DEPARTMENT OF DEVELOPMENTAL SERVICES

Coronavirus (COVID-19)- Interim Quarterly Review of Medication Administration

Year: 2020 Review period: Jan. 1 - March 31 ☐ April 1 - July 31 ☐ Agency: ________________

Address of Residential Site: ________________

Section A:

To be completed by certified staff if the delegating nurse is unable to access the residential site in order to complete quarterly medication administration review due to the COVID-19 pandemic. The delegating RN will assign Section A to be completed by a certified staff. This form must be signed by the certified staff participating in the review process then finalized and signed by the delegating RN.

Please provide information about the following issues related to medication administration:		Yes	No
1.	All medications are correctly stored according to the requirements specific to that type of preparation or as identified by regulation (i.e. Internal and external preparations, controlled drugs, refrigerated)	☐	☐
2.	Access to meds is limited to licensed Nurses & certified staff who are currently delegated responsibility at this site	☐	☐
3.	All On-Site practicums (Checklist A & B) documents are available at the site	☐	☐
4.	All staff have current med certification cards and copies are secured but available for review *Anyone granted an extension (any who expired from March1-June 30, 2020) due to COVID-19 please list names below	☐	☐
5.	Current orders are present from authorized prescribers for all medications administered. Were any orders extended by authorized prescriber? Circle Yes or No. If so, nurse explain below.	☐	☐
6.	An RN is notified of all new orders/changes in orders prior to administration of the medication	☐	☐
7.	Each transcription of orders is checked by another med certified staff or nurse before medication is started	☐	☐
8.	Labels on medications match prescriber orders or contain a sticker referring reader to prescriber's orders	☐	☐
9.	The documentation of medication administration is accurate and complete (i.e., initials in appropriate box, initials are identified on MAR, effectiveness of PRN meds is indicated, hold/refusals noted)	☐	☐
10.	Controlled drugs are counted each shift (at a minimum) and discrepancies are corrected/ acted upon	☐	☐
11.	Medication reference materials and/or medication information is available at the site for all preparations	☐	☐
12.	Unused, outdated, and/or discontinued medications are destroyed per DDS regulation and agency policy Control medications are destroyed by the nurse and one witness.	☐	☐

*List employees who utilized the extension (March1-June30) during this time frame: ________________

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Certified Staff Signature	Date	Printed Legal Name

Section B:

This portion shall be completed by the delegating\covering RN or authorized LPN. Please review above portion completed by med cert staff, fill out section(s) below, sign and date.

If your agency does not have an Electronic Health Record and you cannot access the MAR'S, Control Sheets & Shift Count Sheet for January, February, & March then please have staff fax/scan these documents to you if you can ensure all documents will be maintained confidentially.

Were you able to review all MAR's, Control Sheets & Shift Count Sheets? Yes ☐ No ☐ If no, please explain

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Has there been a need due to COVID-19 to have any extensions to prescribers' orders? If so, please explain:

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Section B:

This portion shall be completed by the delegating\covering RN or authorized LPN. Please review above portion completed by med cert staff, fill out section(s) below, sign and date.

Indicate the number of each type of medication error committed during the review period:

1. Omission __________ **2**. Wrong Person ________ **3**. Transcription ________ **4.** Wrong Medication ________
5. Wrong Dose __________ **6**. Wrong Time ________ **7.** Wrong Route ________ **8**. Documentation ________
9. Other (explain) ________

Please indicate the # of each type of sanctions imposed: Termination _____ Suspension _____ Letter of warning ________
Suspension of Delegation _____ DDS 12 hr. Retraining course _______ Other ______________________________

Please indicate the number of requests for DDS sanctions (revocation or suspension) sent to regional DHS ___________
Comments/Explanation: ____

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1. Were Incident reports (DDS 255m) completed for all medication errors and processed/ sent to DDS in a timely fashion?
Yes ☐ No ☐ Comments: ____
2. Was Retraining provided by the delegating RN for all medication errors or prohibited practices committed?
Yes ☐ No ☐ Comments: ____
3. Was Agency Sanction process implemented by RN for medication errors? Yes ☐ No ☐
Comments: ____

____________________	____________________	____________________
RN signature of full Report	Date of report	Printed Legal Name

e-mail: ______________________________________ Phone: ______________

PLEASE COMPLETE THIS INFORMATION WITHIN 30 DAYS OF THE END OF REVIEW PERIOD AND SEND COPY TO: NURSING SUPERVISOR for DDS Nurses in Public Programs, REGIONAL NURSE CONSULTANT for Private Providers. Original should remain at the residential site available for review.