**Licensed Nurse Competency Checklist-Medication Management**

*State logo added here. If not, delete text box*

**Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Hire Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| **Skill Area** | **Evaluation****(Check One)** | **Method of Evaluation****(Check One)**D = Skills DemonstrationO = Performance ObservationW = Written TestV = Verbal Test | **Verification** **(Initials/Date)** |
| --- | --- | --- | --- |
| **Competency****Demonstrated/****Meets** **Standards** | **Needs Additional Training** |
| **D** | **O** | **W** | **V** |
| **Evaluator complete** **Licensed Nurse Competency Checklist-Medication Management** | Demonstrates involvement of resident/resident representative in the development of the care plan and defining the approaches and goals |  |  |  |  |  |  |  |
| Observes for effectiveness medication and interventions |  |  |  |  |  |  |  |
| Verbalizes understanding of facility approved abbreviations for medication administration (e.g. PRN, QD, BID, TID, QID, AC, PC, etc.) |  |  |  |  |  |  |  |
| Prior to administering medications, performs necessary parameter evaluations (e.g., BP, P and or AP, respirations, blood sugar, etc.) |  |  |  |  |  |  |  |
| Describe common medications recommended to be administered with adequate fluids and/or food |  |  |  |  |  |  |  |
| Demonstrates and describes why medication cart should whenever not attended (e.g., accidental resident ingestion of medication, diversion of medications, etc.) |  |  |  |  |  |  |  |
| Demonstrates hand hygiene before and after medication administration |  |  |  |  |  |  |  |
| Verbalizes understanding of the Medication Regimen Review report (e.g., identified irregularities and recommendations) |  |  |  |  |  |  |  |
| Demonstrates following facility specific procedures for Controlled Drug ordering, receipt, administration, documentation, facility reconciliation procedure, storage and destruction |  |  |  |  |  |  |  |
| Demonstrates/describes protocol for resident refusal of medication  |  |  |  |  |  |  |  |
| Checks the following prior to medication administration:* Right medication
* Right dose
* Right documentation
* Right route
* Right resident
* Right time
* Right reason
 |  |  |  |  |  |  |  |
| Demonstrates proper placement and documentation of date and time on transdermal patches. Upon removal of patch, demonstrates proper disposal (including policy for disposal for fentanyl patches, etc.) |  |  |  |  |  |  |  |
| Demonstrates proper technique in IM injection |  |  |  |  |  |  |  |
| Demonstrates proper technique in SQ injection |  |  |  |  |  |  |  |
| Demonstrates proper mixing of insulin per facility policy (Scope of Practice-RN vs. LPN) |  |  |  |  |  |  |  |
| Verbalizes the different types of Insulin:* Rapid Acting
* Short Acting (regular)
* Intermediate Acting
* Long Acting
* Inhaled
 |  |  |  |  |  |  |  |
| Describes facility on Insulin Pens |  |  |  |  |  |  |  |
| Monitors for the emergence or presence of adverse events related to medication and/or interventions. |  |  |  |  |  |  |  |
| Verbalizes additional areas of Federal Requirements of Participation as it relates to medication management:* Right to be Informed and Participate
* Right to Participate in Care Planning
* Comprehensive Resident-Centered Care Plans,
* Notification of Change
* Chemical Restraints
* Choices
* Social Services
* Admission Orders
* Professional Standards
* Pain
* Diabetic Management,
* Dementia Care
* Behavioral-Emotional Status
* Nutrition
* Hydration
* Sufficient and Competent Staffing
* Physician Services
* Pharmacy Services
* QAA/QAPI
 |  |  |  |  |  |  |  |
| Demonstrates medication administration via NG or G-tube consistent with facility policy |  |  |  |  |  |  |  |
| Flushes nasogastric or gastrostomy tube with the required amount of water before and after each medication unless physician orders indicate a different flush schedule due to the resident’s clinical condition. |  |  |  |  |  |  |  |
| Demonstrates eye medication administration per facility procedure |  |  |  |  |  |  |  |
| Demonstrates proper metered dose inhaler administration * Shakes container
* Position inhaler in resident mouth
* Instruction to resident
* If more than one puff is required, follow manufacturer’s recommendation on wait time
* Manufacturer’s recommendations for rinses
 |  |  |  |  |  |  |  |
| Demonstrates proper medication administration via nebulizer (including cleaning/disinfecting and storage of equipment |  |  |  |  |  |  |  |
| Demonstrates proper IV medication administration |  |  |  |  |  |  |  |
| Describes process for medication errors |  |  |  |  |  |  |  |
| **Other (Describe)**  |  |  |  |  |  |  |  |  |
| **Other (Describe)** |  |  |  |  |  |  |  |  |

**\*I certify that I have received orientation in the above-mentioned areas.**

**\*Employee:**

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

**Initials**  **Signature**  **Date**

**Evaluator/Trainer:**

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

**Initials Signature Date**

***(PLACE IN EMPLOYMENT FILE)***

**References:**

Centers for Medicare and Medicaid Services (CMS) State Operations Manual, Appendix PP-Guidance to Surveyors for Long Term Care Facilities. (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf>

Centers for Medicare and Medicaid Services (CMS) Medication Administration Critical Element Pathway, Form CMS 20056 (10/2017): <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>