Medication Safety Quality Audit

Information in this audit tool was used in part from the Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medication Administration Observation. Form CMS–20056

MEDICATION ADMINISTRATION	YES	NO	NOT OBSERVED	COMMENTS
The medication cart is clean, free of clutter and properly maintained				
Hand hygiene was completed prior to handling medication(s) and after administering medication(s) if resident contact was involved				
The correct procedure was followed when accessing the medication cart and MAR				
The MAR is easily accessible				
Medication orders are current				
Drug reference resources are readily available				
Medication “Rights” were followed: • Right Medication • Right Dose • Right Route • Right Time • Right Resident • Right Resident Communication (Resident was informed of the medications being administered) • Right Documentation				

Medications were administered as ordered (e.g., before, after, or with food such as antacids, correct order of inhalers)				
Vital signs and/or lab values were checked prior to administrating the medications (as indicated)				
Medications were appropriately consumed by the resident (e.g., not left at the bedside)				
The resident was appropriately positioned to take the medication				
The medication cart was locked if left unattended in resident care area				
If controlled medications are given, the correct procedure was followed for count verification and administration				
The medication expiration date was verified (as applicable)				
Adverse medication reactions are appropriately noted with documented physician/provider notification				
The staff member passing medications knows the following for each medication: • General indications for the drug • Usual dose and route • Common side-effects				
Appropriate procedures are followed for nasogastric tube medication administration including tube flushing, adequate fluids with administration, and correct procedures are followed for “Do Not Crush” medications				
Injections are prepared using clean (aseptic) technique and administered in an area that has been cleaned and is free of contamination (e.g., visible blood, or body fluids)				
Single use vials are labeled with resident name and dated				
Insulin pens are clearly labeled				
IM/SQ injection sites are rotated				

Proper technique is used for IV/IM/SQ injection				
IV sites and solutions are appropriately maintained and labeled				
Sharps containers are readily accessible in resident care areas.				
Appropriate MAR and medical record documentation is completed				

Person Completing the Audit: _____ Date: _____

Action:

Follow-Up:

Source – Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medication Administration Observation. Form CMS–20056. One source for the form - http://www.leadingagewi.org/media/80036/cms-20056-med-admin.pdf