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**On-Site Review & Testing Components of Medication Module**

Staff Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Required Policy Review | Yes | No | Comments |
| **1. Pharmacy Packaging-***Demonstrates competency regarding information on the prescription label that is critical to observing the five rights including; the person’s name, name of medication, strength/dose of medication, how to use the medication and any warnings or precautions.* |  |  |  |
| **2. Medication Storage**-*Demonstrates competency in medication storage, according to special instructions/guidelines and agency policies for various medications such as oral, topical, temperature sensitive and controlled medications.* |  |  |  |
| **3. Forms/Documentation**- *Demonstrates competency in systems used in the work setting to track the administration of medications, which includes written medication administration records.* |  |  |  |
| **4. Discontinuing Medications**- *Demonstrates competency in agency policies and practices for proper documentation of the discontinuation of a medication*. |  |  |  |
| **5. Disposing of Medications**-*Demonstrates competency in agency policies and practices for proper medication disposal.* |  |  |  |
| **6. Adverse Reactions**- *Demonstrates competency in potential adverse reactions, side effects, sensitivity, allergic reactions and medication interaction concerns.* |  |  |  |
| **7. Reporting**- *Demonstrates competency in agency policies and practices for the reporting of medication administration errors and the reporting of abuse neglect or exploitation situations that are related to medication supports.* |  |  |  |
| **8. PRN usage**- *Demonstrates competency in agency PRN policies and practices, including appropriate circumstances in which to administer PRNs to the individuals they will support.* |  |  |  |
| **9. Refusals**- *Demonstrates competency in agency policies, procedures and regulations regarding medication refusals or misuse.* |  |  |  |
| **10. Medication Errors**- *Demonstrates competency by accurately providing a description/definition of a medication error and identifies ways to minimize errors.* |  |  |  |
| **11. Missed Medication**- *Demonstrates competency by accurately describing agency protocol for missed medication.* |  |  |  |
| **12. Medical Appointments**-(if DSPs accompany individuals): *Demonstrates competency in agency policy and practice when accompanying individuals to medical appointments.* |  |  |  |
| **13. Self-Medication**- *Demonstrates competency in agency policy and practices regarding self- medication.* |  |  |  |
| **14. Off-Site Administration**- *Demonstrates competency in agency policy and practices regarding medication practices including correct storage and control of medication while on trips or away from home/program.* |  |  |  |

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| --- | --- | --- | --- |
| **15. Person Centered Approach**- *Demonstrates competency in treating each person with respect and assuring privacy in medication supports, to the level desired by the person receiving supports.* |  |  |  |
| **Practice Requirements** |  |  |  |
| **16.**Successful completion of Mock trial of administering a medication (can be to supervisor/co-worker) – see Mock Medication Administration Observation Checklist  \*Initial Only-Not Required for Recertification |  |  |  |
| **17.**Successful documentation of agency Medication Administration Record (MAR) |  |  |  |
| **Skill Test Out Requirements** |  |  |  |
| **18.**If applicable, successful creation of a new agency MAR ☐n/a |  |  |  |
| **19.**Successful administration of 3 medication passes without prompts – attach to this form upon completion |  |  |  |

The employee ***did not*** demonstrate understanding of the topics presented; further training is recommended.

The employee demonstrated understanding of the topics presented and successful administration of medication according to agency policy.

**Date Completed:** \_\_\_\_\_\_\_\_\_\_\_\_  Initial  Annual Recertification

**Supervisor/Authorized Agency Personnel:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print Full Name) (Signature)

*By signing this I attest that the below identified employee was trained on the above mentioned topics and successfully completed the Medication Administration Practice and Skill Test Out Requirements.*

**Employee:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print Full Name) (Signature)

*By signing this I attest that I was trained on the above topics and agree to abide by agency policy. I am aware that if there are any questions or concerns regarding medication administration policies or practices I should contact my supervisor or authorized agency personnel.*

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**Mock Medication Administration Observation Checklist**

**(Initial Only-Not Required for Recertification)**

|  |  |  |  |
| --- | --- | --- | --- |
| Areas of Demonstration | Mock Trial | | Comments |
| Date: | |
| Yes | No |
| 1. Employee washed hands and gathered all necessary supplies (e.g. cup, water, etc). |  |  |  |
| 2. Employee obtained key and opened box. |  |  |  |
| 3. Using the Medication Sheet, the employee found the correct medication to be administered. |  |  |  |
| 4. Employee compared the pharmacy label to the copy of prescription to the Medication Sheet to assure correct medication was to be administered. |  |  |  |
| 5. Employee counted the correct dosage of medication and poured into cup without touching the medication. |  |  |  |
| 6. Employee compared the pharmacy label to the copy of prescription to the Medication Sheet to check again that the correct medication was to be administered. |  |  |  |
| 7. Employee handed the cup to the individual receiving medication. Encouraged the individual to put medication directly in mouth from cup. |  |  |  |
| 8. Employee offered water to the individual (unless otherwise prescribed). |  |  |  |
| 9. Employee watched for the person to swallow the medication and followed any special administration instructions (food, sit upright, etc). |  |  |  |
| 10. Employee initialed the Medication Sheet for the correct medication, day, and time. |  |  |  |
| 11. Employee signed and initialed the Medication Sheet if administering medications for the first time that month on that sheet. |  |  |  |
| 12. Employee ensured the packaging is secure and put everything back in the medication box. |  |  |  |
| 13. Employee locked box and secured key. |  |  |  |

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**Supervisor/Authorized Agency Personnel**

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**Medication Administration Evaluation Form**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Areas of Demonstration | Trial 1 | | Trial 2 | | Trial 3 | | Comments |
| Date: | | Date: | | Date: | |
| Evaluator Initials: | | Evaluator Initials: | | Evaluator Initials: | |
| Yes | No | Yes | No | Yes | No |
| 1. Employee washed hands and gathered all necessary supplies (e.g. cup, water, etc). |  |  |  |  |  |  |  |
| 2. Employee obtained key and opened box. |  |  |  |  |  |  |  |
| 3. Using the Medication Sheet, the employee found the correct medication to be administered. |  |  |  |  |  |  |  |
| 4. Employee compared the pharmacy label to the copy of prescription to the medication administration record/sheet to assure correct medication was to be administered. |  |  |  |  |  |  |  |
| 5. Employee counted the correct dosage of medication and poured into cup without touching the medication. |  |  |  |  |  |  |  |
| 6. Employee compared the pharmacy label to the copy of prescription to the medication administration record/sheet to check again that the correct medication was to be administered. |  |  |  |  |  |  |  |
| 7. Employee handed the cup to the individual receiving medication. Encouraged the individual to put medication directly in mouth from cup. |  |  |  |  |  |  |  |
| 8. Employee offered water to the individual (unless otherwise prescribed). |  |  |  |  |  |  |  |
| 9. Employee watched for the person to swallow the medication and followed any special administration instructions (food, sit upright, etc). |  |  |  |  |  |  |  |
| 10. Employee initialed the Medication Sheet for the correct medication, day, and time. |  |  |  |  |  |  |  |
| 11. Employee signed and initialed the medication administration record/sheet if administering medications for the first time that month on that sheet. |  |  |  |  |  |  |  |
| 12. Employee ensured the packaging is secure and put everything back in the medication box. |  |  |  |  |  |  |  |
| 13. Employee locked box and secured key. |  |  |  |  |  |  |  |

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| --- | --- |
| Signatures - Medication Administration Evaluation Form | |
| Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Employee Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: |
| Evaluator Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Evaluator Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: |
| Evaluator Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Evaluator Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: |
| Evaluator Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Evaluator Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: |