Medication Administration Assessment Tool

Profile Information

Individual Name*: _____ Provider/Program Name: _____

Create Date*: _____ Entered By*: _____ Title: _____

Birth Date: _____ Age: _____

Check all services that apply: ☐ Independent Living ☐ Supported Living ☐ Family Living ☐ Adult Habilitation ☐ Supported Employment

Medical Diagnosis:

	ICD-9/DSM-4/Other	Axis	Description	Diagnosis Date	Diagnosed By
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Allergies: ☐ Yes ☐ No

List Allergies and known reactions to medications, food, other:

1	
2	
3	
4	
5	

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**

Note:- Required fields are marked with an asterisk (*)

Medications: List all current ordered routine and PRN medications. Each medication should have a diagnosis to justify its use. Note any special instructions. List comfort OTC medications/treatments.

Medication Name	Route	Give Amount / Quantity	Measurement Unit	Frequency	Indication /Purpose	Begin Date	End Date	Instruction/ Comments	Medication Type

Assess the individual based on the following criteria.

Section I. Self-Administration of Medications

Is the individual:

- Able to determine if they are receiving the expected response from the medication? □ Yes □ No
- Able to identify each medication, its purpose, dose and most common potential side effects? (This may be a basic understanding such as “One pill for my blood pressure, it could make me dizzy”) □ Yes □ No
- Able to understand the times the medication is to be taken? □ Yes □ No
- Able to take measures to report side effects? (This may be a basic understanding such as “If I get dizzy, I will let someone know”) □ Yes □ No
- Able to understand the circumstances or the reason a medication should be taken “as needed” or PRN? □ Yes □ No
- Able to independently complete the entire process of taking medication from start to finish? □ Yes □ No
- Able to reorder medication/seek assist with reordering medication or a system is planned and in place to support the individual in re-ordering medications? □ Yes □ No

If the answers to all of the questions are “yes”, this individual meets the criteria for Self-Administration of Medications. Proceed to Section IV.

Note: 1. Individuals living in a custodial care facility must have a current Primary Care Practitioner (PCP) order to self-administer medication (NMAC 16.19.11.8.B). Custodial care facilities: a residence for two or more persons, unrelated to the operator, that maintains custody of the resident’s drugs. 2. Written consent for self-administration must be obtained from the individual or their guardian or surrogate health care decision maker.

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**

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Section II. Self-Administration with Physical Assistance by Staff

Is the individual:

- Able to determine if they are receiving the expected response from the medication? ☐ Yes ☐ No
- Able to identify each medication, its purpose, dose and most common potential side effects? ☐ Yes ☐ No
- Able to understand the times the medication is to be taken? ☐ Yes ☐ No
- Able to take measures to report side effects? ☐ Yes ☐ No
- Able to understand the circumstances or the reason a medication should be taken "as needed" or PRN? ☐ Yes ☐ No
- Unable to independently complete the entire process of taking medication due to a physical challenge? ☐ Yes ☐ No
- Able to reorder medication/seek assist with reordering medication or a system is planned and in place to support the individual in re-ordering medications? ☐ Yes ☐ No

If the answers to all of the questions are "yes", this individual meets the criteria for Self-Administration with Physical Assistance by Staff. Proceed to Section IV.

Note: 1. Individuals must have a current PCP order for self-administration with physical assistance by staff. 2. Written consent for self-administration with physical assistance by staff must be obtained from the individual or their guardian or surrogate health care decision maker. 3. These criteria do not apply to individuals who receive their medication via intra-muscular (IM), subcutaneous (SQ), or intravenous (IV) injections, non pre-mixed nebulizer treatments and/or nasogastric tube (NG). See Section IV regarding the criteria for Administration by Licensed personnel. 4. Staff must complete DDSD approved training required for assisting with medication. Staff must provide physical assistance at the least intrusive level necessary for the individual to successfully take his/her medication.

Section III. Assistance with Medication Delivery by Staff

Is the individual:

- Unable to independently complete the entire process of taking medication? ☐ Yes ☐ No
- Able to communicate to staff (verbally/vocally, through gestures or via a communication device) that he/she is experiencing a problem, pain or discomfort? ☐ Yes ☐ No
- Currently physically stable? ☐ Yes ☐ No
- Only receiving medications via the following routes: oral, topical, rectal, vaginal, eye, ear, nose, or pre-mixed nebulizer. ☐ Yes ☐ No

If the answers to all of the questions are "yes", this individual meets the criteria for Assistance with Medication Delivery by Staff. Proceed to Section IV.

Note: 1. Individuals must have a current PCP order for assistance with medication delivery by staff. 2. Written consent for assistance with medication delivery by staff must be obtained from the individual or their guardian or surrogate health care decision maker. 3. Stable: The individual's condition is unchanged; signs and/or symptoms are within established ranges, frequencies or patterns. The individual's condition does not require frequent assessment or monitoring by a licensed nurse to determine their status or their response to medication or treatment.

Section IV. Medication Administration by Licensed (RN/LPN) or Certified Personnel (CMA)

All questions must be answered in this section.

1- Does the individual:

a. Receive medication via a Nasogastric Tube (NG)? ☐ Yes ☐ No

b. Receive medication(s) via Nebulizer treatment that are not pre-mixed ☐ Yes ☐ No

c. Receive medication via intra-muscular (IM) and/or subcutaneous (SQ), and/or intravenous (IV) injection? ☐ Yes ☐ No

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If any answer to Question #1-a-c “yes”, this individual meets the criteria for Medication Administration by a Licensed Nurse (RN or LPN) for that particular medication, unless formally delegated by the nurse.

2- Does the individual receive any medication through a gastrostomy or jejunostomy tube? (G or J Tube) ☐ Yes ☐ No

If the answer to Question #2 is “yes”, this individual meets the criteria for Medication Administration by a Licensed Nurse (RN or LPN) or CMA for that particular medication.

3- Does the individual receive any new prescription medication that requires a routine ordered assessment with each dose? (e.g., pulse or BP for cardiac/anti-hypertensive) ☐ Yes ☐ No

If the answer to Question # 3 is “yes”, this individual meets the criteria for Medication Administration by a Licensed Nurse (RN or LPN) for that particular medication until the person has stabilized (see Section III note); a medical emergency response plan is in place and staff, (including CMAs), demonstrate documented competence on a routine ordered assessment with the delivery of each dose.

See notes below. Proceed to Section V.

1. Individuals who receive paid, family living services from persons related by affinity or consanguinity may receive medications for the conditions listed above IF those providers have completed the DDSD approved training for assisting with medications and have received any individual specific training (such as administration of insulin) conducted by the individual's PCP. 2. If family living providers are not related by affinity or consanguinity, arrangements must be made by the family living provider agency for an RN, LPN or CMA to administer medication via the routes listed above or the Home based provider agency nurse may assess the ability of the surrogate family for possible training to administer these medications as a delegated nursing function in accordance with Board of Nursing Rules and DDSD policy. 3. The Provider Agency nurse may assess the ability of the Direct Support Staff in Community Living settings for possible training to deliver these medications via G tube or J tube as a delegated nursing function in accordance with Board of Nursing Rules and DDSD policy.

Section V. Nurse Comments and Recommendations

Complete appropriate section(s) and add note below.

Self Administration:

1. This individual meets the criteria for Self Administration of Medications ☐ Yes ☐ No ☐ Unknown
2. There is a current PCP order for Self Administration of Medications ☐ Yes ☐ No ☐ Unknown
3. There is a current written consent from the individual, their guardian or surrogate health care decision maker. ☐ Yes ☐ No ☐ Unknown

Self Administration with Physical Assistance by Staff:

1. This individual meets criteria for Self Administration with Physical Assistance by staff. ☐ Yes ☐ No ☐ Unknown
2. There is a current PCP order for Self Administration of Medications ☐ Yes ☐ No ☐ Unknown
3. There is a current written consent from the individual, their guardian or surrogate health care decision maker. ☐ Yes ☐ No ☐ Unknown

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Assistance with Medication Delivery by Staff

1. This individual meets criteria for Medication Delivery by Staff. ☐ Yes ☐ No ☐ Unknown
2. There is a current PCP order for Self Administration of Medications ☐ Yes ☐ No ☐ Unknown
3. There is a current written consent from the individual, their guardian or surrogate health care decision maker. ☐ Yes ☐ No ☐ Unknown

Medication Administration by Licensed or Certified Personnel

1. This individual meets the criteria for Administration by Licensed /Certified Personnel for "specific medication(s)" due to the route of administration. ☐ Yes ☐ No ☐ Unknown
2. This individual meets the criteria for Administration by Licensed /Certified Personnel for specific medications until stable, crisis prevention plans are in place and staff demonstrates competence in routine ordered assessments before delivery. ☐ Yes ☐ No ☐ Unknown
3. This person receives family living services from a person related through affinity or consanguinity that has undergone PCP training and completed DDSD approved training for assisting with medications. ☐ Yes ☐ No ☐ Unknown
4. This person receives family living services from a person that is not related by affinity or consanguinity but that has completed DDSD approved training for assisting with medications. The agency nurse may consider delegation of this task within the NM Board of Nursing rules DDSD policy. ☐ Yes ☐ No ☐ Unknown
5. This person receives supported living services and has a G tube or J tube. The agency nurse may consider delegation of this task within the NM Board of Nursing rules and DDSD policy. ☐ Yes ☐ No ☐ Unknown

Nursing Comments: _____

_____

_____

Nurses Signature(s)

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Section VI. IDT Comments and Determination

IDT comments, provided by CM, can be found in reviewer comments below.

Signature(s)

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**

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