DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
COMMUNITY CRISIS STABILIZATION SERVICES

# Medication Administration Competency Assessment Tool

☐ Probationary
☐ Annual
☐ Other:

| EMPLOYEE NAME | SHIFT |
|---|---|
| | |

**Competency Statement:**

The purpose of this competency assessment tool is to evaluate the employee's knowledge, skills and ability for medication administration. All criteria identified on the assessment is taught to the employee during new employee orientation, periodically or during specific trainings.

**Competency expectations:**

• The delegating nurse is responsible for performing the medication administration competency assessment for staff at the Community Crisis Stabilization Services program.

• The delegating nurse utilizes the tool at designated intervals: time of hire, three months, six months and annually thereafter.

• The delegating nurse directly observes staff during the medication administration process and requests that staff verbalize identified procedures to complete the competency assessment. The discussion portion of the assessment can occur separately or during the medication administration observation process.

METHOD OF VERIFICATION

☐ Observation    ☐ Scenario    ☐ Discussion

## Checklist Criteria for Passing Medication:

| QUALITY INDICATIONS | VALIDATION METHOD | YES | NO | COMMENTS |
|---|---|---|---|---|
| Wash hands | Observe staff prior to process | ☐ | ☐ | |
| Check client allergies | Ask staff what the correct method to identify client allergies is | ☐ | ☐ | |
| Check if client has medications on HOLD | Ask staff to identify procedure for hold medications | ☐ | ☐ | |
| Check medication stop date | Observe staff during medication administration | ☐ | ☐ | |
| **Five Rights:**<br>• Right Patient<br>• Right Medication<br>• Right Dose<br>• Right Time<br>• Right Route | Observe staff execute Five Rights during medication administration | ☐ | ☐ | |
| **Passing Medication:**<br>• Unlock medication cabinet<br>• Compare bubble pack to MAR (dose / time)<br>• Put medication from bubble pack into medication cup<br>• Give medication to client following instructions noted in medication book<br>• Sign MAR on back<br>• Initial box where medication was given<br>• If missed or refused circle initials on box and document on the back of MAR the reason for refusal<br>• Return medication box to locked cupboard | Observe staff during medication administration | ☐ | ☐ | |

| | | YES | NO | |
|---|---|---|---|---|
| Able to verbalize where to find medication / side effect information | Verbalized by staff | ☐ | ☐ | |

**Checklist Criteria for PRN Medication Protocol:**

| QUALITY INDICATIONS | VALIDATION METHOD | YES | NO | COMMENTS |
|---|---|---|---|---|
| State reason for the use of PRN medication | Verbalized by staff | ☐ | ☐ | |
| State documentation elements for PRN medication:<br>• MAR check for reason for the PRN<br>• Give medication according to steps listed above<br>• Document description of effectiveness on back of MAR | Verbalized by staff | ☐ | ☐ | |
| **KNOWLEDGE** | **DIALOGUE** | **YES** | **NO** | **COMMENTS** |
| Patient identifiers | Ask staff to explain procedure for patient identification | ☐ | ☐ | |
| Medication Incident Reporting:<br>• Incorrect controlled medication count<br>• A medication found in facility<br>• Missed medication | Ask staff to explain procedure for incident reporting related to medications | ☐ | ☐ | |

**Competency Assessment Plan:**

I verify the above named staff's competency was assessed for medication administration and criteria for PRN medication protocol.

| DELEGATING NURSE SIGNATURE | DATE | PRINTED NAME |
|---|---|---|
| | | |

Opportunity for improvement:

Supervisor's plan to implement including timeframe for follow-up assessment:

| SUPERVISOR SIGNATURE | DATE | PRINTED NAME |
|---|---|---|
| | | |

| EMPLOYEE SIGNATURE | DATE |
|---|---|
| | |