

Section: Medication Control/Monitoring
Policy: Medication Administration, Storage and Disposal
Policy No: MC 01
Effective: 01/01/1997
Revised/Approved: 06/22/2021

POLICY: It is the policy of Community Counseling Services (CCS) that all medications administered through CCS programs will be administered by a nurse licensed to practice in the state of Mississippi in accordance with the MS Nursing Practice Law and Rules and Regulations; prescribed by a physician or psychiatric mental health nurse practitioner (PMHNP) licensed to practice in the state of Mississippi with appropriate DEA credentials; stored in compliance with standards; and disposed of in compliance with standards when no longer prescribed or in excess of their expiration date.

PURPOSE: To ensure safe administration and storage of medication in the program environment

PROCEDURE: It is the responsibility of supervisors responsible for community living/residential programs and the crisis residential unit to ensure that all medication/drugs are stored in a location utilized only for storage of prescription and nonprescription drugs. Medications are clearly labeled, including the name of the individual for whom they are prescribed, and stored in a well-lighted and securely locked area accessible only by approved personnel. For medication clinics offered in outpatient offices, it is the responsibility of a Registered Nurse and the County Administrator to ensure proper storage.

Storage: Prescription drugs will be stored in a separate cabinet or compartment utilized only for that purpose. Nonprescription medications must be stored separately from prescription medications in a separate cabinet or compartment utilized only for that purpose. Topical medications shall be stored separately from oral medications in separate cabinets or on separate shelves which are plainly labeled according to use. Drugs for external and internal use will be stored in separate cabinets or on separate shelves which are plainly labeled according to use. In the event a medication requires refrigeration, the medication will be stored in a separate refrigerator in a locked area. A locked medication box which is clearly and accurately labeled may be kept in a refrigerator which also contains food items but clear separation should occur and security must be maintained. (Exception for medication storage standards: Supported Living programs)

Disposal: When medication prescribed for a specific person is no longer used by said person, there are two procedures available for medication disposal. 1) A nurse or program supervisor will notify the Pharmacy for which CCS has a current agreement. A representative will pick up the discontinued medication within five (5) business days. Details regarding the medication (name of individual, name and dosage of medication, date picked up, and initials of the representative taking custody of the medication) will be maintained in a log book. The pharmacy will assure CCS that the medication will be disposed of as per federal regulations. 2) Current FDA recommendations (www.fda.gov) on the disposal of unused medication will be followed under the supervision/direction of medical personnel. In the event the medication is a scheduled controlled substance,

the disposal shall be witnessed by another staff member and both shall document the disposal of the controlled substance. Discontinuance and/or disposal of any prescribed medications shall be documented in the medication profile in the medical record for an person receiving service.

Medication Administration: The administration of all prescription drugs and/or other medical procedures must be directed and supervised by a licensed physician or a licensed nurse in accordance with the MS Nursing Practice Law and Rules and Regulations. Only a nurse licensed to practice in the state of Mississippi will administer medications in accordance with the MS Nursing Practice Law and Rules and Regulations. The nurse will review each medication at the time of the individual's appointment for verification of the correct medication and strength as well as to ascertain that the medication has not expired.

Self-Administration: In supervised living/residential programs, a log shall be maintained that identifies the quantity of the medication available as well as a record of each time the medication is self-administered. (Note: There are additional policies, MC 03, MC 04, MC 05, MC 06 for medication control/monitoring at Substance Abuse Residential Treatment facilities and MC 07 for IDD Supervised Living). The program supervisor shall be responsible to ensure that in programs where there is no medical staff, non-licensed staff members may observe people receiving services while they self-administer prescribed medication, in addition to, reminding people to take medication as prescribed. Medications must be clearly labeled, including the name of the person for whom they are prescribed, and stored in a well-lighted and securely locked area accessible only by approved personnel and as indicated under the storage section of this policy.

The goal in monitoring self-administration is to comply with physician recommendations and promote optimal wellness. The "six (6) rights" of medication administration should be followed as identified by the MS Board of Nursing. These 6 rights are as follows:

- Right Medication
- Right Individual
- Right Dose
- Right Route
- Right Time
- Right Documentation

Designated staff members are responsible for adhering to CCS' Policies and Procedures regarding medication monitoring and self-administration. Staff members will not participate in activities that require professional nursing judgment, knowledge, or skill, and notifies appropriate medical staff when professional nursing/medical care is required. Staff members shall never offer expert advice regarding the appropriateness, effectiveness, or advisability of taking or not taking any medication. Responsibilities include, reminding people when it is time to take his/her medication and observing the person to ensure that the person receiving services follows the directions on the container.

Staff may assist the person receiving services in the self-administration of medication by taking the medication in its container from an area where it is stored and handing the container, with the medication in it, to the person. If the person is physically unable to open the container, designated staff may open the container for the person and assist the person in taking or applying the medication. If staff notices or suspects a medication reaction, a medication error, or a change in the person's health status, they must notify the appropriate medical personnel and County Administrator/Program Supervisor immediately. A Self-Administered Medication Observation Log shall be maintained for people receiving services during his/her stay at a community living/residential facility.

The Self-Administered Medication Observation Log will include the name of the person receiving services, case number, and name of program in the heading. Each time a staff member observes a person self-administering a medication, the time, date, medication name, and dosage will be documented, along with the persons and observing staff member's signature. For regularly prescribed medications, forms can be 1) prepared by the pharmacy for up to one month or 2) prepared by a supervisor and approved by a nurse for up to one month. Two or more medications, administered at the same time, can be signed with a single signature on a diagonal line across rows.

Crisis Residential Unit Specific

Crash Cart: A modified crash cart will be available at the Crisis Residential Unit, containing an oxygen canister, tubing, and mask, suction equipment, and Ambu bag for CPR. This is to be used only in an emergency, awaiting EMS personnel to arrive. Medical staff only, including physicians, nurse practitioner, and RN's, will use the modified crash cart. The modified crash cart will be re-stocked as indicated, upon use.

Emergency Medication Kit: An emergency medication kit, containing up to 60 drugs, will be maintained on the Crisis Residential Unit in a locked container behind locked doors. Medical staff only, including physicians, nurse practitioner, and RN's, will use the emergency medication kit. The only time the emergency medication kit can be used is for new admissions before their prescriptions are dispensed. When the emergency medication kit is used, the inventory control form is completed. The supplying pharmacy will re-stock the emergency medication kit upon drugs being used from the kit. The Crisis Residential Unit will have a permit for the emergency medication kit and a permit for controlled drugs from the Mississippi Board of Pharmacy.

Section: Medication Control/Monitoring
Policy: First Aid Kits
Policy No: MC 02
Effective: 2/1/1997
Revised/Approved: 3/28/2017

POLICY: It is the policy of Community Counseling Services to have a first aid kit readily available for staff, people receiving services, and visitors.

PURPOSE: To ensure the availability of first aid materials when needed to provide basic first aid to people within our facilities, including staff.

PROCEDURE: It is the responsibility of the County Administrator/Supervisor to ensure that each program under his/her supervision has a first aid kit. For each facility in which more than one program operates, a single first aid kit may be used by two or more of the programs if it is readily/easily accessible for all people in the programs. A first aid kit must also be present on each vehicle used for client transportation. Each first aid kit shall contain the following, with all items being current:

- Gloves
- Adhesive bandages
- Gauze
- First aid tape
- Sterile pads
- Antiseptic wipes
- A first aid booklet

During orientation, all staff is made aware of the first aid kit location in the building his/her office is assigned. Office Managers are responsible for monitoring the first aid kits in each county office. For employee's who use agency vehicles for transportation, they are responsible for daily monitoring to ensure the first aid kit is maintained and all items remain current.

Section: Medication Control/Monitoring
Policy: Handling Medications on Admission to SUD Residential
Policy No: MC 03
Effective: 10/25/2006
Revised/Approved: 06/22/2021

POLICY: It is the policy of Community Counseling Services that people entering a SUD Residential facility shall bring with them to the facility only those medications which are currently prescribed. No over-the-counter or previously prescribed medications that are not currently being taken may be brought into the facility unless they are sealed and on the list of over-the-counter, recovery approved medications. A licensed nurse or physician must approve all over-the-counter medications for people receiving services at a SUD Residential facility.

PURPOSE: To ensure continuity of current medications for the effective treatment of existing medical conditions; to ensure the safe storage and management of medications for each person receiving services; to minimize the amount of medications contained in the facility that are not currently prescribed to people presently in treatment

PROCEDURE: It is the responsibility of the Program Coordinator to ensure that people are clearly instructed prior to admission that only currently prescribed medications should be brought to the facility. No over-the-counter or previous prescriptions not currently being taken should be brought to the facility. In the event medications other than those currently prescribed are brought to the facility, the medications shall be sent home with a family member present during the admission process, and this action should be noted in the on the person's inventory list. In the event medications other than those currently prescribed are brought to the unit and no family member is available by whom to send the medications home, the medications should be identified, counted, placed in a large brown envelope, sealed, and signed by the person across the seal. This envelope shall then be given to the staff member responsible for the medication room at that time and be placed in a locked filing cabinet in the medication room. The medication will be returned to the person at the time of discharge, except as explained in below. The medication and count should be listed on the person's inventory form at the time of admission.

Prior to admission, all people should be made aware that it is his/her responsibility for having a valid prescription for any medications, as well as, being financially responsible for any refills/new prescriptions needed. All currently prescribed medications should be continued as ordered until ordered otherwise by a physician. All current prescriptions at the time of admission shall be identified, counted and listed on the inventory form of the person. In addition, the medications should be given to the staff member responsible for the medication room at the time of admission in order to initiate the protocols necessary to allow the person to continue receiving the medication as ordered. These protocols are addressed in Policy MC 04, Supervision of Self-Administration of Medication during an Person's Stay at a SUD Residential facility.

Each person should be clearly instructed at admission that all medications, including medications not currently being taken that were unable to be sent home at the time of admission, will be released to him/her at the time of discharge. Each person should

also be clearly informed that, in the event he/she leaves treatment prior to his/her planned and scheduled discharge, medications will only be held for a period of forty-eight (48) hours. After this time, proper disposal will occur in accordance with policy MC 01: Medication Administration, Storage, and Disposal.

Section: Medication Control/Monitoring
Policy: Supervision of Self-Administration of Medication during an Individual's Stay at a SUD Residential Facility
Policy No: MC 04
Effective: 10/25/2006
Revised/Approved: 06/22/2021

POLICY: It is the policy of Community Counseling Services (CCS) that all medications brought to the facility will be in the custody of the staff member supervising the medication room while the person receiving services is at the facility.

PURPOSE: To ensure continuity of current medications for the effective treatment of existing medical conditions; to ensure the safe storage and management of client medications; to provide for the safety and security of medications; to ensure that the rights of people receiving services with regard to medications are preserved and maintained.

PROCEDURE: All medications brought to the facility that are not sent home with a family member shall be identified, counted and listed on the inventory form at the time of admission. Medications are then given to the staff member supervising the medication room to be logged into the med room. The staff member responsible for the medication room should first determine if the medication is or is not a controlled substance. If the medication is determined to be a controlled substance, the medication should be added to the Controlled Substance Log book. Secondly, the medication should be counted to make sure an accurate number of pills are accounted for when being checked in to the medication room. This staff member shall initiate a Self-Administered Medication Observation Log for all medications received and record the person's name, case number, medication, dosage, and any other notes or instructions.

Counting Medication: All staff members actually touching medications for the purpose of counting must wear gloves. In addition, in the event a medication must be removed from a bottle or container for counting, the medication should be carefully emptied on a clean napkin or paper towel. If the medication is in liquid form, the staff member should estimate the percentage of the filled container remaining and note this amount.

Medications Room/Supplies: All medications in the medication room should be clearly labeled including the person's name, medication name, date (of prescription fill, refill, or expiration date as applicable), dosage, route, and self-administration times. The medications can be stored in a zippered plastic bag and/or in a cubicle clearly differentiated from medications belonging to other people. All medications should be correctly stored in original containers and refrigerated when indicated. No food or drinks are permitted in the medication refrigerator. A pitcher of water is maintained at the medication window for people who require liquid for swallowing medications. The person shall obtain his/her drink and then return to the window to self-administer medication. Under no circumstances should the person be permitted to leave the window with medications in order to get a drink.

A binder shall be kept in the medication room that contains Self-Administered Medication Observation Logs Medication for each person during their stay at the facility.

The records will be kept in alphabetical and/or numeric order by the last name of the person or case number. Any staff member must obtain permission from an Administrator/Program Supervisor before the medication binder can leave the medication room for any reason. The primary purpose for binder displacement by staff is daily and random checks of content accuracy by supervisory staff. In the event a Self-Administered Medication Observation Log(s) is requested by a physician/medical provider, a copy should be made and sent as requested. A consent to release information must be completed to share information, unless the request is made as a result of an emergency/life threatening situation. No original documents/logs should leave the facility during the person's stay for any reason.

The medication room should contain a Physician's Desk Reference, a list of Controlled Substances, and other sources of adequate information to answer basic questions about medications. The staff member responsible for observing self-administration shall never offer expert advice regarding the appropriateness, effectiveness, or advisability of taking or not taking any medication. If a person has questions about his/her medications, he/she should be referred to his/her primary care physician/provider or available medical staff (i.e., RN, Nurse Practitioner).

Self-Administered Medication Observation Log completion: A separate Self-Administered Medication Observation Log shall be maintained for each medication. The log will include the person's name, case number, medication, dosage, and any other notes or instructions (i.e., 3x/day). Each time a staff member observes a person taking his/her medication, the staff member will record date, the time of the self-administration, pill count (number of pills taken), staff signature, and signature of person receiving services. Self-Administration Medication Observation Logs must be rewritten when filled. It is not permissible to add extra times or dates to a page that is filled. Staff members working the overnight shift shall prepare new Self-Administered Medication Observation Log(s) for any medication that will require additional documentation space within the next 24 hour period. The new sheet should be placed directly behind the filled sheet of the same medication. All information should be filled out on the new sheet as indicated above. Medications newly prescribed during the stay of a person should be treated in the same manner as those current medications brought to the unit at the time of admission. Staff members must obtain permission from Administrators/Supervisors before purchasing **any** medication for people at the facility.

Discontinuation of Medication: If a Self-Administered Medication Observation Log is maintained for a medication that is no longer being taken/discontinued, an entry should be made indicating the date, statement indicating "discontinued" or if a time limited medication, "medication regimen complete", and the signature of staff and the person receiving services. A comparable notation must be made on the Medication List maintained in the person's record.

Refusal to take Medication: It is the responsibility of all people receiving treatment a SUD Residential facility to know their medication times and to report for medications at their assigned times. People, though encouraged to take all medications as prescribed, have the right to refuse. However, any person refusing medication must report to the medication room window, notify the staff member of the refusal, and initial the Medication Self-Administration Record until such time as the medication has been discontinued or the client has been discharged. Failure of an person to report for

medication, whether taking or refusing will be considered non-compliance with treatment and addressed appropriately by the treatment team. The staff member responsible for the medication room will complete a separate "Notice to Clinical Team" each time a person does not report to the medication room as scheduled or refuses to take his/her medication. It is the responsibility of the clinician and/or program coordinator to follow up with the person and/or primary care provider to determine appropriate action.

Over-the-counter Medication(s): SUD Residential facilities maintain a list of OTC, recovery medications approved for residents of SUD Residential by the medical provider contracting to provide medical services for residents. Staff members must obtain permission from Administrators/Supervisors before purchasing **any** over-the-counter for people and/or the facility. Any medications purchased on behalf of a person should be immediately given to the staff member responsible for the medication room at the time the medications first enter the unit. The staff member responsible for the medication room will initiate a Self-Administration Medication Observation Log and correctly store the medication.

Medication Times: Medication times will be coordinated to follow meal times and before bedtime. In the event a person must self-administer a medication prior to meals or at a time outside a one-hour window of the established medication times, a special arrangement will be made to facilitate the self-administration of this medication. Once a special time has been established, it is the responsibility of the person to report to the medication window at that time. Medication self-administration times will be clearly posted outside the medication room window. In addition, an announcement will be made in the facility in advance of the self-administration time reminding all people to come to the medication room.

General Information: Only one staff member will be assigned/responsible for the medication room at any one time. The staff member will supervise medication self-administration for all residents. The staff member assigned to the medication room should keep the door locked at all times, whether working in the area or away from the area. During medication self-administration times, the staff member supervising medication self-administration should avoid distractions. This staff member should not be called away to answer the telephone or assist with other unit duties while he/she is responsible for medication times. Only one person should report to the medication room at a time to ensure the staff member can focus specifically on the person present and to maintain the person's privacy.

The medication room will be highly secured. The window will be locked at all times except during medication self-administration times. A locked filing cabinet will be housed in the room for medications not currently in use. The door to the room will be secured with a lock and a dead bolt that should be secure at all times. At no time should this room be accessible by staff, clients, or visitors other than those specifically assigned. There will be two keys to this room. One key will be in a secured area in the possession of the Program Coordinator. The other key will be passed from the current assigned staff member supervising/responsible the self-administration of medication at the end of the shift to the individual assuming this duty for the next shift. Under no circumstances should the key to the medication room ever leave the facility. In the event the key to the medication room is lost, the Program Coordinator should be notified

immediately. All door locks will be changed and appropriate disciplinary action will be initiated.

Transfer of Medication Room Responsibilities: Before accepting the medication room for an assigned shift, both the staff member leaving and the individual coming on should verify that all controlled substances are present. This will require the counting of all controlled substances and other medications identified by Administrators/Supervisor that need to be counted during staff assignment changes. All other medications will be counted by staff members during the overnight shift as assigned. In the event a medication is missing, or partially missing, the responsibility will be that of the staff member immediately preceding the discovery. A program Administrator/Supervisor must be immediately notified and an incident report completed. Therefore, it is imperative that all medications are accounted for before accepting responsibility for the medication room. A log will be maintained in the medication room that will note the transfer of responsibility from one staff member to another. This log must be signed each time there is a transfer of responsibility. The staff member leaving the medication room after the assigned shift is responsible for copying and submitting unusual event forms to the clinicians, reporting any significant issues to the Program Coordinator/RCW Supervisor, and disposing of the trash since housekeeping staff does not have access to the area.

Section: Medication Control/Monitoring
Policy: Medication Disposal at the Time of Discharge from SUD Residential facility
Policy No: MC 05
Effective: 10/25/2006
Revised/Approved: 06/22/2021

POLICY: It is the policy of Community Counseling Services that all unused medications be returned to people who are discharged from SUD Residential facility.

PURPOSE: To safely return all unused medications to the person at the time of discharge; to complete medication documentation and submit the Self-Administration Medication Observation Log(s) for inclusion in the medical record; to safely dispose of medications left on the unit in excess of forty-eight (48) hours after the individual's discharge in the event that a person leaves treatment prior to scheduled discharge.

PROCEDURE: It is the responsibility of the clinician to notify the staff member responsible for the medication room that a person is being discharged on that day and the approximate time. The staff member responsible for the medication room during this time should prepare the medications for discharge. A basket should be designated as a discharge bin for medications being sent home. A separate basket should be prepared for each client being discharged on that day. The medications should be placed in zippered plastic bags and placed in the basket. Any medications contained in the locked filing cabinet from time of admission should also be removed from the filing cabinet and placed in the basket. These medications should remain in the sealed envelope. A note should be placed in the basket reminding the staff member of any medications that may be kept in the refrigerator. Refrigerated medications should not be removed from the refrigerator until the actual time of discharge.

Following all other discharge instructions, the person shall be escorted to the medication room window just prior to leaving the facility. The staff member responsible for the medication room should give all remaining medications to the person and the person shall then be escorted to the door by staff. Under no circumstances shall a person with medications in his/her possession be permitted to enter any other area of the facility. In addition, at no time shall the medications be left unattended in any area of the facility. Immediately following discharge, each Self-Administration Medication Observation Log should be documented with the date, time, and word "discharged," as well as the initials of the staff member who released the medications from the medication area. The Self-Administration Medication Observation Log(s) should be removed from the binder at this time and should be submitted for inclusion in the medical record.

In the event that a person does not follow the normal discharge procedure i.e. leaves without notifying staff, does not return from pass, etc., the medication should be prepared for discharge as discussed in Policy MC 03. In the event that the client fails to notify the unit within forty-eight (48) hours of his/her intent to personally pick up the medication, the Program Coordinator/RCW Supervisor shall notify the staff member responsible for the medication room that the person has been discharged for forty-eight (48) hours and has not requested the medication and proper disposal will occur in accordance with policy MC 01: Medication Administration, Storage, and Disposal. The

staff member responsible for the medication room shall note on the Self-Administration Medication Observation Log that the individual was discharged and medications were left more than forth-eight (48) hours, and that medications were disposed of in accordance with agency policy. The Self-Administration Medication Observation Log(s) shall then be removed from the binder and submitted for inclusion in the medical record.

Section: Medication Control/Monitoring
Policy: Providing for the Self-Administration of Medication while on a Pass from a SUD Residential facility
Policy No: MC 06
Effective: 10/25/2006
Revised/Approved: 06/22/2021

POLICY: It is the policy of Community Counseling Services to make arrangements for the availability of medications to individuals who are on an authorized pass from a SUD Residential facility.

PURPOSE: To ensure continuity of current medications for the effective treatment of existing medical conditions.

PROCEDURE: When a pass is authorized by the treatment team, the clinician should determine whether any medications should be self-administered during the pass time by consulting with the staff member responsible for the medication room at that time. The clinician should provide a list of all people going on pass at least one day in advance of the authorized passes so that the staff member supervising self-administration of medications can prepare necessary medications prior to pass. This information should be shared during the transfer of responsibility between staff members supervising the medication room.

All medications that should be self-administered within one hour of a person going on pass or returning from pass should be self-administered at the facility. This may require special arrangements with the staff member supervising responsible for the medication room administration. Special arrangements with the staff member should be made by the clinician authorizing the pass. In the event it is not possible to self-administer medications on the unit as a result of a person being away on pass, medications may be sent on pass with the client.

The staff member should provide the person going on pass with a small zippered plastic bag, and allow the person to place the necessary doses of medication for the pass in the bag. The staff member supervising the self-administration of medication should provide a medication pass slip that lists the person's name, medication, dosage, and time the medication should be taken. The staff member supervising the medication room should make a note on the Self-Administration Medication Observation Log that the medication was sent with the person while on pass. In the column where the individual would normally initial that he/she had taken the medication, the staff member supervising the self-administration of medication should place a "P" indicating that the person was on pass at this time.

Section: Medication Control/Monitoring
Policy: Assistance with Medication Usage by Non-Licensed Personnel in IDD Supervised Living Facilities
Policy No: MC 07
Effective: 6/22/2021
Revised/Approved:

POLICY: It is the policy of Community Counseling Services (CCS) to provide staff training for non-licensed personnel in IDD supervised living facilities to assist with medication usage.

PURPOSE: To ensure continuity of current medications for the effective treatment of existing medical conditions.

PROCEDURE: The Director of IDD services and the HR Department shall be responsible to ensure that non-licensed staff obtain necessary training regarding assisting people with medication usage in IDD Supervised Living facilities. In order for a non-licensed person to assist with medication usage, there must be no clinical decision making needed. The following procedures are considered assisting a person with their medications:

- Opening a dose packet of pills that is packaged by the pharmacy
- Opening a pill bottle labeled for the person and pulling a medication out for the person to take
- Assisting the person in putting medications in his/her mouth
- Documenting that the person took the medication(s)
- Crushing a medication that can be crushed (with the order from the prescriber stating that this can be done)
- Putting medication in food or drink (e.g., applesauce, pudding) and giving that mixture to a person to take orally (with the order from the prescriber stating that this can be done)
- Applying a topical cream
- Applying an eye drop
- Applying an ear drop
- Applying a nasal mist
- Applying a non-narcotic skin patch (e.g., clonidine, estrogen)
- Giving a routinely ordered unit dose nebulizer treatment (e.g., Albuterol, atrovent)
- Assisting a person to use a routinely ordered metered dose inhaler (for asthma or Chronic Obstructive Pulmonary Disease)
- Placing rectal suppository that is routinely ordered
- Taking vital signs

The administration of all prescription drugs and/or other medical procedures other than listed in Rule 13.8.A.1 must be directed and supervised by a licensed physician or a licensed nurse in accordance with the MS Nursing Practice Law and Rules and Regulations. This includes but is not limited to the following:

- Administering medication in a PEG tube
- Administering insulin via a subcutaneous injection
- Administering an “as needed” prescribed medication

Required training consists of two parts and must be repeated annually. Part one is an online elearning course that teaches how to safely and responsibly help people in using their medication. Part two consists of practical examination conducted by a Registered Nurse to ensure staff can safely assist with medication usage. Staff will be expected to complete both parts as follows:

- 1) At time of hire, applicable staff will be registered to complete the online eLearning module *Assistance with Medication Usage* and complete during their orientation process.
- 2) After successful completion of the course, the agency RN will observe non-licensed staff demonstrating the following skills and complete corresponding check-off sheets:
 - Handwashing
 - Hand sanitizing
 - Pharmacy labels
 - Oral pills and capsules
 - Crushing medication
 - Oral liquids
 - Topical medications
 - Eye drops
 - Ear drops
 - Nasal spray
 - Metered dose inhaler
 - Metered dose inhaler with spacer
 - Nebulizer medications
 - Skin patch
- 3) Successful completion of part one and two will be documented with a copy of the course certificate and the check-off sheets maintained in the employees training records.
- 4) Both part one and part two will be completed annually, with corresponding documentation maintained in the employees training records.

Additional information regarding Medication Administration, Storage and Disposal can be found in policy MC 01.