



## SOUTH DAKOTA BOARD OF NURSING

4305 S. Louise Ave., Suite 201 | Sioux Falls, SD 57106-3115  
605-362-2760 | <https://doh.sd.gov/boards/nursing/>

### Medication Aide Clinical Skills Checklist

Complete this checklist for each student during the required 4-hour clinical or skills lab portion of a medication aide training program or to evaluate competency of a medication aide annually. The RN to student/ medication aide ratio must be 1:1.

#### Prior to Medication Administration, the Student or Medication Aide:

<input type="checkbox"/> Checked the medication administration record (MAR) and reviewed for completeness, accuracy, known allergies
<input type="checkbox"/> Checked medication resources and references as needed
<input type="checkbox"/> Clarified questions with the nurse
<input type="checkbox"/> Washed hands
<input type="checkbox"/> Collected needed items (e.g. med cup, water, straw)

#### During Medication Administration, the Student or Medication Aide:

<input type="checkbox"/> Selected the right medication (e.g. from patient's med drawer)									
<input type="checkbox"/> Completed the "Rights" of medication administration including right drug, dose, route, time, and patient									
<input type="checkbox"/> Checked the expiration date of medication									
<input type="checkbox"/> Prepared medication correctly (e.g. poured correct amount)									
<input type="checkbox"/> Identified patient according to agency policy (e.g. checked patient ID bracelet against MAR, called resident by name, or used bar code scanner)									
<input type="checkbox"/> Provided privacy as appropriate									
<input type="checkbox"/> Explained medication procedure to patient									
<input type="checkbox"/> Obtained & documented required measurements (e.g. blood pressure, pulse)									
<input type="checkbox"/> Positioned patient appropriately to administer drug									
<i>Verify competency for each route a nurse will be delegating to the Medication Aide. If a route was not demonstrated and is later required, an RN instructor may provide education and may validate competency for that route at that time.</i>									
<input type="checkbox"/> Administered medication appropriately and safely for the following routes:									
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Ear</td> <td style="width: 33%;"><input type="checkbox"/> Nose</td> <td style="width: 33%;"><input type="checkbox"/> Sublingual</td> </tr> <tr> <td><input type="checkbox"/> Eye</td> <td><input type="checkbox"/> Oral</td> <td><input type="checkbox"/> Topical</td> </tr> <tr> <td><input type="checkbox"/> Inhaled</td> <td><input type="checkbox"/> Rectal</td> <td><input type="checkbox"/> Vaginal</td> </tr> </table>	<input type="checkbox"/> Ear	<input type="checkbox"/> Nose	<input type="checkbox"/> Sublingual	<input type="checkbox"/> Eye	<input type="checkbox"/> Oral	<input type="checkbox"/> Topical	<input type="checkbox"/> Inhaled	<input type="checkbox"/> Rectal	<input type="checkbox"/> Vaginal
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#### Following Medication Administration, the Student or Medication Aide:

<input type="checkbox"/> Used appropriate infection control procedures according to agency policy (e.g. discarded med cup appropriately, washed hands)
<input type="checkbox"/> Handled patient carefully and respectfully
<input type="checkbox"/> Recorded the right documentation on the MAR according to agency policy
<input type="checkbox"/> Reported and recorded patient observations/concerns

RN Name: \_\_\_\_\_ Date: \_\_\_\_\_

Student UMA or UMA Name: \_\_\_\_\_ Date: \_\_\_\_\_

UMA Training Program or Employer Name: \_\_\_\_\_