



**BEACON**  
Specialized Living

## Medication Administration In-Service and Evaluation

Name of Facility/Home: \_\_\_\_\_ Mission Point \_\_\_\_\_

Employee receiving In-Service: \_\_\_\_\_ Heather Pancake \_\_\_\_\_

Date of 1st In-Service: 9/23/21 Time: 8:00 am/pm L&D: Evelyn Northrop

Date of 2nd In-Service: 9/23/21 Time: 2:00 am Medical: Tracie Vineyard

Date of 3rd In-Service: 10/15/21 Time: 8:00 am DMA TTT: Helen Bates

Date of 4th In-Service: 10/19/21 Time: 10:00 am DMA TTT: Helen Bates

Date of 5th In-Service: 10/20/21 Time: 12:00pm DMA TTT: Helen Bates

Date of 6th In-Service: 10/21/21 Time: 7:00 pm HM: Helen Bates

Date of Final Evaluation: 10/25/21 Time: 2:00 am / pm DMA TTT: Vera Cousino

**All staff must complete DMA class, Medical class, Homework and DMA Test in LMS along with In-Services and Final Evaluation for certification.**

Code #1 \_\_\_\_\_ Code #2 \_\_\_\_\_ Code #3 \_\_\_\_\_

In-Service #		1st	2nd	3rd	4th	5th	6th	Eval.	Comments
1.	MEDICATION AREA-	X	X	X	X	X	X	X	
	a. Location of ample supplies before administration.	X	X	X	X	X	X	X	
	b. Report medication that is 10 days or less. Check expiration dates on all medication (special attention to epi-pen, prn medication not commonly used). If a medication is not available contact management and medical to obtain medication or further direction. This must also be reported to recipient rights as medication error verbally and then followed up with an event report	X	X	X	X	X	X	X	
	d. Location of all medication: Internal, External, Refrigerated, Controlled Substances, PRN's. Medications are separated. Location of: High Alert Board, Sharp's container, Medication posting binder, Prescription Book, Medication Book.	X	X	X	X	X	X	X	
	c. Area is clean, organized, and locked.	X	X	X	X	X	X	X	
2	DMA washes hands before administering medications and between each Resident when a sink is in the medication room. If not, wash hands before and between each 3 <sup>rd</sup> person, always sanitizing between each. Sanitizing and wearing gloves is never a substitute for handwashing. Masks should be worn at all times when out of the medication room when required	X	X	X	X	X	X	X	



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3	Medication keys are retained by DMA. When completing DMA change complete appropriate documentation. This is to be completed at shift change and the staff must attest that all medications and event reports written, when applicable	X	X	X	X	X	X	
4	A resident is identified per facility policy and procedure before administering meds. At least 2 patient identifiers per Joint Commission National Patient Safety Goals.	X	X	X	X	X	X	
5	All medications require a prescription including lotions, creams, powders, and OTC medication.	X	X	X	X	X	X	
6	Vital signs are taken per facility policy before administering medications (if applicable), always on cardiac and BP medications	X	X	X	X	X	X	
	a. If Pulse and BP are required, hands and equipment are washed per facility policy	X	X	X	X	X	X	
	b. Follow vital range guidelines unless otherwise specified with a written prescription by the prescribing physician.	X	X	X	X	X	X	
7	c. Beacon vital sign ranges are as follows: Temperature 96-99, Pulse 50-100, Respirations 12-20, Low blood pressure 90/50 or below, High blood pressure 160/90 or higher	X	X	X	X	X	X	
8	Medications Administration per facility policy and procedure: to include a review of the '6 Rights'. Right, Resident, Right Route/Method, Right Medication, Right Time/Date, Right Dose, Right Documentation. Medication administration should not be interrupted, do NOT rush.	X	X	X	X	X	X	
	a. Medications are properly removed from container/blister pack and (.) dot is placed in the appropriate box on MAR. If on EMAR a check ( <input checked="" type="checkbox"/> ) is placed in the appropriate box.	X	X	X	X	X	X	
	b. Liquid medication is poured at eye level on a flat surface, with palm covering label of the stock bottle	X	X	X	X	X	X	
	c. DMA verifies medication and strength with an order as transcribed on medication record per facility policy and procedure. Note: Strength and dose are not always the same.	X	X	X	X	X	X	
	d. Observe Resident to ensure medication is swallowed. If (ODT) disintegrating medication is given, place in a separate cup and ensure medication dissolves.	X	X	X	X	X	X	
	e. Offer adequate and appropriate fluid with medication, full glass of water unless otherwise ordered. Note: Any fluid restrictions, special instructions (nectar thick, etc.), or potential adverse fluid interactions (grapefruit juice)	X	X	X	X	X	X	
	f. DMA should initial the medication the first time they use it at the top of the bubble pack. Initial and date in back.	X	X	X	X	X	X	
	g. Medication record is signed immediately after administration of same. Add initials to box on MAR and complete back page or on EMAR choose Pass selected.	X	X	X	X	X	X	



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	Choose exceptions if needed and document. Check for any blanks on MAR or EMAR and utilize a Late med pass or proper documentation. Any exception requires a misc. note to be completed. This should be completed at every shift change							
	h. Controlled substance record is signed immediately after administration of same. The controlled count is done at DMA change and when administering medication.	X	X	X	X	X	X	
	i. Verify no additional MAR pages have been added, check the high alert board and shift change agenda.	X	X	X	X	X	X	
	j. Infection control technique is reviewed, Handwashing and Universal Precautions.	X	X	X	X	X	X	
9	Medication via gastric tube administered per facility policy and procedure. If applicable Medical will provide hands-on education, support, and training. <ul style="list-style-type: none"> <li>▪ Resident is properly positioned, at a 45° sitting angle</li> <li>▪ Tube is checked for placement and patency</li> <li>▪ Tube is flushed before between and after medications are administered</li> </ul>	X	X	X	X	X	X	
10	Injections are administered by the Resident if there is a physician and psychiatrist order present, or DMA, per facility policy and procedure	X	X	X	X	X	X	
	a. Syringes and needles are disposed of in a sharps container, by the person giving the injection (should be the resident, unless otherwise ordered by PCP) without recapping. Sharp's container must be dated 90 days out for expiration once you begin using.	X	X	X	X	X	X	
	b. Proper glucometer testing is observed. Determination of competence re: accurately perform and read glucometer testing results. Still must remain with resident and verify accurate information and document.	X	X	X	X	X	X	
	c. Insulin Pen and vials are to be dated 28 days out once they are open or used. Pay special attention to storage instructions. Pens are refrigerated before first use. Vials are refrigerated. Bottles and pens must be labeled with the expiration dates	X	X	X	X	X	X	
11	DMA crushes medication according to facility policy and procedure ONLY with written physician's orders. Note: Does it specify in pudding, yogurt, applesauce, and follow orders.	X	X	X	X	X	X	
12	DMA administers eye and ear medication according to facility policies and procedures.	X	X	X	X	X	X	
13	Inhalers should be disinfected between use. If multiple inhalers are used separately by 5 minutes. Always swish and spit after steroid inhalers to prevent infection.	X	X	X	X	X	X	
14	Medication prescription, label, and MAR should all match. Generic and Brand Names should be on the label. Prescriptions can be verified in the binder in the medication room and/or NextStep.	X	X	X	X	X	X	



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15	When a resident is leaving for an LOA ensure you are completing the Release of Responsibility for Medication, if 2 <sup>nd</sup> staff is available best practice would be to have both staff count medication being released. This would be the same process upon return. Ensure staff and party it was released to sign upon leave and return. *Send all medication including PRN's	X	X	X	X	X	X	X	
16	When a resident is leaving on an outing or signing out, ensure they are taking their epi-pen, rescue inhaler, and any other applicable medication and completing appropriate documentation. *Sunblock if applicable	X	X	X	X	X	X	X	
17	Residents' rights are observed. Residents have the right to privacy. Rights to receive their medication as prescribed and right to refuse medication.	X	X	X	X	X	X	X	
18	Location, Procedures, and Documenting for administering PRN including checking history and completing follow-up. PRN medication must be administered as prescribed for a specified reason.	X	X	X	X	X	X	X	
19	DMA follows facility policy and procedure for medications refused or withheld. (ER/ IR written as applicable along with misc. note)	X	X	X	X	X	X	X	
20	Medications are administered within the time frame per facility policy and procedure. There is a 1 hour before and 1 hour after the time frame for medication administration. Once outside the time frame, there is an additional 30 minutes before you must contact medical to receive approval to administer medication.	X	X	X	X	X	X	X	
21	Medication errors are reported to Home Manager, Regional Nurse, and prescribing physician. An IR/ER and misc. note must be completed before the end of the shift. If medication is given to the wrong resident contact poison control immediately followed by medical.	X	X	X	X	X	X	X	
22	The medication area is cleaned and locked after the completion of medication administration. All medication is double locked.	X	X	X	X	X	X	X	
23	DMA can identify the action and common side effects of medications administered. Side effects of psychoactive medication are noted (lethargy, hallucinations) and reported.	X	X	X	X	X	X	X	
24	Approved Abbreviations List is reviewed	X	X	X	X	X	X	X	
25	Seizure precautions and documentation. Follow Beacon's policy unless someone has their medical protocol prescription.	X	X	X	X	X	X	X	
26	After-hour procedures and protocol for found/spilled medication. Location of Epocrates link on staff computer. All medication disposed of must have second staff verification and a complete disposal log. Controlled substances are disposed of in the Dead drug box, all other medication is disposed of in the Rx destroyer jug.	X	X	X	X	X	X	X	



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27	2nd Staff Verification, what it is, when it is needed, and how to document it. (Med disposal, Insulin verification, Med reconciliation, controlled substance count)	X	X	X	X	X	X	X	
28	Refusal of Medication procedures (prompt 3 times, then complete IR/ER as applicable) If medication has been popped, store in a sealed baggie labeled with their initial, time, and date in their medication folder. If medication is not administered per approval as applicable dispose at end of shift.	X	X	X	X	X	X	X	
29	For questions or concerns contact your Regional Nurse during business hours. Follow After hours On-Call procedure as applicable. If a medical emergency contact 911 before Medical. Must know the on-call process and the phone numbers	X	X	X	X	X	X	X	

#### FOLLOW UP CONCERNS

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

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I have received the above In-services 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 Home Manager or Regional Nurse at my Site during open office hours and to the On-Call person after hours.

Walt Paucek \_\_\_\_\_ 10/25/21 \_\_\_\_\_  
Employee Signature Date

[Signature] \_\_\_\_\_ 10/25/21 \_\_\_\_\_  
Home Manager Signature or DMA TTT Date



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## Medication Administration In-Service and Evaluation

Name of Facility/Home:

Mission Point / Fire Lake (Eval)

Employee receiving In-Service:

Heather Pancake

Date of 1st In-Service: 9/23/21 Time: 8:00 am/pm L&D:

Date of 2nd In-Service: 9/23/21 Time: 2:00 am/pm Medical:

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

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

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

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

Date of Final Evaluation: 10/25/21 Time: 10:00 am/pm DMA TTT: HM

All staff must complete DMA class, Medical class, Homework and DMA Test in LMS along with In-Services and Final Evaluation for certification.

Code #1 \_\_\_\_\_ Code #2 \_\_\_\_\_ Code #3 \_\_\_\_\_

In-Service #		1st	2nd	3rd	4th	5th	6th	Eval.	Comments
1.	MEDICATION AREA-							✓	Restock each shift
	a. Location of ample supplies before administration.								
	b. Report medication that is 10 days or less. Check expiration dates on all medication (special attention to epi-pen, prn medication not commonly used). If a medication is not available contact management and medical to obtain medication or further direction. This							✓	



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	must also be reported to recipient rights as medication error verbally and then followed up with an event report								✓	
	d. Location of all medication: Internal, External, Refrigerated, Controlled Substances, PRN's. Medications are separated. Location of: High Alert Board, Sharp's container, Medication posting binder, Prescription Book, Medication Book.								✓	Check Alert Board each time Ask questions
	c. Area is clean, organized, and locked.								✓	Clean each med time
2	DMA washes hands before administering medications and between each Resident when a sink is in the medication room. If not, wash hands before and between each 3 <sup>rd</sup> person, always sanitizing between each. Sanitizing and wearing gloves is never a substitute for handwashing. Masks should be worn at all times when out of the medication room when required								✓	
3	Medication keys are retained by DMA. When completing DMA change complete appropriate documentation. This is to be completed at shift change and the staff must attest that all medications and event reports written, when applicable								✓	Never hand over keys to co-workers
4	A resident is identified per facility policy and procedure before administering meds. At least 2 patient identifiers per Joint Commission National Patient Safety Goals.								✓	
5	All medications require a prescription including lotions, creams, powders, and OTC medication.								✓	
6	Vital signs are taken per facility policy before administering medications (if applicable), always on cardiac and BP medications								✓	
	a. If Pulse and BP are required, hands and equipment are washed per facility policy								✓	Clean after each use w/ alcohol pad
	b. Follow vital range guidelines unless otherwise specified with a written prescription by the prescribing physician.								✓	
7	c. Beacon vital sign ranges are as follows: Temperature 96-99, Pulse 50-100, Respirations 12-20, Low blood pressure 90/50 or below, High blood pressure 160/90 or higher								✓	Posted in med room @ Rife
8	Medications Administration per facility policy and procedure: to include a review of the '6 Rights'. Right, Resident, Right Route/Method, Right Medication, Right Time/Date, Right Dose, Right Documentation. Medication administration should not be interrupted, do NOT rush.								✓	Shut door between passes to ensure no interruptions use 2ed staff
	a. Medications are properly removed from container/blister pack and (.) dot is placed in the appropriate box on MAR. If on EMAR a check (☑) is placed in the appropriate box.								✓	Check mar each shift



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	b. Liquid medication is poured at eye level on a flat surface, with palm covering label of the stock bottle							✓	
	c. DMA verifies medication and strength with an order as transcribed on medication record per facility policy and procedure. Note: Strength and dose are not always the same.							✓	
	d. Observe Resident to ensure medication is swallowed. If (ODT) disintegrating medication is given, place in a separate cup and ensure medication dissolves.							✓	Talk to each resident offer a 2nd water
	e. Offer adequate and appropriate fluid with medication, full glass of water unless otherwise ordered. Note: Any fluid restrictions, special instructions (nectar thick, etc.), or potential adverse fluid interactions (grapefruit juice)							✓	Full Glass
	f. DMA should initial the medication the first time they use it at the top of the bubble pack. Initial and date in back.							✓	
	g. Medication record is signed immediately after administration of same. Add initials to box on MAR and complete back page or on EMAR choose Pass selected. Choose exceptions if needed and document. Check for any blanks on MAR or EMAR and utilize a Late med pass or proper documentation. Any exception requires a misc. note to be completed. This should be completed at every shift change							✓	Check MAR Each Shift for blanks call IF Having any issues
	h. Controlled substance record is signed immediately after administration of same. The controlled count is done at DMA change and when administering medication.							✓	
	i. Verify no additional MAR pages have been added, check the high alert board and shift change agenda.							✓	
	j. Infection control technique is reviewed, Handwashing and Universal Precautions.							✓	
9	Medication via gastric tube administered per facility policy and procedure. If applicable Medical will provide hands-on education, support, and training. <ul style="list-style-type: none"> <li>Resident is properly positioned, at a 45° sitting angle</li> <li>Tube is checked for placement and patency</li> <li>Tube is flushed before between and after medications are administered</li> </ul>								N/A
10	Injections are administered by the Resident if there is a physician and psychiatrist order present, or DMA, per facility policy and procedure							✓	
	a. Syringes and needles are disposed of in a sharps container, by the person giving the injection (should be the resident, unless otherwise ordered by PCP) without recapping. Sharp's container must be dated 90 days out for expiration once you begin using.							✓	
	b. Proper glucometer testing is observed. Determination of competence re: accurately perform and read glucometer testing results. Still must remain with resident and verify accurate information and document.							✓	



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	c. Insulin Pen and vials are to be dated 28 days out once they are open or used. Pay special attention to storage instructions. Pens are refrigerated before first use. Vials are refrigerated. Bottles and pens must be labeled with the expiration dates							✓	mark date on pen
11	DMA crushes medication according to facility policy and procedure ONLY with written physician's orders. Note: Does it specify in pudding, yogurt, applesauce, and follow orders.							✓	
12	DMA administers eye and ear medication according to facility policies and procedures.							✓	
13	Inhalers should be disinfected between use. If multiple inhalers are used separately by 5 minutes. Always swish and spit after steroid inhalers to prevent infection.							✓	
14	Medication prescription, label, and MAR should all match. Generic and Brand Names should be on the label. Prescriptions can be verified in the binder in the medication room and/or NextStep.							✓	
15	When a resident is leaving for an LOA ensure you are completing the Release of Responsibility for Medication, if 2 <sup>nd</sup> staff is available best practice would be to have both staff count medication being released. This would be the same process upon return. Ensure staff and party it was released to sign upon leave and return. *Send all medication including PRN's							✓	
16	When a resident is leaving on an outing or signing out, ensure they are taking their epi-pen, rescue inhaler, and any other applicable medication and completing appropriate documentation. *Sunblock if applicable							✓	
17	Residents' rights are observed. Residents have the right to privacy. Rights to receive their medication as prescribed and right to refuse medication.							✓	
18	Location, Procedures, and Documenting for administering PRN including checking history and completing follow-up. PRN medication must be administered as prescribed for a specified reason.							✓	Always check for last pass
19	DMA follows facility policy and procedure for medications refused or withheld. (ER/ IR written as applicable along with misc. note)							✓	
20	Medications are administered within the time frame per facility policy and procedure. There is a 1 hour before and 1 hour after the time frame for medication administration. Once outside the time frame, there is an additional 30 minutes before you must contact medical to receive approval to administer medication.							✓	
21	Medication errors are reported to Home Manager, Regional Nurse, and prescribing physician. An IR/ER and misc. note must be completed before the end of the shift. If medication is given to the wrong resident contact poison control immediately followed by medical.							✓	



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22	The medication area is cleaned and locked after the completion of medication administration. All medication is double locked.							✓	
23	DMA can identify the action and common side effects of medications administered. Side effects of psychoactive medication are noted (lethargy, hallucinations) and reported.							✓	<i>Always report side effects even if unsure</i>
24	Approved Abbreviations List is reviewed							✓	
25	Seizure precautions and documentation. Follow Beacon's policy unless someone has their medical protocol prescription.							✓	<i>Policy in med room Review weekly</i>
26	After-hour procedures and protocol for found/spilled medication. Location of Epocrates link on staff computer. All medication disposed of must have second staff verification and a complete disposal log. Controlled substances are disposed of in the Dead drug box, all other medication is disposed of in the Rx destroyer jug.							✓	
27	2nd Staff Verification, what it is, when it is needed, and how to document it. (Med disposal, Insulin verification, Med reconciliation, controlled substance count)							✓	
28	Refusal of Medication procedures (prompt 3 times, then complete IR/ER as applicable) If medication has been popped, store in a sealed baggie labeled with their initial, time, and date in their medication folder. If medication is not administered per approval as applicable dispose at end of shift.							✓	
29	For questions or concerns contact your Regional Nurse during business hours. Follow After hours On-Call procedure as applicable. If a medical emergency contact 911 before Medical. Must know the on-call process and the phone numbers							✓	<i>Medical emergency 911 First</i>

#### FOLLOW UP CONCERNS

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

*Continue to ask questions*

I have received the above In-services 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 Home Manager or Regional Nurse at my Site during open office hours and to the On-Call person after hours.



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*Heath Pauwale*

Employee Signature

*9/25/21*

Date

*[Signature]*

Home Manager Signature or DMA TTT

*9-25-21*

Date



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# Medication Administration In-Service and Evaluation

Name of Facility/Home:

Fife Lake

Employee receiving In-Service:

Heather Pancake

Date of 1st In-Service: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_:\_\_\_ am/pm L&D:

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

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

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

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

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

Date of Final Evaluation: 11/22/21 Time: 8:00 am pm DMA TTT:

All staff must complete DMA class, Medical class, Homework and DMA Test in LMS along with In-Services and Final Evaluation for certification.

Code #1 \_\_\_\_\_ Code #2 \_\_\_\_\_ Code #3 \_\_\_\_\_

In-Service #	1st	2nd	3rd	4th	5th	6th	Eval.	Comments
1. MEDICATION AREA-								
a. Location of ample supplies before administration.							✓	
b. Report medication that is 10 days or less. Check expiration dates on all medication (special attention to epi-pen, prn medication not commonly used). If a medication is not available contact management and medical to obtain medication or further direction. This							✓	let manager know 10 days



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	must also be reported to recipient rights as medication error verbally and then followed up with an event report							✓	RR # on Board outside of med room
	d. Location of all medication: Internal, External, Refrigerated, Controlled Substances, PRN's. Medications are separated. Location of: High Alert Board, Sharp's container, Medication posting binder, Prescription Book, Medication Book.							✓	
	c. Area is clean, organized, and locked.							✓	
2	DMA washes hands before administering medications and between each Resident when a sink is in the medication room. If not, wash hands before and between each 3 <sup>rd</sup> person, always sanitizing between each. Sanitizing and wearing gloves is never a substitute for handwashing. Masks should be worn at all times when out of the medication room when required							✓	
3	Medication keys are retained by DMA. When completing DMA change complete appropriate documentation. This is to be completed at shift change and the staff must attest that all medications and event reports written, when applicable							✓	Keep keys on yourself at all times
4	A resident is identified per facility policy and procedure before administering meds. At least 2 patient identifiers per Joint Commission National Patient Safety Goals.							✓	
5	All medications require a prescription including lotions, creams, powders, and OTC medication.							✓	
6	Vital signs are taken per facility policy before administering medications (if applicable), always on cardiac and BP medications							✓	
	a. If Pulse and BP are required, hands and equipment are washed per facility policy							✓	
	b. Follow vital range guidelines unless otherwise specified with a written prescription by the prescribing physician.							✓	
7	c. Beacon vital sign ranges are as follows: Temperature 96-99, Pulse 50-100, Respirations 12-20, Low blood pressure 90/50 or below, High blood pressure 160/90 or higher							✓	
8	Medications Administration per facility policy and procedure: to include a review of the '6 Rights'. Right, Resident, Right Route/Method, Right Medication, Right Time/Date, Right Dose, Right Documentation. Medication administration should not be interrupted, do NOT rush.							✓	
	a. Medications are properly removed from container/blister pack and (.) dot is placed in the appropriate box on MAR. If on EMAR a check (☑) is placed in the appropriate box.							✓	



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	b. Liquid medication is poured at eye level on a flat surface, with palm covering label of the stock bottle							✓	
	c. DMA verifies medication and strength with an order as transcribed on medication record per facility policy and procedure. Note: Strength and dose are not always the same.							✓	
	d. Observe Resident to ensure medication is swallowed. If (ODT) disintegrating medication is given, place in a separate cup and ensure medication dissolves.							✓	
	e. Offer adequate and appropriate fluid with medication, full glass of water unless otherwise ordered. Note: Any fluid restrictions, special instructions (nectar thick, etc.), or potential adverse fluid interactions (grapefruit juice)							✓	
	f. DMA should initial the medication the first time they use it at the top of the bubble pack. Initial and date in back.							✓	<i>Back of Card</i>
	g. Medication record is signed immediately after administration of same. Add initials to box on MAR and complete back page or on EMAR choose Pass selected. Choose exceptions if needed and document. Check for any blanks on MAR or EMAR and utilize a Late med pass or proper documentation. Any exception requires a misc. note to be completed. This should be completed at every shift change							✓	
	h. Controlled substance record is signed immediately after administration of same. The controlled count is done at DMA change and when administering medication.							✓	
	i. Verify no additional MAR pages have been added, check the high alert board and shift change agenda.							✓	<i>Always Check Board for Info</i>
	j. Infection control technique is reviewed, Handwashing and Universal Precautions.							✓	
9	Medication via gastric tube administered per facility policy and procedure. If applicable Medical will provide hands-on education, support, and training. <ul style="list-style-type: none"> <li>▪ Resident is properly positioned, at a 45° sitting angle</li> <li>▪ Tube is checked for placement and patency</li> <li>▪ Tube is flushed before between and after medications are administered</li> </ul>								<i>N/A</i>
10	Injections are administered by the Resident if there is a physician and psychiatrist order present, or DMA, per facility policy and procedure							✓	
	a. Syringes and needles are disposed of in a sharps container, by the person giving the injection (should be the resident, unless otherwise ordered by PCP) without recapping. Sharp's container must be dated 90 days out for expiration once you begin using.							✓	
	b. Proper glucometer testing is observed. Determination of competence re: accurately perform and read glucometer testing results. Still must remain with resident and verify accurate information and document.							✓	



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## Medication

### Administration In-Service and Evaluation

	c. Insulin Pen and vials are to be dated 28 days out once they are open or used. Pay special attention to storage instructions. Pens are refrigerated before first use. Vials are refrigerated. Bottles and pens must be labeled with the expiration dates									✓	
11	DMA crushes medication according to facility policy and procedure ONLY with written physician's orders. Note: Does it specify in pudding, yogurt, applesauce, and follow orders.									✓	Have to have order
12	DMA administers eye and ear medication according to facility policies and procedures.									✓	
13	Inhalers should be disinfected between use. If multiple inhalers are used separately by 5 minutes. Always swish and spit after steroid inhalers to prevent infection.									✓	
14	Medication prescription, label, and MAR should all match. Generic and Brand Names should be on the label. Prescriptions can be verified in the binder in the medication room and/or NextStep.									✓	Ensure Each Time
15	When a resident is leaving for an LOA ensure you are completing the Release of Responsibility for Medication, if 2 <sup>nd</sup> staff is available best practice would be to have both staff count medication being released. This would be the same process upon return. Ensure staff and party it was released to sign upon leave and return. *Send all medication including PRN's									✓	
16	When a resident is leaving on an outing or signing out, ensure they are taking their epi-pen, rescue inhaler, and any other applicable medication and completing appropriate documentation. *Sunblock if applicable									✓	
17	Residents' rights are observed. Residents have the right to privacy. Rights to receive their medication as prescribed and right to refuse medication.									✓	use 2 <sup>ed</sup> staff at med passes
18	Location, Procedures, and Documenting for administering PRN including checking history and completing follow-up. PRN medication must be administered as prescribed for a specified reason.									✓	
19	DMA follows facility policy and procedure for medications refused or withheld. (ER/ IR written as applicable along with misc. note)									✓	
20	Medications are administered within the time frame per facility policy and procedure. There is a 1 hour before and 1 hour after the time frame for medication administration. Once outside the time frame, there is an additional 30 minutes before you must contact medical to receive approval to administer medication.									✓	
21	Medication errors are reported to Home Manager, Regional Nurse, and prescribing physician. An IR/ER and misc. note must be completed before the end of the shift. If medication is given to the wrong resident contact poison control immediately followed by medical.									✓	Ask questions ensure IR/ERS done before shift End



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22	The medication area is cleaned and locked after the completion of medication administration. All medication is double locked.							✓	Lock after finish med time
23	DMA can identify the action and common side effects of medications administered. Side effects of psychoactive medication are noted (lethargy, hallucinations) and reported.							✓	
24	Approved Abbreviations List is reviewed							✓	Continue to learn
25	Seizure precautions and documentation. Follow Beacon's policy unless someone has their medical protocol prescription.							✓	Policy on Door in Med room
26	After-hour procedures and protocol for found/spilled medication. Location of Epocrates link on staff computer. All medication disposed of must have second staff verification and a complete disposal log. Controlled substances are disposed of in the Dead drug box, all other medication is disposed of in the Rx destroyer jug.							✓	
27	2nd Staff Verification, what it is, when it is needed, and how to document it. (Med disposal, Insulin verification, Med reconciliation, controlled substance count)							✓	ensure you all need's Have good staff Verification
28	Refusal of Medication procedures (prompt 3 times, then complete IR/ER as applicable) If medication has been popped, store in a sealed baggie labeled with their initial, time, and date in their medication folder. If medication is not administered per approval as applicable dispose at end of shift.							✓	
29	For questions or concerns contact your Regional Nurse during business hours. Follow After hours On-Call procedure as applicable. If a medical emergency contact 911 before Medical. Must know the on-call process and the phone numbers							✓	

#### FOLLOW UP CONCERNS

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

*Good Eval after med error Heather will be utilizing 2nd staff during med passing while slowing down on shutting med door between residents*

I have received the above In-services 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 Home Manager or Regional Nurse at my Site during open office hours and to the On-Call person after hours.



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# Medication Administration In-Service and Evaluation

*Mark Paucek*

Employee Signature

*11/2/21*

Date

*[Handwritten Signature]*

Home Manager Signature or DMS TTT

*11/2/21*

Date