



**BEACON**  
Specialized Living

0917  
0630  
1001

**Medication Administration In-Service and Evaluation**

Name of Facility/Home: Bunkhouse

Employee Receiving In-Service: Kristen Coffman

Date of 1st In-Service: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_ : \_\_\_ am / pm Trainer: \_\_\_\_\_

Date of 2nd In-Service: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_ : \_\_\_ am / pm Trainer: \_\_\_\_\_

Date of 3rd In-Service: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_ : \_\_\_ am / pm Trainer: \_\_\_\_\_

Date of 4th In-Service: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_ : \_\_\_ am / pm Trainer: \_\_\_\_\_

Date of 5th In-Service: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_ : \_\_\_ am / pm Trainer: \_\_\_\_\_

Date of 6th In-Service: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_ : \_\_\_ am / pm Trainer: \_\_\_\_\_

Date of Final Evaluation: 3/22/21 Time: 8:00 (am) / pm Trainer: Mandy Behrman

**All staff must complete all three (6) In-Services and Final Evaluation**

Instructions: Check (✓) the appropriate box after Employee has been in-serviced.

In-Service #		1st	2nd	3rd	4th	5th	6th	Eval.	Comments
1	Medication Area	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
	a. Location of ample supplies prior to administration	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
	b. Area is clean and organized	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
	c. Area is always locked	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
	d. Location of all medication: Internal, External, Refrigerated, Controlled Drugs (narcotics)	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
2	DMA washes hands prior to administering medications and between each Resident	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
3	Medication keys are retained by DMA	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
4	Resident is identified per facility policy and procedure prior	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
5	Vital signs are taken per facility policy prior to administering medications (if applicable), always on cardiac and BP medications	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
	a. If Pulse and BP are required, hands and equipment are washed per facility policy	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
	b. If Apical Pulse is required, privacy is provided	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
6	Medications Administration per facility policy and procedure: to include review of the '6 Rights'	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
	a. Medications are properly removed from container/blister pack and (.) dot is placed in appropriate box on MAR	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
	b. Liquid medication is poured at eye level, with palm covering label of stock bottle	<input type="checkbox"/>	<input checked="" type="checkbox"/>						



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**Medication Administration In-Service and Evaluation**

	In-Service #	1st	2nd	3rd	4th	5th	6th	Eval.	Comments
19	Medication errors are reported to Site Supervisor and RN teaching medication classes	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
20	Medication area is cleaned and locked after completion of medication administration	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
21	Designated Medication Administrator can identify action and common side effects of medications administered	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
22	Approved Abbreviations List is reviewed	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
23	Seizure precautions and documentation	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
24	After hour procedures, procedures for found/spilled medication, location of Guide to Drugs Book	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
25	2nd Staff Verification, what it is, when it is needed, and how to document it	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
26	Refusal of Medication procedures (prompt 3 times, then write appropriate documentation)	<input type="checkbox"/>	<input checked="" type="checkbox"/>						

**FOLLOW UP CONCERNS**

Specify time frame for completion: \_\_\_\_\_  N/A

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

I have received the above In-service and have read the Organizations **Medical Policies**. I understand what is expected of me as a Designated Medication Administrator. I also understand that any immediate medical questions or concerns should be directed to the Coordinator of Care at my Site during open office hours and to the On-Call person after hours.

Kristin Coffey  
Employee Signature

3-22-21  
Date

M. B.  
Home Manager Signature

3.23.21  
Date