Self-Assessment for Using a Glucometer

Name of Individual: _______________________________ _______________________________________

To be completed by a person who knows the individual well and, when possible, with a second observer present

Signature & Title of Person Performing Assessment ______________________________ Date __________ Time ___________

Signature and Title of Second Observer ______________________________ 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 △

If answers to questions 1-10 are all yes, then go to △

Unable to Use Glucometer With or Without Assistance

Will Require Staff with Medication Administration Certification 1 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

Unable to perform Blood Glucose Monitoring With or Without Assistance

Will Require Staff with Medication Administration Certification 1 to Do All Glucometer Checks as Ordered

Identified Behavior/Justification MUST be documented

Continue on next page →
Continuation of Self-Administration Assessment for Using a Glucometer

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 perform BGM. Specify reminders needed in the individual’s ISP.
  ☐ The individual receives assistance with BGM through physically handing the equipment needed to the individual. Provide specific instructions in the individual’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. If any question, #1-10 is answered “no” use this answer.

☐ 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 individual 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.
  ☐ Describe BGM procedure ________________________________________________________________
  ☐ Ability Level with task ________________________________________________________________
  ☐ Designate if independent 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 individual has a history of unreliability or noncompliance the person doing the assessment may indicate that the individual requires someone to do his / her BGM to assure safety.

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 DN services per the state DN rules

Annual Review By:

First

Second

Signature, Title, & Date

Signature, Title, & Date

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