

**Instructions for Completing the
Medication Administration Skills Validation Form**
(Former name: Medication Administration Clinical Skills Checklist)
Developed by the Division of Health Service Regulation, Adult Care Licensure Section
2708 Mail Service Center, Raleigh, NC 27699-2708 (919) 855-3765

TO ALL ADMINISTRATORS and NURSES and PHARMACISTS:

Requirements of North Carolina G.S. 131D-4.5B and 10A NCAC 13F/G .0503 include all unlicensed staff who perform medication aide duties and supervisors of staff performing medication aide duties in adult care homes must have validation of the staff's competency for tasks or skills that will be performed in the facility prior to the unlicensed staff performing any medication aide duties. The facility must have a licensed pharmacist or registered nurse complete the validation. The Medication Administration Skills Validation Form (DHSR/AC 4605 NCDHHS) is the standardized and **only form to be used for validating staff**. This form is **NOT** transferable between facilities.

Competency validation of staff using the Medication Administration Skills Validation Form is to be done **AFTER** the facility has at least documentation and verification of one of the following on file:

- (1) **Certificate of Completion for the 5-hour Medication Administration Course*** (DHSR/AC 4717 NCDHHS); **OR**
- (2) **Certificate of Completion for the 15-hour Medication Administration Course*** (DHSR/AC 4719 NCDHHS); **OR**
- (3) **Documentation of verification from the [NC Medication Aide Registry](#) for nursing homes that staff is currently listed and completion of at least Section 3 of the [State Approved Infection Control Course for Adult Care Homes](#).**

*In lieu of the certificate of completion for the required state approved medication administration courses for adult care homes, the facility must have all the following on file for staff:

- (1) **Documentation of verification from the [NC Medication Aide Testing](#) website that staff successfully passed the medication exam for adult care homes prior to 10/01/2013; and**
- (2) **Documentation of employment as a medication aide every 24 months since 10/01/2011 (Use of the [Medication Aide Employment Verification form](#) (DHSR/AC 4664 NCDHHS) or documentation of all information on form 4664, if the form is not used for verification.)**

Directions for completing the Medication Administration Skills Validation Form can be found on page 2 of this document.

[Guidelines for Completing the Medication Administration Skills Validation Form \(DHSR/AC 4698 NCDHHS\)](#) is to be used and assist with validation. Tasks listed in the left column of the guidelines match the tasks on Medication Administration Skills Validation Form and the right column of the guidelines provides general information for validation. It will be the responsibility of the pharmacist or nurse to determine that the employee has demonstrated competency in performing the tasks or skills by using the guidelines and resources referenced in the guidelines.

The pharmacist or nurse needs to also be knowledgeable of the [medication training courses](#), [infection control course](#), and [regulations](#) related to medication administration for adult care homes. As indicated on the skills validation form, the guidelines and form should be reviewed prior to the observation of the tasks or skills by staff.

Additional training and testing are required for unlicensed staff to continue with medication aide duties. Refer to N.C. G.S. 131D-4.5B for training, competency validation and testing requirements. The facility must have the required documentation and verification maintained on file at the facility.

Instructions for Completing the Medication Administration Skills Validation Form

Directions for completing the Medication Administration Skills Validation Form:

1. The name of the employee and adult care home are to be written on each page of the form. The form is not transferable.
2. All documentation on the form is to be in ink. Items that have an (*) by the tasks or skills must be checked off only by a registered nurse.
3. When the employee has demonstrated competency for a task or skill, the instructor is to complete the “Satisfactory Completion Date” block and the “Inst. Initials/Signature” block to the right next to the completion block. The “Needs More Training” and “Inst. Initials/Signature” is to be completed if the employee needs further training in an area or needs to be observed again.
4. **Sections 1 through 14** - Must be completed for each unlicensed staff person, unless otherwise indicated on the validation form or guidelines. **** Section 13 K through P – tasks under Licensed Health Professional Support. Refer to regulations 10A NCAC 13F/13G .0504, .0505 and .0903 and the Guidelines for Completing the Medication Administration Skills Validation Form.**
5. **Section 1-** Competency may be determined by asking the employees questions or by a written test.
6. **Sections 2 through 13** - The employee is to be observed actually performing the task or skill or at least be able to verbalize and demonstrate competency to perform the task or skill. Further instructions are provided in the guidelines for the tasks or skills in Section 13.
7. The employee and instructor are to sign and date the form after the completion of tasks.
8. If competency validation for additional tasks on the Medication Administration Skills Validation Form is needed after the employee and instructor have signed the validation form, then the additional tasks/skills may be checked off, initialed and dated by the instructor on the original form and signed and dated by the instructor and employee again in the “Comment” section or a new form may be used and attached to the original form.
9. The “Comment” section may be used to document any additional information, including signatures.
10. The form must be maintained on file in the facility.

**If you have any questions about completing the form or comments, please call the
Adult Care Licensure Section at 919-855-3765.**

**Medication Administration Skills Validation Form
(Medication Administration Clinical Skills Checklist)**

The unlicensed staff must (without prompting or error) demonstrate the following skills or tasks, in accordance with the guidelines for completing the form, with 100% accuracy to a registered nurse or pharmacist. Competency validation by the registered nurse or pharmacist is to be in accordance with their occupational licensing laws. Items that are (*) must be checked off **only** by a registered nurse. **Instructor – Prior to beginning observation of skills or tasks, refer to pages 1 and 2 regarding instructions and guidelines for completing this form.**

Skill/ Tasks	Satisfactory Completion Date	Inst. Initials/ Signature	Needs More Training	Inst. Initials/ Signature
1. Basic Medication Administration Information and Medical Terminology (Refer to Guidelines)				
A. Matched common medical abbreviations with their meaning				
B. Listed/Described common dosage forms of medications and routes of administration				
C. Listed the 6 rights of medication administration				
D. Described what constitutes a medication error and actions to take when a medication error is made or detected				
E. Described resident's rights regarding medications, i.e., refusal, privacy, respect				
F. Defined medication "allergy"				
G. Demonstrated the use of medication resources or references				
2. Medication Orders (Refer to Guidelines)				
A. Listed or Recognized the components of a complete medication order				
B. Transcribed orders onto the MAR 1. Instructions written out completely 2. Calculated stop dates correctly 3. Transcribed PRN orders appropriately 4. Copied orders completely and legibly and/or checked computer sheets against orders and applied to the MAR 5. Discontinued orders properly				
C. Described responsibility in relation to telephone orders				
D. Described responsibility in relation to admission and readmission orders and FL-2				
E. Described or Demonstrated the process for ordering medications and receiving medications from pharmacy				
F. Identified required information on the medication label				
3. Demonstrated appropriate technique to obtain and record the following: (Refer to Guidelines)				
A. * Blood Pressure				
B. * Temperature				
C. * Pulse				
D. * Respirations				
E. Fingersticks/Monitoring Devices such as glucose monitoring (Only required to be validated if the employee will be performing this task.)				

EMPLOYEE NAME : _____

ADULT CARE HOME NAME: _____

Medication Administration Skills Validation Form

Skill/ Tasks	Satisfactory Completion Date	Inst. Initials/ Signature	Needs More Training	Inst. Initials/ Signature
4. If medications are prepared in advance, procedures, including documentation, are in accordance with regulation 10A NCAC 13F/13G .1004. (Refer to Guidelines)				
5. Administration of Medications (Refer to Guidelines)				
A. Identified resident				
B. Gathered appropriate equipment and keeps equipment clean				
C. MAR utilized when medications are administered and also when medications are prepared or poured (if prepouring is allowed)				
D. Read the label 3 times; Label is checked against order on MAR				
E. Used sanitary technique when pouring and preparing medications into appropriate container				
F. Offered sufficient fluids with medications				
G. Observed resident taking medications and assures all medications have been swallowed.				
6. Utilized Special Administration/Monitoring Techniques as indicated (vital signs, crush meds. check blood sugar, mix with food or liquid) (Refer to Guidelines)				
7. Administered medications at appropriate time (Refer to Guidelines)				
8. Described methods used to monitor a resident's condition and reactions to medications and what to do when there appears to be a change in the resident's condition or health status (Refer to Guidelines)				
9. Utilized appropriate hand-washing technique and infection control principles during medication pass (Refer to Guidelines)				
10. Documentation of Medication Administration (Refer to Guidelines)				
A. Initialed the MAR immediately after the medications are administered and prior to the administration of medications to another resident. Equivalent signature for initials is documented.				
B. Documented medications that are refused, held or not administered appropriately				
C. Administered and documented PRN medications appropriately				
D. Recorded information on other facility forms as required				
E. Wrote a note in the resident's record when indicated				

EMPLOYEE NAME: _____

ADULT CARE HOME NAME: _____

Medication Administration Skills Validation Form

Skill/ Tasks	Satisfactory Completion Date	Inst. Initials/ Signature	Needs Training	Inst. Initials/ Signature
11. Completion of Medication Pass (Refer to Guidelines)				
A. Stored medications properly				
B. Disposed of contaminated or refused medications				
C. Rechecked MARs to make sure all medications had been given and documented				
12. Medication Storage (Refer to Guidelines)				
A. Maintained security of medications during medication administration				
B. Stored controlled substances appropriately and counted and signed controlled substances per facility policy				
C. Assured medication room/cart/cabinet is locked when not in use				
13. Administered medications using appropriate technique for dosage form/route & administered accurate amount: (Refer to Guidelines)				
A. Oral tablets and capsules				
B. Oral liquids				
C. Sublingual medications				
D. Oral Inhalers				
E. Eye drops and ointments				
F. Ear drops				
G. Nose drops				
H. Nasal Sprays/Inhalers				
I. Transdermal medications/Patches				
J. Topical (creams and ointments; not dressing changes)				
K. *Clean dressings				
L. *Nebulizers				
M. *Suppositories 1. Rectal 2. Vaginal				
N. *Enemas				
O. *Injections 1. Insulin** 2. Other subcutaneous medications				
P. *Gastrostomy Tube				

EMPLOYEE NAME: _____

ADULT CARE HOME NAME: _____

Medication Administration Clinical Skills Validation Form

Skill/ Tasks	Satisfactory Completion Date	Inst. Initials/ Signature	Needs Training	Inst. Initials/ Signature
Section 14: Other Tasks/Skills (Refer to Guidelines)				
A. Self-Administration of medications				
B. Received orientation to facility's policy and procedures for medication administration				

EMPLOYEE NAME _____

EMPLOYEE SIGNATURE & DATE: _____

ADULT CARE HOME NAME: _____

The employee at the above-named facility has demonstrated competency validation in the areas as indicated on this form. The instructions/guidelines were used to determine the employee's competency.

INSTRUCTOR'S NAME, SIGNATURE, TITLE AND DATE:

INSTRUCTOR'S NAME, SIGNATURE, TITLE AND DATE:

(If more than one instructor completes the form, the initials of each instructor is to document by the instructor's signature and title. The section for comments may be used if additional space needed.)

COMMENTS
