

**State of Connecticut
Department of Developmental Services**

Guidelines for Checklist A of The On-Site Practicum Process

Checklist A is the approved documentation format identified by DDS that is to be used by the RN or DDS Authorized LPN (annual or re-certification only) to record the required agency, site, and individual specific training provided. This section of the On-Site Practicum Process shall occur within the timeframes identified in NS# 08-4 On-Site Practicum Process and only when the non-licensed staff presents a current certification card to the RN or Authorized LPN. If the staff does not have a current card, the DDS Medication Certification Unit shall be contacted for direction.

- ◇ Sections 1 and 2 of this Checklist may be completed on an individual basis with the certified staff or in a classroom setting.
- ◇ Each section shall contain the signature of the nurse that performed that responsibility and the date of signature.

Explanation of documentation expectations:

Identifying Information shall be printed clearly on the first line of the form

- Legal name should be used; Print any other name that was previously used to obtain certification as applicable under this line and indicate reason for change (marriage, divorce, etc.)
- Agency name must be listed. May add current work site.

Status of practicum must be identified

- “Initial certification” should be checked for those persons seeking certification for the first time or those, previously certified, whose certification lapsed and they have become certified again.
- “Recertification” should be indicated for those certified staff that are meeting this requirement on a timely basis (prior to expiration of their current certification)
- “Other” should be indicated for those practicums that occur at a secondary site, are done for a certified person who is new to the agency, for the purpose of documentation of additional training on routes of medication administration, are done as part of the identified re-training following medication errors and/or are done at the discretion of the supervising nurse .

Expectations for Completion of Checklist A Elements:

1. AGENCY SPECIFIC INFORMATION

An RN must present this information if staff is seeking initial certification, or if the staff is seeking to have responsibility for medication administration at an alternate/additional worksite/agency delegated by the RN responsible for that program. Authorized LPNs may reinforce information previously taught by an RN in these areas during recertification only.

The information to be covered in the elements identified in this section includes:

Delegation of Responsibility by RN

- Inform/remind certified staff that the responsibility to administer medications is not guaranteed by the possession of a DDS certification card. The responsibility can be delegated by an RN only when the RN is confident that the certified staff possess the knowledge and skill to safely and correctly perform this task.
- Inform/remind certified staff that the delegation of the responsibility for medication administration can be revoked at any time that the RN feels the safety of consumers may be in jeopardy as demonstrated by the commission of medication errors or prohibited practices or failure to comply with the requirements of the certification process.

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- Inform/remind certified staff that anytime they are advised that the RN has suspended delegation of medication administration responsibilities it means that he/she is not able to administer medication anywhere until that suspension is lifted.

Approved abbreviations and Codes for Documentation

- Review the approved abbreviations for use in medication documentation.
- Identify the approved codes/abbreviations that may be written in a square on the MAR to indicate that the person is not physically present to receive medications from staff and that the person's medication needs are being addressed/documentated in another manner (e.g. "H" may indicate a person is in hospital, "C" may indicate a person is away at camp, "W" may indicate a person is at work, "HV" may indicate that a person is making a visit to a family home).

Administration documentation requirements

- Identify forms and location along with the process for distribution/filing of documentation after completion/at end of the month/to RN. This should include training on completion of:
 - ◇ MAR/Kardex including documentation of PRNs
 - ◇ Prescriber Order Form (90/180 day forms and supplemental)
 - ◇ Controlled Substances Receipt and Disposition Record
 - ◇ Between Shifts Controlled Drug Count Record
 - ◇ Non-Controlled Drug Destruction Record
 - ◇ Leave of absence documentation that indicates release of medications to family, guardian, day program, camp personnel etc.
 - ◇ Medication error report DDS 255m
 - ◇ Re-ordering documentation
 - ◇ Receipt of medication from the Pharmacy
 - ◇ Other agency/site specific forms relating to medication administration

Procedure for medication errors

- Review requirement that all medication errors or prohibited practices shall be immediately reported to the RN.
- Review completion of 255m and requirement that it is completed as soon as possible (not to exceed 24 hours) by the person who discovered the error.

Procedures for working with pharmacy

- Identify the pharmacy that provides medications for the individuals at the site and the process for contacting them.
- Review the procedure for initially obtaining medications and for re-ordering medications from the pharmacy.
- Identify established delivery routine for the site and authorized individuals who can receive medication
- Review process for obtaining new prescriptions or medication supplies for day program, visits away from the home, etc.

Location of policies and procedures

- Identify the location of policies and procedures related to medication administration (DDS and agency) at the site
- Identify resources within the agency for clarification of questions regarding policies and procedures related to medication administration

Storage and Security of Medication

- Review medication storage requirements at the site (internal, external, refrigerated, etc.)
- Review drug security requirements, responsibilities associated with drug security, and process for maintaining security during work and for securing medication keys when going off duty.

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Controlled Drug Counts

- Review process for drug counts between shifts and anytime responsibility is assumed by another.

Orders from Health Care Providers

- Identify the providers who provide health care to the individuals at the site.
- Identify location of orders with original provider's signature
- Remind staff that they cannot receive verbal orders from health care providers and should refer those types of calls to the RN or Pharmacist.

Faxed orders

- Review requirement that only directly faxed orders from the prescriber are considered original signatures for the purpose of administration.

PRN/as needed orders

- Identify the PRN orders for the persons at the site, the process for starting those orders, and the documentation requirements.

Order Transcription process

- Review the process for transcription of orders and the requirement for notification of the RN prior to starting medications.
- Identify process for double check of transcription prior to implementation

Location of reference materials

- Review resources that are available at the site (i.e., reference books, on-line references)
- Identify where to find and how to use reference materials at the site
- Identify other resources than can be accessed (i.e., RN, Pharmacist)

Medication Sanction Policy

- Review information regarding the sanction policy followed by the agency and the process for referral for revocation.

Emergency procedures

- Identify the process for obtaining medications after pharmacy hours
- Indicate agency notification requirements in case of emergency

Leave of absence medications

- Review DDS regulation that indicates only a single dose of medication can be administered by certified staff when the person is away from home. **Single dose is defined as “one or more medications in the prescribed dosages that are scheduled to be administered at the same time on the same day”.** (e.g., an individual who is to receive medications at 4PM and 8PM could only have the 4PM medications pre-packaged even if the meds given at 4PM are different from the medications given at 8PM.) The pre-packaging of more than a single dose is considered a prohibited practice as it violates state law. .
- Indicate that staff must be med certified to administer pre-packaged medications.
- Review requirement that medication(s) should be packaged in an envelope/container that has the following information printed on it:
 - ◇ Name of the person
 - ◇ Date and time of administration
 - ◇ Name and strength of medication
 - ◇ Dose and route of medication
 - ◇ Special instructions for administration (with food, before meals, etc.)
- Indicate that the certified staff who are to administer the single dose of medication shall be the one to prepare the medication(s), place them into the labeled envelope, document administration and maintain the security of the dose until time of administration.
- Review agency procedure for the specifics of documentation of pre-poured/packaged single doses.

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- Remind certified staff that multiple doses of medication for recreation or other LOA activities (e.g., vacations, camping, etc.) may not be prepared by certified staff as this violates CT Pharmacy laws. The acceptable actions to cover this need include rescheduling of the dose by the RN for that day or taking the full medication supply and MAR to the activity. The RN shall provide direction about med security
- Indicate that the only acceptable ways in which an individual's needs for multiple doses for LOA activities such as a home visit of would be to:
 - ◇ Obtaining separate supply from the pharmacy
 - ◇ Releasing medication supply from the facility only when no other option is available
- Remind staff that persons assuming responsibility for the individual's medication should understand the schedule of medication administration and the required security of medication so as to protect the individual and others who may be in the home from harm. There should be documentation that indicates that this person assumes this responsibility, and has been advised of the name and number of medications released to them, and the directions for administration. They should also advise the person assuming responsibility that the medication may not be in childproof containers.

2. REVIEW OF AGENCY COMMUNICATION PROCESS FOR CONTACTING THE 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

- All changes in baseline condition of the person shall be immediately reported to the RN. The observations of staff may be reported initially to the LPN who is physically present in the site at the time of observation, but this information still must be conveyed to the RN as soon as possible.
- Any change in prescribed treatment impacts the plan identified by the RN. If a change is prescribed, it is required that the RN to be advised to determine what if any changes she/he needs to make to the plan of care.

Medication administration issues

- Medication errors shall be immediately to the RN and then to whoever else is identified in the agency policy.
- All problems with medication administration (difficulty swallowing, behavior/non-compliance considerations, lack of availability of prescribed medication, etc.) shall be promptly reported to the nurse
- All issues related to discrepancies in controlled drug counts shall be reported to the RN as soon as possible.

Changes related to effects of medication

- All observations of changes related to medication effects shall be reported to the nurse. The urgency with which these are reported is determined by the significance of the problem. Those symptoms that impact health and safety should be immediately reported. Other observations may be able to wait to report to the nurse the next business day depending on the observation and the person.

Documentation of notification to the nurse

- All information reported to the nurse along with the date and time of reporting, and the name of the nurse reporting to shall be documented as soon as possible following the notification.
- The specific direction provided to the staff by the RN shall also be included.

3. INDIVIDUAL SPECIFIC/SITE SPECIFIC CONSIDERATIONS

Desired therapeutic effect and side effects of medications given at the site

- Review/reinforcement of information regarding all medications administered on a routine or PRN basis to individuals served at the site
- Review regular schedule of medication administration and any exceptions to this routine.

Medication dosage form modifications needed at the site

- Review policy and process for breaking scored tablets, crushing meds, opening caps, thickening liquids

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- Identify individuals who must have one of the identified modifications completed prior to administration.
- Remind staff of notification requirements requiring problems encountered with modifications or individual acceptance/tolerance.

History of allergies and potential/past response to medication (as applicable)

- Indicate the known allergies of the individuals at the home/site especially allergies to medications and foods.
- Review potential effects of medication or other considerations related to medication administration that warrant emergency intervention (e.g., allergy to penicillin, insulin shock)
- Remind staff of emergency procedures in place to address the identified concerns and previous training received.

Participation of consumers in the medication administration process

- Review the participation of individual in medication administration process (e.g., hand over hand administration, self-administration, obtaining beverage)
- Indicate individual preferences for taking meds (i.e., water, juice, applesauce, yogurt)
- Discuss use of adaptive devices or other supportive devices for medication administration and staff responsibility in the use of these devices (i.e., individual specific inhaler with or without chamber, prompting devices for self-administration, pill pod/cassette use, need for non-childproof caps).

Training on administration routes other than oral to meet needs of persons at site

- Provide training on administration routes that were mentioned but not taught as part of the med admin class:
 - ◇ Administration of medication via use of an inhaler or nebulizer
 - ◇ Administration of rectal medications (i.e., suppositories, enemas)
 - ◇ Administration of vaginal medications
 - ◇ Administration of medications via transdermal patch
 - ◇ Administration of medications via an enteral feeding tube

4. COMMENTS

- Indicate the specific training from the previous section that was provided (i.e., training on administration of inhaler and of rectal suppository).
- Document discussion of any additional pertinent information including review of med errors and correction of past administration problems.
- May indicate that person and site specific information and training in required routes has been presented for more than one site. If this occurs, nurse must specify the sites and information presented.
- This field does not require that information be entered.

5. REQUIRED SIGNATURES

- **All identified elements MUST be completed before the signature of the employee and the delegating RN are written.**
- **The dates at the bottom of the form shall not be prior to the dates indicated for section 1,2,and/or 3.**
- The signature of the certified staff is required on this document after the requirements of Checklist A have been fulfilled/form is completed. This signature indicates that the staff person attests to his/her participation in this part of the practicum process, to the participation by the nurse indicated, and that the information identified was reviewed with them by the nurse as specified.
- The signature(s) of the nurse(s) completing each section attests to her/his presentation of the information contained in the indicated section of Checklist A. As there are many options for the presentation of this training, there may be several different signatures. .
- The signature of the supervising/delegating RN is required to indicate that the information documented is true to the best of their knowledge.

CORRECTIONS/ADDITIONS/ DELETIONS TO THIS DOCUMENTATION may be made by the RN as long as these changes are initialed and dated by both the employee and the nurse.