



NURSE DELEGATION PROGRAM SKILLS CHECK LIST

NEW

RENEW

_____ Agency Name Here

Staff Name _____ Date _____
(Print)

MAS Nurse _____
(Print)

The unlicensed staff must, without prompting or error, demonstrate all skills delegated in accordance with the published guidelines with 100% accuracy to the MAS Nurse.

CRITERIA	MAS NURSE INITIALS & DATE	STAFF INITIALS & DATE	COMMENTS
I. Basic Medication Information and Medical Terminology (Refer to Guidelines)			
A. States common medical abbreviations and meanings			
B. Describes common dosage forms of medications and routes of administration			
C. States the 7 rights			
D. Describes what constitutes a medication error			
E. Describes consumer rights related to refusal, privacy and respect			
F. Defines a medication allergy and signs of a possible allergic reaction			
G. State name and location of medication references available in the facility			
II. Demonstrated appropriate technique to obtain and record the following: (Refer to Guidelines)			
A. Blood Pressure			
B. Temperature			
C. Pulse			

D. Respiration			
E. Finger stick blood sugar			
III. Administration of Medications (Refer to Guidelines)			
A. Verifies use of appropriate medication delivery system with pharmacy label			
B. States proper medication storage guidelines			
C. Wash hands			
D. Locates a clean and private area			
E. Gathers equipment needed			
F. Identify consumer and bring/go to medication area			
G. Unlock medication storage area			
H. Read MAR and compare with label on medication container; checks expiration date of med; 7 rights			
I. Acknowledges allergies			
J. Double checks the med label with the MAR using 7 rights			
K. Performs task satisfactorily			
L. Verifies medication was taken/administered			
M. Performs third check of medication label with the MAR			
N. Returns medication to proper storage			
O. Documents appropriately on MAR			
P. Washes hands			
IV. COMPETENCY VERIFICATION OF ASSISTANCE WITH MEDICATIONS			
A. Assistance with medications – Check the type(s) of medications for which demonstrated competency is validated			
<input type="checkbox"/> oral – pills/tablets/capsules			
<input type="checkbox"/> oral – liquid			
<input type="checkbox"/> oral – buccal/sublingual			
<input type="checkbox"/> eye – drops			
<input type="checkbox"/> eye – ointments			
<input type="checkbox"/> eye – patches			
<input type="checkbox"/> ear – drops			
<input type="checkbox"/> ear – topical (creams/lotions)			
<input type="checkbox"/> hearing aids			
<input type="checkbox"/> nose – drops			
<input type="checkbox"/> nose – sprays/inhalers			
<input type="checkbox"/> topical – creams/ointments/paste			
<input type="checkbox"/> topical – lotions/suspensions			

<input type="checkbox"/> topical – sprays/powders			
<input type="checkbox"/> topical – patches			
<input type="checkbox"/> topical – shampoo			
<input type="checkbox"/> respiratory inhalers			
<input type="checkbox"/> rectal medication – Suppositories/Enema/ Other:			
<input type="checkbox"/> vaginal medication – Suppositories Other:			
<input type="checkbox"/>			
<input type="checkbox"/>			
V. OTHER NURSING TASK VALIDATED			
<input type="checkbox"/> Glucometer			
<input type="checkbox"/> Nebulizer			
<input type="checkbox"/> CPAP			
<input type="checkbox"/> Oxygen concentrator/cannula/mask			
<input type="checkbox"/> Epi-pen			
<input type="checkbox"/> Vagal Nerve Stimulator Wand			
<input type="checkbox"/> Blood Pressure Machine			
<input type="checkbox"/> Thermometer			
<input type="checkbox"/> Counting Pulse			
<input type="checkbox"/> Counting Respirations			
<input type="checkbox"/> Hospital Bed			
<input type="checkbox"/> Mechanical Lift			
<input type="checkbox"/> Weight Scales			
VI APPROPRIATE DOCUMENTATION VALIDATED			
MAR			
<input type="checkbox"/> After Assisting with meds			
<input type="checkbox"/> Refused Meds			
<input type="checkbox"/> PRN meds			
<input type="checkbox"/> Missed dose other med error			
<input type="checkbox"/> Meds Held			
<input type="checkbox"/> Self Administration			
<input type="checkbox"/>			
<input type="checkbox"/> Seizure Record			
<input type="checkbox"/> Treatment Record			
<input type="checkbox"/> Narcotic Count Sheet			
<input type="checkbox"/> Health Care Practitioner Sheet			
<input type="checkbox"/> Medication Error Report Form			
<input type="checkbox"/> Incident Report Form			
<input type="checkbox"/> MAC Call Log/Agency Required Form			
<input type="checkbox"/>			

<input type="checkbox"/>			
VII. OTHER SKILLS VALIDATED			
<input type="checkbox"/> Infection Control			
<input type="checkbox"/> First Aid/ Emergency Management			
<input type="checkbox"/> Seizure Management			
<input type="checkbox"/> MAS-MAC Connection			
<input type="checkbox"/> Med/Med Room Security			
<input type="checkbox"/>			

- On-Site Observation
- Skills Lab Observation

SKILLS CHECKLIST SIGNATURE PAGE

DATE MAC II COMPLETED _____

NDP 13
5/8/2013

8 HOURS

Other Amount of Time _____ **Time Range**

Explain _____

STAFF SIGNATURE _____

STAFF Initials _____ DATE _____

MAS Nurse
SIGNATURE _____

MAS Nurse Initials _____ DATE _____