Test Scenario Data for §170.314(a)(16) Electronic medication administration record – inpatient setting only

Reference the Test Scenario Procedure for Test Scenario Data implementation guidance.

TD170.314(a)(16) – 1: Electronically Verify the 5 Rights of Medication Administration

All test data are for adult patients; additional information may be supplied by the Vendor as needed.

Test Data – Set 1 — Use this Test Data Set with the Test Data – Set 1 in TD170.314(a)(16) – 2: Electronically Record the Right Documentation of Medication Administration

First Test Patient—to be used for showing the verification of 5 Rights when all of the Rights are correct

- First Test Patient Information:
  - Patient ID: Vendor-specified (for example, 12345678)
  - Patient Name: Isabella Jones
  - Date of Birth: 05/01/1947

  Vendor creates a record in their EHR for this test patient and generates the materials needed by the assistive technology for identification of this patient (e.g., patient ID bar code)

- First Test Patient Medication Orders:
  This medication will be recorded as administered during this test
  - Name: Albuterol
  - Dose: 2.5mg / 3 mL
  - Route: Inhalation (nebulizer)
  - Frequency: Now, and then four times daily as needed

  Vendor inputs this medication order in the EHR for this test patient and provides the materials needed by the assistive technology for identification of these medications (e.g., unit dose bar codes)

Second Test Patient—to be used for showing the verification of 5 Rights when some or all of the Rights are incorrect

- Second Test Patient Information:
  - Patient ID: Vendor-specified (for example, 23456789)
  - Patient Name: Vendor-specified (for example, Joan Bishop)
  - Date of Birth: Vendor-specified (for example, 04/03/1977)

    Vendor creates a record in their EHR for this test patient and generates the materials needed by the assistive technology for identification of this patient (for example, patient ID bar code)

- Second Test Patient Medication Order:
  This medication will not be recorded as administered during this test, as none of the 5 Rights will be met for this medication
  - Name: ampicillin
  - Dose: 500 mg
  - Route: Oral
  - Frequency: Every 12 hours (start in 4 hours)

  Vendor inputs this medication order in the EHR for this test patient

- Patient/Medication Information to be used for showing the verification of 5 Rights when some or all of the Rights are incorrect:

  (A) Wrong Patient Verification
  Vendor provides materials needed by the assistive technology for identifying a patient who is NOT the Second Test Patient (for example, patient ID bar code for First Test Patient)
  For all other 5 Rights verifications listed below for Second Test Patient, the correct patient ID materials are used

  (B) Wrong Medication Verification
  - Name: Ativan (wrong medication)
  - Dose: 500 mg
  - Route: Oral

  Vendor provides the materials needed by the assistive technology for identifying this medication as a wrong medication (for example, unit dose bar code) for the Second Test Patient

  (C) Wrong Dose Verification
  - Name: ampicillin
  - Dose: 250 mg (wrong dose)
  - Route: Oral

  Vendor provides the materials needed by the assistive technology for identifying this medication as a wrong dose (for example, unit dose bar code) for the Second Test Patient

  (D) Wrong Route Verification
  - Name: ampicillin
  - Dose: 500 mg
  - Route: Intravenous (wrong route)

  Vendor provides the materials needed by the assistive technology for identifying this medication as a wrong route (e.g., unit dose bar code) for the Second Test Patient

(E) Wrong Time Verification
- Name: ampicillin
- Dose: 500 mg
- Route: Oral
- Time: EHR system clock will indicate a time other than a time for which this medication is to be administered (wrong time) for the Second Test Patient

Test Data – Set 2 — Use this Test Data Set with the Test Data – Set 2 in TD170.314(a)(16) – 2: Electronically Record the Right Documentation of Medication Administration

First Test Patient—to be used for showing the verification of 5 Rights when all of the Rights are correct

- First Test Patient Information:
  - Patient ID: Vendor-specified (for example, 000123)
  - Patient Name: Isabella Jones
  - Date of Birth: 05/01/1947

  Vendor creates a record in their EHR for this test patient and generates the materials needed by the assistive technology for identification of this patient (e.g., patient ID bar code)

- First Test Patient Medication Orders:
  This medication will be recorded as administered during this test
  - Name: Ceftriaxone
  - Dose: 1 gram
  - Route: Intravenous
  - Frequency: Now, and then once daily

  Vendor inputs these medication orders in the EHR for this test patient and provides the materials needed by the assistive technology for identification of these medications (e.g., unit dose bar codes)

Second Test Patient—to be used for showing the verification of 5 Rights when some or all of the Rights are incorrect

- Second Test Patient Information:
  - Patient ID: Vendor-specified (for example, 000456)
  - Patient Name: Vendor-specified (for example, Amy Jones)
  - Date of Birth: Vendor-specified (for example, 5/25/70)

  Vendor creates a record in their EHR for this test patient and generates the materials needed by the assistive technology for identification of this patient (for example, patient ID bar code)

- Second Test Patient Medication Order:
  This medication will not be recorded as administered during this test, as none of the 5 Rights will be met for this medication
  - Name: diazepam
  - Dose: 5 mg
  - Route: Intramuscular
  - Frequency: Now, and then repeat in 2 hours

  Vendor inputs this medication order in the EHR for this test patient

- Patient/Medication Information to be used for showing the verification of 5 Rights when some or all of the Rights are incorrect:

  (F) Wrong Patient Verification
  Vendor provides materials needed by the assistive technology for identifying a patient who is NOT the Second Test Patient (for example, patient ID bar code for First Test Patient)
  For all other 5 Rights verifications listed below for Second Test Patient, the correct patient ID materials are used

  (G) Wrong Medication Verification
  - Name: furosemide (wrong medication)
  - Dose: 5 mg
  - Route: Intramuscular

  Vendor provides the materials needed by the assistive technology for identifying this medication as a wrong medication (for example, unit dose bar code) for the Second Test Patient

  (H) Wrong Dose Verification
  - Name: diazepam
  - Dose: 10 mg (wrong dose)
  - Route: Intramuscular

  Vendor provides the materials needed by the assistive technology for identifying this medication as a wrong dose (for example, unit dose bar code) for the Second Test Patient

  (I) Wrong Route Verification
  - Name: diazepam
  - Dose: 5 mg
  - Route: Oral (wrong route)

  Vendor provides the materials needed by the assistive technology for identifying this medicationas a wrong route (e.g., unit dose bar code) for the Second Test Patient

(J) Wrong Time Verification
- Name: diazepam
- Dose: 5 mg
- Route: Intramuscular
- Time: EHR system clock will indicate a time other than a time for which this medication is to be administered (wrong time) for the Second Test Patient

Test Data – Set 3 — Use this Test Data Set with the Test Data – Set 3 in TD170.314(a)(16) – 2: Electronically Record the Right Documentation of Medication Administration

First Test Patient—to be used for showing the verification of 5 Rights when all of the Rights are correct

- First Test Patient Information:
  - Patient ID: Vendor-specified (for example, 000123)
  - Patient Name: Isabella Jones
  - Date of Birth: 05/01/1947

  Vendor creates a record in their EHR for this test patient and generates the materials needed by the assistive technology for identification of this patient (e.g., patient ID bar code)

- First Test Patient Medication Orders:
  This medication will be recorded as administered during this test
  - Name: Albuterol
  - Dose: 0.09 mg ACTUAT, 2 puffs
  - Route: Inhalation
  - Frequency: Now, and then every 6 hours PRN

  Vendor inputs this medication order in the EHR for this test patient and provides the materials needed by the assistive technology for identification of these medications (e.g., unit dose bar codes)

Second Test Patient—to be used for showing the verification of 5 Rights when some or all of the Rights are incorrect

- Second Test Patient Information:
  - Patient ID: Vendor-specified (for example, 000123)
  - Patient Name: Vendor-specified (for example, Mike Williams)
  - Date of Birth: Vendor-specified (for example, 11/5/47)

  Vendor creates a record in their EHR for this test patient and generates the materials needed by the assistive technology for identification of this patient (for example, patient ID bar code)

- Second Test Patient Medication Order:
  This medication will not be recorded as administered during this test, as none of the 5 Rights will be met for this medication
  - Name: ciprofloxacin
  - Dose: 400 mg
  - Route: Intravenous
  - Frequency: Now, and then every 12 hours

  Vendor inputs this medication order in the EHR for this test patient

- Patient/Medication Information to be used for showing the verification of 5 Rights when some or all ofthe Rights are incorrect:

  (K) Wrong Patient Verification
  Vendor provides materials needed by the assistive technology for identifying a patient who is NOT the Second Test Patient (for example, patient ID bar code for First Test Patient)
  For all other 5 Rights verifications listed below for Second Test Patient, the correct patient ID materials are used

  (L) Wrong Medication Verification
  - Name: dexamethasone (wrong medication)
  - Dose: 400 mg
  - Route: Intravenous

  Vendor provides the materials needed by the assistive technology for identifying this medication as a wrong medication (for example, unit dose bar code) for the Second Test Patient

  (M) Wrong Dose Verification
  - Name: ciprofloxacin
  - Dose: 40 mg (wrong dose)
  - Route: Intravenous

  Vendor provides the materials needed by the assistive technology for identifying this medication as a wrong dose (for example, unit dose bar code) for the Second Test Patient

  (N) Wrong Route Verification
  - Name: ciprofloxacin
  - Dose: 400 mg
  - Route: oral (wrong route)

  Vendor provides the materials needed by the assistive technology for identifying this medication as a wrong route (e.g., unit dose bar code) for the Second Test Patient

(O) Wrong Time Verification
- Name: ciprofloxacin
- Dose: 400 mg
- Route: Intravenous
- Time: EHR system clock will indicate a time other than a time for which this medication is to be administered (wrong time) for the Second Test Patient

TD170.314(a)(16) – 2: Electronically Record the Right Documentation of Medication Administration

Test Data – Set 1 — Use this Test Data set with the Test Data – Set 1 in TD170.314(a)(16) - 1: Electronically Verify the 5 Rights of Medication Administration

- Administration documentation for the following medication verified/submitted for First Test Patient:
  - Name: Albuterol
  - Dose: 2.5mg / 3 mL
  - Route: Inhalation (nebulizer)
  - Frequency: Now, and then four times daily as needed

- Administered by (User Name): Vendor-specified (for example, Robert Michaels, RN)
- Administered by (User ID): Vendor-specified (for example, 1234567890)
- Administration Date: Provided automatically by EHR synchronized clock
- Administration Time: Provided automatically by EHR synchronized clock

Test Data – Set 2 — Use this Test Data set with the Test Data – Set 2 in TD170.314(a)(16) - 1: Electronically Verify the 5 Rights of Medication Administration

- Administration documentation for the following medication verified/submitted for First Test Patient:
  - Name: Ceftriaxone
  - Dose: 1 gram
  - Route: Intravenous
  - Frequency: Now, and then once daily

- Administered by (User Name): Vendor-specified (for example, Kelly Brown, RN)
- Administered by (User ID): Vendor-specified (for example, 012345678)
- Administration Date: Provided automatically by EHR synchronized clock
- Administration Time: Provided automatically by EHR synchronized clock

Test Data – Set 3 — Use this Test Data set with the Test Data – Set 3 in TD170.314(a)(16) - 1: Electronically Verify the 5 Rights of Medication Administration

- Administration documentation for the following medication verified/submitted for First Test Patient:
  - Name: Albuterol
  - Dose: 0.09 mg ACTUAT, 2 puffs
  - Route: Inhalation
  - Frequency: Now, and then every 6 hours PRN

- Administered by (User Name): Vendor-specified (for example, Steven Taylor, RN)
- Administered by (User ID): Vendor-specified (for example, 987654321)
- Administration Date: Provided automatically by EHR synchronized clock
- Administration Time: Provided automatically by EHR synchronized clock

Document History

Version Number	Description of Change	Date
1.0	Posted for Feedback	September 11, 2013