|  |  |  |  |
| --- | --- | --- | --- |
| Required Policy Review | Yes | No | Comment |
| 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.* |  |  |  |
| 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.* |  |  |  |
| Forms/Documentation- *Demonstrates competency in systems used in the work setting to track the administration of medications, which includes written medication administration records.* |  |  |  |
| Discontinuing Medications- *Demonstrates competency in agency policies and practices for proper documentation of the discontinuation of a medication*. |  |  |  |
| Disposing of Medications- *Demonstrates competency in agency policies and practices for proper medication disposal.* |  |  |  |
| Adverse Reactions- *Demonstrates competency in potential adverse reactions, side effects, sensitivity, allergic reactions and medication interaction concerns.* |  |  |  |
| 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.* |  |  |  |
| PRN usage- *Demonstrates competency in agency PRN policies and practices, including appropriate circumstances in which to administer PRNs to the individuals they will support.* |  |  |  |
| Refusals- *Demonstrates competency in agency policies, procedures and regulations regarding medication refusals or misuse.* |  |  |  |
| Medication Errors- *Demonstrates competency by accurately providing a description/definition of a medication error and identifies ways to minimize errors.* |  |  |  |
| Missed Medication- *Demonstrates competency by accurately describing agency protocol for missed medication.* |  |  |  |
| Medical Appointments (if DSPs accompany individuals): *Demonstrates competency in agency policy and practice when accompanying individuals to medical appointments.* |  |  |  |
| Self-Medication- *Demonstrates competency in agency policy and practices regarding self- medication.* |  |  |  |
| 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.* |  |  |  |
| 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 |  |  |  |
| Successful completion of Mock trial of administering a medication (can be to supervisor/co-worker) – see Mock Medication Administration Observation Checklist |  |  |  |
| Successful documentation of agency Medication Administration Record (MAR) |  |  |  |
| Skill Test Out Requirements |  |  |  |
| If applicable, successful creation of a new agency MAR ☐ n/a |  |  |  |
| 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

**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.*