

XXXX ARMY COMMUNITY HOSPITAL

Automated Dispensing Cabinet (ADC) Medication Management Competency Assessment

Required Competency or Skill	* Self Assess	Orientation (Preceptor initials & date)	+ Eval Method	Competency Validated by Supervisor (Signature & date)	Comments/Additional Resources
A. Security	◆	◆	◆	LEAVE BLANK	◆
(1) Maintain integrity of electronic signature. Do not share password.					
(2) Report to supervisor immediately if password has been compromised.					
(3) Use of fingerprint biometric scanning is preferred access method.					
(4) Log off immediately after completing medication transaction.					
(5) Access of medication is limited to authorized personnel only.					
B. Drug Diversion	◆	◆	◆	LEAVE BLANK	◆
(1) Awareness of Drug Diversion Monitoring Program.					
(2) Drug Diversion Monitoring Program is Command directed and supported.					
(3) Importance of following guidelines and efforts to eliminate drug diversion.					
(4) Program monitors controlled and non-controlled substances.					
C. ADC Discrepancies	◆	◆	◆	LEAVE BLANK	◆
(1) Ensure exact quantities are taken out on all medications.					
(2) Removed medications must not be returned to stock (use Pharmacy Return Bin).					
D. ADC Overrides	◆	◆	◆	LEAVE BLANK	◆
(1) All medications must be reviewed by pharmacy.					
(2) Two exceptions: Emergency & Licensed Independent Practitioner Present.					
(3) When Pharmacy is closed, pharmacists will provide retrospective review within 24hr.					
(4) Select proper override reason. Do not create new reasons.					
E. Controlled Substances	◆	◆	◆	LEAVE BLANK	◆
(1) Physical count is required whenever a controlled substance is accessed (Blind Count).					
(2) Resolve discrepancies at the time of discovery during every shift and use proper and clear justification.					
(3) Witness is required when wasting controlled substances.					
F. Report any suspicious or negligent medication management practices to supervisor.					
G. Complete ADC tutorial, print certificate and turn in to supervisor.					

*Self Assessment:

1=Experienced
 2=Needs Practice/Assistance
 3=Never Done
 NA=Not Applicable

+Evaluation/Validation Methodologies:

T=Test
 D=Demonstration
 V=Verbal
 I=Interactive Class

INITIAL COMPETENCY ASSESSMENT EVALUATION

I understand that of all the topics listed, I will be allowed to perform only those for my skill level/scope of practice and only after I have successfully demonstrated competency.

Pharmacy's Initials: _____ Printed Name: _____ Signature: _____ Date: _____

Employee Initials: _____ Printed Name: _____ Signature: _____ Date: _____

Supervisor Initials: _____ Printed Name: _____ Signature: _____ Date: _____

ANNUAL COMPETENCY ASSESSMENT EVALUATION

I have reviewed the required competency or skills and updated the *Self Assessment column accordingly.

Employee Initials: _____ Printed Name: _____ Signature: _____ Date: _____

Supervisor Initials: _____ Printed Name: _____ Signature: _____ Date: _____

Employee Initials: _____ Printed Name: _____ Signature: _____ Date: _____

Supervisor Initials: _____ Printed Name: _____ Signature: _____ Date: _____

Employee Initials: _____ Printed Name: _____ Signature: _____ Date: _____

Supervisor Initials: _____ Printed Name: _____ Signature: _____ Date: _____

Employee Initials: _____ Printed Name: _____ Signature: _____ Date: _____

Supervisor Initials: _____ Printed Name: _____ Signature: _____ Date: _____

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