Connecticut Department of Developmental Services
Medication Administration Certification Program
ON–SITE PRACTICUM/CHECKLIST A

PRINT Name: ________________________________ Agency:____

Initial Certification   Recertification   Annual   Other:_________________ Site:________________________

Directions: The RN or DDS Authorized LPN is responsible for reviewing **all** elements identified in the section to which her/his name is signed. RNs shall be responsible for the initial training of the information identified. DDS Authorized LPNs can provide training for recertification only.	Date: mo/day/yr	Signature of RN or Authorized LPN
1. Agency specific information: ▪ Delegation of responsibility by RN ▪ Approved abbreviations & Codes for documentation ▪ Administration documentation requirements ▪ Procedure for medication errors ▪ Procedures for working with pharmacy ▪ Location of policies and procedures ▪ Storage and Security of medications ▪ Controlled drug counts ▪ Orders from Health Care Providers ▪ Faxed orders ▪ PRN /as needed orders ▪ Order transcription process ▪ Location of reference materials ▪ Medication Sanction Policy ▪ Emergency procedures ▪ Leave of Absence medications		
2. Review of agency communication process for contacting RN during business hours and outside of business hours (RN On Call) to report: ▪ Changes in person's condition, &/or prescribed medication/treatments prior to implementation ▪ Medication administration issues (med errors, problems with administration, lack of meds, discrepancies in controlled drug counts, etc.) ▪ Changes related to effects of medication (side or adverse effect, allergic effect, etc.) ▪ Documentation of notification to nurse (i.e., date, time, name of nurse, directions provided)		
3. **Individual specific/site specific considerations (Staff must receive training and documentation must be present at <u>each site</u> where responsibility is delegated)** ▪ Desired therapeutic effect and side effects of medications given at the site ▪ Medication dosage form modifications needed at site (breaking scored tablets, crushing, thickening liquid meds, mixing with food bases, awareness of dysphagia/swallowing risks) ▪ History of allergies and responses to medications (include emergency interventions) ▪ Participation of consumers in the medication administration process ▪ Training on administration routes other than oral and topical to meet needs of persons at site (i.e., inhalant meds, transdermal patches, rectal meds, vaginal medications, meds administered via enteral tube) Identify all routes for which training provided under "comments"		
Comments:		

I certify that all of the above listed items have been reviewed with me on the date(s)and by the nurse(s) noted above. I understand that if I knowingly make any misstatement of fact, I am subject to disqualification from participating in the program, possible disciplinary action and revocation of certification to administer medications.

______________________________________ _______________

Signature of Employee   Date of Signature

As the **Delegating RN**, I certify that I have reviewed the above listed items or have been advised that they have been reviewed with the employee by the above signed RN or DDS Authorized LPN on the date(s) noted. I further certify that the statements made on this on-site practicum by, or to me are true and complete to the best of my knowledge. I understand that if I knowingly make any misstatement of fact, I am subject to possible action by DDS or other agency.

________________________________ ______________ ____________________________________

Signature of RN   Date of Signature   Printed Name of RN