MEDICATION ADMINISTRATION IN THE COMMUNITY COURSE
PREREQUISITE INFORMATION

Nurse-Trainer Webinars

- To complete the Nurse-Trainer course by GoToMeeting Webinar you will have to pre-register for Live Webinars 1 and 2 on the day scheduled for the Medication Administration in the Community course. The links are on the DHS website for Webinars 1 and 2.
- **Webinar 1** - 9:30 am – 11:30 am
- **Webinar 2** – 12:45 pm – 2:45 pm
- Please see more details on the DHS Nurse-Trainer Webinars and for registering at: [http://www.dhs.state.il.us/page.aspx?item=76322](http://www.dhs.state.il.us/page.aspx?item=76322).
Course Credit

- Full course completion of all 3 Webinars must be confirmed by our office prior to assigning the post-test on IDHS OneNet Learning system.
- Five hours of Continuing Education Credits are awarded for full course attendance. No partial credit is given.

Prerequisite for N-T Class

- This prerequisite course contains information necessary for attending Medication Administration Webinars 1 & 2.
- This recorded Webinar reviews the:
  - Basis for Administrative Rule 116
  - Medication Administration course materials
  - Nursing Services Packet completion
TO BECOME A NURSE-TRAINER

- Besides attending all three Webinars, being an RN in Illinois and having RN clinical experience, you must
- Request to become a nurse-trainer by completing Request/Approval for RN Nurse-Trainer Status form
- Complete the open book internet based test administered by the Division of Developmental Disabilities with a score of 90% or better.

Rule 116 History

- Omnibus Budget Reconciliation Act (OBRA) of 1987 – Money dispersal requirements
  - Place ID/DD individual in community
  - Habilitation based on need
  - Have least restrictive environment
OBRA Implementation

- Federal government evaluated providers (large nursing facilities & homes) with questions regarding money dispersal:
  - Do the individuals you have need your level of (nursing) care?
  - If not, placement (in community) must be where needs are met

CILAs and Assumptions

- First CILAs took those needing minimal assistance in community AND were independent in self-medication. So CILAs often did not have nurses.
- Many came from State “Hospitals” & Large Private Nursing Homes; where nurses were part of the staff.
Health Care Finance Administration

• 1998 – HCFA visited Illinois DD Providers
• Unlicensed staff administering medications
• HCFA stated that the Illinois Nurse Practice Act was being violated
• Threat to Federal Medicare (OBRA) funds. A plan was developed to resolve the issue.

Illinois Senate Bill 965

• Passed May 14, 1999 & signed into law August 1999 as PA 91-630 to amend the:
  • Nurse Practice Act [section 50-15 (b) (12)]
  • Mental Health & Developmental Disabilities Act [section 15.4]
  • Rule 115, the “CILA” Rule (115.240)
Nurse Practice Act Amendment

- Section 50-15: Policy; application of Act.
  (b) This Act does not prohibit the following:
  - (12) Delegation to authorized direct care staff trained under Section 15.4 of the Mental Health and Developmental Disabilities Administrative Act consistent with the policies of the Department.

MHDD Act – Section 15.4

- Title: Authorization for nursing delegation to permit direct care staff to administer medications.
  - (a) DHS shall develop training of staff to administer oral & topical medications under supervision & monitoring of professional nurse.
“Print Out” Sections

- **Section 1:** N-T Application and Course Evaluation
- **Section 2:** Administrative Rule 116
- **Section 3:** Memos and Letters

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Section 4
Sample Nursing Assessment Form

Training Program for Authorized Non-licensed Direct Care Staff
Skill Standard 5: Authorized direct care staff recognizes concepts supporting, safe medication administration, and determines basic performance consistencies with these conceptual principles.

Interventional Competencies
Authorized direct care staff must know:
- routes of medication administration.
- medication using.
- basic medication actions.
- basic, medication dose and adverse affects
- basic medication interactions (desired and harmful).
- basic medication categories.
- methods and concepts of medication rounds.
- basic medication dosage concepts.
- principles of weights and measures.
- basic medication uses.
- common medication methods.
- basics of physician orders.
- medication administration related to physician orders.
- basics of medication administration records (MAR) and its relationship with documentation.
- basics of medication administration methods.
- self-administration medications sheets.
- the seven rights of medication administration.
Training Program

Medication Administration Course

Patient's Guide

Skill Standard B: Authorized direct care staff recognizes the components of body systems and know what medications and medications classes have effects on those systems. They must be able to distinguish, document and report those effects to the PTH Nurse-Trainee for follow-up and direction.

Informational Competencies

Authorized direct care staff must know:
- Muscular and skeletal system and related medication classifications.
- Nervous system and related medication classifications.
- Circulatory system and related medication classifications.
- Respiratory system and related medication classifications.
- Reproductive system and related medication classifications.
- Urinary system and related medication classifications.
- Gastrointestinal system and related medication classifications.
- Endocrine system and related medication classifications.
- Integumentary system and related medication classifications.
- Sensory schema system and related medication classifications.

Interventional Competencies

Authorized direct care staff must be able to:
- Name the reasons for the use of each medication given to each individual in terms of body system affected.
- Identify observations that should be reported to the PTH Nurse-Trainee for each medication and/or medication class.
- State special considerations and warnings for each medication and by medication class.
- Describe basic health problems/situations of each individual in terms of body systems.
- Relate medications to the body system they are prescribed to treat.
- Set an individual's care needs resulting from their prescribed medications.
- Set an individual's care needs related to their exact health problems.

Skill Standard C: Authorized direct care staff documents and safely administers medications to identified individuals, using appropriate administration techniques.

Informational Competencies

Authorized direct care staff must know:
- Oral medication procedures.
- Topical medication procedures.
- Eye medication procedures.
- Ear medication procedures.
- Nasal medication procedures.
- Intake medication procedures.

Interventional Competencies

Authorized direct care staff must be able to:
- Identify aspects of developmental disabilities that determine approaches to medication administration for individuals with developmental disabilities.
- Demonstrate oral medication administration.
- Demonstrate topical skin medication administration.
- Demonstrate instillation of nose medication.
- Demonstrate instillation of ear medication.
- Demonstrate instillation of eye medication.
- Demonstrate oral medication administration.
- Demonstrate oral medication administration.
- Demonstrate accurate documentation of administration on an MAR.
- Demonstrate accurate documentation of administration on a MAR.
- Correctly document medication given.
Skill Standard D

Authorized direct care staff recognized medication errors and/or incidents and follow agency specific policies and procedures to ensure the individual's health and safety.

Informational Competencies

Authorized direct care staff must:
- Know the definitions of medication error
- Know any restriction of the seven "rights" (person, time, medication, dose, route, frequency, consistent, record)
- Identify a medication omission error
- Know how to contact the RN Nurse-Administerer
- Know agency specific policies and procedures for medication error

Informational Competencies

Authorized direct care staff must be able to:
- Identify how medication errors can occur
- Identify how medication errors can be prevented
- Identify accurate documentation of errors
- Identify error reporting procedures
- Identify potential observations to be made and reported to the RN Nurse-Administerer due to a medication error.
- State responsibilities to the individual when an error occurs
- Identify the reporting method to the RN Nurse-Administerer
- Name the three accepted reporting methods for medication errors
- Demonstrate accurate documentation of errors
- State the reason for behaviors that prevent medication errors during medication administration
- Demonstrate behaviors that prevent medication errors during medication administration

Notes to Presenters

It is essential to stress each person is the "CEO". At first how how each person signs to the label and obtains a copy of the instruction, any errors, and a comparison for the label. This is important documentation that needs to be kept on file. See the suggested documentation in Appendix B for a suggested label. (For...)

Script

Introduction

Before we begin our class, let's make sure everyone is in the right place. I suggest we start by going through the following steps:

Setting the Stage

During this class, we will discuss the concepts of 1) safe medication administration, 2) body systems, their anatomical function, and how medications affect them, 3) safe medication administration techniques, 4) medication errors, their prevention, and documentation, and 5) non-licensed staff and the Nurse Practice Act.

Let's look at how did we get here? Let's discuss why non-licensed staff, like you, are now administering medications.
INSTRUCTIONS TO THE INSTRUCTOR:

1. Using the MAR (Medication Administration Record), create a mock MAR with medications commonly used by your agency.

2. It is suggested that no more than five and ten medications be placed on the mock MAR with the appropriate information. According to Administrative Rule 16.75 the information on the MAR must include the following: date, time of administration, date the medication was ordered, names of the medications, dose, frequency, route, allergies, instructions, and any other relevant details.

3. To help in the student's learning, the instructor can create a mock MAR. To include the "Seven Rights", the following is suggested:
   a. The individual's name, physician's name, allergies, etc.
   b. The medication name, dose, frequency, route.
   c. The date, time of administration.
   d. The side effects.

4. Using the medication information, have students write the medication information on the MAR. Have the instructor complete the medication information on the MAR. (This is on the next page. Use a MAR to complete the information."

5. Learning Objectives:
   a. The student will be able to:
      a. Use medication information to determine the type of medication.
      b. Read and interpret the medication information on the MAR.
      c. Note the importance of knowing generic names instead of just trade names.
      d. Find and interpret information on the MAR.

6. Training Program for Authorized Non-Licensed Direct Care Staff

    Medication Administration Course
    Skill Standard A: Teaching Materials
<table>
<thead>
<tr>
<th>Classification(s)</th>
<th>Medication Names</th>
<th>Indications/Use</th>
<th>Adv/Side Effects</th>
<th>Special Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-narcotic</td>
<td>Tylenol, Advil,</td>
<td>Pain, fever</td>
<td>Rare anemia,</td>
<td>Caffeine containing</td>
</tr>
<tr>
<td>analgesic,</td>
<td>Naproxen, Aspirin</td>
<td></td>
<td>nausea, rash</td>
<td>fixed may increase</td>
</tr>
<tr>
<td>anti-inflammatory</td>
<td></td>
<td></td>
<td></td>
<td>analgesic effect,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>discourage use with</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>alcohol</td>
</tr>
</tbody>
</table>
# Section 8

Appendix C - SKILL STANDARD C

**TEACHING MATERIALS**

Considerations for Medication

Vehicle Selection

Administration of Medication

Check Lists

**RN PRESENTER’S GUIDE**

For

Training Program

For

Authorized Non-licensed Direct Care Staff

## Medication Administration Module

**Skill Standard C: Teaching Materials**

### Considerations in Selection of a Vehicle for Medication Administration

<table>
<thead>
<tr>
<th>Vehicle</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texture</td>
<td>Too slick</td>
</tr>
<tr>
<td></td>
<td>Drop vehicle until it is in the desired location or select another vehicle.</td>
</tr>
<tr>
<td>Consistency</td>
<td>Too sticky</td>
</tr>
<tr>
<td></td>
<td>Add liquid, condiments, or half an uncooked potato to the bottom of the bottle to even out the surface.</td>
</tr>
<tr>
<td></td>
<td>Too mushy</td>
</tr>
<tr>
<td></td>
<td>Add non-stick spray or butter to the bottom of the bottle to prevent sticking.</td>
</tr>
</tbody>
</table>

Adapted from Bembenek & Roberts (1992)
**Training Program**

**Medication Administration Module**

**Skill Standard 1: Teaching Materials**

**Administration of Oral Medications Practice**

**Student Name: ______________________ Date: _______**

**Skill Completion:**

- [ ] Successful completion
- [ ] Unsuccessful completion
- [ ] Not applicable

**IF INDIVIDUAL IS NOT INDEPENDENTLY SELF-MEDICATING the authorized staff person:**

**Preparation:**

1. Checks an area appropriate to administer medication. (May be done centrally in the classroom.)
2. Attends to task of administering medications even when observed.
3. Selects appropriate device (e.g., oral) for administration of medication.

**Practices:**

4. Collects necessary materials for administering oral medications (medication container, cup, medications administration nurse).
5. Removes medication from locked storage and secures storage container.
6. Obtains the signed medication administration record (MAR) for the individual receiving medication(s).
7. Maintains the individual’s name on the MAR with the individual’s name on the medication container(s).
8. Ensures that the individual is looking at the medicine and that the oral medication is administered.
9. Checks the MAR for allergies to ensure the individual is not allergic to the medication.
10. Checks the MAR for any restrictions related to medication administration.
11. If applicable, teaches self-administration procedure to individual according to the GRT Training Program Manual.
12. Observes the individual before administration for indications of pain or discomfort and for indications that require safe administration. If pain or discomfort is present, does not administer the medication.
13. Administers the medication per protocol. If any indication is noted that indicates the medication administration is safe, continues the medication administration process.
14. Washes hands before preparing the medication(s).

**Administration of Medication**

15. Charts, by medication administration MAR, information about administration (or non-administration), the “Right” of Medication Administration (Individual/Patient, Reader, Drug, Dose, Time administered, Route, Time). All are filled in following steps.

N:02/01/11  C-2  29
Section 9

Overheads
Prerequisites for Authorization
Concepts of Medication Administration
Delegation
Task
Task Delegation
Supervision
Supervision – Direct and Indirect
Skill Standards a - D
Administer/Administration
Authorized Direct Care Staff
Seven “Rights” of Medication Administration

RN PRESENTER’S GUIDE
for
Training Program
by
Authorized Non-licensed Direct Care Staff

Section 10

Appendix E

Testing MATERIALS
Initial Authorization Medication Test
Test Question Bank
Competency Based Training Assessment
(CBTA) for Medication Administration

RN PRESENTER’S GUIDE
for
Training Program
by
Authorized Non-licensed Direct Care Staff
Medication Administration Module

Training Program: Medication Administration Module

INITIAL AUTHORIZATION MEDICATION TEST

KEEP THIS COMPLETE TEST ON FILE

Staff: ___________________________ Test Date: 20_ Score: ___________

This staff member has successfully completed the didactic portion of Medication Administration in the Community training and has passed the practical test to an overall 85%. She has completed the CBTA form for successful medication task proficiency. Medication administration authorization and a list of individuals to whom she can administer medication according to Administrative Rule 116 and Policies and Procedures.

Signature: ___________________________ RN Nurse-Trainer: ___________________________ Date: 20_

DIRECTIONS: Choose the BEST answer and circle the letter.

1. Authorized Direct Care Staff are responsible for ______ when giving medications:
   A. Initiating the task on the Individual Medication Administration (IMA) indicating the individual has been administered the medication
   B. Notifying the doctor that the medication was given after administering medication to the individual
   C. Initiating the task on the Individual Medication Administration (IMA) indicating the medication was given
   D. Initiating the task on the Individual Medication Administration (IMA) indicating the nurse was contacted

2. Authorized Direct Care Staff should only perform those medication administration tasks:
   R. that the RN Nurse-Trainer has trained them to do.
   F. that the doctor asked them to do.
   C. that the nurse was contacted
   D. all of the above

3. Forgetting to administer a medication on time is an example of:
   A. Misspent B. unethical behavior C. slander D. neglect

4. What is the FIRST thing you should do if you make a medication error?
   A. Isolate the individual
   B. Page the RN Nurse-Trainer
   C. Call 911
   D. Just watch the individual closely.

N-02-01-11

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Competency Based Training Assessment (CBTA) for Medication Administration by Non-Licensed Direct Care Staff in the Community for those with a Developmental Disability

Evaluator to be Authorized to Edit completion:

Evaluator Name: ___________________________ RMS Home: ___________________________

Evaluator Notes:

Directions: To successfully complete the basic, intermediate, and advanced for Medication Administration, non-licensed direct care staff must, under the direct supervision of a licensed nurse, have evidence of the following competencies. The task is integrity the individual's ongoing assessment for successful medication task proficiency. Medication administration authorization and a list of individuals to whom she can administer medication according to Administrative Rule 116 and Policies and Procedures.

Evaluating Key:
- Competent or Complete
- Incomplete or Incomplete
- Incomplete or Incomplete
- Not Attempted

Mandatory Requirements (Mandatory; must be achieved for additional points toward competency)

| 1. | Uses appropriate dose of appropriate medicine and makes sure the medication is properly administered. |
| 2. | Focuses on proper amount of administration to ensure medicine is given properly and correctly. |
| 3. | Monitors appropriate temperature for proper administration of medication. |
| 4. | Focuses on proper administration of medication to ensure medication is given properly and correctly. |
| 5. | Uses appropriate liquid medication when given. |
| 6. | Uses appropriate oral medication when given. |
| 7. | Completes medication to ensure proper administration. |

N-02-01-11

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COMPLETION OF THE NURSING SERVICE PACKET

Division of Developmental Disabilities
This memo states effective...
SELF-ADMINISTRATION OF MEDICATION ASSESSMENT

“SAMA” form
Physical Status Review

“Health Risk Screening Tool”
### INSTRUCTIONS (Continued)

8. Use the COMMENTS section after each CATEGORY to explain or justify ratings. Label all entries in the COMMENTS section with the letter of the ITEM, e.g., A. Savings. Bold of entries.

9. After rating each ITEM and entering the ITEM rating score in column 2, compute the CATEGORY SCORES. One of the CATEGORY SCORES is 1. Functional Status; 2. Behavioral; 3. Safety; 4. Nutrition; and 5. Summary. All entries are determined by simply adding each of the ITEM SCORES in the category and placing the sum in the appropriate CATEGORY SCORE blank (e.g., 1).

The PHYSIOLOGICAL CATEGORY SCORE is computed by adding the PHYSIOLOGICAL, all of the ITEM SCORES to the category and place the sum in the appropriate blank (same as Category 5).

### BEHAVIOR CATEGORY SCORE

#### 1. PHYSIOLOGICAL

<table>
<thead>
<tr>
<th>STATUS CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.</td>
<td>Poor</td>
</tr>
<tr>
<td>S.</td>
<td>Satisfactory</td>
</tr>
</tbody>
</table>

#### 2. PHYSIOLOGICAL

<table>
<thead>
<tr>
<th>STATUS CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F.</td>
<td>Fair</td>
</tr>
<tr>
<td>I.</td>
<td>Inadequate</td>
</tr>
</tbody>
</table>

#### 3. PHYSIOLOGICAL

<table>
<thead>
<tr>
<th>STATUS CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>E.</td>
<td>Excellent</td>
</tr>
<tr>
<td>M.</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

### PHYSIOLOGICAL CATEGORY SCORE = P + S + F + I + E + M

#### Revised (2020)

12. To calculate the Health Care Level, enter each of the ITEM SCORES from column 2, add them together for a TOTAL SCORE.

### Identification of Health Care Level

<table>
<thead>
<tr>
<th>ITEM</th>
<th>FUNCTIONAL STATUS CATEGORY SCORE</th>
<th>BEHAVIOR CATEGORY SCORE</th>
<th>SAFETY CATEGORY SCORE</th>
<th>PHYSIOLOGICAL CATEGORY SCORE</th>
<th>TOTAL CATEGORY SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. Count the number of ITEM ratings for all 23 ITEMS and enter in TOTAL of ITEM ratings blank.

#### Check yes or no. Was ITEM "Q", TREATMENTS, scored?  

<table>
<thead>
<tr>
<th>ITEM</th>
<th>TREATMENTS</th>
<th>scored</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. Evaluate each item in the CARE LEVEL form. If ITEM "Q" in medicine, "YES", place in Level 4.

### Care of the Health Care Level form

<table>
<thead>
<tr>
<th>ITEM</th>
<th>CARE LEVEL</th>
<th>scored</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15. Use the TOTAL SCORE, TOTAL of ITEM ratings, and ITEM "Q", score to identify the HEALTH CARE LEVEL. For example, Code is identified Level 3. The ITEM "H", CARE LEVEL 3, through 6 use an in-depth review of the HIST by an RN Reviewer and completion of STEPS 10 and 11 are REQUIRED.
CATEGORIE III - PHYSIOLOGICAL

11. Asthma

2. No history of aseptic meningitis or syphilis.

3. No negative test for syphilis.

4. No history of aseptic meningitis or syphilis.

5. No negative test for syphilis.

6. No history of aseptic meningitis or syphilis.

7. No negative test for syphilis.

8. No history of aseptic meningitis or syphilis.

9. No negative test for syphilis.

10. No history of aseptic meningitis or syphilis.

11. No negative test for syphilis.

12. No history of aseptic meningitis or syphilis.

13. No negative test for syphilis.

14. No history of aseptic meningitis or syphilis.

15. No negative test for syphilis.

16. No history of aseptic meningitis or syphilis.

17. No negative test for syphilis.

18. No history of aseptic meningitis or syphilis.

19. No negative test for syphilis.

20. No history of aseptic meningitis or syphilis.

21. No negative test for syphilis.

22. No history of aseptic meningitis or syphilis.

23. No negative test for syphilis.

24. No history of aseptic meningitis or syphilis.

25. No negative test for syphilis.

26. No history of aseptic meningitis or syphilis.

27. No negative test for syphilis.

28. No history of aseptic meningitis or syphilis.

29. No negative test for syphilis.

30. No history of aseptic meningitis or syphilis.

31. No negative test for syphilis.

32. No history of aseptic meningitis or syphilis.

33. No negative test for syphilis.

34. No history of aseptic meningitis or syphilis.

35. No negative test for syphilis.

36. No history of aseptic meningitis or syphilis.

37. No negative test for syphilis.

38. No history of aseptic meningitis or syphilis.

39. No negative test for syphilis.

40. No history of aseptic meningitis or syphilis.

41. No negative test for syphilis.

42. No history of aseptic meningitis or syphilis.

43. No negative test for syphilis.

44. No history of aseptic meningitis or syphilis.

45. No negative test for syphilis.

46. No history of aseptic meningitis or syphilis.

47. No negative test for syphilis.

48. No history of aseptic meningitis or syphilis.

49. No negative test for syphilis.

50. No history of aseptic meningitis or syphilis.

51. No negative test for syphilis.

52. No history of aseptic meningitis or syphilis.

53. No negative test for syphilis.

54. No history of aseptic meningitis or syphilis.

55. No negative test for syphilis.

56. No history of aseptic meningitis or syphilis.
CATEGORY IV - SAFETY

B. Injuries
1. Head injury or other injury requiring medical intervention.
2. Any injury or condition causing 3 or more days away from work or restrictions on work activity due to injury.
3. Any injury or condition requiring medical intervention or follow-up care.
4. Any injury or condition requiring 7 or more days away from work or restrictions on work activity due to injury.

C. Falls
1. No falls.
2. 1 fall per year.
3. 2 falls per year.
4. Any fall which results in fracture or hospital admission due to injury.

CATEGORY V - FREQUENCY OF SERVICE

Professional Health Care Services
1. No visits other than annual check-ups or health maintenance.
2. 2 visits per year for minor physical conditions.
3. 3 visits per year for chronic conditions.
4. 4 or more visits per year for serious medical conditions.

Emergency Room Visits
1. No Emergency Room visits.
2. Any Emergency Room visits for minor injuries or illnesses.
3. Any Emergency Room visits for serious injuries or illnesses.

Hospital Admissions
1. No hospital admissions.
2. Any hospital admissions for scheduled surgery or procedures.
3. Any hospital admissions for emergency surgery or procedures.
4. Any hospital admissions for any reason in the past 12 months.
5. Any hospital admissions for any reason in the past year.