waist-high. Lock the bed wheels.
6. Help the resident into a left-sided Sim's position. Cover with a bath blanket.
7. Uncover the resident enough to expose the buttocks only.
8. Unwrap the suppository.
9. Put on gloves.
10. Lubricate the suppository as needed.
11. Spread the buttocks to expose the anal area.
12. Using your index finger, insert the suppository 3-4 inches in.
13. Ask the resident to take deep breaths, as it will help him relax and retain the suppository.
14. Withdraw the finger and briefly hold the toilet paper against the anus. Discard the toilet paper.
15. Remove and discard gloves. Wash your hands.
16. Remove the bath blanket and cover the resident. As the resident to retain the suppository as long as possible. Make the resident comfortable.
17. Put on clean gloves and provide a bedpan or assistance to the bathroom when needed.
18. Remove and discard gloves. Wash your hands.
19. Return the bed to its lowest position. Remove privacy measures.
20. Clean and store reusable equipment. Discard any disposable items or trash. Wash your hands again as needed.
21. Place the call light within the resident's reach.
22. Report any changes in the resident to the nurse.
23. Document administration of the medication on the MAR.

Procedure for Administering a Commercially Prepared Disposable Enema

1. Verify the physician's order to administer the enema.
2. Gather equipment before entering the resident's room.
3. Identify yourself by name. Identify the resident by name and date of birth (or photo).
4. Explain the procedure, speaking clearly and calmly to the resident.
5. Provide for privacy.
6. Wash your hands.
7. Put on gloves.
8. Position the resident in the left Sim's position.
9. Place linen saver under the resident's buttocks.
10. Have the bedpan or commode nearby.
11. Remove the cap from the commercially prepared enema, using the non-dominant hand, lift the right buttock exposing the anus, using the dominant hand, insert the pre-lubricated tip of the enema into the resident's rectum (3-4 inches) pointed toward the navel and squeeze the bottle to instill the solution at a slow, steady rate until all is instilled. If the resident has any cramping during the procedure, ask the resident to take deep breaths.
12. Instruct the resident to hold the solution for as long as possible for the best results.
13. Remove the enema tip; replace the used enema unit in its original container and discard.
14. Warn the resident about the potential adverse reaction of abdominal cramping. Discard gloves. Wash hands.
15. Place the resident in a comfortable position.
16. Place the call light within the resident's reach.
17. When the resident is able to defecate, observe the stool and assist with perineal care.
18. When documenting the administration of the enema and the effect of the procedure in the resident's clinical record, include color, consistency, and the amount of results.
19. If the resident has not had results within an hour, notify the nurse.

Procedure for Administering Medications by the Vaginal Route

1. Identify yourself by name. Identify the resident by name and date of birth (or photo).
2. Wash your hands.
3. Explain the procedure to the resident. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
4. Provide for the resident's privacy with a curtain, screen, or door.
5. Adjust the bed to a safe level, usually waist-high. Lock the bed wheels.
6. Help the resident into the dorsal recumbent position. Cover with a bath blanket or other drape.
7. Unwrap the suppository or prepare the medication applicator. If using an applicator, inspect it for any breaks, cracks, or rough edges before use. This helps prevent injury to the vagina. If you observe any problems with the applicator, do not use it, and notify the nurse.
8. Put on gloves.
9. Lubricate the suppository or applicator as needed.
10. Insert the applicator into the vagina 3-4 inches. If using an applicator, press the plunger fully to release the medication, then remove and discard the applicator. Do not force the applicator into the vagina if you meet resistance. If you are unable to insert the applicator, stop and notify the nurse.
11. Gently wipe the area around the vagina with a tissue if needed. Discard the tissue.
12. Remove and discard gloves. Wash your hands.
13. Remove the bath blanket and cover the resident.
14. Return the bed to its lowest position. Remove privacy measures.
15. Place the call light within the resident's reach. Remove privacy measures.
16. Report any changes in the resident to the nurse.
17. Document administration of the medication on the MAR.



Procedure for Administering a Subcutaneous Injection

1. Wash your hands.
2. Check and double-check the order.
3. Assemble the equipment.
4. Prepare the injection.
5. If a rubber stopper vial, clean the rubber stopper with an alcohol wipe and allow to dry.
6. Draw air into the syringe in the amount of the dose to be given.
7. Insert the needle into the stopper. Invert the bottle and inject the air.
8. Draw the ordered amount of medication into the syringe.
9. Recheck the order.
10. Identify yourself by name. Identify the resident by name and date of birth (or picture).
11. Explain the procedure to the resident. Speak clearly, slowly, and directly.
12. Provide for the resident's privacy with a curtain, screen, or door.
13. Clean the resident's skin with an alcohol wipe and allow it to dry.
14. Verify that no air is in the syringe, expel air if necessary.
15. Grasp a cushion of flesh between the thumb and forefinger. Avoid muscle, moles, or scars.
16. Inject the needle at a 45–90-degree angle.
17. If placement is correct, inject the medication slowly but steadily.
18. Wait a few seconds, then withdraw the needle quickly. Wipe the injection area with an alcohol wipe.
19. Apply pressure to the injection site and apply a Band-Aid if necessary.
20. Dispose of the syringe used in the puncture-resistant Sharps container and discard any trash.
21. Remove gloves, wash your hands, and dispose of your gloves properly.
22. Make the resident comfortable, remove privacy measures, and place the call light within the resident's reach.
23. Document administration of the medication on the MAR including the site of the injection to ensure site rotation practices are followed.

Procedure for Administering Insulin

Be certain that the correct insulin type is identified and used. Allow insulin to warm to room temperature before use. Date ALL insulin bottles with the date of first puncture or date removed from refrigerator. Depending on manufacturer's recommendations, insulin must be replaced 10-42 days after first use.

Always have a nurse verify the amount of the insulin in the syringe/Flexpen with the MAR before the insulin is injected into the resident.

Only administer the insulin if the resident's blood sugar is within the parameters set by the physician and the resident is not exhibiting signs of hypoglycemia.

1. Wash your hands.
2. Check and double-check the order.
3. Assemble the equipment.
4. Prepare the injection.

For Vial:

5. Swab rubber cap on the insulin vial with an alcohol wipe.
6. Insert the same amount of air as the dose to be given.
7. Hold insulin syringe with correct calibration at eye level and withdraw the ordered dosage of insulin.
8. Cover needle with protective sleeve or cap.
9. Check medication with MAR a 3rd time and verify with nurse that the appropriate dose has been drawn up.
10. Apply gloves once entering the resident's room.
11. Identify yourself by name. Identify the resident by name and date of birth (or picture).
12. Explain the procedure to the resident speaking slowly and clearly.
13. Cleanse the injection site with an alcohol wipe.
14. Insert the needle quickly at a 90-degree angle. Aspirate to ensure there is no blood.
15. Inject the insulin slowly until the entire dose is administered. Remove the needle and hold pressure if needed. Do not recap the needle. Engage the safety device and discard the needle and syringe in the Sharp's container.
16. Remove and discard gloves.
17. Wash or sanitize hands.
18. Document the site of administration. Injection site should be rotated with a minimum of 72 hours.

For Insulin Pen:

5. Never share insulin pens between patients.
6. Remove pen cap.
7. Attach a safety shield needle. Always use a new sterile needle for each injection Wipe the rubber seal of pen with alcohol swab. Remove protective seal from new needle, line the needle straight with the pen and screw the needle on.
8. Prime the Pen and Clear Air from Needle: Turn dose know at end of the pen to 1 or 3 units. Hold the pen with needle pointing upward. Press dose knob while watching for insulin drop or stream to appear. Repeat if needed, until insulin is seen at tip. The dial should be back at zero after priming is complete.
9. Select insulin dose: Turn know to “dial in” insulin dose.
10. Cover pen needle with protective cap.
11. Check medication liable with MAR a third time, and a nurse to verify this time.
12. Apply gloves once entering the resident room.
13. Introduce yourself by name. Identify the resident by name and date of birth (or picture).
14. Explain the procedure to the resident speaking slowly and clearly.
15. Choose an injection site and cleanse with an alcohol swab. Allow to dry completely. The abdomen is the preferred site for many types of insulin. The top of the thighs and back of upper arms may also be used.
16. Inject the insulin: Quickly insert the needle straight in at a 90-degree angle-no second hand, no pinch up technique is needed for safety pen needles. Use your thumb to press down on the dose knob until it stops (the dose window will be back to zero). Needle should remain in subcutaneous tissue for 10 seconds to allow all of the medication to be

administered properly. Pull the needle straight out of the skin. You may slightly pat the site with a tissue or cotton ball, but do not massage the area.

17. Prep the insulin pen for future use: Remove the needle from the pen. A second shield automatically protects you from the back-end needle.
18. Throw the used needle away in the Sharp's container. Replace pen cap on the pen and store for the next injection.

Procedure for Administering Medication via Nebulizer Treatments

A nebulizer is used to deliver medications into the lungs when a person inhales. It works by changing a liquid medication into a fine mist that is inhaled through a mouthpiece or mask. The most common types of medications used in nebulizers are bronchodilators. A nebulizer is powered by an air compressor which is plugged into an electrical outlet.

1. Wash your hands.
2. Assemble the equipment.
3. Check and double-check the order.
4. Introduce yourself by name. Identify the resident by name and date of birth (or picture).
5. Explain the procedure speaking slowly and clearly to the resident.
6. Twist the cap off of the single-use vial of medication and squeeze the contents into the nebulizer cup.
7. Attach the filled medication cup to the machine. Next connect the tubing from the cup to the nebulizer machine. The tubing should be securely connected to the compressor and mouthpiece (or mask). A mouthpiece will generally deliver more medication than a mask, but if the resident cannot hold the mouthpiece in their mouth correctly, a mask is then preferred.
8. Plug the nebulizer machine into the outlet.
9. The resident should be placed in a comfortable, upright position. Instruct the resident to hold the medication cup to avoid spillage.
10. Turn the compressor on and check the nebulizer for misting. When using a finger valve, cover the air hole to force air into the nebulizer. If not using a finger valve, the nebulizer will mist continually.
11. If using a mouthpiece, the resident shall put it into their mouth, between teeth, and close lips around it to make a seal. If using a mask, be sure the mask fits snug, but is not constrictive. The mask should be covering the nose as well as the mouth. The 2 holes of the mask should be lined up so that when the patient inhales, the air from their nose will blow in and out of the holes.
12. Instruct the patient to take slow, deep breaths through the mouth. The treatment is complete when all of the medication has been inhaled. The amount of time for a treatment may vary. Generally, when there is no more white fog coming from the area of the medication cup and there is no more liquid in the cup, the treatment is complete. The nebulizer will most likely begin sputtering when it is empty.
13. After the treatment is complete, clean the medication cup and unplug the machine.
14. If more than one resident uses the same nebulizer machine, separate mouthpieces are to be used for each patient.
15. The air filter should be changed on the nebulizer on the nebulizer machine following the recommendations of the manufacturer.
16. After each use:

a. Remove the mask or mouthpiece and T-shaped elbow from the cup of the nebulizer machine. Remove the tubing and set it aside. It is NOT recommended to wash or rinse the tubing.
b. Rinse the mask or mouthpiece and T-shaped elbow in warm, running water for 30 seconds.
c. Put the mask or mouthpiece and T-shaped elbow, cup, and tubing back together, and connect the device to the compressor. Run the nebulizer machine for 10-20 seconds to dry the inside of it.
d. Disconnect the tubing from the compressor. All parts of the nebulizer machine should be dry before storing it.

17. Wash your hands.
18. Document administration of the medication on the MAR.

Procedure for Administration of EPIPEN

Note: EPIPENs are to be administered only when signs of a life-threatening allergic reaction are present and a physician's order has been obtained.

1. Identify the resident using 2 identifiers.
2. Explain the procedure.
3. Provide privacy.
4. Flip open the yellow cap of the EpiPen Auto-Injector carrier tube.
5. Remove the EpiPen Auto-Injector by tipping and sliding it out of the carrier tube.
6. Grasp the unit with the orange tip pointing downward.
7. Form a fist around the unit with the orange tip down.
8. With your other hand, pull off the blue safety release.
9. Hold orange tip near outer thigh-DO NOT INJECT INTO BUTTOCKS.
10. Swing and firmly push against the outer thigh until it clicks so that the unit is at a 90-degree angle to the thigh.
11. Hold firmly against thigh for approximately 10 seconds to deliver the drug.
12. Remove the unit from the thigh.
13. CALL 911 to seek immediate medical attention.
14. Send used auto-injector to the hospital emergency department.

DO NOT: Put thumb, fingers, or hand over the orange tip. Press or punch the orange tip with thumb, fingers, or hand. Remove blue safety release until ready to use. Use solution if discolored. Attempt to take the auto-injector apart. Re-use an auto-injector.

Procedure for Performing Fingerstick Blood Sugars

Note: The CMA must follow manufacturer instructions for the use of and for cleaning the glucometer.

Assemble the equipment needed prior to the procedure (glucometer, strips, lancet and lancet pen, alcohol wipe, and cotton ball).

1. Verify the physician's order.
2. Identify the resident using the name, DOB, or photo.
3. Explain the procedure to the resident speaking clearly.
4. Provide for privacy.
5. Wash your hands.
6. Apply gloves.
7. Assemble lancet pen.
8. Cleanse area for obtaining a drop of blood with alcohol and dry with a cotton ball.
9. Puncture skin to obtain a drop of blood. Do not stick the fleshy part of the fingertip. You may use the side of the finger to obtain the drop of blood.
10. Follow the manufacturer's instructions for use of the meter, as every meter is different.
11. After the test is completed, wipe the area with cotton ball to remove the remaining blood.
12. Dispose of the lancet in the sharp's container.
13. Dispose of any other waste.
14. Record results on the MAR. If the blood glucose reading is outside the physician's parameters, notify him of the results.