

**Department of
Developmental Disabilities
Training Manual for
CERTIFICATION 1**

Prescribed Medications



and

Health-Related Activities



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Note to Teachers

You will notice that the content is arranged into broad categories. The ordering of these categories may or may not be compatible with the way you prefer to present the content.

Teachers are free to present the content in any order that is logical to them and meets the needs of the group they are teaching.

Teachers are NOT free to OMIT any of the content between pp. 6 and 101, although they are free to teach the content in a different order.

The materials in the Appendix are for use as desired and are NOT required.

Please share any supplemental materials you use with the RN Trainer group so others can have the benefit of your wisdom and adopt or adapt your materials if they wish.

Thank-you for your dedication and commitment to training personnel to safely administer medications and perform health-related activities.

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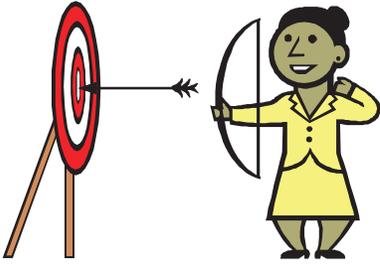
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Note to Teachers:

Any materials in the appendix may be used as the teacher wishes. These materials are optional and may or may not be relevant for the group you are teaching.

Feel free to add any other material you deem relevant. It would be nice if you shared these materials with other nurse trainers so they could also use them if they wished.



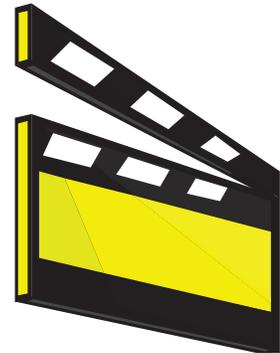
COURSE OBJECTIVES

1. Certified personnel will demonstrate:

- ♣ The preparation, administration and documentation procedure when administering prescribed medication presented in the curriculum.
- ♣ How to perform and document the health-related activities presented in the curriculum.
- ♣ Possessing a minimum knowledge base for administering medications or performing health-related activities by passing a written exam with no less than 80%.

2. Certified personnel will identify:

- ♣ What is required to maintain and renew their certification for medication administration and performing health-related activities.
- ♣ How the rules and regulations governing administration of medications and performance of health-related activities apply to their care - giving activities.
- ♣ What action to take when signs and symptoms may indicate a significant health problem or medication side effect.



Information about Certification 1 Course:

1. The course length is a **minimum of 14 hours**. The course may be lengthened to meet the needs of the class participants or the nurse trainer.
2. To obtain state certification, Developmental Disabilities (DD) personnel must:
 - ◆ Attend the **ENTIRE** program, participate in discussion and activities and complete and submit an evaluation of this program to the instructor.
 - ◆ Successfully demonstrate performance of health-related activities and medication preparation, administration, and documentation for each route of medication administration presented in the 14 hour course.
 - ◆ Pass a closed book course written exam with a score of 80% or better.

Failure to pass the written exam will result in the personnel being required to retake the entire 14 hour course before attempting to take the written exam again. Follow your agency's policy for the number of times you may retake the course in order to pass the test.

NOTE: Before administering medication or performing health-related activities, certified personnel must have individual specific training (IST). It is the responsibility of the certified personnel and employer to ensure individual specific training is done.



Attend entire 14 hour class



Earn minimum score of 80% on closed book test at end of course



Accurately perform all return demonstrations

What You Need To Know About Your Certificate

1. It belongs to you and you only. If you lose your certificate, you can get another copy.
2. It is good for any Developmental Disabilities (DD) environment only in the State of Ohio.
3. It is good for 1 year only and must be renewed each year on or before your anniversary date.
4. We recommend that your renewal and return demonstration be completed **no earlier than** 6 months after certification and **no later than** your actual anniversary date.



Renewing your Certificate:

At least 8 weeks before your anniversary date, check with your supervisor about the procedure you should follow to renew your certificate. If you are an IP (independent provider), check with your county board about the options open to you for renewing your certificate.

1. To renew your certificate, you **must have 2 hours** of approved continuing education on or before your renewal (anniversary) date.
2. You must **demonstrate relevant medication administration skills and relevant health-related activities**.
 - ♣ If you are in a site with nursing delegation, a nurse will observe your demonstration.
 - ♣ If you are in a site without nursing delegation, return demonstrations are performed and monitored per agency policy and procedure.
 - ♣ If you are an individual provider, your return demonstration can be done by the county board or the nurse that provides your continuing education.

What happens if you fail to renew your Certificate:

1. Should you not maintain certification due to lack of obtaining continuing education training, your certification will be put on hold (suspended) for up to 60 days. During this time, you must complete at least 2 hours of continuing education. You may NOT administer medications or perform health-related activities during this time period.
2. Should you allow your certification to be in suspension for more than 60 days, your certification is considered lapsed and you will be required to re-enroll in the 14 hour certification course to regain your certification to administer medications and perform health-related activities.

The 14 hour certification course for administration of medications and performance of health-related activities must be completed **before obtaining further certifications** to administer medications per feeding tube (Certification 2) or administer insulin (Certification 3).

State of Ohio Data Base

1. There is a state database listing all personnel certified by the Department of Developmental Disabilities (DODD).
2. Certification of DD personnel follows the certified personnel from DD employer to DD employer.
3. The original certificate is the property of the certified personnel.
4. Certified personnel are required to receive individual specific training (IST) prior to performing medication administration and health-related activities or medication and food administration per stable / labeled gastrostomy tube or stable / labeled jejunostomy tube or administration of subcutaneous insulin.
5. There will be public access to the database for purposes of confirming the certification of DD personnel and the status of their certification.



Suspension and Revocation

1. Anyone (employer, delegating nurse, county board nurse, or QA nurse as appropriate) who finds that certified personnel are not safely performing or will not safely perform their duties shall immediately suspend that certified personnel's ability to perform any certified functions. **Suspension may be temporary, but could lead to revocation, depending upon circumstances.**
2. Revocation of certification will occur if certified personnel do not demonstrate compliance and / or are not performing their duties in a safe manner according to certification training. **Revocation is a permanent removal of certification**
3. The employee may appeal the revocation.

Liability

There is immunity from liability as long as:

- ◆ The rules and statute were being followed.
- ◆ Certified personnel acted in accordance with what they were taught.
- ◆ Certified personnel did not act in a manner that constitutes deliberate or reckless misconduct.

Authority of DD Personnel to Perform Services by Type – Reference Grid

(Refer to OAC 5123:2-6-01 through 5123: 2-6-07)



Applicable Settings

County Board (CB) responsibility for Quality Assessment (QA) by RN. See outlined boxes

	(Certification 1) HRA* (Health-Related Activities)	(Certification 1) MA (Prescribed Oral and Topical Med Admin)	(Certification 2) G / J Tube Prescribed Med Admin	(Cert 2) Tube* Feedings	(Cert 3) Insulin Admin
Elementary, Pre-School, School age Services	With nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation	Prohibited
Adult Services	With nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation	Prohibited
Family Support Services	Without nursing delegation	Without nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation
Certified Supported Living Services (1-4 individuals per living arrangement)	Without nursing delegation	Without nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation
Certified Home and Community-Based Services (1-4 individuals per living arrangement)	Without nursing delegation	Without nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation
Other Services by DD Boards or by Ohio Dept of DD	With nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation	Prohibited
Residential Facilities: 1-5 beds	Without nursing delegation	Without nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation
Residential Facilities : 6-16 beds	With nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation	Prohibited
Field Trip participants from residential facilities: 17 or more beds	With nursing delegation – not more than 5 participants on trip.	With nursing delegation – not more than 5 participants on trip.	With nursing delegation – one staff may not serve > than 2 participants	With nursing delegation – one staff may not serve > than 2 participants	Prohibited

*As per OBN Chapter 4723-13, a RN may delegate specified tasks after first assessing both the client's stability and the personnel's ability to perform the task. Certification may not be required for any task that can be delegated per OBN rule.

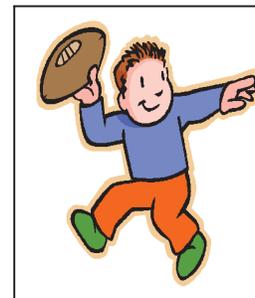
The Process of Delegation from Licensed Nurse to DD Personnel

A. Definitions:

Delegation: Transferring to a person certified by the Department of Developmental Disabilities (DODD) the authority to perform a selected nursing task or activity in a selected situation.

Delegator: The nurse who makes the delegation.

Delegatee: DD personnel who receive the delegation from the nurse.



B. Authority for Delegation:

Ohio Administrative Code (OAC) 5123:2-6-03 authorizes the nurse to delegate giving and / or applying prescribed medications, performing health-related activities, administration of food or medications via gastrostomy and / or jejunostomy tube, and / or administration of insulin to certified unlicensed personnel in specified environments.

Ohio Board of Nursing rule OAC 4723, Chapter 13 allows a registered nurse or a licensed practical nurse under the direction of a registered nurse, to transfer the performance of a particular nursing activity or nursing task to another person who is not otherwise authorized to perform the activity or task.

C. Delegation Procedure:

1. Developmental Disabilities (DD) personnel who are trained and certified will be selected to administer medications and perform health-related activities in those settings where delegation is required.
2. DD personnel who are trained and certified will be selected to perform administration of food and medication through a stable-labeled gastrostomy tube or stable-labeled jejunostomy tube or to administer insulin at the direction of a licensed nurse.
3. The nurse shall assess the individual receiving delegated nursing to determine that the individual's condition is stable and that delegation of the medication, health-related activities, tube feeding, and / or insulin administration is appropriate.
4. The nurse will complete a statement of delegation for each individual who requires delegation of medication administration, performance of health-related activities, administration of food or medication by stable-labeled gastrostomy or jejunostomy tube and / or insulin.
5. Certified personnel will receive individual specific training, including detailed information regarding medication administration, performance of the health-related activity, administration of food or medication by stable-labeled gastrostomy tube and stable-labeled jejunostomy tube or insulin administration.
6. The nurse will observe the skills of certified personnel at least annually or more often as needed and the nurse has the authority to withdraw delegation if the nurse believes the certified personnel is not or will not safely perform the delegated nursing task or activity.
7. The nurse will provide ongoing supervision of the delegated nursing activity and comply with all rules and regulations as set forth by the Ohio Board of Nursing, the Ohio Department of Developmental Disabilities (DODD) and the policies and procedures of the employer.

Where Delegation is Not Required

In settings where delegated nursing is not required, the employer is responsible for:

- ◆ Overseeing medication administration and performance of health-related activities as specified in the Ohio Department of Developmental Disabilities (DODD) law and rule.
- ◆ Ensuring annual relevant skills check for certified personnel.
- ◆ Stopping medication administration and health-related activities performance when there is a question about the skill or activity being performed by the certified personnel.
- ◆ Performing other safe medication and health-related activity oversight.

Function of Others Involved in the Well-Being of Individuals With Developmental Disabilities Regardless of Setting

A. Physician: Prescribes treatments, medication and tube feedings. Also determines route, dosage, and frequency for medications and tube feedings. The physician may be consulted should there be a question about any treatment, medication, feeding tube formula or insulin.



B. Nurse: Where applicable, the licensed nurse delegates duties to certified personnel, provides training for medication administration, health-related activities, administration of food via a stable-labeled gastrostomy or jejunostomy tube, and insulin administration. The nurse performs an assessment of the individual receiving services and provides ongoing recommendations.

The nurse should be consulted when there are questions regarding medications, health-related activities, administration of medication or food via a stable-labeled gastrostomy or jejunostomy tube and insulin administration, as well as for any concerns about the individual.



The nurse is the only one who can transcribe tube feeding and insulin orders onto the Medication Administration Record (MAR).

Advanced nurse practitioners with prescriptive authority may also write prescriptions.

C. Pharmacist: Fills prescriptions and provides information about the medication. The pharmacist **DOES NOT** write prescriptions. The pharmacist may be contacted when there is a question regarding medications including dose, route, and side effects.



D. Employer: Ensures that certified personnel perform medication administration and health-related activities according to the law and rule. In settings where delegation by a nurse is NOT required, it is the employer who oversees medication administration and performance of specific health-related activities and ensures annual skills checks.

E. Other Licensed Healthcare Provides: Dentists, podiatrists, nurse practitioners, clinical specialists and dietitians.



Health Needs



Social Needs



Daily Activity Needs



Training on any equipment

Individual Specific Training (IST)

Individual Specific Training (IST) must be done **after** certification and **before** administration of any medication or performance of any health-related activities. The training can be done in person or over the phone. Documentation of IST must be maintained. Agencies must have a policy and procedure in place for documenting and tracking all IST completed as well as needed updates. **Remember, if it isn't documented, it wasn't done!**

IST is the information you will need as a provider to ensure the safest care is provided to an individual. **IST must include:**

- ♣ The individual's needs (physical, social, and emotional)
- ♣ A summary of the individual's current health care information
- ♣ The individual's health care plan must be part of the Individual Service Plan and implemented.

5123.42(C) (4) makes IST a responsibility shared by the employer and employee. The employer is to ensure providers receive the training. Certified personnel are not permitted to perform any task presented in Medication Administration without it.

See Appendix A for an example of a form that could be used to document IST.

Standard and Universal Precautions

The concept of Universal Precautions presumes all body fluids to be potential carriers of infectious diseases and therefore blood and all body fluids are presumed contaminated. Hand washing is an important part of Universal Precautions and the number one (1) technique used in controlling transmission of infections.

Protective measures of personal hygiene are recommended as follows:

1. Keep the body clean
2. Practice good hand washing
3. Don't share personal items such as drinking cups, eating utensils, combs, brushes, etc.
4. Avoid exposure to individuals with communicable diseases
5. Cover the mouth and nose when sneezing

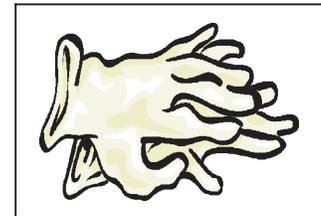
The Centers for Disease Control (CDC) recommends that hands be washed in certain situations including:

- ◆ Before preparing medications
- ◆ Before and after contact with an individual
- ◆ After handling any contaminated equipment
- ◆ Before and after applying topical medications
- ◆ After contact with organic material; i.e. after toileting or assisting with toileting, after covering your mouth and nose when sneezing or coughing



The CDC recommends the use of personal protective equipment such as gloves or other items as necessary when there is a possibility of coming into contact with blood or body fluids. Guidelines for using gloves are:

- ♣ Dispose of gloves following approved procedures
- ♣ Change gloves before assisting a different individual
- ♣ Always wash hands **before** applying gloves and **after** disposing of them
- ♣ Be aware of and follow your agency's general universal precaution policy



Waterless hand washing products are available for use in alternative settings when using soap and water is not possible. Follow instructions with the specific product you are using. Refer to your agency's policy and procedure for other pertinent information.

Overview of When to Seek Assistance:

(Adapted from Safety Alert #27-6-05: Observable Signs and Symptoms of Illness and Injury)

Examples of When to Call for an Ambulance or Call 911

- ◆ Chest pain
- ◆ Sudden loss of vision
- ◆ Severe, constant abdominal pain
- ◆ Bleeding heavily despite heavy pressure
- ◆ Person appears very ill; sweating, skin looks blue or gray
- ◆ BP below 90 for upper number when normally above 90
- ◆ Possible stroke; new weakness, loss or change in speech
- ◆ BP 220 or more for upper number and / or 120 or more for lower number
- ◆ Repeated vomiting / diarrhea less than 12 hours but not responding normally
- ◆ Symptoms develop suddenly; individual stops usual activity or starts to act unusual
- ◆ First time seizure; **roll to side**, protect head, and move obstacles that may pose a threat
- ◆ Seizure lasting more than 2 - 5 min (or as specified by the doctor); one seizure right after the other; person does not wake up after seizure; person does not start breathing within 1 minute after seizure stops (Is CPR needed?)
- ◆ Pulse rate is less than 40 or more than 140
- ◆ Difficulty breathing and / or severe wheezing
- ◆ Bloody or coffee grounds looking vomit / diarrhea
- ◆ Fainting, loss of consciousness, or won't wake up



For the injuries cited below, DO NOT MOVE THE INDIVIDUAL; KEEP INDIVIDUAL WARM:

- ◆ Fall, limb deformity noted (bone sticking out, swelling, unusual position of arm, leg)
- ◆ Fall with severe head injury (fall on face, bleeding, change in level of consciousness)
- ◆ Fall, unable to get up on own and normally would be able to do so, or in a lot of pain when lying still or trying to get up.

(From Safety Alert #27-6-05)

Examples of When to Take an Individual to the ER / Hospital

- ◆ Temperature is 95 or less rectally
- ◆ Shaking chills with or without fever
- ◆ Burn that blisters or skin comes off
- ◆ Fall, gets up on own but complains of pain or can't walk normally
- ◆ 24 hours of poor eating / drinking / urination with dry mouth, tongue or eyes
- ◆ Moderate bleeding that stops after 5 minutes of direct pressure, sutures seem needed; **apply pressure while transporting**
- ◆ New onset of confusion lasting over 1 hour
- ◆ Repeated vomiting / diarrhea over 12 hours
- ◆ Fever over 103 by rectum or 102 by mouth or axillary

(From Safety Alert #27-6-05)



Examples of When to call the Delegating Nurse, Doctor's Office, or Health Care Professional

- ◆ New rash
- ◆ Earache or sore throat
- ◆ New onset incontinence
- ◆ Repeated vomiting / diarrhea more than 6 but less than 12 hours; not holding down small sips of liquids; responds normally.
- ◆ Other times as designated by your agency's policy
- ◆ Increase in seizure numbers, type or duration
- ◆ Fever greater than 103 rectal; 101 by mouth / axillary
- ◆ First degree burns, including sunburn (that are reddened or blistered)

(Adapted from Safety Alert #27-6-05)



When to Call Poison Control

- ◆ Ingestion of toxic substances
- ◆ Ingestion of wrong medication with potential to poison
- ◆ Ingestion of wrong amount of prescribed medication and unable to consult with a health care professional.
- ◆ Number for poison control is: **1-800-222-1222**

(Adapted from Safety Alert #27-6-05)

If you think there may be a health problem:

- ◆ Call or talk to your nurse, your supervisor, or the individual's doctor
- ◆ Document date, time, what you see, whom you notified and what you were told to do (Example presented on Appendix p. 105, example #2)
- ◆ **If you think the client's life is in danger, call 911 immediately**



Guidelines for Emergency Situations

An emergency is defined as a life-threatening condition in which death or permanent disability may result within the hour. Immediate action is necessary to preserve life or prevent permanent disability. **Call 911 for any of the conditions below.**

Examples of life-threatening conditions include:

- ☞ Poisoning
- ☞ Uncontrolled bleeding
- ☞ Coma; unconsciousness
- ☞ Cardiac arrest (loss of heart beat)
- ☞ Respiratory failure (breathing stops)
- ☞ Difficulty or problems with breathing
- ☞ Crushing injury of head, chest, abdomen
- ☞ Fractures of the long bones of the arms or legs
- ☞ Status epilepticus / uncontrolled seizures lasting more than 5 minutes (or as specified by client's physician)
- ☞ Unable to arouse from a seizure within 20 minutes following the seizure
- ☞ Hypoglycemia (low blood sugar which does not respond to nutritional intervention)
- ☞ Severe allergic reaction – sometimes called an anaphylactic reaction -
(often characterized by: ♦massive hives ♦difficulty breathing
♦swelling of the throat, tongue, lips, and mouth)
- ☞ Blow to the head comparable to that of a strongly swung baseball bat or fall on concrete floor (remember individuals who fall and hit their head can also have neck injury – protect the neck as trained in First Aid)



Situations Which Must be Reported (per Employer Policy and Procedure)

1. Any concerns certified personnel have regarding the individual's physical health condition.
2. Any missed doses of medication, suspected adverse reactions to medications, medication errors, or situations identified by the employer's policies and procedures.
3. If an emergency situation develops, follow the employer's emergency procedures.

Signs and Symptoms to Observe and Report

Some situations may not be urgent, but it is important to recognize and report signs and symptoms of disease and / or side effects of medication so that proper treatment can be carried out.

All persons who provide services to individuals have responsibility to recognize and report the first potential signs / symptoms of problems that may be noted through observations during baths/showers, meal times and recreation periods.

Examples of the common signs and symptoms which will require further evaluation and should be called to the attention of the nurse or the physician for evaluation and / or the employer are listed below:

A. General Body Symptoms

1. Dehydration
2. Shaking chills
3. Loss of appetite
4. Allergic reaction
5. Increased thirst
6. Eating problems
7. Rapid weight gain
8. Weight loss without dieting
9. Dizziness, weakness, fainting
10. Frequent or severe headache
11. Swelling in any part of the body
12. Abnormal posture, movement or gait



B. Vital Signs: TPR and BP

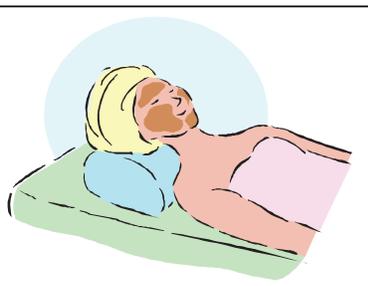


1. Low temperature
2. Elevated temperature
3. Weak, thready pulse
4. Fast or slow pulse
5. Irregular pulse
6. Noisy respirations
7. Difficulty breathing
8. Shallow or deep respirations
9. Painful breathing

Get instructions about when to call the doctor, supervisor, or delegating nurse.

C. Skin

1. Burns
2. Too dry / moist
3. Yellowing of skin
4. Rash, moles, open sores
5. Pale or reddened bruises
6. Unusual bruising or bleeding
7. Wounds or sores that do not heal



D. Eyes

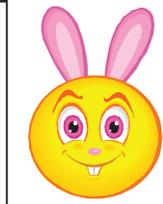
1. Profuse tearing
2. Discharge or bleeding
3. Loss of sight (full or partial)
4. Redness of eyes or eyelids
5. Twitching, sensitivity to light
6. Dullness, brightness, dark circles
7. Dilated (big) or contracted (small) pupils
8. Foreign body in the eye (scratchy feeling in the eye or eye pain)
9. Change in color, bluish or yellowish eyes, swelling of the lids



Signs and Symptoms to Observe and Report (cont'd)

E. Ears

1. Loss of hearing
2. Discharge or bleeding
3. Pain in ear or back of ear
4. Profuse hardened ear wax
5. Foreign body in ear (do Not attempt to remove)



F. Nose

1. Sneezing
2. Breathing difficulties
3. Repeated nosebleeds
4. Foreign body in the nose
5. Runny nose (not chronic)
6. Chronic discharge



G. Mouth

1. Hoarseness
2. Jaw swelling
3. Tongue: coated, red, pale
4. Swollen and / or discolored lips
5. Teeth: sharp, broken, toothache
6. Difficulty in swallowing or talking
7. Gums: swelling, bleeding, ulcer sores that do not heal
8. Rash or blisters in mouth or throat, sore throat
9. Coughing or choking when drinking or eating



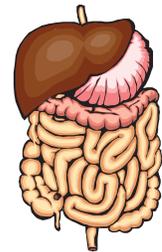
H. Neck

1. Stiffness or pain in neck
2. Swelling or lumps in neck



J. Abdomen

1. Rigid abdomen
2. Nausea or vomiting
3. Pain in the abdomen
4. Any swelling or lumps in abdomen or groin*



*Do NOT press on any lumps or bumps in abdomen. Follow agency policy for whom to notify if lump or bump found.

I. Chest

1. Pain in chest
2. Coughing up blood or pus
3. Lump in breast or under arm
4. Chronic or congested cough (lasting longer than a week)
5. Shortness of breath or difficulty breathing



K. Rectum

1. Hemorrhoids
2. Bleeding or drainage from rectum
3. Abnormal bowel movement, (blood, mucous, worms, diarrhea, fluid)
4. Chronic constipation (dry, hard stool)



Signs and Symptoms to Observe and Report (cont'd)

L. Genitals and Urine

1. Itching
2. Redness
3. Swelling
4. Discharge
5. Pain or difficulty in urination
6. Abnormal color or odor of urine
7. Unable to void; voids frequently
8. Incontinence if unusual for this individual



M. Arms and Legs

1. Deformities
2. Varicose veins
3. Lumps, bruises
4. Swelling or pain
5. Wounds or sores that do not heal
6. Unusual weakness in arms or legs
7. Inability to move arm or leg or hand



N. Feet

1. Swelling, pain
2. Corns or bunions
3. Thick, discolored nails
4. Ingrown toenails
5. Deformities

*If person diabetic, inspect feet weekly or as instructed by doctor, nurse, or supervisor.



O. Mental State

1. Fatigue
2. Agitation
3. Sudden change in behavior
4. Drowsiness, change in alertness
5. Unusual confusion or disorientation
6. Comatose or unconscious
7. Nearly unconscious/semi-conscious



Pain

Being as pain free as possible is a client right.

Anytime a client verbalizes being in pain, or acts like he/she may be in pain, you must call the delegating nurse, supervisor, or other appropriate person per your agency's policy to evaluate the client.

Document:

- ◆ Time
- ◆ Date
- ◆ Whom you called
- ◆ What you were instructed to do.



NOTE: A good rule of thumb is that - depending on the setting - whenever you see anything that is **not normal for the client**, call the delegating nurse, supervisor, employer, doctor, or guardian. Someone needs to evaluate the client to determine what, if anything, needs to be done. See p.105 for examples of how to document a pain episode.

Quick Overview

Selected Emergency Situations:

◀ Anaphylaxis



Allergic Reaction

◀ Status epilepticus



Prolonged Seizure

◀ Hypoglycemic Reaction



Symptoms of low blood sugar

Condition by Physician-Directed Medication / Actions

Condition / Situation	Physician Directed Action to Take
Anaphylaxis (Severe allergic reaction)	<ul style="list-style-type: none"> ◆ Administer EpiPen Auto-Injector as ordered ◆ Call 911 (call 911 immediately if no EpiPen ordered) ◆ Stay with client ◆ Keep client quiet until emergency personnel arrive to evaluate client ◆ Give emergency personnel EpiPen used for initial treatment
Status Epilepticus (Seizure that goes on and on or more than 1 seizure in a specified time period)	<ul style="list-style-type: none"> ◆ Give Diastat as ordered if seizure goes beyond specified time limit ◆ Keep client's airway open ◆ Protect client from injury ◆ Stay with client ◆ Call nurse / doctor / supervisor / employer as directed per agency policy
Hypoglycemic Reaction (Low blood sugar)	<ul style="list-style-type: none"> ◆ Administer Glucagon as ordered if client unable to speak clearly and / or swallow without difficulty, and level of alertness decreases ◆ Stay with client ◆ Call nurse / doctor / supervisor / employer / emergency personnel as directed per agency policy

It is important you know how to recognize each of these serious situations and know what to do to assist the client to recover as quickly as possible to prevent disability or possibly death.

Further information is presented on the following pages.

Anaphylaxis

What is anaphylaxis?

It is a sudden, severe, potentially fatal systemic allergic reaction that can involve various areas of the body.

Symptoms occur within minutes to two hours after contact with the allergy-causing substance. In rare cases, a reaction may occur up to 4 hours later.

Individuals at most risk are those who have: ♦asthma ♦eczema ♦hay fever

Common causes of Anaphylaxis

- ◀ Food (nuts, shellfish)
- ◀ Medications (penicillin, sulfa)
- ◀ Insect venom (bee stings)
- ◀ Latex



What to do if Anaphylaxis Occurs

Act quickly.

If EpiPen ordered, administer as specified on the MAR.

Do NOT discard EpiPen that was used. Send to hospital with emergency personnel.

Call 911.

Administer rescue breaths if breathing stops. Keep airway open as best you can.

Do NOT attempt to drive the person to a medical facility yourself.

Common Symptoms (Symptoms) of Anaphylaxis

- ◀ Hives
- ◀ Difficulty breathing or swallowing
- ◀ Swelling of the throat, lips, tongue, or around the eyes



Other Symptoms of Anaphylaxis can include:

- ◀ Collapse
- ◀ Increased heart rate
- ◀ Loss of consciousness
- ◀ A sudden feeling of weakness
- ◀ Metallic taste or itching in the mouth
- ◀ Anxiety or an overwhelming sense of doom
- ◀ Abdominal cramps, nausea, vomiting, or diarrhea
- ◀ Generalized flushing, itching, or redness of the skin
- ◀ Rapidly decreasing blood pressure (and accompanying paleness)

If an ambulance or EMS is not available, then the client must be taken to the nearest hospital emergency department as soon as possible by whatever means is available.

At times the individual can seem to recover and be normal after the initial injection of epinephrine. However, sometimes the individual can have a recurrence of the anaphylactic reaction that may be more severe than the original episode.

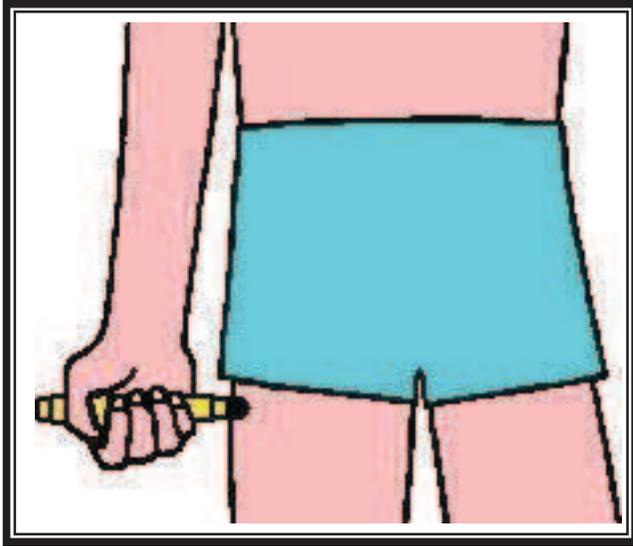
Therefore, it is important for the individual to be evaluated by medical personnel following an anaphylactic reaction and be monitored for a subsequent reaction.

The 3 Rs for Treating Anaphylaxis:

- ♦Recognize the symptoms
- ♦React quickly
- ♦Review what happened and attempt to prevent it from reoccurring.

How to Administer the EpiPen Auto-Injector

1. Put on disposable gloves
2. Pull off the gray safety cap
3. Place black tip on outer thigh (always apply to thigh)



4. Using a swinging motion, jab the black tip into the thigh. Press hard until the Auto-Injector mechanism functions. Hold the black tip hard against the thigh and count to 10 to be sure the contents of the auto injector empty into the thigh.
5. Remove the black tip from the thigh and massage the area for 10 seconds with your gloved hand.
6. Call 911 and request the individual be transported to a medical facility as soon as possible.

Other Important Information

Although removing the clothing is preferred, the auto injector may be used directly through the individual's clothing if there is no time to remove the clothing or it is awkward to remove the clothing. Be sure that nothing in the clothing will prevent the needle from getting to the skin.

The effects of the injection wear off after 10-20 minutes, therefore it is important to get further medical assistance. Be sure to save the auto injector to pass off to medical personnel so they will know how much epinephrine the individual was given.

Do not refrigerate the EpiPen. This may cause the unit to malfunction.

Do not expose the EpiPen to direct sunlight; light can cause epinephrine to oxidize and go bad (turns brown).

Do not expose the EpiPen to extreme heat – such as leaving it in the glove compartment of a car.

Replace EpiPen before the expiration date on the injector. (See box to the right for explanation of the expiration date.)

Expiration Date:

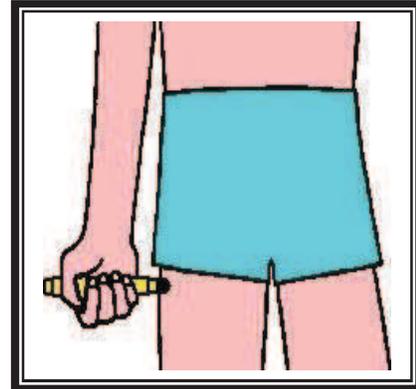
The expiration date indicates when the medication should no longer be used.

If the expiration date is August 10, 2020, it can be used up until midnight of August 10, 2020. It should not be used **after** midnight, August 10 of 2020.

In other words, the medication should not be used on August 11, 2020 or thereafter.

Health-Related Activities Skills Checklist for EpiPen

Place a check mark before each step completed.



- _____ 1. Put on disposable gloves.
- _____ 2. Pull off gray safety cap.
- _____ 3. Place black tip on outer thigh.
- _____ 4. Using a swing motion, jab black tip into thigh until Auto-Injector mechanism functions.
- _____ 5. Hold black tip firmly against thigh and count to 10.
- _____ 6. Remove black tip from thigh and message area for 10 seconds.
- _____ 7. Call 911 and request the individual be transported to a Medical facility as soon as possible.
- _____ 8. Keep Auto-Injector and hand to medical personnel when they arrive.

Employee _____ Date: _____

Nurse: _____ Supervisor _____

Comments:

Seizures

A seizure occurs when there is abnormal electrical activity in the brain. The brain's cells literally misfire, causing a wide range of behaviors, depending on where the "misfirings" occur. Some seizures cause the person to fall to the ground and have strong, uncontrolled movements. Other seizures cause the person to stare off into space for a few seconds or minutes or engage in strange behaviors.

The good news is that people do not die from the seizure itself. They can die from injuring themselves during a seizure. For example, a person could sustain a serious head injury if falling to the ground or striking his head on an object when falling to the ground while having a seizure. The person who "stares off into space" during a seizure could cause a serious accident if driving or drown if swimming.

Whatever type of seizure a person has, keeping him or her safe during the seizure is important. It is important to be aware of things in the environment that could pose a hazard to the person who is diagnosed with a seizure disorder as well as things in the environment that might precipitate a seizure or act as a seizure trigger.

Some people have a warning (called an aura) before having a seizure. The warning (aura) is person specific and may include such things as a smell, headache, hearing a noise or a voice, getting confused, seeing a flashing light, etc.



Most seizures are short, ending within two minutes. Depending on the type of seizure, the person may be sleepy after the seizure ends. If this is the case, allow the person to sleep. Most people are fully awake within 20 – 30 minutes.

The safest place for the person to have a seizure involving involuntary muscle movement is on the floor, with furniture moved out of the way so the person does not injure himself while arms and/or legs are flailing. If possible, position the person on his side to prevent aspiration and maintain the airway. Never force anything between the teeth to prevent biting of the tongue.

Potential Seizure Triggers

- ♣ Flickering lights (from the TV, from strobe lights)
- ♣ Bright sun light
- ♣ Not getting enough rest
- ♣ Not taking anti-seizure medication properly
- ♣ Getting too hot (avoid the hot tub, strenuous exercise)

See Safety Alert #8-3-02

Take the Following Precautions

- ◆ Take shower rather than tub bath to avoid risk of drowning if seizure occurs while bathing
- ◆ Turn down water temperature to avoid burns if seizure occurs in bathtub / shower
- ◆ Wear a life jacket while swimming. Never swim alone.

See Safety Alert #8-3-02

Seek emergency Medical Assistance if any of the Following Occur:

- ✓ The person stops breathing
- ✓ Seizure lasts longer than specified by physician
- ✓ Person remains unconscious after the seizure
- ✓ Person sustains an injury during the seizure
- ✓ One seizure follows another without a break
- ✓ This is the first seizure the person has ever had

Treatment of Repetitive or Prolonged Seizure with Diastat

Some individuals with seizure disorder may have seizures that are repetitive or prolonged. These kinds of seizures may be hard to stop and emergency treatment may be required to stop the seizure and prevent brain damage. Diastat is a drug that can be administered rectally while the person is still having a seizure.

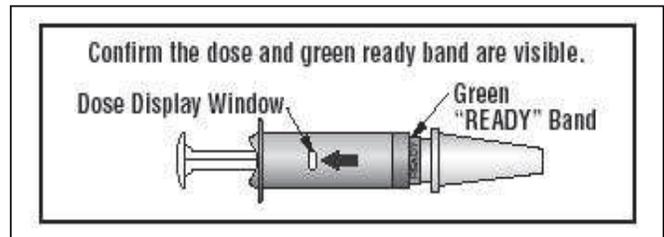
Diastat is not a generic medication and shall only be used for an individual when ordered for that specific individual by a physician or another health care provider with prescriptive authority. Prescriptions for Diastat shall be specific as to when to use (eg. Seizure lasts more than five minutes; use if more than two seizures in a period of 12 hours, etc.)

What is Diastat?

Diastat is a unique gel formulation of diazepam. It is used for at-home treatment of serial or cluster seizures.

When should Diastat be given?

Diastat is ordered by a physician to be given for repetitive seizures or for seizures that last longer than specified by the physician.



How soon should seizures stop after giving Diastat?

Seizures usually stop within 5-15 minutes. If seizures continue, call your nurse supervisor, or 911 for help.

Where can Diastat be given?

Diastat is transportable. It can be taken anywhere and given anywhere the client is. It does not need to be refrigerated. However it needs to be kept where it does not get too hot or too cold. Do not ever leave it in the trunk or in the glove compartment of a car.

If Diastat is used, does the client still need to take his / her other seizure medications?

Diastat is an emergency medication to be used only as directed by the physician. It does NOT take the place of other seizure medications. Do NOT stop giving other medications without first asking the client's doctor.

How to Administer Diastat:

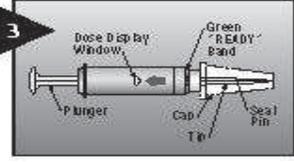
For the procedure on how to administer Diastat, refer to the next page.



Call for emergency help if:

- ◆ Seizures lasts more than 15 minutes after giving Diastat
- ◆ Seizure behavior is different from other episodes
- ◆ You are alarmed by the frequency or severity of the seizure(s)
- ◆ You are alarmed by the color or breathing of the client
- ◆ The client is having unusual or serious problems

Steps for the Administration of Diastat

			
<p>Place person on their side where they can't fall</p>	<p>Get the medicine</p>	<p>Get syringe. NOTE: Seal Pin is attached to the cap</p>	<p>Push up with thumb and pull to remove cap from syringe. Be sure Seal Pin is removed with the cap</p>
			
<p>Lubricate rectal tip with lubricating jelly</p>	<p>Turn person on side facing you</p>	<p>Remove clothing from lower body</p>	<p>Bend upper leg forward to expose rectum</p>
	<p>SLOWLY COUNT OUT LOUD TO THREE...1...2...3</p>		
<p>Gently insert tip into rectum. NOTE: Rim should be snug against rectal opening</p>			
 <p>ONCE DIASTAT® IS GIVEN</p>	<p>Slowly count to 3 while gently pushing plunger in until it stops</p>	<p>Slowly count to 3 before removing syringe from rectum</p>	<p>Slowly count to 3 while holding buttocks together to prevent leakage</p>
<p>Keep person on side facing you, note time given and continue to observe</p> <p>Call for help if any of the following occur:</p> <ul style="list-style-type: none"> ◆ Seizure(s) continues 15 minutes after giving Diastat or per doctor's instructions ◆ Seizure behavior is different from other episodes ◆ You are alarmed by the frequency / severity of the seizures ◆ You are alarmed by the breathing or color of the person ◆ The person is having unusual or serious problems 	<p>Disposal Instructions:</p> <ul style="list-style-type: none"> ◀ Pull plunger until it is completely removed from the syringe body ◀ Position over sink or toilet ◀ Reposition plunger into syringe body, gently pushing plunger until it stops. ◀ Flush toilet or rinse sink with water until gel is no longer visible ◀ Discard all materials in safe place away from children. Do not reuse. 		

Health-Related Activities Skills Checklist: Administration of Diastat

Place a check before each step completed

_____ 1. Put the individual on their side in a location where they cannot fall.

_____ 2. Get the medication.

_____ 3. Put on gloves.

_____ 4. Get the syringe from the package.

_____ 5. Remove the protective cover from the syringe with a downward firm pulling away motion.

_____ 6. Lubricate the rectal tip with the lubricating jelly in the package.

_____ 7. Turn individual **toward you** and pull down clothing to expose the buttocks.

_____ 8. Bend their upper leg forward to expose the rectum.

_____ 9. Separate the buttocks to expose the rectum.

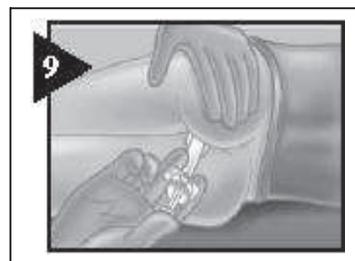
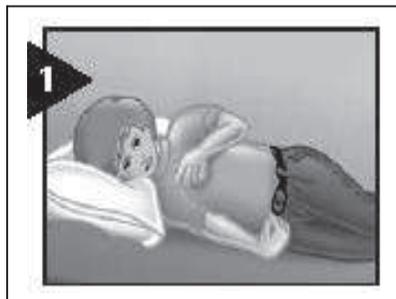
_____ 10. Gently insert the syringe tip into the rectum.

_____ 11. **SLOWLY** count to three while gently pushing the plunger in until it stops.

_____ 12. **SLOWLY** count to three again before removing the syringe from the rectum.

_____ 13. **SLOWLY** count to three while holding the buttocks together to prevent leakage

_____ 14. Keep the individual on their side facing you. Note the time the Diastat was given and continue to observe.



Employee _____

Date: _____

Nurse: _____

Supervisor _____

Comments:

Diabetes Mellitus

(Adapted from Health and Safety Alert #15-8-02)

Diabetes Mellitus (DM) is the full name for the disease most commonly called “Diabetes.” People with DM either cannot produce enough insulin or cannot effectively use the insulin they do produce to control their blood sugar (glucose) level. As the incidence of Diabetes in the US is increasing rapidly, everyone should be aware of this potentially fatal disease. The earlier diabetes is found and treated, the fewer the complications may be.

Risk Factors:

- ◆ Family history
- ◆ Inactive lifestyle
- ◆ Obesity

See Health and Safety Alert #15-8-02

Symptoms of Diabetes:

- ◆ Hunger
- ◆ Frequent urination
- ◆ Fatigue
- ◆ Unexplained weight loss
- ◆ Blurry vision
- ◆ Sores that don't heal
- ◆ Extreme thirst
- ◆ Frequent infections

Complications:

- ◆ Blindness
- ◆ Nerve damage
- ◆ Kidney disease
- ◆ Amputations
- ◆ Death from heart attack, stroke, or peripheral vascular disease



See Health and Safety Alert #15-8-02

Prevention of Complications:

- ◆ Exercise
- ◆ Consume balanced diet
- ◆ Maintain a healthy weight
- ◆ Take medication as ordered
- ◆ Keep blood sugar under control
- ◆ Monitor blood glucose as directed
- ◆ Inspect skin, especially feet at least weekly
- ◆ Keep shoes or slippers on feet when up to prevent cuts and other foot injuries that could lead to infection and possibly amputation



Screening Exams:

- ◆ Annual eye exam to detect eye disease
- ◆ Annual exam for peripheral neuropathy (nerve problems)
- ◆ Blood pressure screen
- ◆ Blood lipids (fats in the blood that can predispose to heart attack / disease)
- ◆ ECG changes (heart disease)

Special Instructions for Care of Any Person With Diabetes

- ◆ Get recommended dental checks.
- ◆ Never put lotion between the toes.
- ◆ Serve meals and snacks as scheduled.
- ◆ Always wear a shoe or slipper when up.
- ◆ Have person engage in some physical activity daily.
- ◆ Wash feet daily and dry thoroughly between the toes.
- ◆ Have only a health care professional cut client's toenails.
- ◆ If lesions found anywhere on the person's body, contact your supervising nurse or supervisor per agency policy.
- ◆ Only give insulin if directed by delegating nurse and certified to do so.
- ◆ Remember to apply the lancet to the side of the chosen finger, never the pad. Rotate finger sites to avoid callus formation.

Normally, blood sugar should fall between 70-110. When blood sugar is too high (above 120), it is called **HYPERGLYCEMIA**. When blood sugar is too low (below 70) it is called **HYPOGLYCEMIA**. Signs and symptoms for Hyper and Hypo-glycemia are listed in the boxes below.



Signs of Hyperglycemia (High blood sugar)

- ◆ Feel weak
- ◆ Drowsy, sleepy
- ◆ Pain in abdomen
- ◆ Nausea, vomiting
- ◆ Dehydration, dry mouth and skin
- ◆ Stuporous, not alert
- ◆ Skin flushed, red and warm
- ◆ Slow, lethargic movements
- ◆ Rapid respirations

Onset: slow
Get emergency treatment



Because the **onset of hypoglycemia is rapid** and the person can quickly deteriorate (go into a coma), we will spend more time describing hypoglycemia and what to do if the person has a hypoglycemic episode. In the boxes below are listed many of the **physical symptoms** of hypoglycemia as well as **mental** and **emotional symptoms** that are also commonly seen.

Signs of Hypoglycemia (low blood sugar)

Physical Symptoms(Sx) can include:

- ◆ Nausea
- ◆ Headache
- ◆ Fast pulse
- ◆ Feel hungry
- ◆ Blurred vision
- ◆ Unsteadiness
- ◆ Tingling in hands, feet or face
- ◆ Feel too hot / cold
- ◆ Tremors, shakiness
- ◆ Feel dizzy / lightheaded
- ◆ Feels like heart pounding
- ◆ Excessive sweating
- ◆ Slurred speech

On the next page are instructions for what to do if the client demonstrates signs and symptoms of hypoglycemia. Quick action on your part is important to prevent coma and possibly death.

If unsure about what the client is demonstrating, and you cannot check the blood sugar, assume it is hypoglycemia and give a sugar source.

Mental Sx of Hypoglycemia can include:

- ◆ Inability to follow directions
- ◆ Sleepy or drowsy, weakness
- ◆ Difficulty concentrating, slow thinking
- ◆ Feeling that something isn't quite right
- ◆ Confusion or being disoriented: not knowing where they are, what time it is, or not recognizing people they usually know.

Emotional Symptoms of Hypoglycemia can include:

- ◆ Anger
- ◆ Irritability
- ◆ Looking frantic
- ◆ Change in usual behavior
- ◆ Inappropriate giggling
- ◆ Sudden crying
- ◆ Feeling anxious

If the person's symptoms do not reverse with the intake of a sugar source, get emergency treatment as soon as possible.

Treatment for Hypoglycemia (low blood sugar)

In most cases, an episode of hypoglycemia is easily reversible if we take the correct action. Discuss with the delegating nurse or supervisor the specific parameters for low and high blood glucose (sugar) for each of the client(s) for whom you are caring diagnosed with DM and what you are supposed to do if the blood sugar is too high or too low.

Causes of hypoglycemia include: ♦ stress ♦ illness ♦ increased activity level ♦ not eating enough. Generally speaking, if the person's blood sugar reading on the glucometer is below 70, you need to take immediate action to get the blood sugar above 70. Below are some general guidelines you can follow if the client's blood sugar goes below 70.

If the client is alert:

Perform a glucometer check. If the reading is less than 70, give the client any one of the items listed in the box below. Each one of these items is equal to 15 grams of a fast acting carbohydrate (sugar) and should raise the blood sugar approximately 30-45 points.

Examples of Sugar Sources to Give if Blood Sugar Reading Below 70

- ♥ 6-8 Life Saver candies
- ♥ 1 cup (8 ounces) of milk
- ♥ 2 tablespoons of raisins
- ♥ ½ cup (4-6 ounces) fruit juice
- ♥ 2-3 regular candies, hard or soft
- ♥ 1 small tube cake decorating gel
- ♥ 1 small tube of cake frosting
- ♥ 1 piece of fruit (the size of a tennis ball)
- ♥ ½ cup (4-6 ounces) regular (not diet) soda
- ♥ ½ tube of glucose gel or instant glucose (eg. Instaglucoose)
- ♥ 1 tablespoon honey, jelly, jam, corn syrup, or pancake syrup
- ♥ Three glucose tablets (5 grams CHO each)
- ♥ Four glucose tablets (4 grams CHO each)

15-20 minutes after giving one of the food items above, recheck the client's blood sugar again. If the reading is still below 70 and the client is alert, can follow directions, can chew and swallow, give another food item or repeat the same food item from the above list.

Wait 15-20 minutes. Recheck the blood sugar again. If the blood sugar is still below 70, and the client is still having symptoms of hypoglycemia or at any time becomes sleepy or unconscious, contact emergency medical personnel (911) immediately, then call the delegating or on-call nurse or follow your agency's procedure. **Do not leave the client alone.**

Symptoms Going Away

If the client's symptoms are going away, the blood sugar is above 70, and it is close to a meal or snack time (within 30-60 minutes), have the client eat his or her planned meal or snack at the time it is scheduled.

If it is not close to snack or meal time, have the client eat a food that will be slowly digested such as a slice of bread, a slice of cheese, six crackers, one cup of milk, or 1 tablespoon of peanut butter.

Treatment for Hypoglycemia (low blood sugar) (cont'd)

NOTE: If the client has a feeding tube, the delegating nurse may give you instructions about how to give the appropriate carbohydrate to treat hypoglycemia.

If at any time, the client is observed to be increasingly symptomatic and / or becomes less alert, loses consciousness, has difficulty breathing or has a seizure, immediately stop food and / or beverage and call emergency medical services and the delegating nurse. Follow the individual specific instructions provided by the delegating nurse and the client's physician.

This action is very important because prolonged hypoglycemia can result in damage to the brain.

If the client becomes less alert or loses consciousness: Call for emergency medical services immediately and notify the delegating or on-call nurse.

Do not try to feed the individual if you note any of the following:

- ♥ Symptoms become worse
- ♥ Level of alertness declines
- ♥ Becomes unconscious
- ♥ Seizure occurs
- ♥ Decline in ability to chew or swallow
- ♥ Decline in ability to follow directions
- ♥ Difficulty breathing

If a Glucagon Emergency Kit has been prescribed for the client, inject the Glucagon first, then contact emergency medical services and notify the delegating or on-call nurse. The order of treatment steps are:

1. Administer Glucagon
2. Call emergency medical personnel
3. Call the delegating or on-call nurse



A glucagon emergency kit may be prescribed for the treatment of severe low blood glucose (hypoglycemia) that can result in unconsciousness, seizure, or inability to take food or fluids by mouth (or by feeding tube).

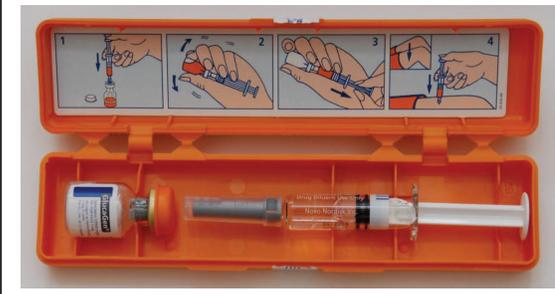
Information about Glucagon:

- ♥ It is a hormone
- ♥ It must be injected
- ♥ If prescribed, it should be listed on the MAR
- ♥ **It is for hypoglycemic (low blood sugar) emergencies only**
- ♥ It should be used only if the person is unable to swallow food (carbohydrate)
- ♥ When injected, it releases glucose stored in the liver into the blood and raises the level of glucose (sugar) in the blood quickly.
- ♥ Glucagon comes in an emergency kit containing all of the supplies that are needed to administer the Glucagon by injection:
 - ◀ The Glucagon emergency kit usually contains a vial of Glucagon powder and a syringe filled with a special liquid to dissolve the powder in the vial.
 - ◀ The powder and liquid are premeasured so there is no danger of giving too much of this medication

General Instructions for Use of a Glucagon Emergency Kit

- ◆ Before you ever need to use the glucagon emergency kit prescribed for your client, get it out. Look at it. Become familiar with what is in it so you will know what to do if you ever need to activate it. Not all glucagon emergency kits are the same. One client's kit may be different from another client's kit.
- ◆ Be aware of how to properly store the kit. Follow the manufacturer's or pharmacist's instructions.
- ◆ Note the expiration date. When expired, make arrangements to replace as instructed.
- ◆ Do NOT prepare the glucagon for injection UNTIL you need it.
- ◆ Glucagon is given in the buttock, arm, abdomen, or thigh (same sites as for insulin).
- ◆ Some people vomit when given glucagon. Before injecting, turn the client on his side to prevent choking if he vomits.
- ◆ After injection, if the client becomes responsive (usually within 15 minutes) and can swallow, then give food as directed by the delegating nurse, physician, or emergency medical services.
- ◆ After injection, if the client does not become responsive, then wait for emergency medical services to arrive since you have already contacted them. Maintain an open airway. Be prepared to perform CPR if needed.
- ◆ As soon as they arrive, be sure to let emergency personnel know you gave glucagon and hand them the prefilled syringe you used so they know how much you gave.

Guidelines for Preparing the Glucagon Emergency Kit

- Be sure your work area is clean and dry.
 - Wash your hands thoroughly.
 - Carefully remove the flip seal from the glucagon powder vial. Avoid touching the rubber stopper.
 - If you accidentally touch the rubber stopper, wipe the stopper with an alcohol sponge.
- 
- Carefully remove the needle cover from the prefilled syringe.
 - Inject all the fluid from the syringe into the glucagon powder vial.
 - Remove syringe, hold syringe above your waist with needle pointing up.
 - Gently** shake vial with other hand until powder dissolved (solution will be clear). Do not use if the solution is cloudy. Call your supervisor or delegating nurse per agency policy.
 - When powder is dissolved, reinsert needle into vial and remove entire contents from vial. (If you touched the rubber stopper, be sure to clean it with an alcohol swab before inserting needle)
 - Recap the needle, being careful not to contaminate it or stick yourself.
 - Take prepared glucagon to client.
 - Administer per skills checklist on pages 35-36.



Documentation of Hypoglycemic Episode Should Include:

- ◆ All glucometer readings, along with time of each reading
- ◆ Symptoms exhibited by the client (eg. Sweating, irritable, dizzy, etc)
- ◆ Treatment provided (food / beverage given, injection of glucagon)
- ◆ Response of the client to treatment (stated feeling better; became confused and drowsy)
- ◆ Who was notified (nurse, supervisor, emergency services)
- ◆ Time line depicting the order of events during the episode (see example below)

Example of Documentation of Hypoglycemic Episode

Date: X / XX / XXXX

- Time:** 10:45am Client is sweating and states he feels “funny.” Client is alert and talking clearly. Blood glucose checked and was 68. I gave client 6 life savers.
- 11:05-11:10 Client still sweating and saying he feels like he is going to throw up. He says he thinks his heart is racing. Pulse checked and is 110. Client still alert and has no problems swallowing. Blood glucose checked and was 60. Jane Doe, supervisor/nurse, notified. She instructed me to give client a full glass of OJ with a teaspoon of sugar in it and to call 911.
- 11:10am Client given OJ with teaspoon sugar per Jane Doe’s instructions. 911 called.
- 11:14am Client beginning to get sleepy. I had client lie down on sofa in living room.
- 11:15-11:20am Emergency personnel arrived and administered glucagon emergency kit kept with client’s medications
- 11:20am Client transported to hospital by emergency personnel. Called Jane Doe (supervisor) to inform her of client’s transport to hospital. Supervisor stated she would meet me and client at hospital.
- 11:23am Left for hospital after locking up the client’s apartment.

Proper Disposal of Sharps

If in a setting with delegated nursing: Follow agency / employer policy and procedures

If in a setting without delegated nursing: Follow employer policy and procedures

Acceptable Sharps

Containers must be:

- ◀ Closeable
- ◀ Leak proof
- ◀ Puncture resistant
- ◀ Used as a sharps container only - properly labeled or color coded

Unacceptable Sharps Containers Include:

- ◀ Soft plastic soda or water bottles and plastic bags
- ◀ Milk or water containers
- ◀ Cardboard containers
- ◀ Glass jars



Coffee can with lid



Bleach / detergent container



Biohazard Container

How to Prevent Accidental Puncture Wounds from Sharps

- ◆ Never recap or bend a used needle
- ◆ Never place your hand UNDER a trash bag.
- ◆ Alert a supervisor if the client's setting has no acceptable sharps container
- ◆ Give full attention to what you are doing when handling a sharp – no multi-tasking
- ◆ The sharps container should be no more than arm-length away when you use a sharp
- ◆ Get a new sharps container when the one in use gets to be 75% full
- ◆ Never place your hand IN a trash bag for any reason
- ◆ Have client discard the sharp if he/she is able
- ◆ Never shake a sharps container

If you Receive a Puncture Wound:

- ◆ Run warm water over the area immediately
- ◆ Wash the area thoroughly with warm water and soap
- ◆ Rinse well, allowing water to flow toward finger tips
- ◆ Follow your employer's policy for whom to notify and what to do



Skills Checklist: Administering Glucagon

Place a check mark before each step completed by the trainee. Must be checked off on all steps to pass (can demonstrate per simulation or verbalize in classroom setting only).

Preparing the Glucagon

- ___ 1. Be sure work surface clean and dry.
- ___ 2. Wash hands.
- ___ 3. Get Glucagon Emergency Kit from secured storage area.
- ___ 4. Remove elements of Glucagon Emergency Kit from package and place on a clean, dry work surface.
- ___ 5. Carefully remove flip seal from vial containing glucagon powder.
- ___ 6. Remove needle protector from fluid-filled syringe.
- ___ 7. Insert needle into rubber stopper; inject all fluid from syringe into Glucagon vial.
- ___ 8. Remove needle. Hold syringe above level of waist with needle upright. With other hand gently shake vial until Glucagon powder dissolves into a clear liquid.
- ___ 9. Reinsert needle into rubber stopper; draw up all solution from vial into syringe by pulling back gently on the syringe plunger.
- ___ 10. Once all solution drawn into syringe, remove needle from vial and carefully recap.
- ___ 11. Place filled syringe in a safe, but accessible place close to the client.



Giving the Injection:

- ___ 12. Put on gloves then locate the injection site. (Same as sites for insulin).
- ___ 13. Clean the site with alcohol. Make sure site is clean and dry before injecting.
- ___ 14. Pick up syringe and remove cap from needle.
- ___ 15. Hold needle in your dominant hand (hand you write with).
- ___ 16. Place thumb and forefinger of other hand on either side of the injection site, about 2 inches apart, and pinch up the skin.
- ___ 17. With a darting motion of the wrist, quickly insert needle at a 45 -90 degree angle into the pinched up skin between your thumb and forefinger. Insert needle all the way into the skin.
- ___ 18. Keeping your thumb and forefinger on the skin, slide your thumb and forefinger apart, releasing the skin. Keep thumb and forefinger on either side of the injection site while holding the syringe in place with your writing hand.
- ___ 19. **SLOWLY** push down on the plunger until all the glucagon has been injected.

Removing the needle from the injection site

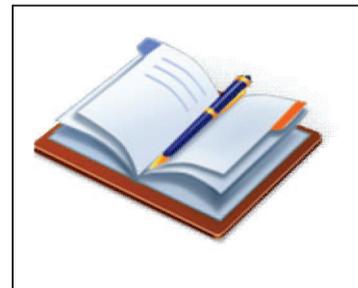
- _____ 20. While holding the syringe in place with your writing hand, count to 5 and then quickly pull the needle straight out. If there is bleeding at the site, use a clean Band Aid, gauze, or cotton ball to apply gentle pressure until bleeding stops.

After the procedure is completed

- _____ 21. As soon as the injection is completed and the needle removed, dispose of the glucagon syringe in a sharps container per your agency's policy and procedure for disposal of sharps.
- _____ 22. Turn the client on his side to help prevent choking because Glucagon can cause nausea and vomiting.
- _____ 23. Call emergency medical personnel (911).
- _____ 24. Remove gloves and wash hands.
- _____ 25. If the client becomes alert, and can eat, drink and swallow, give food or beverage as directed by the nurse, doctor, or emergency medical personnel.
- _____ 26. If the client does not become alert, wait for emergency medical personnel; do not attempt to feed the client and do not leave the client alone.

Documentation

- _____ 27. Document per your agency policy and procedure (see example of documentation p. 33).



Employee _____

Date: _____

Nurse: _____

Supervisor _____

Comments:

Medication Administration

If the client is not capable of self-medication or self-medication with assistance, then medication must be administered to them. Training for Developmental Disabilities (DD) personnel will be provided to assure safe practice is followed as well as compliance with the Ohio Revised Code and Ohio Administrative Code. To determine the necessary training, refer to OAC 5123:2-6-03, OAC 5123:2-6-06 and refer to the chart on p. 10.

Giving or Applying of Medication

A. The person giving or applying a medication should know and consider the following:

- ◆ Why the medication is being given and the expected result
- ◆ Potential side-effects and precautions to take.

B. **Six rights** of medication Delivery (**Dr. Ti MD**)

D = Right dose

R = Right route

T = Right Time and date (may be given 1 hour before to 1 hour after time ordered)

I = Right Individual (client)

M = Right Medication

D = Documentation



C. Stay with the client until the medication has been taken. **Be sure medication is swallowed.**

D. Medications are to be given and documented by the person who prepared the dose(s).

- ◆ **NEVER give any medication set up by another person.**
- ◆ Give **ONLY** medications you personally have set up.

E. Never give pills from a pill-minder, unless you personally prepared the pill minder for a specific occasion (ie. on an outing with client at time medication is to be given). You **MUST** follow the procedure taught in the Certification 1 course for medication administration. **Do NOT deviate** from the procedure taught in this course.

F. **Give medications only from containers:**

- ◆ That have an intact pharmacy label - if it is a prescription drug
- ◆ That have a manufacturer's intact label - if it is a non-prescription / OTC drug / remedy

G. If giving a first dose of a medicine, closely observe the client for 20 minutes for any adverse reaction.

H. **Individual Specific Training (IST):** Before giving or applying medication to or performing health-related activities for a client, the certified personnel must receive IST.

Medications Certified Personnel Are Not Permitted to Apply / Administer

1. Medications administered through a nasogastric (NG) tube
2. Parenteral or intramuscular injection
3. Intravenous injection
4. Any debriding agent used in the treatment of a skin condition or minor abrasion
5. Subcutaneous (sub Q) injection

EXCEPTIONS for Sub Q Injections:

- ◀ Certified personnel may administer insulin if certified in insulin administration (completed Certification 3 curriculum) and delegated to do so by a licensed nurse after the nurse has assessed the client.
- ◀ Certified personnel may inject Glucagon after receiving appropriate Individual Specific Training and the licensed nurse has delegated the task to the certified personnel.
- ◀ Certified personnel may use an EpiPen after receiving appropriate Individual Specific Training and the licensed nurse, or other appropriate personnel per agency policy, has delegated the task to the certified personnel.

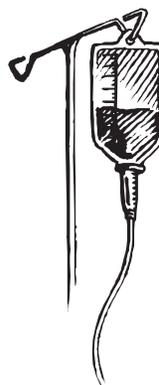
Certified Staff may NOT Administer



Any Medications
through a Naso-
gastric (NG) Tube



Parenteral or
Intramuscular
Injections



IV Medications



Any Debriding
Agents

PRN and OTC Medications

The Latin phrase *Pro re nata* means "for the thing born." In medicine, this phrase is used to mean "as needed," and the acronym PRN is used to denote medication that is not taken on a daily basis, but as needed for the relief of symptoms such as headache, diarrhea, itching, or upset stomach. The use of PRN medications is left to the discretion of the caregiver or the client.

All medications given by certified staff must be ordered by the physician. This includes all prescription medications as well as PRN medications such as Imodium, Acetaminophen (Tylenol), Pepto Bismol, or any other medicine that can be purchased over the counter (OTC) from any store without a prescription.

Even though a PRN medication can be taken at the discretion of the client, or given at the discretion of the caregiver, this does not mean that the client is free to take unlimited amounts of a PRN or a prescribed medication. The prescribed daily dose cannot be exceeded. The client is not free to take more than is prescribed and is NOT to take a PRN medicine unless needed.

When the physician prescribes a PRN medication(s), the order(s) must be exact. In other words, the order must be written in such a way that certified DD staff are clear about exactly how much of the medication to administer. Orders must be written so that no independent judgment by staff is required or even possible.

The order cannot read:

"Give one to two tablets" or "Give every four to six hours"

Further, two PRN medications cannot be ordered for the same thing. The doctor needs to order a single PRN for cough, a single PRN for pain, a single PRN for itching, a single PRN for upset stomach, etc. If we discover that the client has more than one PRN for a given symptom, we need to call the doctor and clarify which medication is to be given.

An order cannot be written for two PRNs for the same symptom:

"Give Motrin for headache." And another order saying *"Give Tylenol for headache"*
(In other words, there **cannot be an order for both** Tylenol and Motrin for headache.)

The doctor needs to order **either** Motrin **or** Tylenol for headache, **not both**.

All PRN medications ordered for the client need to be placed on the MAR. The exact medication, dose, route, date, time, reason, initials of the person giving need to be documented when a PRN is given.

Generally, 30-60 minutes after any PRN medication is given, the effectiveness of the medication needs to be documented per agency policy.

NOTE: PRN medications need to be individual specific to each client. You may **not ever** use one client's PRN medication for another client who has the same symptom, even though the PRN order may have been for an OTC drug. In other words, you may not ever give Billy's PRN medication (i.e. TUMS) to Joe. It doesn't matter that Joe's symptom is exactly like Billy's.

On the next page there are examples of acceptable orders for PRN medications.

Examples of Correctly Written Orders for PRN Medications

Example #1

Acetaminophen 325mg by mouth every 4 hours as needed for headache, or fever over 100°F. Not to exceed 6 tablets in 24 hours

This order allows any brand of Acetaminophen to be given for a headache or a fever over one hundred degrees Fahrenheit

The medication would need to be available for the individual in this dosage. Staff cannot use a different dosage, i.e. 500mg tablets.

If the above order was for Tylenol and not Acetaminophen, only Tylenol brand should be provided. The MAR must indicate the date, time, and reason, and the initials of the person giving the medication.

Be sure to ask the doctor to write the order so that generic substitutions can be used.

Example # 2

Imodium 2 mg, 2 tablets after the first loose stool and 1 tablet after each subsequent loose stool by mouth, not to exceed more than 4 tablets in 24 hours.

Take each tablet with 6 ounces of water.

Example # 3

Pepto-Bismol 2 tablets by mouth every hour for stomach upset, not to exceed 16 tablets in 24 hours.



Example # 4

Ibuprofen 200mg by mouth every 6 hours for pain, not to exceed more than 4 tablets in 24 hours.

When documenting on the MAR, the date, time and location of pain, and initials of the giver needs to be documented.

Example # 5

Lorazepam 1mg by mouth at bedtime when patient will not stop yelling for 30 minutes.

If a medication is given for behavior, there must be a behavioral plan in place. All steps must be taken as written in the plan. Documentation needs to reflect this.

It is recommended that an incident report be written detailing this information. There needs to be an order for the symptom when the medication is to be used.

An order for increased agitation is not specific. The order must explain the specific activity which describes the increased agitation. For example, yelling for 15 minutes; hitting walls; unable to sleep for half an hour.

There must be detailed written directions given when PRN medication is ordered for the client.



Receipt and Transcription of Medication Orders:



- A. Only staff certified to administer Oral / Topical Medications and perform Health-Related Activities may receive and transcribe orders onto the Medication Administration Record (MAR) or the Treatment Administration Record (TAR).
- B. Certified staff may receive and transcribe to the MAR written or verbal orders from a health care professional with prescriptive authority only for the following:
- ◆ Changes in dose, frequency of or a time of administration of a medicine already prescribed by the health care professional and dispensed by a pharmacist.
 - ◆ A medication that does not require a prescription (i.e. An over-the-counter medication) and pharmacist is not involved in the dispensing of the medication.
 - ◆ Performance of health-related activities or change in frequency of health – related activities.
- C. Certified staff may **NOT accept or transcribe verbal orders for a NEW medication**. You must have the physician write the prescription for the new medication and take that prescription to the pharmacy, or have the physician call the order directly to the pharmacy.
- D. **Certified staff may NOT add any new prescription to the MAR until they have the new medication from the pharmacy**. Once certified staff have the new medication from the pharmacy, they may copy information from the label onto the MAR.
- E. If the pharmacy supplies a self-stick label with information, certified staff can attach that label to the MAR as soon as they receive it.
- F. Only personnel certified in administration of oral and topical medications shall transcribe onto the MAR medication instructions as soon as possible after receiving the dispensing container from the pharmacy.
- G. The entry shall be dated and signed by the certified personnel. Accuracy of transcription of orders shall be checked by the next available certified personnel, ideally at the time of transcription. This accuracy check shall be signed and dated by the certified personnel performing the check.
- H. Agency policy must reflect whether receipt and transcription of health care professional's orders will or will not be done by certified personnel (indicate what settings, if applicable).
- I. Procedures for receiving and transcribing written and verbal orders must be developed and included in staff training.

J. Certified personnel in early intervention, preschool, school aged and adult services can only receive and transcribe health care professional orders if agency policy permits **AND**, if applicable, delegating nurse delegates the authority to do so.

K. Certified personnel **cannot** receive or transcribe orders for medication or food to be administered via gastrostomy or jejunostomy tube or for the administration of insulin. According to the rule, only the delegating licensed nurse shall receive physician's orders for food and / or prescribed medication to be administered by stable, labeled gastrostomy or stable labeled jejunostomy tube or insulin administration. Only the delegating nurse shall transcribe these prescriptions onto an individual's MAR (medication administration record) or TAR (treatment administration record).



L. Certified personnel are prohibited from receiving and transcribing orders for medications which require them to calculate dosage based on body weight. Prescribing health care professionals must give an **EXACT dosage** in order for certified personnel to be able to receive and transcribe the prescription. (The script should never read "1-2 tabs." -- This is not an exact dosage.)

M. Wherever feasible, certified personnel shall request a written order from the prescribing health care professional (ie. Prescription, fax, etc). Verbal orders for medications and treatments shall be accepted only under circumstances where it is impractical for the orders to be given in a written manner.

N. A dated and signed copy of the verbal order must be obtained within seven (7) days of receipt and all orders (written and verbal) must be checked by a supervisor, manager, employer, pharmacist or nurse (depends upon agency resources and protocol) within seven (7) days of receipt. Verification by a second person must be documented.

O. Any questions regarding a verbal order or written order or dispensed medication must be referred to the prescribing health care professional and according to agency protocol. If prescribing health care provider is unavailable, then refer questions to employer, supervisor, manager, nurse or pharmacist (based on agency's protocol and resource availability).

P. Refer to your Agency's policy and procedure regarding the receipt and transcription of orders by certified personnel.

Recommended Procedure for Certified Personnel Receiving Verbal Orders



Remember, you may receive verbal orders for:

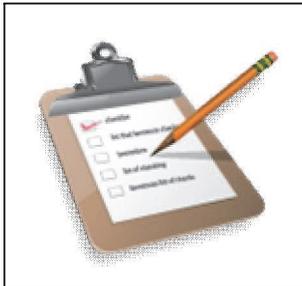
- ◆ Change in frequency or dose of an already prescribed medication
- ◆ Performance of or change in frequency of health-related activity
- ◆ Over-the counter (OTC) medications not requiring a prescription

- A. If possible, have a second certified staff listen to the order along with you
- B. Tell the person giving you the order who you are (name and title) and ask for their name and title. Have them spell their name.
- C. Write all information on a piece of paper or form supplied by your agency.
- D. Ask the health care professional with prescriptive authority to: (may be nurse without PA)
 1. Spell the name of the OTC or health related activity (H-RA)
 2. State the dose of the OTC to be given
 3. State when the OTC medication or health-related activity is to start
 4. State the exact times the OTC medication is to be given
 5. State the route for giving the OTC medication (by mouth, apply to skin, etc)
 6. State the length of time the OTC medication is to be given or the H-RA is to be done
 7. State the reason for giving the OTC medication
 8. Tell you about any side effects of the OTC medication
- E. Repeat back to the health care professional giving you the order what was said to assure accuracy of the order you wrote down
- F. Tell the person giving you the verbal order you need a hard copy of the verbal order within 7 days
- G. Write this information on the MAR or TAR using black or blue ink after verifying the accuracy of the order. Check what you transcribed on the MAR 3 times with the order you received.
- H. Do not use any abbreviations on the MAR or the TAR
- I. Call the health care professional back if you have any concerns about the order you transcribed or follow your agency's policy.
- J. Check the MAR for the following:
 1. Date
 2. Allergies
 3. Staff signature and initials
 4. Individual's name
- K. If feasible / applicable, have another certified staff member check what you copied onto the MAR / TAR with the order you were given.

Recommended Procedure for Certified Personnel When Recording Orders from a Dispensing Container

A. Check the pharmacy dispensed medication package or typed information provided by the pharmacy for insertion into the MAR for the following:

1. Date of the dispensing (3-18-2XXX)
2. Individual's name (John Doe)
3. Name of medication (Dilantin)
4. Medication dosage (1 capsule; 100 mg)
5. Times the medication needs to be given (once a day, three times a day, etc.)
6. The route the medication needs to be given (by mouth, topical, in the eye, etc)
7. Special instructions (give one hour before eating)
8. Start and stop times (10 days beginning 3-18 through 3-27; 3 refills until _____)
9. Reason for medication (control seizures)



B. Check the MAR for the following:

1. Staff signature and initials
2. Individual's name
3. Date
4. Allergies

C. Place the name of the medication, dose, route, and times to be given on the medication administration record (MAR). Document in black or blue ink. Be sure your entry is legible.

D. Check the order label against the MAR three times.

E. Have another certified staff member check the medication order as soon as one is available to do so.

F. Do NOT use abbreviations when transcribing the order.

G. If there is a question or concern regarding the order, contact the prescribing health care professional or pharmacist or follow your agency's policy.

Documentation of Medications Administered And Health-Related Activities Performed

Certified staff need to be sure to document all medications administered as well as all health-related activities and tasks completed.

There will be variations of employer procedures in the following areas:

- a. Unusual incident reporting
- b. Communicating to appropriate individuals and agencies
- c. Identification of personnel making entries in the record (eg. Initials, signature)



Documentation of medication administration shall be done according to the employer's policies.

The medication record is a legal document:

- ◆◆ No erasure or correction fluid is to be used.
- ◆◆ Use black or blue ink to make all entries (black often Xeroxes better than blue).
- ◆◆ If a recording error is made:
 - ◆◆◆ Draw a single line through the error.
 - ◆◆◆ Write the word "void" or "error" above the wrong words.
 - ◆◆◆ Place your initials and date above the wrong words.
 - ◆◆◆ Write correct entry.

See
example
on next
page

Never document for anyone else.

Never leave a blank space for late entries.

Write a **late entry** as soon as possible by placing it in the record under the current date as follows:

Record current date. State, "Late entry for John Doe for (give date), then proceed to make the entry for that date. Sign your name

Documentation of Controlled Substances

At the end of every shift, controlled substances should be counted and documented by each certified personnel administering a controlled substance. This procedure is very important to ensure that an individual receives the prescribed amount of a controlled substance as well as ensure that the controlled substance is not being stolen and used by others.

If an individual dies, **DO NOT** dispose of the prescription medication(s) until informed it is okay to do so by law enforcement, Coroner or Investigative Agent from the County Board. If the drug is discontinued, or the drug is contaminated follow your agency policy pertaining to discontinued or contaminated drugs.

Controlled substances should be counted by two persons (certified personnel, nurse, pharmacist) to ensure correct count at time of death. Other medications should also be counted to ensure correct count at the time of death.

Documentation Rules

Begin each entry with the date and time. Be sure to sign your entry at the end. Leave no blank space between your entry and your signature. Draw a line from the end of your entry to your signature. That way, no one else can make an entry under your name. (See example below)

If you make an error in charting, DO NOT erase or scratch it out or white out the error. Instead, draw a single line through the entry. Above the lined out entry place the word "void," or "error" your initials, and the date. (See example below)

<p>Example: 3-9-09</p> <p>Void or Error JD 3-9-09</p> <p>Mickey was mean-spirited stated he was fed up with my waking him up at 7:30 every morning and he was going to get me fired for not allowing him to sleep in because it is "his right to do whatever he pleases." He remained in bed until 10am despite prompts at 7:30, 8:00, 8:30 and 9:00 to get up.</p> <p><i>Jane Doe, MR/DD SA</i> JD</p>
--

Your signature must be legible. The client's record is a legal document and a legible signature is a requirement.

Entries must be legible. Print your entries if your cursive is sloppy and illegible. Other staff need to be able to read what you have written. If there is ever a lawsuit, others need to be able to read what you have written. Illegible writing can lead to mistakes and misinterpretations.

Entries must be factual. No opinions should ever appear in an entry.

<p>NO! NO! NO! NO!</p> <p>Sally had a bad day and was hostile</p> <p>Jim was uncooperative today. He refused to follow his ISP.</p>		<p>YES! YES! YES!</p> <p>Sally yelled at her roommate and smashed the roommate's favorite cup on the floor when the roommate asked Sally to give back an item she had borrowed two days ago.</p> <p>Jim stated he would not clean up the kitchen or vacuum the living room today. When reminded these were his tasks listed on the chore sheet for today he said, "I have rights. You can't make me."</p>	
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If giving a medication, be sure to document the client's response. **For example:** "Sally choked on her multivitamin. She said it's hard for her to swallow."

Always complete documentation before leaving for the day. Keep documentation current.

NEVER abbreviate route or frequency on the MAR. Write everything out.

NEVER Use "ditto" marks in an entry.

NEVER make an entry with a pencil. Use black or blue ink only.

NEVER document you did something before you actually did it. Always document after the fact.

NEVER make entries for another person or leave space for entries to be made at a later time.

Sample Policy for Recording of Medications or Health-Related Activities

- A. The nurse or the pharmacist will prepare a **medication administration record (MAR)** or **treatment administration record (TAR)** for each individual which will include:
- ◆The individual's name
 - ◆The name of the medication
 - ◆The dose
 - ◆The administration time
 - ◆The route
 - ◆A discontinuation date when applicable
 - ◆Special instructions (eg. Take pulse before giving, give with food, do catheter care before breakfast, no tomato-based foods for 3 days before collecting stool specimen, etc.)
- B. After the medication is given or health-related activity is performed, the person who gave the medication or performed the health-related activity will initial the appropriate time space under the correct date on the MAR or the TAR.
- C. If a medication is not given or is not taken, initial the appropriate time square on the MAR, then circle the initials and note the reason; if a health-related activity is not given or not taken, initial the appropriate time square on the TAR, then circle the initials and note the reason; or if the facility has a different procedure, follow the facility's procedure for documenting these occurrences.
- D. Medications regularly administered away from the facility or health-related activity regularly performed away from the facility will be documented according to the facility's policy.
- E. If a medication is given on a PRN basis, record the time it was given on the MAR, the reason it was given, and the effectiveness of the medication.
- F. Initials on the MAR or TAR must correspond to a full signature on the same page.
- G. Signatures must be legible.
- H. The MAR and the TAR are legal documents. All entries are to be made in ink. Do not erase your mistake(s) and do not use correction fluid. If a recording error is made, draw a single line through the error, write the word "error" or "void" above the wrong word(s), initial and date, and then write the correct entry.

Storage and Care of Medications

Only medications and the equipment for preparation are to be stored in the designated secured area that is to be used consistently.

Medication Storage and Preparation Areas

Storage and preparation areas must be functional and provide:

1. Adequate space for storage.
2. Ability to separate oral medications from medications given by other routes.
3. Adequate lighting so that labels can be clearly seen.
4. Accessible hot and cold running water.
5. Medication cupboards that can be secured as necessary.
6. Adequate uncluttered counter top or table space to prepare medications.
7. Prep and storage areas must be kept clean and orderly.



Medications Stored in the Refrigerator

If possible, a separate refrigerator only for medications would be ideal. If this is not possible, medications stored in the refrigerator must have a dedicated space in the refrigerator for their storage. Place these dispensed medication containers inside a basket, box, or bowl (ie. Tupperware unit) to protect them and keep them from getting misplaced.

Maintaining potency (strength) of medications

- ◆ Follow the instructions provided by the pharmacy.
- ◆ Keep away from direct light sources (window sill, beneath a light).
- ◆ Keep away from heat sources (stove, top of refrigerator, window ledge).
- ◆ Keep away from sources of humidity (near the sink, in the bathroom, near the stove).

If you are uncertain about the proper storage of a medication, contact the pharmacist.

Do NOT use medications that:



- ◆ Are discontinued
- ◆ Are expired (past expiration date) →
- ◆ Have missing labels
- ◆ Have unreadable labels
- ◆ Are missing the original dispensing label

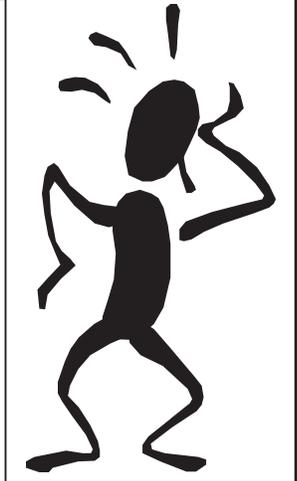
If the expiration date is August 10, 2020, the drug may be used up until midnight of August 10, 2020. The drug may NOT be used on Aug.11, 2020 or thereafter.

Follow your agency's/ employer's policy for disposal of outdated / unused medications



Medication Errors

If you make a medication error, follow your employer's procedure for reporting and documenting the error.



Types of Medication Errors Include, but are not limited to:

1. Giving the wrong medicine
2. Giving medication at the wrong time
3. Giving medication to the wrong client
4. Giving medication by the wrong route
5. Giving the incorrect dose of the medication
6. Giving expired (outdated) medication
7. Giving medication that was improperly stored (potency may have been affected)
8. Giving medication without a physician order
9. Omitting a medication
10. Improper documentation

Causes of Medication Error

1. Reading the label incorrectly
2. Not waiting for the client to swallow the medication
3. Not documenting immediately that a medication was given
4. Error in transcription from the dispensing label to the MAR
5. Inaccurate transcribing of a verbal order onto the MAR
6. Incorrect documentation of medication given
7. Multi-tasking while setting up medication – not giving the task your full attention
8. Environmental distractions (noise, talking to another while setting up, cluttered work area)



Missed Doses of Medication

If you miss giving a medication in the correct time, report and document according to your Employer's policy.

For any medication, when a dose is missed, use the pharmacy information sheet or call the pharmacy to see if it is still OK to administer that dose. If you call the pharmacy, document the name of the pharmacist with whom you spoke along with date and time. Document any instructions given by the pharmacist per agency policy. Call the delegating nurse if applicable. Always complete a UI (Unusual Incident) Report and give this report to your supervisor per agency policy.

Documentation Errors

Initialing in the wrong space (time, date, medication) on the MAR is a documentation error. It is a medication error and can lead to an additional medication error. Follow your Employer's instructions for correcting this type of error. If at all possible, have the person making the error correct it immediately.

Preventative Measures to Reduce Medication Errors:

- ◆ More training / education of staff certified to give medications
- ◆ Re-evaluation of Employer's or DODD policies and procedures
- ◆ Review of corrective actions to be implemented or followed

Missed Medications

(Adapted from Safety Alert #45-06-08)



When a medication is not received consider how significant it is for that client based on the seriousness of their condition. **Ask: Should the prescribing physician be consulted immediately?** Is there a risk for the client?

Tell someone when there is an error or missed medication. Missing a medication, taking the wrong medication, or receiving more or less than prescribed is always recorded on an incident report. Recording incidents should result in action to understand the cause and take preventative measures when needed,

Common Reasons Medications are Not Given or Taken

- ◆ Refusal of the medicine
- ◆ Not liking the taste of the medicine
- ◆ Prescription was not filled
- ◆ Caregiver / client forgot about the medicine
- ◆ Not liking the way the medicine makes me feel
- ◆ Confusion about how / when to take the medicine

General Rules

Make sure **ORIGINAL LABELS** are intact

Keep records **CURRENT** and clearly written

Keep medications in a **SAFE PLACE** to avoid misuse

NEVER give the client medications prescribed for another client

KNOW YOUR LIMITS if you are responsible for administering medication

PREPARE a list of medications the client is taking and take that **LIST** to the doctor

KEEP medicines in the package they come in – so there is no confusion over contents.

INFORM the doctor about allergies or medications that have caused problems in the past.

NEVER change the medication dosage without consulting a physician. Only a doctor can do that.

NEVER skip a dose or take extra later to make up for a missed dose without consulting the prescribing physician.

If you have a **QUESTION** about a medication, write it down and get it answered by your delegating nurse, pharmacist, or doctor.

Make sure a **DOCTOR [or pharmacist]** evaluates all medicines a client takes.

REMEMBER: Some medicines don't interact well with each other.

PROPERLY DISPOSE of all medicines that are past the expiration date or that have been discontinued by the prescribing physician. Contact the pharmacist or vendor regarding proper disposal or follow your agency's policy.

ADDITIONAL INFORMATION about specific medications can be found online at search sites such as <http://www.fda.gov/cder/drug/default.htm>



Questions You Should Ask the Doctor, Delegating Nurse , or Pharmacist

- ❖ What is the medicine for?
- ❖ How much should be taken?
- ❖ How often should it be taken?
- ❖ Are there any special instructions?
- ❖ Can we do anything to prevent side effects?
- ❖ Will it interact with medications already being taken?
- ❖ Should it be taken with food or on an empty stomach?
- ❖ What should we do if a dose is missed or incorrect dose given?
- ❖ Are there side effects we should watch for; should we report them?
- ❖ Do blood levels need to be checked with this medicine? How often?
- ❖ Are there any foods or other medications, supplements, or other things that should not be taken with it?



Doctor



Delegating Nurse



Pharmacist

(Adapted from Safety Alert #45-06-08)

For additional information, please contact the MUI/Registry Unit at:
MUI.Unit@dmr.state.oh.us

Also refer to Appendix at the end of this curriculum for :
Health and Safety Alert #38-12-06 (Exceeding Manufacturer's Recommended Dose)
Health and Safety Alert #11-03-08 (Excessive Psychotropic Medication and Psychotropic Medication Side Effects)



Preparation of Medication for Administration

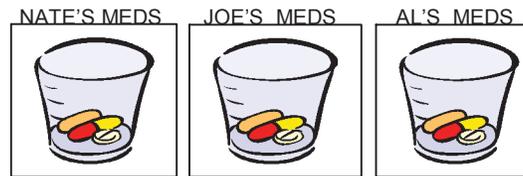
- A. Check the **MAR (medication administration record)** to see if the dose for this administration time has been given. If not, proceed to set up the medication.

If it has been given, you will not give this medication at this time.

- B. Check the MAR for the client's allergies.

- C. Select the medication(s) to be given.

- D. Use a separate cup or container for each client. All oral medications for a given client can go into the same cup. If you are giving medicine to more than one client, each client must have his / her own separate cup with his / her medications placed in it. Never place any oral medication (ie. tablet, capsule, pill) into your own hand – always put oral medications into a cup. To assure safety, it is best to prepare medications for just one client at a time. Prepare the next client's medications only after you have completed administering medications and documenting for the first client.



- E. Check each medication with the MAR.

- F. Give **FULL ATTENTION** to preparing the medications you are giving.

- G. Check the label on each medication container with the MAR. Never use unlabeled medications. Never give medications from a pill minder – not even if the client's parent or guardian tells you it is OK. It is **NOT** okay to give medications from a pill minder – ever.

(Exception: You may put into a pill minder any medications that **YOU** will be giving the client while he is away from home.)

- H. **READ THE LABEL THREE TIMES:**

✓ **When** checking the MAR

✓ **Before** removing the medication from the container

✓ **Immediately after placing** the medication in the cup from which the client takes his/her medication

- I. Medications prepared for giving, but not given, are to be recorded according to the Employer's policy and procedures.

- J. If you have any questions regarding the medications seek assistance by following the policies established by your employer. Resources for medication questions include the client's physician, nurse, or pharmacist.

Special Instructions

Medications Given Under the Tongue (Sublingual)

(i.e. Nitroglycerine pills or spray)

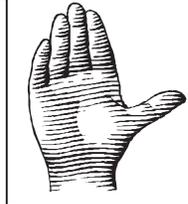
1. Sublingual medications are placed under the tongue and kept there until dissolved. This type of medication cannot be chewed or swallowed.
2. Stay with the client until the medication has dissolved.
3. After taking a sublingual, have the client wait at least 30 minutes before consuming any food or fluids.
4. Observe the client for any side effects of the drug.
5. Be sure to follow the physician's orders for each medication ordered because some sublingual medications come with additional instructions.



Note: Be sure to check for expiration date.

Techniques for Measuring Liquid Medicines

1. Pour liquid away from the label – place the labeled side of the container against the palm of your hand to protect the label from drips and runs.
2. Pour liquid at eye level. Never hold the measuring cup/ device in your hand. Always place it on a flat surface. Squat down to get at eye level if the measuring device is on a table. You may stand if the measuring device is placed on a shelf at the level of your eyes.
3. Use a measuring device that is exact. You may use a calibrated cup, syringe designed to draw up medications from a bottle, or actual measuring spoon. Never pull a spoon from the silverware tray to use. “Teaspoons” from the silverware tray may or may not hold an actual “teaspoon” of liquid or powder.



Warming Medications

Warm medications (ear drops or eye drops) by holding the dispensing container in your closed hand for several minutes.

Never place in the microwave or in hot water. You may accidentally change the chemical composition of the medicine if you get it too warm.



Overview of Medications by Category

Category of Medicine	Category Defined	Examples of Medications
Alzheimer	Slows down progression of the disease, but does not cure it.	Aricept, Exelon, Namenda, Razadyne
Analgesics	Used to control pain.	Aspirin, Acetaminophen, Morphine, Demerol
Antacids	Used to control "sour stomach," heart burn	Pepcid AC, Tagamet, Reglan
Anti-anxiety	Used to control anxiety disorders; calms the nerves; may be called a tranquilizer	Valium, Luvox, Lexapro, Tranxene, Xanax
Antiarrhythmics	Used to regulate an irregular heart beat	Toprol, Calan, Sotolol
Antiasthmatics	Used to treat asthma – to assist the person to breathe better without wheezing	Singulair, Albuterol, Symbicort, Proventil
Antibiotics	Used to treat infections caused by bacteria	Penicillin, Amoxicillin, Ceclor
Anticonvulsants	Used to treat seizure disorders; May also be used to control mood swings in bipolar disorder	Depakote, Dilantin, Tegretol, Lamictal, Keppra, Trileptal, Neurontin
Antidepressants	Used to treat depression – to lift the person's mood / spirits	Elavil, Cymbalta, Effexor, Zoloft, Lexapro, Celexa
Anti-diarrheals	Used to stop diarrhea (watery stools)	Imodium, Loperamide
Antihistamines	Used to treat allergic reactions	Zyrtec, Claritin, Benedryl, Singulair
Antihypertensives	Used to control blood pressure	Verapamil, Catapres, Minipres, Coreg, Cardizem
Antiparkinsons	Used to control tremors caused by Parkinson's Disease and involuntary tremors from long-term use of antipsychotic medications	Levodopa, Artane, Akineton, Sinemet, Stalevo
Antipsychotics	Used to control symptoms (hallucinations, delusions) associated with severe mental illness	Zyprexa, Clozeril, Melleril, Haldol, Risperdol, Geodon, Abilify, Seroquel,
Antipyretic	Used to treat elevated body temperature	Aspirin, Ibuprofen, Aleve
Antitussives	Used to treat cough	Robitussin, Codeine, Benlyn, Delsym
Birth Control	Used to prevent pregnancy	LoOverall, Estradiol, Ortho-Cept, Yasmin

Overview Cont'd)

Category of Medicine	Category Defined	Examples of Medications
Controlled Substances	Federally regulated. Have a high potential for abuse and or addiction. Tolerance develops. Prescriptions are not easily renewed. Rated in order of abuse risk and placed in schedules from I (highest risk) to V (lowest risk). Must be kept secured (locked up) and signed out when given. Must be counted at the end of each shift.	Morphine derivatives, Benzodiazepines, Hallucinogens, Cannabis, Amphetamines,
Diabetic Drugs (oral)	Used to treat type II diabetes	DiaBeta, Glucatorl, Diabinese, Starlix, Avandia
Diuretics	Used to rid the body of excess fluid – to treat fluid retention and help control blood pressure.	Lasix, Zaroxolyn, Hydrodiuril, Aldactone
Expectorants	Used to thin secretions and promote coughing to rid the lungs of foreign substances	Mucinex, Biotek, Congestac, Humibid, Benylin Expectorant
Hormones	Used to treat hormone - related conditions. Includes meds for birth control, menopause symptoms, and thyroid disorders.	Prempro, Estrogen, Levothyroxine
Laxatives	Used to treat constipation and promote peristaltic action in the intestines	Miralax, Senna, Cascara, Metamucil, Colace
Mood Stabilizers	Used to even out erratic mood swings and promote an even disposition	Lithium, Tegretol, Depekene
Nutritional Supplements	Used to make up for deficiencies in vitamins and minerals missing in the diet	Calcium Citrate, Centrum Multivitamin, Ensure
Osteoporosis	Used to increase bone density as well as treat / prevent complications of osteoporosis. These meds require special administration procedures.	Miacalcin Nasal Spray, Fosamax, Boniva, Actonel
Oxygen	A gas to be given through a mask or cannula to treat breathing problems or deliver more oxygen to the heart or brain.	Oxygen (O ₂)
Psychotropics	Any drug used to treat mental illness. Includes all classes of psychiatric drugs	Any drug used to treat mental illness
Sedatives / Hypnotics / Sleep Aids	Used to promote rest and sleep	Lunesta, Nytol, ProSom, Sonata, Rozerem
Skeletal Muscle Relaxants	Used to control muscle spasms and pain from injury to the body	Dantrium, Flexeril, Skelaxin, Baclofen, Norflex
Stimulants	Used to calm individuals with attention deficit disorder.	Amphetamines, Ritalin, Epinephrine, Adderall, Caffeine

Things to Know About These Kinds of Medications

Analgesics (pain medications)

Many cause stomach upset, so give with food as directed. **Be sure to document effectiveness of medication by asking client 30 minutes after dosing if pain is better.** If not, call delegating nurse, supervisor, or employer.

Document and report any side effects

Anti-anxiety (Tranquilizers)

These drugs can be abused as tolerance can develop when these drugs are taken over time.

Do not stop this drug suddenly. The person must be weaned off gradually.

These drugs cannot be combined with alcohol. Death can result.

Be aware of signs of overdose (unsteady gait, drowsiness, slurred speech)

Antiasthmatics

These medications can cause stomach irritation. If so, give with food.

Monitor pulse after giving drug as heart rate may increase. Report heart rate above 100 to delegating nurse, supervisor, or employer.

May interfere with sleep. If so, dose well before bedtime

Anticonvulsants (Controls seizures)

Read all instructions carefully. Some of these meds cannot be taken with food (ie. Dilantin)

Always use seizure precautions with anyone taking these meds.

Call for help if client becomes unresponsive.

Antacids

May cause constipation. Monitor BMs

Can interfere with absorption of other meds. Give 2 hrs after other meds or 1 hour before

Antiarrhythmics (regulate heart beat)

You may need to check the client's pulse before administering these drugs. MAR will tell you when to hold medication if pulse too low (usually below 60 beats per minute)

Notify doctor, nurse, or supervisor if client's heart beat is irregular.

Antibiotics (anti-infective drug)

Be aware of potential for allergic reaction or other adverse effects such as diarrhea or nausea.

Remember, an order for every 8 hours is not the same as an order for 3 times a day. Pay attention to how the drug frequency is specified.

Take all the pills in the container –even if you feel better. Not doing so can result in developing an antibiotic resistant infection in the future.

Antidepressants (psychotropic drug)

Any individual on these medications should be observed for signs of suicide. Be aware of any special instructions from the pharmacist. Some antidepressants have strict dietary restrictions, others do not.

Photosensitivity can be a problem. Be sure client wears sunscreen and sun glasses when outdoors, even in the winter.

These drugs can take as long as 4-8 weeks before the client experiences therapeutic effects.

Dry mouth can be a huge problem. Keep hard candies and juicy fresh fruits on hand.

Anti-Diarrheals (Lomotil, Imodium AD)

- ◆ Be sure to clean rectal area well after each stool
- ◆ Notify nurse, supervisor if stools continue beyond specified time
- ◆ Record color, odor, consistency, number of stools
- ◆ Give bland diet as long as diarrhea persists.

Antihypertensives (control blood pressure)

You may be asked to monitor the client's BP. Use an automated device. Have client sit quietly for 5 minutes with legs uncrossed, feet flat on floor. No talking while BP is being taken.

MAR will tell you parameters for BP and when to notify doctor, nurse or supervisor.

Some of these drugs have dietary restrictions. Follow instructions given to you by the pharmacist or delegating nurse.

Grapefruit may be forbidden if client on this type of drug. Check with pharmacist.

Antipsychotics (Neuroleptics)

It is not unusual for clients taking these drugs (for mental illness) to eventually develop diabetes. Be aware of signs of diabetes and seek medical care early.

Also be aware of signs of Neuroleptic Malignant Syndrome: fever, rigid muscles, sweating, renal failure, muscle wasting, pallor.

Photosensitivity can be a problem. Be sure client wears sunscreen and sun glasses when outdoors, even in the winter.

Antihistamines (allergy medicine)

Can cause severe drowsiness in some people as well as dry mouth, decreased concentration and motor coordination.

Have client be careful if riding a bike or using other equipment requiring coordination.

Antiparkinsons

Anyone on these drugs is at risk for falls. Be very aware of anything in the environment that could cause a fall.

Always walk close to this person to offer assistance when needed.

Antipyretic (Reduces fever)

Be sure to give plenty of fluids to prevent dehydration.

Give these medications with food to avoid stomach upset.

Do not give these medications if client on anticoagulant therapy (on Coumadin). Blood can get too thin.

Antitussives (cough medicines)

If cough does not improve, take client to see physician to be sure his lungs remain clear.

Cough drops may be used if physician orders these and they are added to the MAR.

Take only as directed on MAR – usually recommended dose taken up to 4 times a day.

Birth Control (Depo-Provera, Ortho Novum)

Report any leg pain or visual disturbances immediately to doctor, nurse, or supervisor.

Effectiveness of this med may be affected adversely by antibiotics, barbiturates and anticonvulsants.

Smoking increases risk of blood clots.

Diabetes Drugs – Oral

(Avandia, Metformin)

Monitor client's blood glucose as instructed

Infection can raise the client's blood sugar

Expectorants (get secretions out of lungs)

Be sure client drinks enough fluid

Have client cough and deep breath as instructed

Monitor and record type and frequency of cough

Diuretics (gets rid of extra water in the body)

Weigh as ordered by nurse or physician

Monitor urinary output

Observe for decrease in swelling in ankles and lower legs, hands

You may be asked to check girth of abdomen to verify decrease in fluid retention.

Mood Stabilizers (usually given to people with wide mood swings)

Watch for signs of toxicity. These should be listed on the MAR. Report lethargy, gait disturbance, ringing in the ears and severe vomiting to nurse, doctor, or supervisor immediately.

Be sure client takes in adequate fluids throughout the day to prevent drug buildup in the body leading to toxicity.

Laxatives

Use for a short time only so body does not become dependent upon laxative for BM.

Give after meals

Be sure fluid intake throughout day adequate – at least 6-8 eight ounce glasses of water during waking hours.

Daily fiber intake needs to be a minimum of 25 grams to move waste through the bowel.

Oxygen (O₂)

Be sure no one smokes around oxygen. Post sign on door: **OXYGEN IN USE. NO SMOKING.**

If person having difficulty breathing, DO NOT increase the oxygen concentration. Call the delegating nurse or your supervisor. **YOU MAY NEVER INDEPENDENTLY CHANGE THE CONCENTRATION OF O₂ DELIVERED.**

Document oxygen level as instructed by the delegating nurse.

Nutritional Supplements

May be needed if the diet is inadequate or the client taking a diuretic which can deplete the body of potassium. Apples, oranges, potatoes, bananas, raisins good sources of potassium

Calcium intake often insufficient. Adults need at least 1200 mg calcium per day. Caffeinated beverages deplete the body of calcium. Limit soda intake to only one 12 ounce can per day.

Most Americans deficient in fiber intake. Whole grains, fruits, vegetables excellent sources.

Iron found in red meats, poultry, eggs and dark green leafy vegetables

Iron pills can upset the stomach. Give with food after checking with pharmacist.

Overview of Psychotropic Medications:

(Adapted from Safety Alert #11-03-08: Excessive Psychotropic Medication & Psychotropic Medications Side Effects)

Medications prescribed to improve a person's mental health or their behavior symptoms of mental illness are referred to as psychotropic medications. Anti-depressants, antipsychotics, mood stabilizers, anti-anxiety agents, sleep agents, stimulants, anti-parkinson and anti-cholinergic agents are such medications. If used for psychotropic purposes, anti-convulsants and cardiac medications are also considered psychotropics.

Individual Rights

In choosing the treatment for persons who are dually diagnosed with mental illness and mental retardation, we must always recognize the right of the person with mental retardation to receive appropriate care and treatment in the least intrusive manner, and the right to be free from unnecessary chemical or physical restraint.

Black Box Warning

A Black Box is a type of warning that appears on the package insert for prescription drugs that may cause serious adverse effects. It is so named for the black border that surrounds the text of the warning.

Commonly Used Psychotropic Medications with a Black Box Warning

Anafranil	Ludiomil	Remeron
Ascendin	Marplan	Serzone
Aventyl	Nardil	Surmontil
Celexa	Norpramin	Tofranil
Desyrel	Parmate	Vivactil
Effexor	Paxil	Wellbutrin
Elavil	Prozac	Zoloft
Lexapro		

What to do:

- ✓ Be informed about the black box warning
- ✓ Obtain immediate medical treatment for serious signs and symptoms of possible medication side effects
- ✓ Keep the health care provider and guardian informed of any and all side effects.

Observation and Reporting of Side Effects

An individual who is taking psychotropic medications may be unable to adequately verbalize symptoms or medication side effects. Therefore, it is important for care givers to be observant for possible side effects that need to be reported to the nurse, physician, and/or employer for evaluation.

Minor Side-Effects Common to Psychotropics include:

- ◀ Dry mouth
- ◀ Change in sex drive
- ◀ Sensation of thirst or increased need for fluids
- ◀ Drowsiness

Serious Side Effects to Report Immediately

- ◀ Allergic reaction (difficulty breathing, swelling of lips/face/tongue, rash, or fever)
- ◀ Change in level of alertness (excessive sleepiness, insomnia or confusion)
- ◀ Eating problems (nausea, vomiting, weight gain or loss)
- ◀ Change in stool pattern (constipation, diarrhea)
- ◀ Change in heart beat (slow, fast, irregular) or blood pressure (high or low)
- ◀ Fainting or dizziness, especially with changes in position (e.g. Going from sitting to standing)
- ◀ Abnormal posture, movements, or gait
- ◀ Yellowing of the eyes or skin
- ◀ Unusual bruising or bleeding

Websites you can visit:

WebMD.com
Medline Plus.com
Medline.com

Refer to Health and Safety Alert #11-03-08 in Appendix at the end of this curriculum. Look for *Excessive Psychotropic Medication & Psychotropic Medication Side Effects*

Scheduled / Controlled Substances

Scheduled / Controlled substances are drugs that are restricted due to their potential for abuse or addiction. They include:

- Narcotics
- Stimulants
- Depressants
- Hallucinogens
- Cannabis

The drugs with the highest potential for abuse (LSD, PCP, crack/cocaine) are placed in Schedule I. The drugs with the least potential for abuse (Robitussin A-C, Lomotil) are placed in Schedule V. In other words, as the Schedule number increases, the abuse potential decreases.

Narcotics

Can be broken down into two groups:

- Opiates (opium, heroin, morphine, and codeine).
- Non-opiate synthetics (Demerol, methadone)
- Narcotics are physically addicting and used mostly for management of pain.

Stimulants

Includes cocaine and amphetamines.

May be used to treat depression and narcolepsy

Cocaine is psychologically addicting and withdrawal can result in depression.

Depressants

Includes barbiturates and tranquilizers such as valium and Librium.

These drugs used to induce sleep, sedation, and combat anxiety.

These drugs are addicting and if combined with alcohol can lead to death.

Hallucinogens

Includes LSD, mescaline, and peyote.

These drugs are non-addicting.

These drugs affect the brain and seriously alter the person's ability to accurately perceive reality.

Cannabis

Includes marijuana and hashish. It is normally smoked and acts as an intoxicant.

Non-addicting and has been used in the treatment of glaucoma.

All scheduled drugs are highly regulated and must be carefully tracked. If your client receives a scheduled drug, you will need to keep careful records to account for each dose. Follow your agency's procedure for securing and tracking these drugs.

Sedatives / Hypnotics

Can cause dizziness. Be careful of falls.

Should not be taken until client ready to get into bed for the night.

Do not give after midnight if client has to be up by 8 the next morning

Usually not effective after 2 weeks.
Tolerance a problem – it takes more and more to get the desired effect.

Skeletal Muscle Relaxants

Can cause dizziness and drop in blood pressure.

Caution client not to get up quickly from a sitting to standing position.

Do not stop this drug suddenly. Must be weaned off.

Can cause respiratory depression in older or debilitated clients.

Monitor urinary out put. Kidney dysfunction can be a problem.

Stimulants

These drugs can increase the effects of anticoagulants, anticonvulsants, and tricyclic antidepressants.

Some people lose weight on these drugs. Monitor weight as directed by nurse, doctor, or other health care professional.

Some of these drugs can cause addiction and should not be stopped suddenly.

If desired effect not apparent, report to nurse, physician, or supervisor.

Give last dose for the day no later than 4 pm because these drugs can interfere with ability to sleep.

Clients on these drugs should avoid caffeine.

Urinary Tract Infection Medications

These drugs may discolor the urine

They should be taken with food to avoid stomach irritation.

Client needs to drink lots of water to keep the bladder flushed. Offer 8 ounces of fluid every hour.

Documentation of Certified Staff Performance of Skills Covered in Certification 1 Class: Initial Certification

Certified DD Staff Name: _____ Date: _____

Below is a list of skills included in the Prescribed Medication Handbook and Health-Related Activities Training Manual. The skills below were presented in the Certification Level 1 course and the staff person was evaluated on these skills by :

RD Return demonstration in the classroom setting , or

VOK Verbalization of knowledge of how to perform the skill in the classroom setting

_____ EpiPen	_____ Diastat	_____ Glucagon E. Kit
_____ Oral Medications	_____ Inhaler	_____ Nebulizer
_____ Eye Medications	_____ Ear Medications	_____ Nose Drops/Spray
_____ Topical Medications	_____ Rectal Medications	_____ Vaginal Medications
_____ Temperature	_____ Pulse	_____ Respirations
_____ Blood Pressure	_____ Clean Dressing	_____ Intake/Output
_____ Oral Suctioning	_____ Clean Catch Urine Sample	_____ Urinary Catheter Care
_____ Glucometer	_____ Empty Urinary Catheter Bag	_____ Empty and/or Replace Colostomy Bag

All of the above skills must be included in the class provided by the nurse trainer and checked off as RD or VOK. For any skill / task listed as VOK the employer may wish to have the certified DD personnel perform a return demonstration prior to assigning that skill / task to the certified personnel.

A copy of the Medication Administration Curriculum and Skills Check List can be found at www.odmrdd.state.oh.us under Health & Safety.

Receipt of Category 1 certification indicates that DD personnel have successfully completed training for medication administration and performance of specific health-related activities according to ORC 5123.41-47 and OAC 5123:2-6-01 thru 07. Nurses, employers, and DD personnel are reminded that receipt of certification is not necessarily a guarantee of skill competency. Consequently, trained and certified DD personnel may require additional observation, evaluation of skill, and review of procedures as needed. Successful re-demonstration of skill is ultimately at the determination of the nurse trainer during training, and the delegating nurse and / or employer, where applicable, post training. Medication and health-related activities information received during training is preliminary to individual specific instruction.

Nurse Trainer Signature: _____ Date: _____

Annually, the employer is responsible for having DD personnel complete return demonstrations of any tasks (MA and HRAs) they have performed as a part of their assigned duties during the previous year.

Medication Administration Certification 1 Skills Checklist

General: (To be used at the beginning for EACH medication administration skill to be checked off)



- _____ 1. Wash hands thoroughly
- _____ 2. Start at the beginning of the medication record and review, checking for the following:
 - a. Individual's name
 - b. All medications ordered
 - c. Medications to be given at this time
 - d. Dose for this time period has not been given
 - e. Order is current
 - f. Any allergies
 - g. Special instructions for giving (Individual Specific Training)
- _____ 3. Read **entire** name and dose of medication you will be giving for this individual at this time.
- _____ 4. Obtain the medication from the secure storage area.
- _____ 5. Check the expiration date on the label of package or container and read the **entire** label carefully.
- _____ 6. Place the medication package by the name of the drug on the medication record and be *positive* the package/container and the Medication Administration Record (MAR) coincide (1st check).
- _____ 7. Read the directions to give the medication from the MAR and be *positive* that the label and the medication record coincide (2nd check).
- _____ 8. If they do **not** coincide, do not give the medication until there has been clarification regarding medication. Clarification should be sought through the employer's policy.

If the expiration date is August 10, 2020, the drug may be used up until midnight of August 10, 2020. The drug may NOT be used on Aug.11, 2020 or thereafter.

Trainee Name: _____ **Date:** _____

Instructor initials: _____ Instructor Name: _____

COMMENTS:

Certification 1 Skills Checklist: Oral (by mouth):

Follow steps 1-8 on "General Checklist for Administering Oral Medications" then



- _____ 9. Obtain medication cup using separate cup for each individual.
- _____ 10. Compare medication label and MAR (3rd check). Then prepare the medication without touching the medication with your fingers.
- _____ 11. Check medication label and return container to secure storage area.
- _____ 12. Identify individual to receive the medicine and explain to the individual you are giving his/her medication for that specific hour.
- _____ 13. Tell the individual the name of the medication and its purpose when you give the medication to him/her.
- _____ 14. Be certain the medication was taken (swallowed). Check client's mouth if uncertain.
- _____ 15. Leave the individual in a safe and comfortable manner.
- _____ 16. Initial in the square for the specific hour and date; this indicates you have given the medication for that time.
- _____ 17. Write your initials, full name, and title in space provided for signatures.
- _____ 18. Document any complaint/concern and action taken.
- _____ 19. Return equipment to storage area.
- _____ 20. Wash your hands before contact with another individual or further contact with this individual other than administering more oral medications.

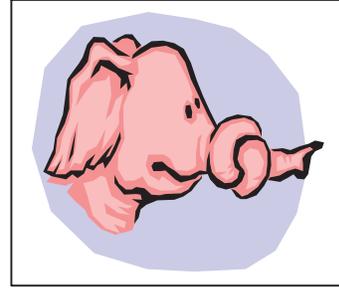


DOCUMENTATION EXAMPLE:
Sue had trouble swallowing whole vitamin. Called pharmacy. Spoke with Jim Smith, RP. He said I could split vitamin in half. Split vitamin and Sue took without difficulty.

Trainee Name: _____ **Date:** _____

_____ **Instructor initials** **Instructor Name:** _____

COMMENTS:



Eye, Ear and Nose Medications

This section includes information on the procedures for giving eye, ear and nose medications to the client . Since this section cannot include all medications clients may be prescribed, trainees are expected to ask questions about the medications used in their respective agencies.

Safety : Based on the client’s cooperation, ability to follow directions and history, the medication record will state how much assistance is needed. **If the client’s level of cooperation or condition changes, notify the prescribing health care provider for further instructions before giving or applying the medication and follow your employer’s policy and procedure.**

In the table below is presented an overview of uses of eye, ear, nose medications and inhaled medications.

	USES	Helpful Information
Eye (Ophthalmic) Medications	USES: ♥ Relieve pain ♥ Treat allergies, ♥ Treat or prevent infections ♥ Treat diseases such as glaucoma	Note: Miotic medications are used to relieve intraocular pressure or pressure within the eyeball. Relief of this pressure also reduces pain.
Ear (Otic) Medications	USES: ♥ Treat infection ♥ Relieve pain ♥ Soften wax	Note: Before instilling ear drops you need to straighten the client’s ear canal by grasping the center of the outer ear and gently pulling back and up.
Nose (Nasal) Medications	USES: ♥ Relieve pain ♥ Treat allergies ♥ Treat infections ♥ Relieve congestion	NOTE: The client can enlarge the opening to his nose by placing his index and third finger on his face just below the cheekbone at the lower edge of the opening (nares) for instillation.
Inhaled Medications	USES: ♥ Treat Asthma ♥ Treat bronchitis ♥ Treat emphysema ♥ Relieve wheezing	NOTE: Most medications come in a pressurized container called an inhaler. Other devices include discs or units that require the insertion of a capsule that is crushed and the powder in the capsule is inhaled.

Long fingernails may interfere with your ability to safely administer eye medications. Please be sure nails are trimmed to no more than a quarter inch in length. If nails peek over your finger tips when held at the level of your eyes, it is time for a trim.



Categories of Eye Medications



	Examples of Medications		Examples of Side Effects	Related Care
	Brand	Generic		
<p>Anti-Infectives (Used to treat infections of the eye)</p>	Gentacidin Tobrex Neosporin	Gentamicin Tobramycin Polysporin	<ul style="list-style-type: none"> ◀ Itching ◀ Blurred vision ◀ Hypersensitivity (increased redness watering, swelling) 	<ul style="list-style-type: none"> ◀ Observe for changes in eyes and document ◀ Avoid sharing towels and washcloths ◀ Keep hands away from eyes.
<p>Anti-Inflammatory (used to decrease swelling in or around the eye)</p>	Pred-Forte Decadron	(no generic) Dexamethosone sodium phosphate	<ul style="list-style-type: none"> ◀ Blurred vision ◀ Burning, stinging and watering of eyes upon application 	<ul style="list-style-type: none"> ◀ Not for long-term use ◀ Keep hands away from eyes ◀ Observe for changes in eyes and document
<p>Miotics (Used to treat intraocular pressure)</p>	Pilocar Isopto Carpine Timoptic	Pilocarpine Pilocarpine Timolol	<ul style="list-style-type: none"> ◀ Stinging, itching, burning and watering of eyes upon application ◀ Sweating, nausea, dizziness and weakness 	<ul style="list-style-type: none"> ◀ Warn client that vision may be blurry for a period of time after application ◀ Refrigerated liquid or gel should be brought to room temperature before giving/applying.**
<p>Lubricants (Used to relieve burning and irritation from dryness of the eye and prevent further irritation)</p>	Tears Natural II Murine Plus	Lubricant eye drops Lubricant eye drops	No known Side-effects	<ul style="list-style-type: none"> ◀ Do not touch tip of container to any surface ◀ Do not use solution if discolored or cloudy ◀ Report any eye pain, changes in vision, continued redness or irritation to nurse or employer per agency policy

**** Warm refrigerated liquid or gel by placing in your closed hand for 5-10 minutes. DO NOT put container in the microwave, hot water, or warm over the stove.**

Certification 1 Skills Checklist: Eye (Ophthalmic) :

Follow steps 1-8 on “General Checklist for Administering Oral Medications” then

- _____ 9. Identify individual to receive the medicine and explain to the individual you are giving his/her medication for that specific hour.
- _____ 10. Tell the individual the name of the medication and its purpose when you give medication to him/her.
- _____ 11. Put on gloves.
- _____ 12. If required, cleanse affected eye while closed with rayon “cotton” ball. Wipe from inner corner of eye outward once. If drops or ointment are to be instilled into both eyes, use a clean rayon “cotton” ball for each eye.
- _____ 13. Draw up the ordered amount of medication into dropper and recheck to ensure the label on medication container matches the medication record.
- _____ 14. Position the individual with the head back and looking upward.
- _____ 15. Separate lids by raising upper lid with forefinger and lower lid with thumb.
- _____ 16. Approach the eye from below with the dropper remaining outside the individual’s field of vision.
- _____ 17. Avoid contact with the eye.



Special Note: Always hold eye dropper level with the eye. Do not point the dropper toward the eye. Never let the dropper touch the eye.

IF DROPS:

- _____ 18. Apply the drop gently near the center of the inside lower lid not allowing the drop to fall more than 1 inch before it strikes the lower lid.

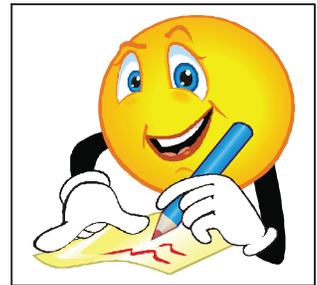
IF OINTMENT:

- _____ 18. Apply the ointment in a thin layer along inside of lower lid. Apply amount of ointment prescribed (usually about ½ inch long “ribbon” of ointment). Break off ribbon of ointment from the tube by relaxing the pressure and removing the tube. Do not use your fingers!

IF BOTH EYES INVOLVED:

- _____ 18. If both eyes involved, give the client a separate clean cotton ball for each eye. Change gloves between eyes to avoid transferring contamination from one eye to the other.

- _____ 19. To prevent contamination, do not touch the end of the bottle or the dropper on any part of the eye.
- _____ 20. Allow the eye to close gently.
- _____ 21. Instruct the individual to keep eyes closed for a few minutes.
- _____ 22. Wipe excess medication from eye with a clean rayon "cotton" ball using separate rayon "cotton" balls for each eye.
- _____ 23. Leave individual in a comfortable position for a few minutes. Follow the medication administration record regarding supervision of the individual during this time.
- _____ 24. Remove gloves; dispose of gloves and cotton balls according to facility policy.
- _____ 25. Wash hands
- _____ 26. Clean and replace equipment as specified on the medication record.
- _____ 27. Document giving the medication including:
 - a. Medication given
 - b. Number of drops installed or amount of ointment instilled
 - c. The eye(s) in which the medication was instilled
 - d. Your initials
 - e. Any unusual complaints and action taken



Note: Long fingernails may interfere with or make it difficult to apply eye medications properly. Ask trainees to check their fingernails before they give/apply medication and trim if necessary.

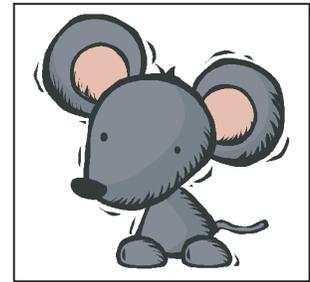
Trainee Name: _____ **Date:** _____

_____ **Instructor initials** **Instructor Name** _____

COMMENTS:

Categories of Ear Medication

Otic medications are medications for the ear. There are several uses for medications specific to the ear. An otic anti-infective medication resolves infection in the ear. Medications to cleanse the ear are used to remove wax build-up that often causes discomfort in the ear and possibly hearing loss. Other medications are used to control inflammation and edema.

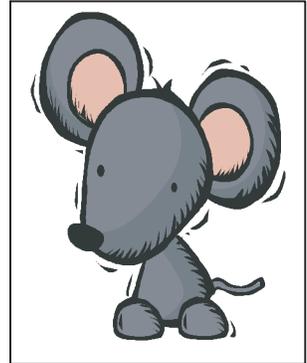


	Examples of Medications	Examples of Side Effects	Related Care
<p>Anti-Infectives</p> <p>(Used to treat infections of the ear)</p>	<p>Cortisporin Otobiotic</p>	<ul style="list-style-type: none"> ◀ Stinging ◀ Burning <p>NOTE: If a cotton ball is placed in the ear after instillation of drops, the client may have some loss of hearing in that ear.</p>	<ul style="list-style-type: none"> ◀ Observe ears for change and document. ◀ Keep hands away from ears ◀ Never place a Q-tip inside the ear canal. ◀ Use a shower cap when showering to keep water out of ears.
<p>Ear Cleansers</p> <p>(Used to dissolve and remove ear wax build-up)</p>	<p>Debrox</p>	<p>No known side-effects</p>	<ul style="list-style-type: none"> ◀ Do not use if client also has an ear infection or has ear tubes in place ◀ Keep hands away from ears
<p>Corticosteroids</p> <p>(Used to control inflammation and edema in the ear)</p>	<p>Medrol Cortame Otal</p>	<p>May mask an underlying infection</p>	<ul style="list-style-type: none"> ◀ Do not use if eardrum is draining ◀ May be used concurrently with an antibiotic

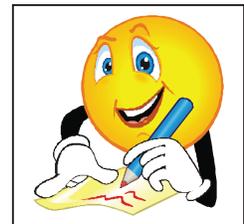
NOTE: After instilling ear drops, you may insert a loose cotton ball for up to an hour. Be sure to take it out after an hour. **However,** it is best to not insert a cotton ball at all. Have the client remain with ear to the side for several minutes before becoming active. This should eliminate any need for a cotton ball to be inserted in the ear.

Certification 1 Skills Checklist: Ear (Otic) :

Follow steps 1-8 on “General Checklist for Administering Oral Medications” then



- _____ 9. Identify individual to receive medicine and explain to the individual you are giving his / her medication for that specific hour.
- _____ 10. Tell the individual the name of the medication and its purpose when you give medication to him/her.
- _____ 11. Position the individual by having him/her lie down or sit in a chair, tilting head sideways until ear is as horizontal as possible.
- _____ 12. Put on gloves.
- _____ 13. Cleanse the entry to the ear canal with a clean cotton ball.
- _____ 14. Draw up the ordered amount of medication into dropper and recheck to ensure the label on the medication container matches the medication record.
- _____ 15. Administer the ear drops by pulling the mid-outer ear gently backward and upward then instilling the ordered number of drops.
- _____ 16. To prevent contamination, do not touch any part of the dropper to the inner ear.
- _____ 17. If ordered, may place a cotton ball loosely in the ear and allow it to remain in place for 30 – 60 minutes.
- _____ 18. Encourage the individual to stay in the original position for 2 – 3 minutes.
- _____ 19. Remove gloves; dispose of gloves and cotton balls according to facility policy.
- _____ 20. Wash Hands
- _____ 21. Clean and replace equipment
- _____ 22. Document giving the medication including:
 - a. **Medication given**
 - b. **Number of drops instilled**
 - c. **Ear in which instilled**
 - d. **Your initials**
 - e. **Any unusual complaints**
And action taken

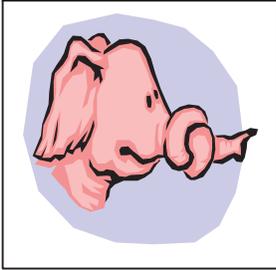


Trainee Name: _____ **Date:** _____

_____ **Instructor initials** **Instructor Name:** _____

COMMENTS:

Categories of Nose Medications



Normally the nose is not a sterile cavity, but because the nose is connected to the sinuses, which can become infected easily, utmost caution must be used when instilling medication into the nares (nostrils).

Besides serving as the olfactory (smell) organ, the nose also functions as an airway to the lower respiratory tract and protects the tract by cleansing and warming air that is taken in by breathing.

	Examples of Medications	Examples of Side Effects	Related Care
<p>Anti-Inflammatories and Decongestants</p> <p>(Used to clear nasal passages)</p>	<p>Flonase</p> <p>Nasonex/Isfedrol</p> <p>Veramist</p>	<ul style="list-style-type: none"> ◀ Dry, irritated throat ◀ Abnormal sense of taste ◀ Nasal burning or bleeding 	<ul style="list-style-type: none"> ◀ Discourage prolonged use ◀ Store at room Temperature ◀ Do not exceed recommended dose

NOTE: If the client develops a nose bleed, have him / her lean forward and pinch the end of the nose firmly. Place a towel on the lap and provide an emesis basin to catch any blood. Place a cooled washcloth or ice pack in the back of the neck. If bleeding does not stop within the time frame specified by your health care provider, call the delegating nurse or supervisor per your agency's policy.

NOTE: In low humidity environments (house during the winter), use a humidifier to keep air moist to prevent nasal passages from drying out.

NOTE: Have client use disposable tissues rather than cloth handkerchiefs to blow his nose and instruct the client to wash his / her hands after blowing his nose.

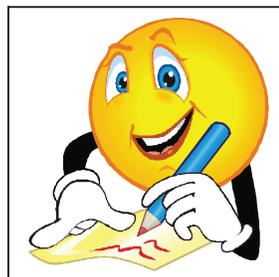
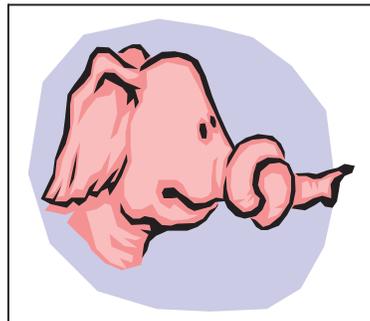
NOTE: There are now expanding uses for medications applied nasally (ie, insulin, flu remedies, etc.)

PRECAUTION: If drops are used in the nose, be certain the dropper bottle is labeled for nose drops and follow the instructions.

Certification 1 Skills Checklist: Nose (Nasal) :

Follow steps 1-8 on “General Checklist for Administering Oral Medications” then

- _____ 9. Identify client to receive the medicine and explain to the individual you are giving his/her medication for that specific hour.
- _____ 10. Provide tissues for the individual.
- _____ 11. Tell the client the name of the medication and its purpose when you give medication to him/her.
- _____ 12. Position the client according to manufacturer’s instructions.
- _____ 13. Put on gloves.
- _____ 14. Recheck to ensure the label on medication container matches the medication record.
- _____ 15. Instill medication per manufacturer’s instructions
- _____ 16. Instruct the individual not to blow his / her nose for at least 15 minutes after instilling medication.
- _____ 17. Leave the individual in a comfortable position for a few minutes. Follow the medication record regarding supervision during this time.
- _____ 18. Remove gloves and dispose of them according to facility policy.
- _____ 19. Wash hands.
- _____ 20. Clean and replace equipment as specified on the medication record.
- _____ 21. Document giving the medication including:
 - a. Medication given
 - b. Number of drops installed
 - c. The nares in which the medication was instilled
 - d. Your initials
 - e. Any unusual complaints and action taken

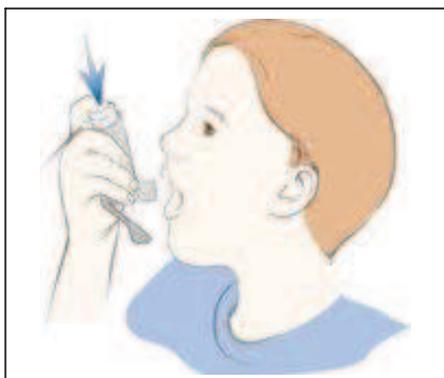


Trainee Name: _____ **Date:** _____

_____ **Instructor initials** **Instructor Name** _____

COMMENTS:

Categories of Inhaled Medications

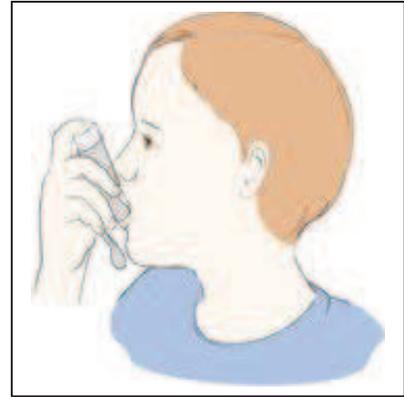


Inhalation is the act of breathing in and out. Inhaled medications are medications that are taken into the body through the nose or lungs. They are also called pulmonary medications. Some inhaled medications are prescribed as “rescue” medications medication for sudden wheezing or shortness of breath and some are used routinely to prevent the the occurrences of distressing respiratory symptoms.

	Examples of Medications	Examples of Side Effects	Related Care
<p>Bronchodialators (Used to relax airway muscles making breathing easier; given by nebulizer or inhaler)</p>	<p>Alupent Proventil Atrovent</p>	<ul style="list-style-type: none"> ◀ Tremors ◀ Agitation ◀ Faintness ◀ Hyperactivity ◀ Increased pulse ◀ Bad taste in mouth ◀ Nausea, vomiting 	<ul style="list-style-type: none"> ◀ Observe breathing and secretions ◀ Do not share a nebulizer or an inhaler ◀ Rinse mouth after use ◀ Clean inhaler after Use
<p>Steroids (Maintenance treatment for breathing problems associated with chronic obstructive pulmonary disease [COPD]. COPD includes both chronic bronchitis and emphysema.)</p>	<p>Advair® Aerobid® Azmacort® Flovent® Pulmicort Respules® Pulmicort Turbuhaler®</p>	<ul style="list-style-type: none"> ◀ Dry mouth ◀ Constipation ◀ Difficulty passing urine ◀ Thrush in the mouth 	<ul style="list-style-type: none"> ◀ Observe breathing and secretions ◀ Use a disc with a fine powder that is inhaled or a handi-haler that a capsule is inserted into and crushed ◀ Rinse mouth or brush teeth after use
<p>Nebulizer (Used when a larger amount of medication is needed. Requires the use of a breathing machine.)</p>	<p>Atrovent Proventil</p>	<ul style="list-style-type: none"> ◀ Tremors ◀ Agitation ◀ Faintness ◀ Hyperactivity ◀ Increased pulse ◀ Bad taste in mouth ◀ Nausea, vomiting 	<p>The medication comes in a liquid form and is measured into a container. A medicated mist is inhaled as air passes through the liquid medication. The medication is delivered through a mask or a mouthpiece.</p>

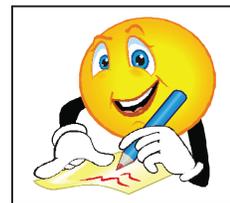
Certification 1 Skills Checklist: *Administering Inhalers*

Follow steps 1-8 on “General Checklist for Administering Oral Medications” then



- _____ 9. Check equipment and clean if dirty.
- _____ 10. Wash hands and put on gloves
- _____ 11. Identify client to receive the medicine and explain you are giving his / her medication for that specific hour.
- _____ 12. Assist client to a comfortable sitting position.

- _____ 13. Tell client the name of the medication and its purpose when you give the medication to him.
- _____ 14. Give client tissues
- _____ 15. Insert metal canister into end of mouthpiece and remove protective cap.
- _____ 16. Invert canister and shake thoroughly.
- _____ 17. With mouthpiece pointing into the air, away from everyone, press once on upended canister base to ensure canister contains medication and is operating properly.
- _____ 18. Have client enclose mouthpiece with their lips while holding canister vertically.
- _____ 19. Have client exhale deeply, then slowly inhale through the mouth while pressing firmly on the upended canister.
- _____ 20. Have client hold his/her breath for a few seconds, then remove mouthpiece and ask client to exhale slowly. If more than 1 puff is ordered, repeat steps 15-20 for subsequent puffs.
- _____ 21. If a **second inhaler (a 2nd medication given per inhaler)** is ordered, wait at least 5 minutes before administering the 2nd inhaled medication and repeat steps 14-20.
- _____ 22. Replace protective cap and have client rinse mouth with water and spit into an emesis basin.
- _____ 23. Leave client in a comfortable position following observation of the results.
- _____ 24. Remove and dispose of gloves properly and wash hands.
- _____ 25. Cleanse and replace equipment as specified on the MAR
- _____ 26. Document medication(s) given including:
 - ✓ Name of medication
 - ✓ Your initials
 - ✓ Number of inhalations given
 - ✓ Note any complaints / any action taken



Trainee Name: _____ **Date:** _____

_____ **Instructor initials** **Instructor Name:** _____

COMMENTS:

Certification 1 Skills Checklist: *Nebulizer Treatment* :

Follow steps 1-8 on “General Checklist for Administering Oral Medications” then

- _____ 9. Put on gloves
- _____ 10. Identify the individual and provide tissues to the individual
- _____ 11. Check equipment. Clean if dirty (if you clean equipment, rewash hands and apply clean gloves)
- _____ 12. Explain the procedure to the individual and assist them to a sitting position
- _____ 13. Take and record pulse and respiration as ordered by the physician before beginning treatment. If these vital signs are not within the acceptable range, follow the instructions of the delegating nurse, physician, or your agency’s policies and procedures.
- _____ 14. If vital signs are not within limits prescribed, follow protocol from physician orders.
- _____ 15. Connect nebulizer to power source (i.e. oxygen or compressed air as ordered by the physician).
- _____ 16. Add medication to the nebulizer medication administration container per the MAR
- _____ 17. Place in the individual’s mouth having them use their lips to form a tight seal on the mouthpiece. (If the client uses a mask instead of a mouth piece, be sure the mask fits well).
- _____ 18. Turn the machine on. Adjust flow of oxygen as ordered. Encourage the client to breathe deeply; the medication works better with deep inhalations
- _____ 19. Follow physician’s or nurse’s instructions re taking and documenting the individual’s pulse and respirations.
- _____ 20. If appropriate, continue the treatment until all medication is given, usually 10-15 minutes.
- _____ 21. Per physician orders, record the individual’s pulse and respirations at the end of the treatment and document the effects of the treatment.
- _____ 22. Remove gloves and dispose of them appropriately according to the facility’s policy.
- _____ 23. Wash hands, then clean and replace equipment as specified.
- _____ 24. Document giving the medication including each of the 6 rights, pulse and respirations at the end of the treatment, any complaints and any action taken.



Trainee Name: _____ **Date:** _____

_____ **Instructor initials** **Instructor Name:** _____

COMMENTS:



Transdermal Medications

Transdermal medications are a type of topical medication. Transdermal medications are in sticky “patches” that are applied on the skin for a period of time and changed as ordered. Transdermal patches are used for a variety of reasons (ie. birth control, pain, heart problems, etc.).

If a transdermal patch is ordered for the client, you must follow the same procedure for preparing this medication as with any other medication you administer. Transdermally applied medications are just as potent / strong as medications ordered by other routes.

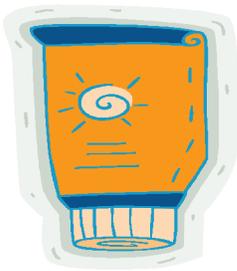
Special Instructions:

- ♣ Be sure to wear gloves.
- ♣ If the client is wearing a transdermal patch have him or her remove the patch if able. If not, carefully remove the patch, so as not to tear the skin covered by the patch and place the old patch in a plastic bag for disposal.
- ♣ Clean and dry the skin from where the old patch was removed.
- ♣ Select another site as directed for the new patch to be applied. Be sure the new site is clean and dry before applying the new patch.
- ♣ Be sure to reapply daily transdermal medications at the same time every day to ensure a continuous delivery of medication.
- ♣ Be sure to alternate sites as directed to prevent skin irritation.
- ♣ Always check with the assigned nurse or other health care professional before giving cough preparations. Cough preparations, as with any over the counter preparation or medication, can reduce the effects of other medications the client may be taking.
- ♣ Be sure to observe the client for such side effects as skin irritation, rash, dizziness, headache, or drowsiness or any other side effect as directed.
- ♣ Do not apply a transdermal patch over scars, calluses, folds or wrinkles in the skin, or irritated skin.
- ♣ If the adhesive strip falls off before it is due to be replaced, notify the appropriate health care professional or supervisor for instructions.
- ♣ If the client is able, have the client wash his / her hands and apply own transdermal patch.

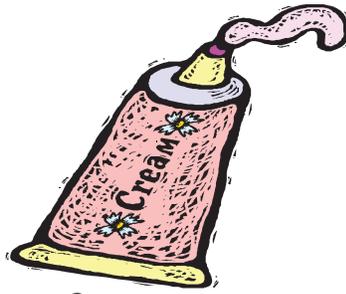
Topical, Rectal and Vaginal Medications

These medications may be used to treat skin conditions, provide relief when the individual cannot keep down oral medications due to vomiting or nausea, and treat vaginal diseases.

	USES	Helpful Information
<p>Topical Medications</p> <p>(Applied to the skin or mucous membranes)</p>	<p>USES: ♥ Relieve pain, burning, itching</p> <ul style="list-style-type: none"> ♥ Treat fungus and parasite infestations ♥ Treat or prevent infections ♥ Treat inflammation 	<p>Change bed sheets often</p> <p>Keep areas covered to protect affected areas and furniture</p> <p>Store in cool (not cold) location to maintain integrity of the Cream / lotion / ointment</p> <p>No sharing of towels and washcloths</p>
<p>Rectal Medications</p> <p>(Inserted into the rectum)</p> <p>Used when person cannot swallow</p>	<p>USES: ♥ Lower fever</p> <ul style="list-style-type: none"> ♥ Relieve pain ♥ Stimulate bowel movement ♥ Relieve nausea and vomiting ♥ Hemorrhoids ♥ Seizures 	<p>Have client lay on left side if possible when inserting suppository</p> <p>Place a pad under client to protect bed</p> <p>Be sure to lubricate suppository and/or applicator</p> <p>Encourage client to retain suppository for at least 20 minutes before expelling if suppository for bowel movement</p> <p>If suppository for pain, instruct client to call for assistance before getting out of bed</p> <p>Store as directed by pharmacist or packaging label.</p>
<p>Vaginal Medications</p> <p>(Inserted into vagina)</p>	<p>USES: ♥ Relieve pain</p> <ul style="list-style-type: none"> ♥ Treat infections ♥ Birth control 	<p>Have client empty bladder before inserting vaginal medication</p> <p>Have client remove clothing from waist down</p> <p>Place protective pad on bed</p> <p>Have client remain in supine position (on her back) in bed for at least 30 minutes after insertion of medication.</p>



Lotions



Creams



Ointments

Categories of Topical Medications

	Examples of Medications	Examples of Side Effects	Related Care
<p>Anti-Infective</p> <p>Used to treat infections on the skin and mucous membranes</p>	<p>Bactin</p> <p>Neosporin</p> <p>Bactroban</p>	<ul style="list-style-type: none"> ◀ Temporary dryness in affected areas ◀ Allergic reaction can occur after application ◀ Allergic reaction may look like symptoms of the original problem area 	<p>Cleanse area as instructed in individual specific training</p>
<p>Anti-fungal</p>	<p>Mycostatin</p> <p>Fungisone</p> <p>Lotrimin</p>	<p>See above</p>	<p>See above</p>
<p>Anti-Inflammatory</p> <p>(Used to treat local swelling)</p>	<p>Cortaid</p> <p>NSAIDs</p> <p>Naprosyn</p>	<p>See above</p>	<p>See Above</p>
<p>Parasite Topical</p> <p>Used to treat pinworm, head lice, And scabies</p>	<p>Nix Cream Rinse</p> <p>Kwell Cream, lotion, or shampoo</p>	<p>See above</p> <p>Skin irritation occurs with repeated use</p>	<ul style="list-style-type: none"> ◀ Check other clients for possible infestation ◀ Measure medication sparingly ◀ Clean any adaptive equipment used by client <p>See below for more information</p>

Related Care: Parasite Infestation

- ◀ All clothing and bed linen should be laundered according to detergent directions after an application of medication is applied to the client.
- ◀ Use fine tooth comb to remove nits after application

Certification 1 Skills Checklist: Topical Medications

Follow steps 1-8 on “General Checklist for Administering Oral Medications” then



- ___ 9. Identify the client
- ___ 10. Explain the procedure to the client and provide privacy as needed
- ___ 11. Position the client according to directions
- ___ 12. Wash hands and put on disposable gloves
- ___ 13. Examine the affected area and if ordered, cleanse the area with soap and water, then dry thoroughly.
- ___ 14. Apply medication according to directions
- ___ 15. Leave the client in a comfortable position and supervise as indicated
- ___ 16. Remove gloves and dispose of gloves and other materials as instructed
- ___ 17. Wash hands
- ___ 18. **Document:**
 - ✓ Medication applied
 - ✓ Dosage or amount
 - ✓ Areas of body to which applied
 - ✓ Your initials
 - ✓ Unusual complaints and action taken
 - ✓ Results of medication application after prescribed length of time



Trainee Name: _____ **Date:** _____

___ Instructor initials Instructor Name _____

COMMENTS:



Rectal Medications

	Examples of Medications	Examples of Side Effects	Related Care
<p style="text-align: center;">Antiemetic</p> <p style="text-align: center;">Used to relieve nausea and vomiting</p>	<p>Phenergan Tigan Compazine</p>	<ul style="list-style-type: none"> ◀ Sedation ◀ Dizziness ◀ Blurred vision ◀ Dry mouth 	<ul style="list-style-type: none"> ◀ Do not drink alcoholic beverages ◀ Do not drive – coordination may be impaired ◀ Cover exposed skin areas when outside in the sun
<p style="text-align: center;">Analgesic / Anodyne</p> <p style="text-align: center;">Used to relieve pain</p>	<p>Aspirin Motrin Tylenol</p>	<ul style="list-style-type: none"> ◀ Tinnitus (ringing in the ears) ◀ GI upset, nausea, vomiting, diarrhea 	<p>Check with physician if client on anticoagulants such as Coumadin</p>
<p style="text-align: center;">Antipyretic</p> <p style="text-align: center;">Used to reduce elevated body temperature</p>	<p>Aspirin Motrin / Advil Tylenol</p>	<ul style="list-style-type: none"> ◀ Tinnitus (ringing in the ears) ◀ GI upset, nausea, vomiting, diarrhea 	<ul style="list-style-type: none"> ◀ Encourage rest ◀ These medications must be ordered by an individual with prescriptive authority and documented on the MAR
<p style="text-align: center;">Laxative</p> <p style="text-align: center;">Used to relieve chronic constipation by stimulating intestinal action, softening the waste products</p>	<p>Glycerine Dulcolax Fleets</p>	<p>Nausea and vomiting</p> <p>Abdominal cramps</p>	<ul style="list-style-type: none"> ◀ Do not give at meal time ◀ Discourage frequent or prolonged use ◀ Encourage fluids and fiber intake of at least 25 grams per day
<p style="text-align: center;">Hemorrhoidal</p> <p style="text-align: center;">Relieve burning, itching from hemorrhoids</p>	<p>Preparation H Proctofoam</p>		<ul style="list-style-type: none"> ◀ Keep rectal area clean ◀ Carry disposable wet wipes to use when away from home ◀ May need to wear a pad to protect clothing

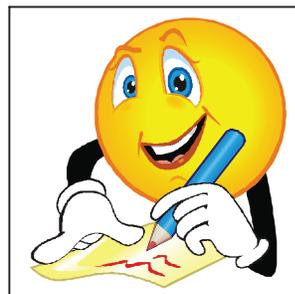
NOTE: Any over the counter drug given to a client MUST be ordered by a physician and documented on the MAR

Certification 1 Skills Checklist: Rectal Suppositories

Follow steps 1-8 on “General Checklist for Administering Oral Medications” then



- _____ 9. Identify the client
- _____ 10. Explain the procedure to the client and provide privacy as needed
- _____ 11. Position the client according to directions – left side unless contraindicated
- _____ 12. Wash hands and put on disposable gloves, gather Kleenex or toilet paper
- _____ 13. Unwrap suppository and lubricate the tip
- _____ 14. Lift upper buttock to expose rectal area
- _____ 15. Slowly insert suppository into rectum well beyond the muscle at the opening (sphincter), pushing gently with your gloved, lubricated forefinger
- _____ 16. After slowly withdrawing your finger, press a folded tissue or piece of toilet paper against the anus or hold the buttocks together until the urge to expel the suppository subsides.
- _____ 17. Leave the client in a comfortable position lying down for about 15 minutes providing supervision as indicated on the MAR
- _____ 18. Remove gloves and dispose of gloves and other materials according to agency policies.
- _____ 19. Wash hands.
- _____ 20. **Document:**
 - ✓ Medication inserted
 - ✓ Dosage or amount
 - ✓ Your initials
 - ✓ Any complaints and action taken
 - ✓ Results achieved by giving the medication after the prescribed length of time

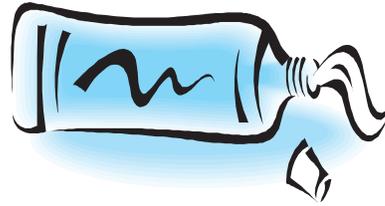
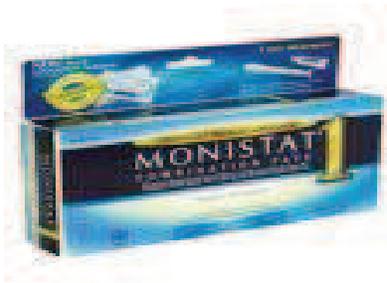


Trainee Name: _____ **Date:** _____

_____ Instructor initials Instructor Name _____

COMMENTS:

Vaginal Medications



Vaginal medications are given for birth control, infection, and inflammation. They come in the form of suppositories, creams, gels, ointments, and douches. When administering a medication vaginally, it is important to provide privacy and gain the cooperation of the client who may need to remain still for as long as 30 minutes after instillation of the medication.

	Examples of Medications	Examples of Side Effects	Related Care
<p>Infection: Anti-fungal</p> <p>Used to treat infections of the vaginal walls (internal mucous membranes)</p>	<p>Gyne-Iotrimin Monistat 7</p>	<p>Burning, itching, stinging</p>	<p>Provide pads to prevent staining of clothing</p> <p>May need to remain in their back or side for as long as 30 minutes after installation. Be sure bladder emptied before instillation of medication</p> <p>Place protective pad on bed or provide client with a peripad while she is waiting to get up</p>
<p>Infection: Anti-infective</p> <p>Used to treat infections of the vaginal walls (internal mucous membranes)</p>	<p>Mycostatin Terazol 7</p>	<p>Burning, itching stinging</p>	<p>See above</p>
<p>Lubricant</p> <p>Used to moisten dry mucous membranes</p>	<p>K—Y Jelly Estrogen Cream</p>		<p>Human sexuality training</p> <p>Teach proper care and disposal of any equipment used</p>

Certification 1 Skills Checklist: Vaginal Mediations

Follow steps 1-8 on “General Checklist for Administering Oral Medications” then



- ___ 9. Identify the client
- ___ 10. Explain the procedure to the client and ask her to empty her bladder and remove clothing from waist down.
- ___ 11. Provide privacy and position client on her back with knees bent and legs separated unless contraindicated or another position is recommended by the client's physician or nurse
- ___ 12. Place towel or protective pad under the client's buttocks
- ___ 13. Wash hands and put on disposable gloves
- ___ 14. Place medication in applicator. Lubricate as directed on MAR if instilling a tablet or suppository.
- ___ 15. Spread labia with one hand and gently insert applicator or medication into the vagina with other hand. Angle applicator slightly downward toward tail bone. It will usually go in about 2 inches. **DO NOT FORCE.**
- ___ 16. If using an applicator, push the plunger in while holding the barrel of the applicator still.
- ___ 17. Remove applicator and instruct client to remain still for 30 minutes. Provide supervision as needed.
- ___ 18. Provide with peri pad if needed after 30 minutes.
- ___ 19. Remove gloves and dispose of gloves and other materials according to agency policies. Wash hands
- ___ 21. **Document:**
 - ✓ Medication inserted
 - ✓ Dosage or amount
 - ✓ Your initials
 - ✓ Any complaints and action taken
 - ✓ Results achieved by giving the medication after the prescribed length of time



Trainee Name: _____ **Date:** _____

___ Instructor initials Instructor Name _____

COMMENTS:

Self Medication / Self-Medication With Assistance

Self - Medication

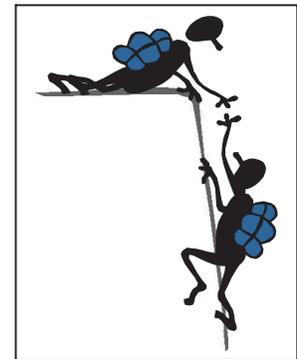


Each individual has the right, if capable, to self-medicate or self-medicate with assistance. A self-medication assessment should be completed as mentioned in OAC 5123:2-6-02. The self-medication assessment should be completed prior to the completion of the service plan. The result should be included as part of that plan.

Self - Medication with Assistance

When assessing the client. It is important to be sure that the client is proficient in manipulation of the delivery mode (bottle vs blister pack) and able to take the medicine in the way it is to be taken (swallowed whole vs split in half or crushed).

It is entirely possible for the client to be proficient in the use of one delivery mode, but not another. We cannot assume that the client's skill to self medicate automatically transfers across modes of delivery or ways of taking the medication.



Each time the medication delivery mode changes or the manner in which the medication is taken changes, the client must be reassessed to be sure he or she can correctly self-administer. **Examples of changes can include, but are not limited to:**

- ◆ Going from a container with a lid to a blister pack or vice versa
- ◆ Going from a solid to be swallowed to a liquid to be measured or vice versa
- ◆ Going from a solid to be swallowed to a solid to be dissolved in the mouth
- ◆ Going from a tablet to be swallowed to a medicine that must be injected
- ◆ Going from a whole pill to a half pill
- ◆ Going from a whole pill to crushing the pill and mixing in water or applesauce
- ◆ Going from taking the med with food to taking 1 hour before or 2 hrs after eating

A Self Administration Tool is found on page 87. This tool is easy to use and directions are found on the page immediately after the tool. This tool is used to assess the client's ability to self medicate with or without assistance. It is not meant to be used with the ODDP which is used for funding purposes.

Introduction to Completion of Self-Administration Assessment

The purpose of the Self-Administration Assessment is to ensure that the client is able to **SAFELY** accomplish medication administration and health-related activities. Every client with developmental disabilities (DD) has the right to self-administer their medications. The CB and the service provider are responsible for the safety of the individual with DD.

When it is determined a Self – Administration Assessment is needed:

Consider the client's safety. If on occasion the client cannot safely self administer medications (e.g. ◀ client experiences an episode of mental illness, ◀ client becomes physically ill, ◀ client goes to a new environment and cannot transfer skills to the new environment right away), **certified** staff will need to provide assistance or medicate the client during those times. When the client is able, he or she can self medicate as indicated in the ISP.

The self administration assessment needs to be completed at a minimum of every 3 years, with a review done annually. A new assessment will be completed in the event of (but not limited to) the following occurrences:

- The needs of the individual changes
- The medication packaging changes (ie. bubble pack to bottle; pill to liquid, etc)
- There is a change in the usual medication routine (new location, new provider)

Where to complete the assessment

Complete the assessment in the setting where the client takes his / her medications or receives medication administration. This is to determine if the client is able to safely take their medications in their own environment.

Using the form

Answer each question on the form. Questions are answered with a "Yes" or "No." Follow the instructions on the form to determine where to go following a "Yes" or "No" response.

Processing the Assessment results

Once the assessment is completed, the Individual's Service Plan should specify how medication administration will be done. See the form for statements that could be used. Check the appropriate statements to include in the ISP.

Other

Remember, clients have the right to do as many steps of the medication administration as that can do either independently or with support, even if they are not assessed to be able to self-administer with or without assistance (5123: 2-6-02 (C)).

Medication(s) assessed at this time:

Attach another page if there is not enough space on the form to record meds or attach a copy of the MAR. Multiple Self-Administration Assessments may be used for an individual.

For example, if a client requires certified staff assistance due to multiple medications at 8am but can self – administer 1 medication at 12N, or can use the glucometer, separate Self –Administration forms must be used and should be included in the ISP.

Reviewed by (May be other than those completing Self Administration Assessment Form):

- ◆ If the client has a SSA, the SSA should review the results and make the applicable indications on the IP.
- ◆ If nursing delegation is used, the nurse should view and sign the assessment. If a nurse is not available, Indicate with N/A. Nursing delegation may not be needed in all situations.
- ◆ The Med Administration course is a training for DD personnel and does not constitute authorization, or delegation from the RN teaching the course.

If two people do not agree with the assessment, a third party should be consulted. If an agreement cannot be determined, the DODD representative should be consulted.

Rev 9-29-08

Self – Administration Assessment

(p1 of2)

Name of Individual: _____
 Signature and Title of Person Observing Assessment (2 required). Form should be completed by the provider that best knows the individual and a County Board Employee or representative.

_____ Date: _____ Time: _____

_____ Date: _____ Time: _____

Persons conducting assessment will need to have ALL necessary information regarding the individual's current medications including medicine name(s), dose(s), route(s), time(s), reason for medication(s), and basic side effects. See reverse side for additional documentation.

1. I can recognize my medication by color, size, shape and/or by reading the label. I will not take my medicine if it looks different.

YES Go to 2. NO Go to 

2. I can tell you what my medicine is for (pain, nerves, breathing).

YES Go to 3. NO Go to 

3. I know and recognize how much medicine I'm to take (1/2 pill, the cup filled to this line). I will not take my medicine if it is the wrong amount.

YES Go to 4. NO Go to 

4. I will recognize and know who to tell if I don't feel good (pain, nausea, dizzy). It may be a side effect.

YES Go to 5. NO Go to 

5. I know who to tell when I have 3-4 days of medicine left so I never run out.

YES Go to 6. NO Go to 

6. I know who to call if my medicine is wrong and will tell him/her right away.

YES Go to 7. NO Go to 

7. I take my medicine at the right time every day by using the clock or my routine (after the news, before lunch, etc).

YES Go to 8. NO Go to 

8. I can get medication to and from storage, out of the container and to my mouth without spills.

YES  and NOTE NO Go to  & NOTE



Unable to Self Administer With or Without Assistance

Will Require Medication Administration Certified Staff to Administer Medication
 Continue to next assessment question.
 Complete this form in its entirety.



Self Administer With Assistance
Service Plan to Include Time Reminder

Continue To 8



Self Administer With Assistance
Service Plan to Include Assist with Removal from Storage Removal from Container And/or To my mouth



Self - Administer Without Assistance
 (answered YES to all 8 questions)

NOTE:
 Reasons this form shall be completed again in its entirety include but are not limited to:

- ◀ Client moves
- ◀ Medication Packaging changes
- ◀ Client has change in health status
- ◀ Client exhibits changes in behaviors

Once the assessment is completed, the service plan for the individual should specify how medication administration will be done. Any of the following statements could be used in their service plan depending on what is correct for each specific person.

- I can self-administer medication(s) without assistance.
- I can self-administer medication(s) with assistance (select one of the following related to the assistance).
 - The individual receives assistance with self-administration of medication(s) through reminders of when to take the medication(s). Specify reminders needed in the client's ISP.
 - The individual receives assistance with self-administration of medication(s) through physically handing the medication container to client. Provide specific instructions in the client's ISP.
 - The individual is physically impaired and the provider may open the medication container for the individual to assist with self-administration of medication. Place specific instructions in the ISP.
 - The individual is physically impaired and the provider physically assists them with opening the medication container and getting the medication to their mouth to prevent spilling, therefore, assisting with self-administration of medication. Place specific instructions on the client's ISP

Other:

- I need certified staff to administer my medication. Use this if answer to any question leads you to the top box on the right side of this form. If any question, #1-6 is answered "no" use this answer.
- I require certified staff to administer my medications while I am learning to self-medicate. IP Team should consider Skill Development programs as appropriate. Use this answer if the client cannot consistently self-medicate. A specific plan should be written with goals and time frames. See 5123:2-6-02 (C).
- I can self-administer specific medication or task (ie. Inhaler, nebulizer, sublingual, etc.)
 - Describe medication and/or task _____
 - Ability Level with task _____
 - Designate if independence or staff administration of a task/ medication is applicable to a specific location or time of day (ie. Work setting) _____
- I have demonstrated unsafe behaviors and am therefore unable to self-administer medication with or without assistance. Identify behavior / justification.

If the client has a history of unreliability or noncompliance the person doing the assessment may indicate that the client requires med administration for his / her own safety.

RESULT:

- Self Administration with assistance
- Self Administration

Medication Administration/ Delegated Nursing (DN)

- I live in a 5 bed or less setting and will receive my medication from staff that have a level one certification for medication
- (or)**
- I will receive DN services per the state DN rules

Medication(s) assessed at this time: (Attach another page if more space needed – or copy of MAR)

Medication Name	Dose	Route
_____	_____	_____
_____	_____	_____

Reviewed by:

SERVICE SUPPORT ADMINISTRATOR / COORDINATOR (signature & date): _____

NURSE (signature & date): _____

Overview of Health-Related Activities

In some settings, the certified personnel will be performing health-related activities under nurse delegation and in other settings they will provide these services while being supervised by whomever normally supervises them without the oversight of delegated nursing. Refer to the chart on page 10 in of the manual for further details.

According to the guidelines established under OAC 4723-13, the health related activities should be taught by the nurse. After initially teaching the health-related activities, the nurse must refer to OAC 5123:2-6-03. Guidelines related to these activities are further established within that rule.

Health-Related Activities Include:

- ♥ Taking vital signs (TPR and BP)
- ♥ Application of clean dressings not requiring health assessment
- ♥ Basic measure of bodily intake and output
- ♥ Oral suctioning
- ♥ Use of a glucometer
- ♥ External urinary catheter care
- ♥ Emptying and replacing colostomy bag
- ♥ Collection of specimens by noninvasive means

Taking the Pulse (P)

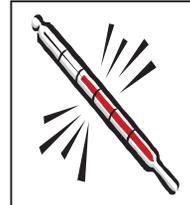
(No disposable gloves needed)

- ♥ Radial pulse located on thumb side of wrist where wrist bends.
- ♥ Place index and 3rd finger on this location and you will feel the pulse
- ♥ Count pulse for at least 1 full minute
Note if pulse is strong /weak, regular / irregular. Document
- ♥ Normal pulse range is 60-100. Report any pulse outside this range to the nurse or supervisor or per agency policy. Document.
- ♥ Never use your thumb to take a pulse. Your thumb has a pulse and you will be feeling your own pulse, not the client's

Taking the Temperature (T)

(Wear disposable gloves)

- ♥ If using a digital device:
 - ♣ Turn on device
 - ♣ Insert under tongue if oral.
 - ♣ Remove when beeps
 - ♣ Insert in armpit if axillary. Remove when beeps
- ♥ If using other device, follow manufacturer's Instructions.
- ♥ Do not let client smoke, eat, or drink for at least 10 minutes before taking an oral temp. These activities alter the temp of the mouth and you will get an inaccurate body temperature reading.
- ♥ Document type of device used to take the temp.
- ♥ Do not use a mercury thermometer
- ♥ Normal range is between 97 and 99.8 degrees Fahrenheit. Report any reading outside this range or range specified for this client per your agency policy and document.



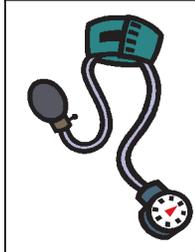
Counting Respirations (R)

(No disposable gloves needed)

- ♥ A single respiration consists of a rise and fall of the chest.
- ♥ Count respirations immediately after taking the pulse. Keep your fingers on the wrist while you count respirations. Do not tell client you are counting respirations. Just count them.
- ♥ Respirations should be slow and easy and should range between 12-20 per minute. Notify nurse, supervisor or per agency policy if respirations fall outside this range. Document.
- ♥ If client in respiratory distress, call 911 immediately or follow the instructions provided by the nurse or supervisor or your agency's policy.

Taking the Blood Pressure (BP)

- ♥ Use an automated device and follow manufacturer's instructions. Document reading when finished.
- ♥ Have client sit quietly for at least 5 minutes before taking the BP.
- ♥ Do not allow client to cross legs while BP taken, Crossed legs increase the BP
- ♥ Do not allow client to sing, hum, talk or make any sounds while BP is being taken. These activities alter the BP.
- ♥ Be sure to use the proper BP cuff size. Measure the upper arm half way between the elbow and the shoulder and follow manufacturer's instructions for proper cuff size.
- ♥ Apply cuff snugly to upper arm at least 1 inch above the elbow.
- ♥ Be sure tubes are on the bottom of the cuff and over the brachial artery which is located on the inside of the upper arm just above bend in the arm (palm facing up).
- ♥ Normal BP range is generally between 90/60 and 140 / 90. Follow nurse's or physician's or agency's policy for reporting BP outside this range.
- ♥ Check medical record for any instructions pertaining to your client's BP.



Application of Clean Dressing

- ♥ You may be asked to change a dressing covering a surface wound. In most cases, the dressing is used to protect the wound and to keep it clean.
- ♥ Even if the wound is scabbed over, you will need to wear gloves. The dressing protects the scab from getting dislodged.
- ♥ If the wound is draining, wear disposable gloves and discard old dressing as instructed by nurse, supervisor, or agency policy.
- ♥ Document per instructions from nurse, supervisor, or agency policy.

Measuring Intake and Output (I & O)

- ♥ I&O is measured to monitor the ratio of fluid a person takes in and the fluid the person puts out to assure an appropriate ratio is being maintained.
- ♥ Measure any fluid the person takes in as well as any food item that turns to liquid at room temperature such as Jell-O or ice cream.
- ♥ Output is any fluid that passes out of the body, including urine, liquid stool, vomit, blood loss, or drainage from a wound.
- ♥ I and O is measured in either CCs or ounces.
- ♥ See appendix p. 109 and for example of a form for recording Intake only and p. 110 for an example of a form for recording I & O.

Oral Suctioning

- ♥ Person's who cannot handle the amount of secretions in their mouth, may need to be suctioned. A small plastic suction catheter (Yankauer) is placed in the mouth to remove secretions and prevent choking and aspiration.
- ♥ Never suction for longer than 15 seconds. If any bleeding is noted during suctioning or the person has trouble breathing during suctioning, call the healthcare provider immediately or follow your agency's protocol.

Appropriate Sharps Container

An appropriate sharps container must be:

- ◀ Puncture proof
- ◀ Not easily broken
- ◀ Leak proof
- ◀ Have a lid

Examples of appropriate sharps containers:

- ◀ Metal coffee can with a lid
- ◀ Hard plastic container with a lid

Unacceptable sharps containers:

- ◀ Glass jars
- ◀ Soft plastic containers (milk, soda, water)

You must seal and discard sharps container when it is no more than 75% full.

External Urinary Catheter Care

- ◆ Internal (indwelling) catheters in the urinary bladder must be inserted and removed by a nurse or doctor. This is because a sterile procedure must be followed to avoid transmission of bacteria into the bladder.
- ◆ The tubing that exits the body as well as the exit site must be cared for and cleaned to prevent infection and the transmission of bacteria into the urinary tract and bladder.
- ◆ Application of an external (condom) catheter may be done by any person trained to do so.
- ◆ External catheters must be periodically removed so that the penis can be properly cleaned to prevent skin breakdown and infection.
- ◆ Both condom and indwelling catheters are attached to drainage bags that must be emptied at specified times.
- ◆ MR/DD personnel should never detach the catheter tube from the tubing that goes into the collection bag. To do so could result in the introduction of bacteria into the system.
- ◆ If the tube from the bladder and the tube leading to the collection bag accidentally become detached, follow the protocol established by the nurse or agency policy for re-attaching the two tubes.

Use of Glucometer



- ◆ For clients who are diabetic, there may be a need to monitor their blood sugar in order to adjust their diet or medications.
- ◆ Follow instructions provided by the manufacturer for proper use and care of the glucometer and lancets used by the client.
- ◆ Follow instructions provided by the nurse, supervisor, medication record or agency policy for reporting glucometer readings outside the parameters specified for the client and the actions to take if the reading is not within the specified range for that client.
- ◆ If using the finger as a collection site, be sure to apply the lancet to the side of the finger – never the pad. Rotate finger sites to avoid formation of calluses. Any redness, bruising, or calluses would require choosing another site for sample collection and needs to be reported per your agency's policy.
- ◆ Be sure the client has a properly labeled or color-coded sharps container for disposal of lancets.

Emptying / replacing Colostomy Bags

- ◆ When a colostomy is done, the intestine is cut and brought to the outside of the body. The opening created is called a stoma. This site in the abdomen is where body wastes are expelled instead of through the rectum.
- ◆ The bag placed over the site to collect the waste products is called a colostomy bag. MR/DD personnel may be assigned the task of emptying and replacing the bag on a routine basis.

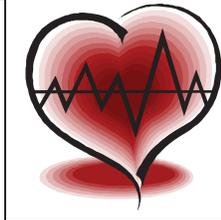
Collection of Urine Specimens by Non-invasive Means

If the physician needs a urine sample to validate the presence of a bladder infection, trained MR/DD personnel may be assigned the task of obtaining the specimen using a "clean catch" procedure.

Health-Related Activities Skills Checklist: Vital Signs

Pulse

- _____ 1. Wash hands
- _____ 2. Locate pulse and count rate for one full minute
- _____ 3. Record results
- _____ 4. Able to verbalize normal range



Employee Name _____
 Date: _____
 Instructor Name _____

Respirations

- _____ 1. Wash hands
- _____ 2. Observe and count respirations for one full minute
- _____ 3. Record results
- _____ 4. Able to verbalize normal range



Employee Name _____
 Date: _____
 Instructor Name _____

Temperature

- _____ 1. Wash hands and put on gloves
- _____ 2. Cleanse thermometer if necessary or use disposable protector
- _____ 3. Place thermometer according to manufacturer's instructions and waits specified time
- _____ 4. Removes thermometer and reads according to manufacturer's instructions. Remove gloves / wash hands
- _____ 5. Records results including site: Otic (ear), Oral (mouth), Axillary (armpit)
- _____ 6. Clean thermometer according to facility procedures
- _____ 7. Able to verbalize normal range



Employee Name _____
 Date: _____
 Instructor Name _____

Blood Pressure

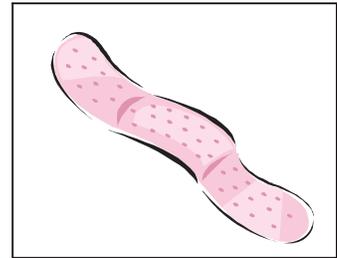
- _____ 1. Wash hands
- _____ 2. Has client rest for 5 min before taking BP
- _____ 3. Selects proper size cuff
- _____ 4. Correctly wrap cuff around upper arm
- _____ 5. Activates BP device according to manufacturer's instructions
- _____ 6. Reads result and records
- _____ 7. Able to verbalize normal range



Employee Name _____
 Date: _____
 Instructor Name _____

Health-Related Activities Skills Checklist: Application of Clean Dressing / No Assessment Required

- _____ 1. Assemble supplies
- _____ 2. Identify client and take to a private location
- _____ 3. Position the client while maintaining comfort
- _____ 4. Wash hands and apply gloves
- _____ 5. Remove old dressing and discard in a disposable bag
- _____ 6. Take off dirty gloves, wash hands, put on clean gloves
- _____ 7. Cleanse area if required by physician's order
- _____ 8. Open package of new dressing material without handling it or placing it on bedding or other material surrounding the individual.
- _____ 9. Apply medication and dressing as ordered
- _____ 10. Place client in a comfortable position.
- _____ 11. Remove gloves and wash hands
- _____ 12. Discard waste supplies and wash hands again
- _____ 13. Return unused supplies to storage area
- _____ 14. Record exactly what was done and how the client responded to the procedure
- _____ 15. Report the following to healthcare provider:
 - Odors
 - Color of skin (turning red?)
 - Color of drainage
 - Pain in or around wound area



Trainee Name: _____ **Date:** _____

_____ Instructor initials Instructor Name _____

COMMENTS:

Health-Related Activities Skills Checklist: Basic Measuring of Bodily Intake and Output

- _____ 1. Assembles supplies
- _____ 2. Wash hands and apply gloves if measuring output
- _____ 3. Measure and record liquids taken by the client. Liquids can be measured in cubic centimeters (cc) or in ounces, according to your agency's policy.
- _____ 4. If measuring output, ask client to use a urinal, bedpan, or plastic "hat" that can be placed beneath the toilet seat.
- _____ 5. Clean all equipment according to agency's policy when finished.
- _____ 6. Remove and dispose of gloves appropriately, wash hands
- _____ 7. Record any output measured. If feces mixed with urine, it may cause inaccurate measurement. Be sure to include this in the documentation if it occurs.
- _____ 8. If a client vomits, document the frequency of vomiting, not necessarily the amount.



<p>FACT: One ounce of fluid = 30 cc.</p> <p>Converting ounces to cc's: Multiply ounces consumed by 30. Example: Eight ounces of fluid = 240 cc (8 oz X 30cc = 240cc)</p>	<p>30 cc = one fluid ounce</p> <p>Converting cc's to Ounces: Divide cc's consumed by 30. Example: 300 cc's = 10 fluid ounces (300cc ÷ 30cc = 10 oz)</p>
---	---

Trainee Name: _____ **Date:** _____

_____ **Instructor initials** **Instructor Name** _____

COMMENTS:

Health-Related Activities Skills Checklist: Oral Suctioning



Yankauer

- _____ 1. Place suction machine on sturdy surface that will support its weight and plug in
- _____ 2. Wash hands. Put on disposable gloves
- _____ 3. Connect tubing to the outlet port on the lid of the collection container
- _____ 4. Attach the suction catheter (Yankauer) to the other end of the connecting tube
- _____ 5. Turn on suction machine and check for negative pressure. Do this by kinking the connecting tube with the machine running and note the reading on the gauge. The correct setting should be (3) for adults, (2) for children, and (1) for infants. Adjust the pressure by turning the adjustment knob on the suction machine.
- _____ 6. Insert the suction catheter into the mouth advancing slowly to the back. If the client starts to cough or gag, wait until the client recovers before continuing. **NEVER SUCTION FOR LONGER THAN 15 SECONDS****
- _____ 7. After suctioning the client, suction water through the suction catheter until the catheter and tubing are clear. **NEVER ALLOW THE COLLECTION CONTAINER TO RISE ABOVE THE FILL LIMIT LINE.**
- _____ 8. Turn machine off
- _____ 9. Empty collection container and clean thoroughly. Put equipment away.
- _____ 10. Remove and dispose of gloves appropriately and wash hands.

**If you suction for 15 seconds and the client is having trouble breathing, use first aid guidelines for calling 911. If the client is gurgling, call 911 immediately.

Trainee Name: _____ **Date:** _____

_____ **Instructor initials** **Instructor Name** _____

COMMENTS:

Health-Related Activities Skills Checklist: Using a Glucometer For Blood Sugar Monitoring

- ___ 1. Assemble equipment.
- ___ 2. Identify individual and explain procedure.
- ___ 3. Wash hands and apply gloves
- ___ 4. Place lancet in pen if a pen is used for the procedure with this client
- ___ 5. Set up glucometer
- ___ 6. Have client wash hands thoroughly. If no soap and water available, you may use a non-alcohol based cleanser such as a baby wipe. Be sure the finger is dry before applying the lancet.
- ___ 7. Turn glucometer on, then apply lancet to side of finger (never the finger pad)
- ___ 8. Point finger downward and gently squeeze to get an adequate blood sample.
- ___ 9. Place blood drop on test strip and wipe finger with gauze pad and hold in place, applying gentle pressure until bleeding stops.
- ___ 10. Read and record result or store result in the glucometer if this option available.
- ___ 11. Clean equipment and dispose of used supplies appropriately.
- ___ 12. Remove and dispose of gloves appropriately and wash hands.
- ___ 13. Follow process for medication administration or request assistance if necessary.



*With some glucometers, sites other than the side of the finger may be used. If using the fingers, be sure to use the sides of the finger, never the pads. Rotate finger sites to avoid formation of calluses. Be sure to document finger site used.

Trainee Name: _____ **Date:** _____

___ Instructor initials Instructor Name _____

COMMENTS:

Health-Related Activities Skills Checklist: External Care of Urinary Catheter



- _____ 1. Assemble supplies
- _____ 2. Wash hands and apply gloves
- _____ 3. Provide privacy and explain to the client what you will be doing
- _____ 4. Position client on his / her back exposing only a small area where the catheter enters the body. **Be sure catheter bag is ALWAYS lower than the bladder.**
- _____ 5. Wash the area surrounding where the catheter enters the body as directed. **If you are working with an uncircumcised male, be sure to retract the foreskin and cleanse well as a part of cleaning catheter entry site.**
- _____ 6. Wipe the tube as directed, starting at the point where the catheter enters the body and moving downward. Never wipe upward-always wipe away from where the catheter enters the body. Clean from the catheter entry point to the connection point between the catheter and the tube connecting the catheter to the collection bag.
- _____ 7. Check for any kinks or coils in the tubing between the catheter and the collection bag. If any are found, straighten them out so that urine can freely drain into the collection bag.
- _____ 8. Clean up any equipment and discard or return to storage area appropriately.
- _____ 9. Remove and discard gloves appropriately and wash hands.

Trainee Name: _____ **Date:** _____

_____ **Instructor initials** **Instructor Name** _____

COMMENTS:

Health-Related Activities Skills Checklist: Emptying the Urine Collection Bag

- _____ 1. Wash hands and put on disposable gloves
- _____ 2. Gather equipment
- _____ 3. Remove urine bag outlet from its holding area and open it over an appropriate container. Drain contents of urine bag, being careful not to splatter any urine.
- _____ 4. Re-clamp outlet to urine bag and place it back into its holding area.
- _____ 5. Measure and record amount of urine if required.
- _____ 6. Note any unusual color or odor, or volume of output unusual for this client. Report per your agency's policy.
- _____ 7. Clean equipment and return to storage
- _____ 8. Remove and dispose of gloves appropriately. Wash hands



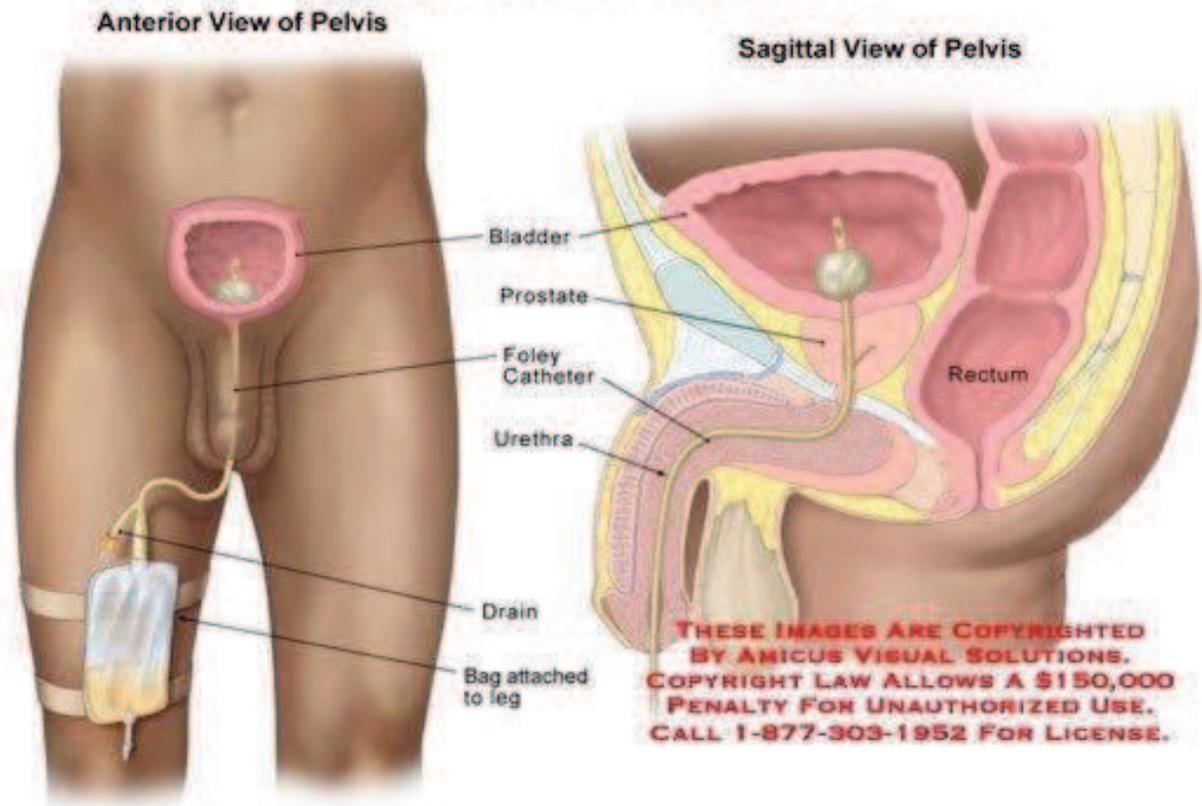
See next page for picture of catheter placement

Trainee Name: _____ **Date:** _____

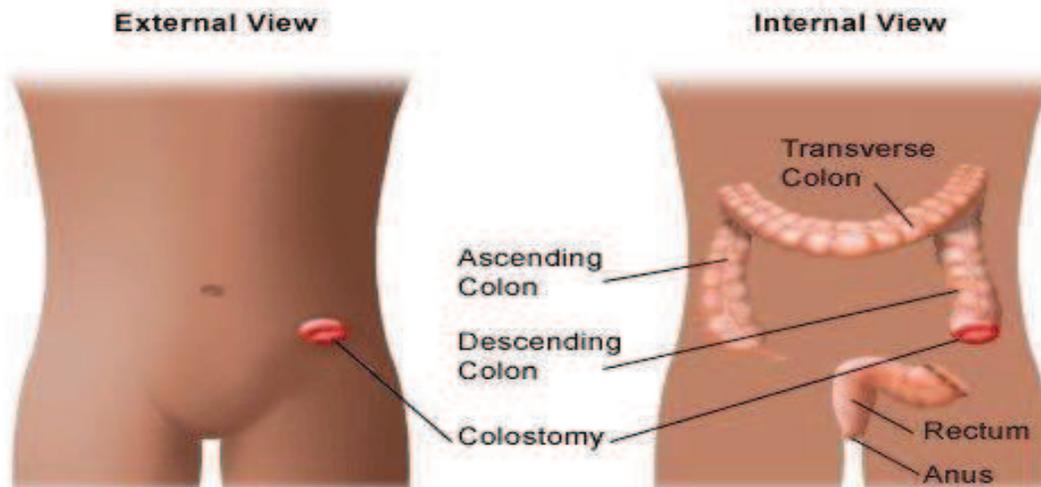
_____ **Instructor initials** **Instructor Name** _____

COMMENTS:

Foley Catheter Placement



Bowel Resection and Colostomy



A colostomy is the procedure performed to bring a small piece of the colon to the surface of the abdomen. Bodily waste is carried out of the body through the stoma (the end of the colon that sits on top of the abdomen). You may be asked to care for the stoma as well as change the bag that collects body waste from the bowel.

Health-Related Activities Skills Checklist: Emptying and Replacing a Colostomy Bag



Emptying a colostomy Bag (See diagram of colostomy on previous page)

- _____ 1. Assemble supplies. (Make sure all colostomy care supplies are clearly labeled for colostomy care only)
- _____ 2. Wash hands and apply gloves
- _____ 3. Explain to the client what you will be doing
- _____ 4. Place client in a comfortable position as instructed and provide privacy
- _____ 5. Remove the clip, clear out the contents and rinse the bag as instructed
- _____ 6. Close and re-seal the bag using the clip or other provided device
- _____ 7. Clean up supplies and discard as appropriate.
- _____ 8. Remove and dispose of gloves appropriately. Wash hands

Replacing a Colostomy bag

Perform steps 1-4, then

- _____ 5. Gently remove the soiled colostomy bag from the stoma site and place in a double bag
- _____ 6. Clean site as instructed and if necessary apply a new wafer as instructed
- _____ 7. Apply a new pouch
- _____ 8. Gather wastes and dirty material being sure to secure it tightly. Discard as directed.
- _____ 9. Remove and discard gloves appropriately and wash hands.
- _____ 10. Document procedure performed, time, observations and any reaction the client had to the procedure.



Trainee Name: _____ **Date:** _____

_____ Instructor initials Instructor Name _____

COMMENTS:

Health-Related Activities Skills Checklist: Collection of Clean Catch (Mid-Stream) Urine Sample

- _____ 1. Gather equipment
- _____ 2. Wash hands and put on gloves
- _____ 3. Explain to the client what you will be doing
- _____ 4. Clean the genitals thoroughly with soap and water if client unable to do for self.
- _____ 5. Have client begin to urinate into toilet. After stream has begun, insert specimen cup into stream. After desired amount of specimen obtained, remove specimen cup from stream as client continues to empty the bladder.
- _____ 6. If client unable to do step 5 above, have the client urinate into a urine hat or urinal which has been thoroughly cleaned with bleach water or another appropriate solution. Pour sample collected into the specimen cup supplied by the lab or doctor's office
- _____ 7. Do not touch the inside of the collection cup, underside of the lid, top rim of the cup, or lay the lid face down on a surface. If unable to take to the lab or physician's office immediately, store specimen as directed by physician or other appropriate health care provider.



Trainee Name: _____ **Date:** _____

_____ **Instructor initials** **Instructor Name** _____

COMMENTS:

Appendix:

Sample Forms and Tools

To be adopted or adapted for use as desired

Page #	Name of Appendix
103	Documentation Rules
104	Documentation Examples
105	Documentation of Pain Episode
106	Guidelines for Managing Diabetes
107	Suggestions to Follow When Calling a Pharmacy
108	Sample Form When Taking Verbal or Written Orders
109	Intake [only] Record
110	Intake and Output
111	DOs and DON'Ts of the indwelling Foley Catheter
112	Managing Your Colostomy
Quick Reference to Psychotropic Medications	
113	Anti-anxiety Medications; Hypnotics; Over-the-counter (OTC)
114	Antidepressants
115	Medications for Bipolar Disorder; Psychostimulants; Anti-obsessional
116	Antipsychotics
117	EPSEs (Extrapyramidal Side Effects associated with psychotropic meds)
Health and Safety Alerts	
118	#11-03-08: Excessive Psychotropic Medication & Psychotropic Medication Side Effects
119	#38-12-06: Exceeding Manufacturer's Recommended Dose
Glucometer: Ability to Use	
120	Self-Assessment for Using a Glicometer
121	Instructions for Use of Self-Assessment for Using a Glucometer
Individual Specific Training	
122-123	Individual Specific Training Information
Statements of Delegation	
124	Statement of Delegation (form A)
125	Statement of Delegation (form B)

Documentation Rules

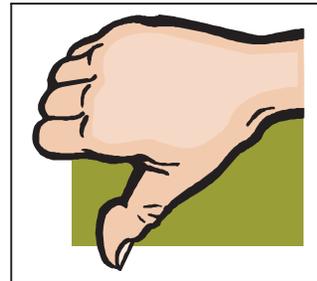
DOs

- ◆ Write legibly
- ◆ Avoid spelling errors
- ◆ Spell out words or use only approved abbreviations
- ◆ Document with non-erasable ink (preferably blue or black ink)
- ◆ Begin each entry with the date and time and end with your signature
- ◆ Line through any blank areas before your signature or initials
- ◆ Correct documentation errors immediately
- ◆ Keep documentation current



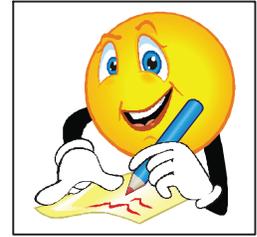
DO NOTs

- ◆ Use “ditto” marks
- ◆ Use pencil or correction fluid
- ◆ Leave blank spaces in your documentation
- ◆ “Scratch out,” erase or otherwise make a mistaken entry unreadable
- ◆ Document before a task has been completed or before an event has occurred
- ◆ Use the client record to air grievances or criticize other caregivers or administrators
- ◆ Accept or assign fault on the MAR
- ◆ Document for another person
- ◆ Guess or provide opinions





Documentation Examples



Poor Documentation

Mickey lost his temper and was very hostile today.

Red Riding Hood refused to cooperate with her roommate and used bad language with me and her roommate.

Cinderella had a bad day today. She refused to get out of bed and go to her 9:00 workshop. Cinderella is lazy and just does what she wants to do, regardless of what's in her ISP.

Bad Wolf's brother came by tonight and started a fight with me. The brother is obnoxious and threatening. When I told BW's brother I was going to call the police on him, he got mad and hit me.

Fluffy refuses to stay on her diet. She won't listen when told she's not allowed to have sweets.

Pluto and I followed the ISP today.

Acceptable Documentation

When asked to pick up his area, Mickey threw his shoe at the wall and yelled, "You can't tell me what to do. This is my place and I can do what I want."

Red Riding Hood would not help her roommate cook dinner. She said she didn't feel like cooking. When I reminded her that her ISP said she was to help with meal preparations, Red yelled, "You mother f..in bitch. You don't live here. You and Goldilocks (roommate) are stupid and I won't eat the shit you fix. It tastes like crap."

Cinderella said she was not going to workshop today. Said "That's a waste of my time. I don't like going there. It's so boring. Leave me alone. I want to sleep." I could not get Cinderella to get up until 10:30.

Bad Wolf's brother came by tonight and accused me of stealing Bad Wolf's things. I asked what I had stolen and he said "you know." When I told him I had no idea what he was talking about, he raised his voice and said, "You GD people are all alike. You think you can do anything. Well, you'd better give me back what you took, or I'll beat the shit out of you." I told Big Wolfe he'd better leave his hands off me, then he hit me on my left shoulder. I called 911. I completed an Incident report and gave it to Mother Goose, MRDD coordinator at (give agency name).

Fluffy would not eat the breakfast I fixed for her this morning. I explained why she needed to eat the foods I fixed and she pushed me aside, put the food in the disposal and grabbed 3 of her roommate's donuts. She ate them quickly, washing them down with a 12 ounce can of Coke. She told me to "shut up." I informed my supervisor, Mother Goose, about what happened at breakfast.

Per Pluto's ISP, we went to the park for 2 hours after workshop to ride bikes and play Frisbee, then out to Wendy's for a sandwich. I assisted Pluto to shower and wash his hair and do a load of laundry. We watched American Idol and ER before Pluto went to bed at 11.



How to Document a Pain Episode

Example #1

3-17-08
2:14am

Goldilocks woke up and stated she had a headache. I gave her the PRN Tylenol ordered for headache. Goldilocks returned to bed at 2:30. At 2:45 Goldilocks said her headache was better and she thought she could go back to sleep. At 3:00 Goldilocks looked like she was sleeping peacefully. Her breathing was slow and regular and she did not respond when I softly called her name.

Example #2

5-10-08
1:20pm

Cinderella vomited the contents of her lunch. She said she felt "bad" and laid down on her bed. I called Lucy Brown, my supervisor and she instructed me to give Cinderella the PRN Pepto Bismol ordered for stomach upset. I gave Cinderella the Pepto Bismol at 1:30. At 2:00 I checked on Cinderella and she said she was feeling worse and her stomach really hurt a lot. She was lying on her bed in a curled up position, moaning. I called Lucy Brown, supervisor and she instructed me to take Cinderella to the Urgent Care Center right away. I took Cinderella to Urgent Care at 2:10.

Example #3

6-17-08
6pm

Humpty Dumpty told me his lower arms and chest were itching "like crazy." His arms and chest were red and bleeding in places from scratching. I applied the PRN Lanocaine ordered to relieve severe itching to Humpty's arms and chest. I notified BoPeep, the on-call supervisor and reported what I had done. She instructed me to apply dry dressings over the affected areas to protect them and to apply ice packs to cool Humpty's arms and chest. At 6:15 I applied dry dressings to the bleeding areas and placed ice packs on Humpty's lower arms and chest. At 6:30 Humpty said the itching was almost gone and the ice packs felt good.

Guidelines for Managing Diabetes:

← Foods to have whenever you want: →

Meats
Fish
Fowl
Aged cheeses
Eggs
Onion

Celery
Carrots
Mushrooms
Salad dressings (regular)
Sugar free Jell-O
Heiner's 35 (bread)

Red/green/yellow peppers
Sugar snap peas
Spinach
Broccoli
Tomato
Green beans



Good foods to have before going to bed at night

Aged cheese
5 saltine crackers with peanut butter
2% milk

Celery with peanut butter
Cold chicken – 4 oz
1 oz nuts (almonds, walnuts, peanuts)

Foods to avoid:

White breads	Cakes/ pies
White rice	Candies
White potatoes	Cookies/muffins
White pasta	Bagels/donuts
Regular soda	Juices
Noodles	Chips

Good Hi-fiber foods to have

Bran Buds (1/3 cup = 13 fiber grams)
Heiner's 35 Wheat Bread (2 fiber grams / slice)
Thomas Lite English Muffins (8 fiber grams / muffin)
Muller's low-carb spaghetti (12 fiber grams / serving)
94% fat free popcorn 12 fiber grams in a bag
**Good fiber foods have at least 3 fiber grams per serving.

Allowable sweets in moderation

Carb Smart Ice cream by Breyer
Pecan Sandi (no more than 2)
Low-carb cheese cake
3 Hershey Kisses
Fruits of all kinds

Other Tips

Use Smart Balance Butter spread
Cook with Olive oil if you need oil
Use Splenda as a sweetener
Experiment with spices for flavor

Read Those Food labels

- *No more than 180-200 carbs per day
- *Take in about 25 fat grams per day
- *Take in 50-60 protein grams per day
- *Take in at least 30 fiber grams per day

Fluids

Drink at least 64 oz of fluid per day
Water is the best, especially iced
Limit soda to one 12 oz can per day
Have at least 3 glasses of milk a day

Take a field trip to the grocery store. Read labels. Discover low carbohydrate (CHO) and high fiber foods. Plan out menus for 3 days at a time. Discover favorite dishes you love to fix.

Suggestions to follow when calling a pharmacy

Be sure you have consumer's DOB (Date of Birth). You will be asked for this information

May I speak to a registered pharmacist, please?

Hello, my name is _____.
I am a support staff for Developmentally Disabled clients.

I am calling to seek clarification about a medication prescribed to (give name of consumer). The medication I need help with is (give name of drug and also spell it).



Select any of the following that apply:

- Could you please clarify the dosage for (name the drug). The MAR does not agree with the label on the prescription bottle.
- Could you please clarify how often the medication is to be administered? The label on the medication container is confusing to me.
- Could you please clarify how many teaspoons I am to give the client? The MAR says I am to give 250 mg, but it does not specify how much that is.
- May I crush this medication and mix it in applesauce or juice or cream cheese?
- The consumer is having trouble swallowing (name the medication). Is it alright to split this tablet? To crush this tablet? To dissolve this tablet in water or juice?
- The label says to give the medication every 8 hours. The problem is that (give consumer's name) goes to bed by 9pm and doesn't get up until 7am. Would it be alright to give the (name the medication) at 7, 2, and 9 so I don't have to wake him (or her) up to give the medicine?

These suggestions are not exhaustive. I'm sure you can think of other scenarios. The point is that we need to be very clear and precise when calling the pharmacist to avoid confusing the pharmacist and perhaps making an error.

Medicating the consumer is not an easy task. In fact, it is a very hard task and carries with it awesome responsibility for safe-guarding the consumer's safety. There is no such thing as a "safe" medicine or drug. All medicines (even non-prescription medicines and herbs) have the potential to cause harm – even death – if not used properly.

Sample Form for Taking Verbal Orders:

Name of individual for whom the medication or Health-related Activity (H-R) is for: _____

Name of person receiving the verbal order _____

Name of second person listening to verify order if applicable _____

Name of 2nd person checking the order (next shift, etc.) _____

Date: _____ Date medication or H-R activity is to begin: _____

Name of medication or H-R activity: _____

Dosage (size or amount, eg. Milligrams, micrograms, milliliters, # of): _____

Exact time or times the medication is to be given or H-R activity that is to be done: _____

Route of Medication:	<input type="checkbox"/> Oral	NOSE	<input type="checkbox"/> Right Nares	EYE	<input type="checkbox"/> Right Eye only
	<input type="checkbox"/> Topical		<input type="checkbox"/> Left Nares		<input type="checkbox"/> Left Eye only
	<input type="checkbox"/> Rectal		<input type="checkbox"/> Both Nares		<input type="checkbox"/> Both Eyes
	<input type="checkbox"/> Vaginal				

Other:

Length of time medication is to be given or Health-Related activity is to be done: _____

Reason for medication or H-R activity: _____

Special instructions for medication administration or reporting observations during health-related activity:

Allergies: _____

Side effects or contra-indications: _____

Repeat the order back to the health care professional? Yes No

Hard copy of order obtained? Yes No

Signature and date of personnel receiving hard copy of this order: _____

DOs and DON'Ts of External Foley Catheter Care

DO:

- Anchor the catheter securely to client's upper leg or abdomen using _____ tape to prevent pulling.
- Instruct client to drink adequate amounts (about 64 ounces) of fluids.
- Teach client how to keep a daily record of how much he or she drinks
- Teach client how to keep the catheter tubing free from kinks
- Check the tubing to be sure it is long enough to reach the collecting bag.
- Observe the catheter system for kinking, obstruction, sediment, leaking, and irritation or pulling in the genital area.
- Be sure tubing and bag are below hip level when the client is up and about.
- Have the client change body position frequently to assist the bladder to empty more easily.
- Hang the collecting bag so it does not touch the floor.
- Report any redness, discharge or irritation in the catheter area.



DO NOT

- Pull on the collecting bag or the catheter
- Disconnect the catheter tubing. If it accidentally comes apart, wipe the ends with alcohol and reconnect.
- Lay the collecting bag on the bed (it needs to be lower than the client's bladder in order to promote drainage of urine from the bladder)
- Raise the collecting bag and tubing above the level of the bladder.



Managing Your Colostomy

Adapted from: *Managing Your Colostomy* University of Pittsburgh Medical Center web site – patient information

General Tips

- ◆ Eat a well-balanced diet daily
- ◆ Drink at least 6-8 glasses of fluids daily
- ◆ Avoid chewing gum, smoking, drinking from a straw
- ◆ Consuming yogurt or buttermilk may help reduce gas
- ◆ Refrain from eating after 8pm
- ◆ If gas is a problem, sprinkle Beano on the first bite of food
- ◆ Weight gain or loss can affect the way your pouch fits

Colostomy Care

- ◆ If able, perform colostomy care in the bathroom
- ◆ If putting on a new wafer, be sure skin is clean, dry and smoothed out
- ◆ After applying a new wafer, place your hand over the stoma and wafer for 30 seconds
- ◆ Be sure to cleanse stoma with warm water and mild soap. Rinse thoroughly
- ◆ Cleanse stoma after each bowel movement

Traveling

- ◆ Carry a squirt bottle for rinsing the pouch away from home
- ◆ Carry wet-wipes or tissues to use in public bathrooms
- ◆ Carry an extra pouching system
- ◆ Never store colostomy supplies in glove compartment of the car
- ◆ Keep ostomy supplies with you – not in a suitcase that will be checked

The Pouching System

- ◆ Do not use toxic chemicals or agents in your pouch – they may harm the stoma
- ◆ Change the pouch (replace the pouch) every 5-7 days. Sooner if pouch leaks
- ◆ Write date on pouch indicating when pouch should be replaced
- ◆ You may spray inside of pouch with a non-stick cooking oil to reduce stool sticking to pouch

Bathing / Showering

- ◆ You may bathe or shower with bag / pouch on or off
- ◆ Colostomy may function during this time
- ◆ Use mild soap to cleanse around stoma

Wearing the pouch

- ◆ Wear pouch inside underwear to support it
- ◆ Place a cloth barrier between the pouch and your skin to protect skin

Reducing Odor

- ◆ Use air deodorizers in the bathroom
- ◆ Rinse pouch 1-2 times daily after you empty it
- ◆ Add deodorant such as Super Banish or Nullo to pouch
- ◆ Limit odor causing foods such as broccoli, fish, cabbage, onions, garlic to reduce odor
- ◆ With each emptying, carefully clean opening of pouch inside and out with toilet tissue
- ◆ Never use aspirin in the pouch to reduce odor as aspirin can cause ulcers on the stoma

Call the doctor if you experience any of the following symptoms:

- ◆ Purple, black, or white stoma
- ◆ Swelling from the stoma to more than ½ inch larger than usual
- ◆ Severe skin irritation or deep ulcers
- ◆ Severe watery discharge from stoma lasting more than 6 hours
- ◆ Bulging or other changes in your abdomen
- ◆ No output from colostomy for three days
- ◆ Severe cramps lasting more than two hours
- ◆ Excessive bleeding from the stoma
- ◆ Pulling inward of the stoma below the skin level

Quick Reference to Psychotropic Medications:

(Adapted from J.Preston, PsyD. www.PsyD-fx.com; Preston and Johnson. (2007). Clinical Psychopharmacology Made Ridiculously Simple (5th ed.)

Anti-Anxiety

NAMES		Single Dose	Equivalence ¹
Generic	Brand	Dosage Range	
BENZODIAZEPINES			
diazepam	Valium	2-10mg	5mg
chlordiazepoxide	Librium	10-50 mg	25mg
prazepam	Centrax	5-30mg	10mg
clorazepate	Tranxene	3.75-15mg	10mg
clonazepam	Klonopin	0.5-2mg	0.25mg
lorazepam	Ativan	0.5-2mg	1mg
alprazolam	Xanax, XR	0.25-2mg	0.5mg
oxazepam	Serax	10-30mg	15mg
OTHER ANTIANXIETY AGENTS			
bupirone	BuSpar	5-20mg	
gabapentin	Neurontin	200-600mg	
hydroxyzine	Atarax, Vistaril	10-50mg	
propranolol	Inderal	10-80mg	
atenolol	Tenormin	25-100mg	
guanfacine	Tenex	0.5-3mg	
clonidine	Catapres	0.1-0.3mg	



1 – Doses required to achieve efficacy of 5 mg of diazepam



Hypnotics

NAMES		Single Dose
Generic	Brand	Dosage Range
flurazepam	Dalmane	15-30mg
temazepam	Restoril	15-30mg
triazolam	Halcion	0.25-0.5mg
estazolam	ProSom	1-2 mg
quazepam	Doral	7.5-15mg
zolpidem	Ambien	5-10mg
zaleplon	Sonata	5-10mg
eszopiclone	Lunesta	1-3mg
ramelteon	Rozerem	4-16mg
diphenhydramine	Benadryl	25-100mg

Over the Counter

Name	Daily Dose
St. John's Wart ^{1,2}	600-1800mg
SAM-e ³	400-1600mg
Omega-3 ⁴	1-9g

1 Treats depression and anxiety
 2 May cause sig drug-drug interactions
 3 Treats depression
 4 Treats depression and bipolar Disorder



Quick Reference to Psychotropic Medications:

(Adapted from J.Preston, PsyD. www.PsyD-fx.com; Preston and Johnson. (2007). Clinical Psychopharmacology Made Ridiculously Simple (5th ed.)



Antidepressants

NAMES		Usual Daily Dose	Sedation	ACH ¹	Selective Action on Neurotransmitters ²		
Generic	Brand	Range			NE	5-HT	DA
imipramine	Tofranil	150-300mg	mid	mid	++	+++	0
desipramine	Norpramin	150-300mg	low	low	+++++	0	0
amitriptyline	Elavil	150-300mg	high	high	++	+++++	0
nortriptyline	Pamelor, Aventyl	75-125mg	mid	mid	+++	++	0
protriptyline	Vivactil	15-40mg	mid	mid	++++	+	0
trimipramine	Surmontil ³	100-300mg	high	mid	++	++	0
doxepin	Sinequan, Adapin ³	150-300mg	high	mid	++	+++	0
clomipramine	Anafranil	150-250mg	high	high	0	+++++	0
maprotiline	Ludomil	150-225mg	high	mid	+++++	0	0
amoxapine	Asendin	150-400mg	mid	low	+++	++	0
trazodone	Desyrel	150-400mg	mid	none	0	++++	0
fluoxetine	Prozac ⁴ Sarafem	20-80mg	low	none	0	+++++	0
bupropion-X.L.	Wellbutrin-X.L. ⁴	150-400mg	low	none	++	0	++
sertaline	Zoloft	50-200mg	low	none	0	+++++	0
paroxetine	Paxil	20-50mg	low	low	+	+++++	0
venlafaxine	Effexor-E.R. ⁴	75-350mg	low	none	++	+++	+
fluvoxamine	Luvox	50-300mg	low	low	0	+++++	0
mirtazapine	Remeron	15-45mg	mid	mid	+++	+++	0
citalopram	Celexa	10-60mg	low	none	0	+++++	0
escitalopram	Lexapro	5-20mg	low	none	0	+++++	0
duloxetine	Cymbalta	20-80mg	low	none	++++	++++	0
MAO INHIBITORS							
phenelzine	Nardil	30-90mg	low	none	+++	+++	+++
tranylcypromine	Parnate	20-60mg	low	none	+++	+++	+++
selegiline	Emsam (patch)	6-12mg	low	none	+++	+++	+++

¹**ACH**= Anticholinergic Side Effects: ▲memory impairment ▲constipation ▲urinary retention
▲confusional states) ▲blurred vision ▲dry mouth

²**NE**: Norepinephrine, **5-HT**: Serotonin **DA**: Dopamine (These are neurotransmitters in the brain)
(0 = no effect, + = minimal effect, +++ = moderate effect, +++++ = high effect)

³**Uncertain, but likely effects**

⁴ Available in standard formulation and time release (XR, XL or CR).
Prozac available in 90-mg time release / weekly formulation

Quick Reference to Psychotropic Medications:

(Adapted from J.Preston, PsyD. www.PsyD-fx.com; Preston and Johnson. (2007). Clinical Psychopharmacology Made Ridiculously Simple (5th ed.)



Bipolar Disorder



NAMES		Daily Dosage Range	Serum ¹ Level
Generic	Brand		
lithium carbonate	Eskalith, Lithonate	600-2400mg	0.6-1.5mEq/l
olanzapine / fluoxetine	Symbyax	6/25-12/50mg ⁴	2
carbamazepine	Tegretol, Equetro	600-1600mg	4-10+ mcg/ml
oxcarbazepine	Trileptal	1200-2400mg	(2)
valproic acid	Depakote / Divalproex	750-1500mg	50-100 mcg/ml
gabapentin	Neurontin	300-2400mg	(2)
lamotrigine	Lamictal	50-500mg	(2)
topiramate	Topamax	50-300mg	(3)
tiagabine	Gabitril	4-12mg	(3)

(2) Serum monitoring may not be necessary
 (3) Not yet established
⁴ Available in 6/25, 6/59, 12/25, and 12/50 mg formulations

Psycho-Stimulants

NAMES		Daily Dosage ¹
Generic	Brand	
methylphenidate	Ritalin	5-50mg
methylphenidate	Concerta ²	18-54mg
methylphenidate	Metadate	5-40mg
methylphenidate	Methylin	10-60mg
methylphenidate	Daytrana (patch)	15-30mg
dexmethylphenidate	Focalin	5-40mg
dextroamphetamine	Dexedrine	5-40mg
pemoline	Cylert	37.5-112.5mg
d-and l-amphetamine	Adderall	5-40mg
modafinil	Provigil, Sparlon	100-400mg

Note: ¹ Adult doses
² Sustained release



Anti-Obsessional

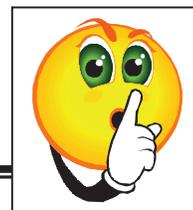
NAMES		
Generic	Brand	Daily Dosage
clomipramine	Anafranil	150-250mg
fluoxetine	Prozac ¹	20-80mg
sertaline	Zoloft ¹	50-200mg
paroxetine	Paxil ¹	20-60mg
fluvoxamine	Luvox ¹	50-300mg
citalopram	Celexa ¹	10-60mg
escitalopram	Lexapro ¹	5-20mg

¹ Often higher doses are required to control obsessive-compulsive symptoms than the doses generally used to treat depression.



Quick Reference to Psychotropic Medications:

(Adapted from J.Preston, PsyD. www.PsyD-fx.com; Preston and Johnson. (2007). Clinical Psychopharmacology Made Ridiculously Simple (5th ed.)



Antipsychotics

NAMES		Dosage range ¹	Sedation	Ortho ²	EPS ³	ACH Effects ⁴	Equiv ⁵
Generic	Brand						
LOW POTENCY							
chlorpromazine	Thorazine	50-100mg	high	high	++	++++	100mg
thioridazine	Mellaril	150-800mg	high	high	+	+++++	100mg
clozapine	Clozaril	300-900mg	high	high	0	+++++	50mg
mesoridazine	Serentil	50-500mg	high	mid	+	+++++	50mg
quetiapine	Seroquel	150-400mg	mid	mid	+ / 0	+	50mg
HIGH POTENCY							
molindone	Moban	20-225mg	low	mid	+++	+++	10mg
perphenazine	Trilafon	8-60mg	mid	mid	++++	++	10mg
loxapine	Loxitane	50-250mg	low	mid	+++	++	10mg
trifluoperazine	Stelazine	2-40mg	low	mid	++++	++	5mg
fluphenazine	Prolixin ⁵	3-45mg	low	mid	+++++	++	2mg
thiothexene	Navane	10-60mg	low	mid	++++	++	5mg
haloperidol	Haldol	2-40mg	low	low	+++++	+	2mg
pimozide	Orap	1-10mg	low	low	+++++	+	1-2mg
risperidone	Risperdal	4-16mg	low	mid	+	+	1-2mg
paliperidone	Invega	3-12mg	low	mid	+	+	1-2mg
olanzapine	Zyprexa	5-20mg	mid	low	+ / 0	+	1-2mg
ziprasidone	Geodone	10-160mg	low	mid	+ / 0	++	10mg
Aripiprazole	Abilify	15-30mg	low	low	+ / 0	+	2mg

1 Usual daily oral dosage. 2 Orthostatic Hypotension Dizziness and falls

3 Acute Parkinson's, dystonias, akathisia. Does not reflect risk for tardive dyskinesia (TD).
All neuroleptics may cause TD, except clozapine

4 **Anticholinergic side effects:** ▲dry mouth ▲constipation ▲urinary retention
 ▲blurred vision, ▲memory impairment, ▲confusional states

5. Dose required to achieve same effect as (efficacy) 100mg of chlorpromazine (Thorazine)

6 Available in time-release IM (intramuscular / injection) format

EPSEs (Extrapyramidal Side Effects) Associated with Psychotropic Medications

(SE) Side Effect	Signs/Symptoms	When SE Appears	What you should do
Acute Dyskinesia (Uncontrolled muscle movements)	<ul style="list-style-type: none"> ◀ Blinking ◀ Writhing limbs ◀ Protrusion of the tongue ◀ Uncontrolled movements of face (tics) / grimaces 	Usually within 1-5 days of starting medication	Hold the medication and call supervisor or delegating nurse (DN) immediately
Akathesia (Restlessness)	<ul style="list-style-type: none"> ◀ Pacing ◀ Rocking ◀ Restlessness ◀ Foot tapping ◀ Inability to sit still ◀ Restless legs <p style="text-align: center;">Verbal complaints of: “jitters: “crawling out of my skin”</p>	Usually within 5-60 days of starting medication	Hold the medication and call supervisor or delegating nurse (DN) immediately
Dystonia (Distorted movements of the body; sustained muscle contractions)	<ul style="list-style-type: none"> ◀ Rigidity ◀ Lock jaw ◀ Head snapped back or to side ◀ Eyes rolled up ◀ Contorted face ◀ Back arching 	Usually within 1-5 days of starting medication	Hold the medication and call supervisor or DN immediately
Pseudo-parkinsonism (Mimics Parkinson's disease)	<ul style="list-style-type: none"> ◀ Tremor ◀ Drooling ◀ Pill rolling ◀ Shuffling gait ◀ Slow / no movement ◀ Cogwheel rigidity ◀ Lack of expression ◀ Decreased blinking 	Usually within 5-30 days of starting medication	Hold the medication and call supervisor or delegating nurse immediately
“Rabbit” Syndrome (Mimics chewing motions of a rabbit)	<ul style="list-style-type: none"> ◀ Lip tremor ◀ Perioral (around the mouth) tremor 	Can occur early in treatment or later	Hold the medication and call supervisor or DN immediately
Tardive Dyskinesia (Repetitive, involuntary, purposeless, movements)	<ul style="list-style-type: none"> ◀ Chewing ◀ Drooling ◀ Protrusion of the tongue ◀ Uncontrolled movements of face (tics) / grimaces ◀ Licking lips ◀ Writhing limbs ◀ Blinking bursts 	Usually does not occur until client has been on medication for at least 1 or more years	Hold the medication and call supervisor or delegating nurse immediately

Psychotropic drugs (medicines) are used to treat major mental disorders such as depression, bipolar disorder, anxiety disorders, and schizophrenia. It is important that psychotropic medicines be administered as prescribed and that clients not stop taking them cold turkey.

Call for help immediately if client experiences:

- ◆ BP less than 80/50
- ◆ BP greater than 140 / 90
- ◆ Heart rate over 110
- ◆ Convulsions
- ◆ Sweating
- ◆ Fever
- ◆ Loss of bladder control
- ◆ Respiratory distress

Excessive Psychotropic Medication & Psychotropic Medication Side Effects

(Adapted from: Health and Safety Alert #11-03-08)

....The incidence of mental illness among people with mental retardation has been estimated at 30-40%..... In choosing treatment we must always recognize the right of the person with retardation to receive appropriate care and treatment in the least intrusive manner, and the right to be free from unnecessary chemical or physical restraint.

Medications which are prescribed to improve a person's mental health or their behavior symptoms of mental illness are referred to as psychotropic medications. Anti-depressants, anti-psychotics, mood stabilizers, anti-anxiety agents, sleep agents, stimulants, anti-parkinson, and anti-cholinergic agents are such medications. If used for psychotropic purposes, anti-convulsants and cardiac medications are also considered psychotropics.

An individual who is taking psychotropic medications may be unable to adequately verbally express symptoms or medication side effects. Therefore, observation for possible side effects is necessary. Side effects may result from the use of a single medication, or from the interaction of multiple medications.

Some side effects are minor, such as the sensation of thirst or increased need for fluids. Side effects such as these can be tolerated when the medication is effective in treating the mental illness...Other side effects are more severe. Potential side effects of a specific medication should be provided by the pharmacy.

Common side effects of psychotropic medications can include:

- ◀ Allergic reactions
- ◀ Constipation or diarrhea
- ◀ Yellowing of the eyes or skin
- ◀ Unusual bruising or bleeding
- ◀ Abnormal posture, movements, or gait
- ◀ Eating problems (nausea, vomiting, weight gain or loss)
- ◀ Change in level of alertness (sleepiness, confusion, insomnia)
- ◀ Change in heartbeat (slow, fast, irregular)
- ◀ Change in blood pressure (high or low)
- ◀ Fainting or dizziness, especially with change in positions such as upon standing

Be aware if the medication(s) the client is taking carries a "Black Box" warning. This warning means that the medication carries a significant risk of serious or even life-threatening adverse effects. **Keep in mind that people with heart disease and elderly individuals with dementia have a higher likelihood of serious side effects or sudden death. Some of the antidepressants are contraindicated for these people.**

Commonly used psychotropic medications that have a black-box warning:

- | | | | | |
|--------------------|------------|------------------------|-------------|--------------|
| ◆ Anafranil | ◆ Effexor | ◆ Nardil | ◆ Prozac | ◆ Tofranil |
| ◆ Asendin | ◆ Elavil | ◆ Norpramin, Pertofran | ◆ Remeron | ◆ Vivactil |
| ◆ Aventyl, Pamelor | ◆ Lexapro | ◆ Parnate | ◆ Serzone | ◆ Wellbutrin |
| ◆ Celexa | ◆ Ludiomil | ◆ Paxil | ◆ Surmontil | ◆ Zoloft |
| ◆ Desyrel | ◆ Marplan | | | |

What to do:

- A. Be informed about the black-box warnings and side effects of medications that are being received.
- B. Obtain immediate medical treatment for serious signs and symptoms of possible medication side effects
- C. Keep healthcare provider and guardian informed of any and all side effects.



Exceeding Manufacturer's Recommended Dose

(Adapted from Health and Safety Alert #38-12-06)

Exceeding the recommended manufacturer's dose can present significant risks. Guardians, providers, and families should discuss with the physician the potential side effects and benefit / risk ratio of exceeding the manufacturer's recommended maximum dose.

Staff should closely monitor individuals who receive increased dosages for:

1. Changes in eating
2. Changes in speech or vocalization
3. Changes in ability to walk or sit upright
4. Changes in ability to perform daily activities
5. Changes in levels of alertness, abilities

Alert the physician when you see any of the above changes.

Persons responsible for the individual's health care should also ensure that appropriate monitoring of liver function tests along with drug and metabolic levels are performed. Serum ammonia levels can help diagnose occult liver disease even in the absence of toxic drug levels but this testing is not routine and requires special testing.

Don't be afraid to ask on behalf of the individual.

For any questions or comments regarding the above Alert, please contact the MUI/Registry Unit at (614) 995 – 3810.

12 / 06

Self - Assessment for Using a Glucometer

(p1 of 2)

Name of Individual: _____

Signature & Title of Persons **Observing** Assessment (2 required):

Signature: _____ Date: _____ Time: _____

Signature: _____ Date: _____ Time: _____

Persons conducting assessment will need to have ALL necessary information regarding the individual's current medications and physician's orders for glucometer checks. In addition, the persons doing the assessment must know how to properly use and maintain the type of glucometer being used by the individual. See reverse side for additional documentation.

1. I can check my glucometer to make sure it is working correctly. I know what to do if it is not working correctly.
YES Go to 2. NO Go to 

2. I know how to check the code on my test strip with the code on the glucometer. I know what to do if the codes do not match.
YES or NA Go to 3. NO Go to 

3. I know how to clean my glucometer and lancet pen.
YES Go to 4. NO Go to 

4. I can use the lancet and / or pen correctly.
YES Go to 5. NO Go to 

5. I have demonstrated that I can correctly place the blood sample on the test strip and successfully complete the glucometer check.
YES Go to 6. NO Go to 

6. I know what to do if the number is too high or too low.
YES Go to 7. NO Go to 

7. I know who to tell when I have 4-7 days of test strips left so I never run out.
YES Go to 8. NO Go to 

8. I know to wash my hands and change the finger I use for the finger stick.
YES Go to 9. NO Go to 

9. I have demonstrated that I do my glucometer check at the right time every day by using the clock or my routine (after the news, before lunch, before taking insulin, etc).
YES Go to 10. NO Go to 

10. I can get the glucometer supplies to and from storage, out of the container, and properly dispose of used needles.
YES Go to 11. NO Go to 

11. I have demonstrated harmful behaviors to self and am unable to self-administer my glucometer check with or without assistance.
YES Go to  NO Go to 


Unable to Use With or Without Assistance
Will Require Medication Administration Certified Staff to Do All Glucometer Checks as Ordered
Continue to next assessment question. Complete this form in its entirety.


Able to Use Glucometer With Assistance
Service Plan to Include all that apply:

- Time Reminder
- Physical Assistance with any of the following:
 - ◀ Use of pen and lancet
 - ◀ Cleaning the glucometer
 - ◀ Checking with test solutions
 - ◀ Set-up and storage of equipment

Continue To Next Step


Able to do own Blood glucose monitoring Without Assistance


Unable to perform Blood Glucose Monitoring With or Without Assistance
Will Require DD Staff with Certification 1 to Perform Blood Glucose Monitoring
Identified Behavior/Justification MUST be documented

Self Assessment for Using a Glucometer (Continued)

(p2 of 2)

Once the assessment is completed, the service plan for the individual should specify how Blood Glucose Monitoring (BGM) will be done. Any of the following statements could be used in the service plan, depending on what is correct for each specific person.

- I can perform my own blood glucose monitoring (BGM) without assistance.
- I can perform BGM with assistance (select one of the following related to the assistance).
 - The individual receives assistance with BGM through reminders of when to administer the insulin. Specify reminders needed in the client's ISP.
 - The individual receives assistance with BGM through physically handing the equipment needed to the client. Provide specific instructions in the client's ISP.

Other:

- I need certified staff to do my blood sugar testing. Use this if answer to any question leads you to the top box on the right side of this form.
- I require certified staff to do my blood sugar checks while I am learning how to do them. IP Team should consider Skill Development programs as appropriate. Use this answer if the client cannot consistently do own BGM. A specific plan should be written with goals and time frames. See 5123:2-6-02 (C).
- I can do my own BGM (blood glucose monitoring).
 - Describe BGM procedure _____
 - Ability Level with task _____
 - Designate if independence or staff performance of BGM is applicable to a specific location or time of day (ie. Work setting) _____
- I have demonstrated unsafe behaviors and am therefore unable to do my own BGM with or without assistance. Identify behavior / justification.

If the client has a history of unreliability or noncompliance the person doing the assessment may indicate that the client requires someone to do his / her BGM (blood glucose monitoring) to assure safety.

manner

RESULT:

- Self BGM with assistance
- Self BGM – no assistance needed.

BGM / Delegated Nursing (DN)

- I live in a 5 bed or less setting and will receive my BGM from staff that have been trained to do BGM.
- (or)**
- I will receive Delegated Nursing (DN) services per the state's DN rules

Schedule for BGM (Attach another page if more space needed – or copy of MAR)

Schedule and Method for BGM

(Time) _____ (Method) _____ Site _____

Reviewed by:

SERVICE SUPPORT ADMINISTRATOR (signature & date): _____

NURSE (signature & date): _____

Individual Specific Training Information

This form is to be completed and reviewed with each certified personnel **before** administration of medications or health-related activities.

*Name _____ * Identified by (Name, Picture, etc) _____

*Address: _____

*Allergies: _____

*Diagnosis / Health Care Information: _____

*Special Instructions (where and how takes meds eg. takes meds only in kitchen, with apple juice, prefers blue mug, etc.)

*Emergency medications (Diastat / EpiPen / Glucagon) and or prn behavior medications _____

*Behaviors demonstrated for PRN meds: _____

Medication Routes: (Check all that apply)

- Oral Inhaler Optic (Rt eye / Lt eye) Rectal Subcutaneous
 Sublingual Nebulizer Otic (Rt ear / Lt ear) Vaginal Insulin / Glucagon
EpiPen / Other _____

Date of Training	Time	Signature of DD Personnel Receiving Training	Signature of Trainer	Date First Task Completed by Personnel	Date of update/ changes	Date of update/ changes	Date of update/ changes

Date of First Medication Administration; _____

