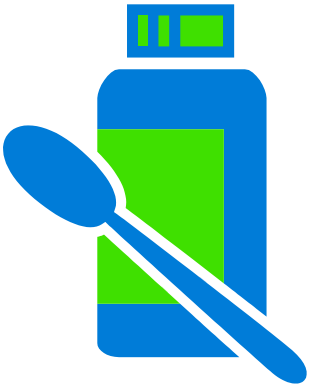
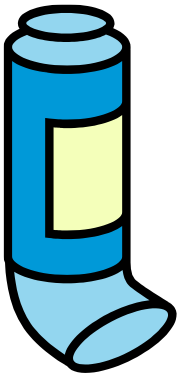
Ohio | Department of Developmental Disabilities
Medication Administration

Category 1 Certification Training Curriculum

Prescribed Medications

and

Health-Related Activities

*****Report to DODD immediately if you have received training that does not meet the legal standards for Initial or Renewal requirements (1-800-617-6733). You must receive the legally required training before administering medications*****



January 2020 Edition

CAUTION!

If you receive orders or directions to perform ANY medical care:

- **not specified in this curriculum**
- **or anything you do not understand**

Contact your supervisor.
Additional training or nursing delegation may be required.

Category 1
Table of Contents: Prescribed Medication Administration and Health-Related Activities Training Manual

******If RNs or an Agency rearrange this book prior to printing, create and include a revised Table of Contents for users to be able to quickly locate reference material.***

Notes to RN Trainers:

This manual contains the STEPS to perform Medication Administration and the 13 Health-Related Activities. EVERY SKILL NEEDS TO BE CHECKED. Steps are imbedded in the curriculum. Corresponding skills checklists are on the DODD website.

All the content in this curriculum is required to be taught[1] [2]. RN Trainers may supplement with any additional materials they believe to be relevant for the group they are training. The content is arranged into broad categories. RN Trainers may present the content in any logical order that meets the needs of the group being trained. Additional time beyond the 14 hours minimum classroom instruction, is required for training agency specific procedures.

[1] The RN Trainer may waive the material on Standard & Universal Precautions if it has been covered elsewhere within the previous year as per OAC (Ohio Administrative Code) 5123:2-6-06.

[2] Nasal Versed® (midazolam) may be taught at the RN Trainer's discretion.

Use manufacturer's instructions to train for Valtoco® (diazepam nasal spray).

Table of Contents Indexed by Subject

Table of Contents Arranged in Alphabetical Order by Page Title

(continued on next page)

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Definition of Terms Found in this Curriculum

Abdomen: Located between the chest and the pelvis; the "belly".

Acute: Rapid onset, severe symptoms, lasts for only a few days or weeks.

Accessible: Available; easily reached or obtained.

Adequate: Acceptable; satisfactory.

Administer/administration: To give something to someone (ex. gives medication).

Advanced Practice Registered Nurse: A nurse with specialized education for a specialty certification by the Board of Nursing: a Certified Nurse Practitioner; Mid-wife; Nurse Anesthetist or; Clinical Nurse Specialist.

Anaphylaxis: Severe allergic reaction that can result in death if not reversed quickly.

Apply: Place one thing on to another (ex. put a band aid on a wound; put ointment on the skin).

Assure: To inform; to remove doubt.

Aura: Warning sign or sensation of an on-coming seizure (varies according to person and condition).

Bracing: Protective position a person takes when in pain or about to get injured.

Bunion: Enlargement of the joint of the big toe. Causes toe to shift to the side.

Carbohydrate: Chief fuel for the body. Found in fruits, vegetables, grains, breads, and sweets.

Category: Grouping together of items with similar features.

Certificate/Certification: A legally issued credential that allows for actions that a person without certification may not do.

Certified Nurse Practitioner (CNP): An Advanced Practice Nurse with state certification that gives the ability to prescribe medications and other care beyond the scope of an RN or LPN.

Certified personnel: Personnel who have completed the medication administration course and have a current certification issued by DODD.

Chronic: A condition that lasts for more than 6 weeks; a condition that gets worse over time or shows little improvement over time. (Examples: diabetes, arthritis, multiple sclerosis, asthma)

Cognitive: The way a person thinks and makes sense out of experiences.

Competent: Able to do a task or job correctly and independently.

Confirm: To support; to validate; to establish the accuracy of information.

Confusion: Bewilderment; not understanding what is happening; inability to think clearly.

Congestion: Stuffy nose that can make it difficult to breathe.

Console: To comfort.

Contaminated: Dirty; containing impurities or germs.

Convulse: To have a seizure; uncontrolled, spastic movement of any part of the body especially arms, legs, and torso.

Corn: Thickening of the skin often on the toes and caused by shoes rubbing on the area where the thickened skin develops.

Crucial: Most important; necessary.

Curriculum: A course of study; the content of a course, class or program of study.

Debriding agent: Chemical (medicated cream, ointment or liquid) used to remove dead tissue from a wound.

Deformity: Malformed; not the typical shape. Usually involves a body part (ex. missing limb, club foot).

Delegate: To transfer or pass on responsibility to another person.

Demonstrate/demonstration: To show someone how to do a task or job; to show that you know how to do a task or job.

Developmental Disability (DD): A chronic mental or physical impairment that is diagnosed before the age of 22.

Developmental Disability Personnel (DDP): The workers who provide specialized services to people with developmental disabilities as either a DODD Independent Provider or as an employee of a DODD certified agency. (OAC 5123:2-6-01)

Disorientation: Not knowing where one is, who one is, or what time it is (season or month); not aware of time, place, or self.

Dispense: To give out or distribute to another.

Dispose/disposal: To get rid of; throw away.

Documentation: To record or write down what has happened and/or what has been done.

Dominant hand: The hand you use to write with.

Dose: The amount of medication to be taken (ex. 2 tablets of Depakote 500mg).

Duration: The length of time a medication is to be taken or the length of time a medication works.

Elements: Component parts.

Episode: An occurrence; the display of symptom or behaviors associated with an underlying condition.

Error: A mistake; a wrong action. Medication errors are defined in Rule OAC 5123:2-6-01.

Excess/excessive: More than what is ordered or is required.

Exposure: Contact with a thing (ex. contact with a substance, material, or surface).

Facility: A licensed place where care is given and where people with support needs reside.

Feasible: Capable of being done; realistic ability to do something.

Fracture: To break (ex. a broken bone).

Frequency: How often a medication or treatment is given (ex. once a day; twice a day; every 8 hours).

Gait: The way a person walks or moves about on foot.

Gastrostomy/Jejunostomy tube (G/J): A tube that goes through the skin of the abdomen into the stomach (G-tube) or small intestine (J-tube), for administration of food, fluids or medications.

Generic: The chemical name of a medication that is not identified by a registered trademark or brand name (ex. acetaminophen is the generic version of Tylenol®).

Glucagon: Hormone injected during a low blood sugar emergency.

Glucose: Sugar.

Glucometer: A device used to check or measure a person's blood sugar.

Hard copy: Document that is printed out on paper.

Healthcare Professional (HCP): Physician (MD or DO), Certified Nurse Practitioner (CNP), Registered Nurse (RN), Licensed Practical Nurse (LPN), Pharmacist (RPh), Dentist (DDS), Podiatrist (DPM), Chiropractor (DC), Physician's Assistant (PA).

Health-Related Activity (HRA): One of 13 nursing tasks authorized by Category 1 Medication Administration Certification.

Hemorrhoid: Dilated vein that may be internal or external. Commonly found inside or outside the rectum.

Hormone: A substance secreted in the body for a specific purpose (ex. insulin that is needed by the body to use carbohydrates; glucagon that is used by the liver to release stored glucose).

Hyper: Higher than what is considered normal (ex. hypertension = high blood pressure; hyperglycemia = high blood sugar).

Hypo: Lower than what is considered normal (ex. hypotension = low blood pressure; hypoglycemia = low blood sugar).

Immunity: Free from blame; protected from blame.

Implement: To start something; to begin a plan or act.

Inappropriate: Not consistent with the situation (ex. laughing when feeling sad).

Incontinence: Spontaneous exit of urine or stool/feces (to wet or soil oneself).

Incorrect: Wrong; not accurate.

Individual Specific Training (IST): Training provided by a licensed nurse or employer that addresses the unique needs of the person; a summary of relevant health care information and the health care plan (OAC 5123:2-6-01).

Ingest: To take into the mouth and swallow.

Inhale: To breathe in; to take in air or medication into the lungs.

Inject/injection: Placing a medication into the body through the skin by using a sterile needle and syringe (a "shot").

Instill: To put a medication in a body cavity or on a mucous membrane (ex. eye drops, or ear drops).

Intact skin: Skin without a cut or tear.

Intellectual disability: A disability characterized by significant limitations both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behavior, which covers a range of everyday social and practical skills. This disability originates before the age of 22.

Intramuscular: To give an injection (a shot) into a muscle.

Invert: To turn the container upside down.

Lancet: A type of needle used to stick the finger to get a drop of blood for checking blood sugar.

Legal: Pertaining to the law; something the law says is OK to do.

Lesion: Injury or wound; area of skin that has an alteration.

Lethargy: Sluggishness; drowsiness; inactivity; showing lack of energy; fatigue.

Liable/Liability: Responsibility; what you are held accountable for, by law, or by company rules and policies.

Licensed: Legal permission granted by the state to take specific actions that are not allowed to be taken by people without the license.

Licensed Physician Assistant (PA): A specially trained and licensed person who works under the supervision of a physician.

LPN: Licensed Practical Nurse (ORC 4723.01).

Lifestyle: The way a person chooses to live their life.

Maintain: To keep something going, working, or functioning.

Medication Administration Record (MAR): Where all medications to be administered are transcribed and all medications given, held, missed or declined are documented.

Mental State: Describes one's alertness, orientation.

Metabolic Glycemic Disorder: Medical conditions specifically related to blood sugar metabolism such as diabetes, pre-diabetes and metabolic syndrome.

Metered Dose Inhaler: A device or package that dispenses a specific amount of the medication to be inhaled.

Monitor: To observe someone for a specific purpose.

Muscle wasting: Loss of strength in a muscle or muscle group; decrease in muscle mass, strength and endurance; decrease in size of a muscle.

Nasal cannula: Device placed in the nostrils of the nose for delivery of oxygen.

Nasogastric tube (NG): A tube inserted through the nose, past the throat and into the stomach.

Ohio Administrative Code (OAC): The state departmental rules that explain details of laws.

Omit: To leave out.

Oral: Mouth; taken into the mouth and swallowed (ex. taking a pill by mouth).

Ohio Revised Code (ORC): The state laws put in place by the Legislature.

Organic: Coming from a person or animal; living matter.

Occupational Safety and Health Administration (OSHA): The legally authorized federal agency responsible for creating and implementing rules related to worker's safety and health at their worksites.

Over-the-Counter (OTC): Medication that can be purchased without a prescription.

Oversight: Supervise; make sure a task is done correctly; be sure personnel are properly trained and performing to the standard.

Packaging: Container medication comes in; wrapping around a medication.

Pallor: Lack of color; paleness.

Parenteral: Medication route that does not involve the digestive system (ex. injections/shots).

Peripheral: Away from the center of the body (ex. hands, feet, lower legs; at the edges).

Persistent: Long-lasting; not giving up; keeping at a task for a long period of time; enduring.

Personal Protective Equipment (PPE): Items used to put a barrier between the caregiver and all body fluids. Examples include gloves, gown, mask, eye protection and shoe covers.

Pharmacy/Manufacturer's Label: The information found on a prescribed medication or an over-the-counter medication identifying the name of the medication, the amount and strength of the medication, and how and when to take the medication.

Photosensitivity: Sensitive to sunlight (ex. sunburns easily; inability to tolerate bright light).

Pill Caddy/Pill Minder: A container that is filled for multiple doses of medication to be accessed by a person for multiple days (ex. a week or month of medications put in the caddy).

Policy: A written statement of actions to be taken in specific situations.

Potency: The power of a medication to be effective.

Prefilled: Syringe or other container that has medication placed in it by the manufacturer or pharmacy.

Prescription/Prescribe: A directive/order for medication/treatment by a healthcare professional with a license that allows them to legally order healthcare tasks and medications.

Procedure: Steps taken to do a task properly.

Protocol: States what is to be done in specific situations; plan of action.

Psychotropic: A medication that causes changes in the mind/brain.

Puncture resistant: Something that a sharp will not go through or penetrate.

Range: The amount of variation considered as normal (ex. pulse rate between 60 and 100 is regarded as a normal range/variation for the number of times per minute the heart should beat).

Rectum/Rectally: The anus or "butt hole"; medication given in the anus.

Remedy: A treatment; solution to a problem.

Renal: Pertaining to the kidneys.

Renew: To replenish; to restore; to start over.

Repetitive: To do over and over; to do the same thing many times.

Resolve: To find the answer; to solve the problem.

Responsive: Answering or replying right away; alert.

Restrain: To refrain from acting; to keep another from acting or controlling another's ability to act.

Revoke/Revocation: To take away or remove permanently.

Rigid muscle: A stiff or tight muscle.

RN: Registered Nurse (OAC 4723.01).

Rotate: To choose a different location.

Route: Where a medication goes or how a medication is given (ex. in the mouth, in the ear, on top of the skin, etc.).

Scheduled substance: Legal FDA Drug classifications I, II, III, IV, V that, by law, rate a drug's potential for misuse or abuse and the need to count supplies routinely.

Secure: To make safe.

Self-administer: To be able to take medication independently (OAC 5123:2-6-02).

Sharp/Sharps: A device with sharp points or edges that can puncture or cut the skin.

Sign: Evidence that something is wrong.

Specific: Well defined; elaborated upon; spelled out.

Strength: The volume of medication per unit such as milligrams per tablet or milligrams per CC of liquid (ex. Depakote 500mg tablet or Depakene 500mg per 10CC liquid).

Subcutaneous: Beneath the skin; in the fatty tissue not in the muscle.

Suspension: Temporary removal of certification.

Sustain: To maintain, to support or to keep going.

Swirl: Stir by moving the container in a circular motion.

Symptom: An experience of a person that something is wrong.

Symptomatic: Currently having symptoms.

Systemic: Affects the entire body; more than one part of the body is affected.

Treatment Administration Record (TAR): Where all treatments to be administered are transcribed and all treatments given, held, missed, or declined are documented.

Topical/Topically: Placed on body surfaces including skin, hair, nails, eyes, ears, nose, rectum, vagina and oral surfaces.

Toxic: Harmful, destructive, or deadly.

Transcribe: To copy prescribed orders from a pharmacy label, or to change a current order on an MAR/TAR.

Tremor: Involuntary shaking.

Trigger: Something that causes a reaction or symptom.

Universal Precautions: Treating all body fluids as if they can cause disease in others. The plan for use of personal protective equipment (PPE) when in contact with or having the potential to come into contact with body fluids. Proper cleansing of the hands and other surfaces.

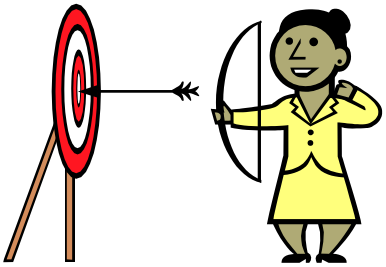
Unlicensed DD Personnel: Workers, without a healthcare professional's license, who provide specialized services to people with developmental disabilities.

Unusual Incident (UI): An event or occurrence that is not consistent with the person's routine, care or service plan. **All medication errors are an unusual incident** (OAC 5123-17-02).

Unusual: Out of the ordinary.

Void: To urinate or to put a single line through an entry on a document that was written by mistake.

Wheezing: Breathing that has a high-pitched, coarse, whistling or squeaking sound that indicates a tight, inflamed, or partially blocked airway that requires prompt action (use of inhaler or 911).



Course Goal: To teach DD personnel how to administer oral and topical medications and perform the 13 health-related activities (HRAs) specified by the Ohio Department of Developmental Disabilities

COURSE OBJECTIVES

OBJECTIVES

By the end of this course, the participant will be able to:

Demonstrate:

- **How to prepare, administer and document the performance of the 13 HRAs and the administration of prescribed oral, topical, and inhaled medications, and application of topical OTC medications for musculoskeletal comfort.**

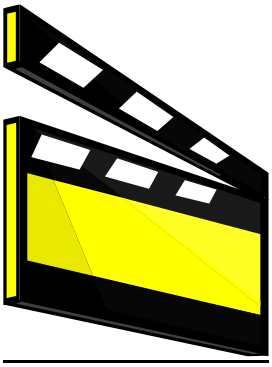
- **Having a minimum knowledge base, by scoring 80% or better on a closed book test.**

Explain:

- **What is required to maintain and renew certification for medication administration and performance of health-related activities.**

- **How the rules and regulations governing the administration of medications and performance of health-related activities apply to caregiving activities.**

- **What actions to take when signs and symptoms may indicate a significant health problem or medication side effect.**



Information about the Initial Category 1 Certification Course

(OAC 5123:2-6-06)

1. **Although 14 hours is the legal MINIMUM time for training, the principles of quality adult learning indicate that additional hours are needed, and that many consecutive hours of training, without break times, are not effective for information retention.** The 14 hours minimum time must consist of engaged learning time in the classroom and does not include lunch and break time. The course may be lengthened to meet the needs of the class participants and/or the RN trainer, and employer.

   - ❖ Everyone should have their own personal copy of the entire curriculum to use during the course.
   - ❖ Anyone can obtain a copy of the curriculum for personal use from the DODD website: *dodd.ohio.gov*
   - ❖ A copy of the curriculum must be readily accessible on site where medication is being administered or health-related activities are being performed.

2. To obtain the Initial Category 1 DODD medication administration certification, Developmental Disabilities (DD) personnel must do all the following:

   - ❖ Attend the **ENTIRE** program and participate in discussions and activities.
   - ❖ Successfully demonstrate performance of the 13 health-related activities, and the preparation, administration, and documentation for each route of medication presented in the initial Category 1 certification training course.
   - ❖ Pass a closed book written exam with a score of 80% or better. Personnel who do not pass the written exam with 80% or higher are required, by rule, to retake the entire initial certification training course before attempting to take the written exam again.
   - ❖ Complete and submit an evaluation of this program to the RN trainer.

The RN Trainer may provide additional time for skills development and/or study prior to testing and determining if the student meets the requirements for certification.

After certification and **before** administering medication or performing health-related activities, with any given person, the certified personnel must have **individual specific training** (IST) **about that person.**

- ❖ It is the responsibility of the personnel, and employer to assure IST has been done.
- ❖ If delegation is required, the delegating nurse must do the IST.

Attend the entire initial certification training course.

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

Accurately perform all return demonstrations.

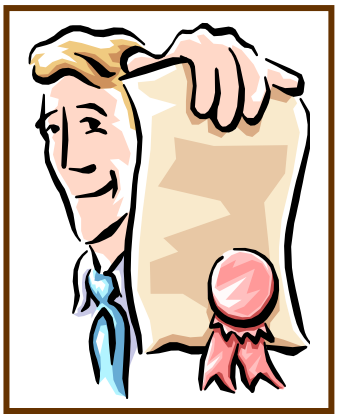
What You Need to Know About Your Certification

1. **<u>You</u> are responsible for your certification**. **<u>You must verify that you are currently certified to administer medication/HRAs. You must confirm your Category 1 initial certification and renewals on the DODD website</u>**. *<u>dodd.ohio.gov</u>*

2. This certification is valid only for Developmental Disabilities (DD) service settings and only in the State of Ohio.

3. Certification is valid for 1 year and must be renewed each year before the certification expiration date.

4. It is recommended that the renewal continuing education (CE) and return demonstrations be completed at **least 60 days before** your certification expiration date.



Renewing your Certification:

At least 90 days before your expiration date, plan to complete the required education and skills for renewal.

1. To renew certification, requires completing **2 hours** of continuing education related to medication administration and/or health-related activities. **AND**

2. You must **demonstrate skills of medication administration and health-related activities**

   - ♣ Skills must be demonstrated annually to be used. Any skill not demonstrated as part of renewal must be demonstrated prior to performing the skill when needed.
   - ♣ If you work at a site with nursing delegation, a nurse must observe your demonstration.
   - ♣ If you work at a site without nursing delegation, return demonstrations are performed and monitored by the person designated by the employer.
   - ♣ If you are an independent provider, your return demonstration can be done by a county board nurse or any DODD certified RN trainer.

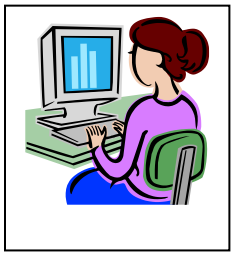
The RN Trainer attesting to renewal requirements must be sure the person verifying skills and/or providing CE, has the knowledge, skills, and ability to do so.

What happens if you do not renew your Certification:

1. You have 60 days past the expiration date to renew your certification without retaking the initial certification training course. You may **NOT administer medications or perform HRAs** during that 60-day post-expiration period.
2. **If you allow your certification to be expired for more than 60 days**, you are **required to retake the** initial certification training course to become certified again.

The initial Category 1 certification training course for administration of medications and performance of health-related activities must be completed before **obtaining further certifications** to administer medications per G/J tube (Category 2) or administer insulin and injections for treating metabolic glycemic disorders (Category 3).

State of Ohio Certification Registry



1. There is a state registry listing all personnel certified by the Department of Developmental Disabilities (DODD).
2. Law requires public access to view certifications in the registry for confirming the status of current and expired certifications. This can be found on the DODD website: *dodd.ohio.gov*
3. Certification remains valid when personnel change employers. Medication Administration Certification of DD personnel is registered with DODD (not the employer).

Suspension and Revocation

1. Anyone who finds that certified personnel are not safely performing or will not safely perform their duties shall immediately remove that certified personnel's responsibility to perform medication administration. This includes the employer, delegating nurse, county board nurse, or QA nurse as appropriate.
2. **Suspension of certification is done by DODD pending further investigation. It may be temporary but could lead to permanent revocation depending upon circumstances.**
3. Revocation of certification may occur if certified personnel do not demonstrate compliance with the rules and curriculum, are not performing their duties in a safe manner according to certification training or have shown disregard for the safety and welfare of a person. **Revocation is a permanent removal of certification.**
4. The Certified DD Personnel may appeal DODD's intent to revoke certification per the rule, OAC 5123: 2-6-07.

Liability

You are accountable for your own actions. However, the law, Ohio Revised Code 5123.422, establishes immunity from liability if:

- ♦ All applicable laws and rules were being followed.
- ♦ Certified personnel acted in accordance with the steps in the curriculum and/or the instructions of a delegating nurse. (see OAC 5123:2-6-07).
- ♦ Certified personnel do not act in a manner that constitutes deliberate or reckless misconduct.

What it Means to Be a Certified DD Personnel

Classes and skill checks for initial certification or renewal do not equal certification. You are NOT authorized to administer medications or treatments, until your certification has been entered and viewed as current on the DODD website.

Having a certification from the Ohio **D**epartment of **D**evelopmental **D**isabilities (DODD) for the administration of medications and performance of health-related activities means you have been authorized to complete certain tasks. People who are not certified do not have this authorization.

This certification **does not** allow you to provide care any way that you would like. The Law requires that you follow the instructions given to you during this certification course. You must follow the instructions provided in the curriculum always, NO EXCEPTIONS.

With a valid Medication Administration Certification 1, you may

- ☐ Administer topical, oral, and inhaled medications that have been prescribed for a person.
- ☐ Perform the 13 health-related activities.
- ☐ Apply OTC topical medications for musculoskeletal comfort without a prescription.

Note: In some settings, you will also need a nurse to authorize and supervise your administration of medications and treatments. That is called nurse delegation.

You must know what you are doing. If you are ever in doubt about what to do, or how to do it, you must contact your supervisor or a healthcare professional for additional directions or training.

You must speak up if you need more training. Do not assume others automatically know what you need.

Your certification DOES NOT allow you to:

- ♦ Make independent diagnoses and act on them.
- ♦ Perform activities not addressed in this curriculum even if you know how.
- ♦ Represent yourself as a licensed healthcare provider.
- ♦ Discontinue a medication without a healthcare professional's order.
- ♦ Administer a medication without a prescription (except topical OTC medication for musculoskeletal comfort).
- ♦ Independently adjust the dosage of any medication.
- ♦ Independently change the frequency for administering any medication.
- ♦ Independently perform an activity in a way not specified by this curriculum.
- ♦ Give medications or perform any health-related activities that have not been prescribed.
- ♦ Share health related information with anyone who is not actively on the person's care team.

Medication Administration
Self-Administering or Help Needed

Each person has the right, if capable, to self-administer or self-administer with assistance. Prior to restriction of a person's right to self-administer their medication or healthcare task, the DODD approved Self-Administration Assessment must be completed (OAC 5123:2-6-02)**.**

A person is presumed to be able to self-administer unless there is a substantive indication that the person wants or needs supports. The diagnosis of Intellectual or Developmental Disability does not automatically mean a person can be assumed to need help with medication administration. **People who self-administer do not need to document on a MAR.**

5123:2-6-02 Self-administration or assistance with self-administration of prescribed medication.

(A) An individual who can safely self-administer prescribed medication or receive assistance with self-administration of prescribed medication has the right to self-administer or receive assistance with self-administration.

(B) Prior to restriction of an individual's right to self-administer prescribed medication, the service and support administrator or qualified intellectual disability professional, as applicable, shall ensure that a department approved self-administration assessment is completed for an individual who requires prescribed medication administration. Based on the outcome of the self-administration assessment, the individual plan, or individual service plan, as applicable, shall document when the individual cannot safely self-administer prescribed medication or receive assistance with self-administration of prescribed medication. The service and support administrator or qualified intellectual disability professional, as applicable, shall ensure that the self-administration assessment is reviewed annually to confirm continued need for support for medication administration. A new self-administration assessment shall be completed at least once every three years or more often when there is a change that affects the individual's medication routine such as a change in medication route, service setting, service provider, or health status.

(C) Each individual plan or individual service plan shall indicate when the individual is able to safely self-administer prescribed medication or receive assistance with self-administration of prescribed medication including:

(1) When the individual is able to safely self-administer medication independently;
(2) When the individual is able to safely self-administer medication with assistance; and
(3) When the individual is not able to successfully self-administer medication with or without assistance and include a statement of how medication administration will be completed.

(D) When the self-administration assessment indicates an individual cannot safely self-administer prescribed medication or receive assistance with self-administration of prescribed medication:

(1) Further assessment shall be conducted to determine exactly what specific steps of self-administration of medication the individual is able to safely complete. The individual shall participate in these steps under the supervision of developmental disabilities personnel who have current certification in health-related activities and prescribed medication administration and have received individual-specific training.
(2) The details of the individual's specific abilities and the specific necessary support from licensed or certified personnel to complete medication administration shall be noted in the individual plan or individual service plan.

(E) Developmental disabilities personnel who are not specifically authorized by other provisions of the Revised Code to provide assistance in the self-administration of prescribed medication may, under section 5123.651 of the Revised Code and this rule, provide that assistance as part of the services they provide to individuals. To provide assistance with self-administration of prescribed medication, developmental disabilities personnel are not required to be trained or certified in accordance with section 5123.42 of the Revised Code and rules 5123:2-6-05 and 5123:2-6-06 of the Administrative Code.

(F) When assisting in the self-administration of prescribed medication, developmental disabilities personnel shall take only the following actions as needed and identified in the individual plan or individual service plan:

(1) Remind an individual when to take the medication and observe the individual to ensure that the individual follows the directions on the container;

(2) Assist an individual by taking the medication in its container from the area where it is stored, handing the container with the medication in it to the individual, and opening the container, if the individual is physically unable to open the container; or

(3) Assist, on request by or with the consent of, a physically impaired but mentally alert individual, with removal of oral prescribed medication or topical prescribed medication from the container and physically assist with the individual's taking or applying of the medication. If an individual is physically unable to place a dose of oral prescribed medication to the individual's mouth without spilling or dropping it, developmental disabilities personnel may place the dose in another container and place that container to the individual's mouth.

(G) When an individual has been assessed as able to safely self-administer prescribed medication or self-administer prescribed medication with assistance, developmental disabilities personnel are not authorized to verify accuracy of medication being taken by the individual on a routine basis unless specified in the individual plan or individual service plan. When there is reason to question the individual's self-medication skills, a new self-administration assessment shall be completed. 5123:2-6-02

Anyone can:

- Remind a person when to take medication.
- Observe to assure directions on container are followed.
- Remove medication from and return to storage.
- Open the container if the person unable.
- Assist the person to remove medication from the container.
- At the direction of a person who is cognitively able but physically unable, physically assist a person to get medication from the container and to take/apply.

To provide the types of assistance listed above personnel do not need medication administration certification.

Introduction & Instructions for Completion of Self-Administration Assessments
Oral and Topical Medication; Inhaled Medications; Oxygen Administration; Using a Glucometer;
Performance of Health-Related Activities;
Medication, Nutrition, Fluids per G/J Tube;
Insulin/Metabolic Glycemic Disorder Medications

The purpose of the Self-Administration Assessment is to ensure that the person is not able to SAFELY accomplish medication administration and/or complete health care tasks prior to implementation of supports that could violate the inherent right of a person to self-administer medications and treatments (Ohio Administrative Code 5123:2-6-02). Prior to restriction of a person's right to self-administer medication, or perform health care tasks, the DODD approved Self-Administration Assessment must be completed.

When should a Self-Administration Assessment be completed?

The self-administration assessment is completed when a person/guardian/advocate is requesting support services for medication administration/treatments/health-related activities or when the SSA/QIDP or another team member identifies the potential need for support. A person is presumed to be able to self-administer unless there is a substantive indication that the person wants/needs support. The person's team must have reason/information to believe there is a potential need for the service of medication administration/treatments/health-related activities prior to use of the assessment. The presence of any given medical/psychiatric diagnosis is not evidence of an inability to self-administer. There must be some indication, other than diagnoses, to warrant assessment of the need for support with administration of medication/treatments/health-related activities.

- Indications that a person may need help with medication administration/treatments/health-related activities, and that an assessment should be done can include:
  - Person/guardian/advocate requesting support with medication administration/treatments/health-related activities and expressing indications for concern
  - Significant levels of assistance needed with other Activities of Daily Living (ADLs) that require similar skills to those needed for medication administration (ex: recognition of routines/times of ADLs, memory of basic information, awareness of physical condition/status, recognition of units/amounts)
  - The person has not completed necessary steps to obtain refills (i.e. calling pharmacy, making or keeping scheduled prescriber appointments)
  - Indications that health conditions continue to get worse despite current medications for those conditions
  - Not using supports already identified to assist with medication (such as notifying personnel of the need for refills, or appointments)
  - Statements by the person that indicate lack of medication awareness/compliance

- If/when the assessment is used to establish the need for medication administration/treatments/health-related activities assistance or support, it must be completed at a minimum of every three years; with a review for potential status changes done at least annually. The reassessment may indicate changes in the level/type of supports needed. Supports may need to be increased or may be decreased due to development of knowledge, skills and ability.

- A reassessment may also need to be completed in the event of, but not limited to, the following occurrences that can affect the steps a person is completing and/or needing support with:
  - A change in medication route, packaging, or medication delivery system
  - A change in service setting
  - A change in the person's health status
  - A change in the usual medication routine (new location, new provider)
  - A change in functional status of other Activities of Daily Living (ADLs)
  - A change in nutritional formula packaging

- If, a person who has historically been able to self-administer but due to a change is unable to do so safely, the assessment is updated. The assistance and supports are provided according to the assessment result(s) and listed in the ISP. Training and support should be provided to help the person return to self-administration status. The person should be reassessed for the ability to resume self-administration as soon as the circumstances allow. Examples of such occasions include, but are not limited to:
  - Physical/psychiatric illness affecting memory or functional capacity
  - New medications the person is not yet familiar with
  - Post-operative; post-sedation
  - Environmental changes during which time training is needed to transfer skills to the new environment

- When family is delegating to an independent HPC provider the assessment does not need to be completed, unless the team believes the person's preferences and rights may be being violated. Family must reside with the person that is receiving family delegation. Additionally, family can never delegate to an agency provider.

- Children under the age of 18 do not have an inherent right to self-administer. The guardian/team may decide to use the assessment as a guide for planning and education. The guardian/team may allow self-administration.

- If medication administration/treatments/health-related activities are not part of the supports being requested, a self-administration assessment does not need to be done. If the team has concerns about the health and safety of a person, it should be addressed with a person-centered planning process. This may include discussion of the concerns with the person and identifying risks, providing education, and/or developing potential solutions that may or may not include direct assistance/supports with medication administration.

Where to complete the assessment?

Complete the assessment in each setting where the person will receive medication/treatments or perform health-related activities. A person-centered approach dictates the assessment be conducted in a manner that takes into consideration the location and circumstances under which the medication/treatment will be needed. The assessment is done in each applicable location to determine:

- What, if any, supports the person may need within the context of their personal environments
- Knowledge, and skills that may/may not transfer across different settings
- If appropriate, a single form may be used for multiple settings; list all settings assessed

The approach to the assessment should be trauma-informed. Every effort should be made to assure the person feels comfortable, calm, unhurried, and unthreatened by the assessment process. The assessment should never be applied like a quiz or a test.

Who completes the assessment?

- It is recommended that the Self-Administration Assessment be completed by a person who is familiar to the person; who knows the person well and; who is knowledgeable about the person's mode of communication. Ultimately, it is the responsibility of the SSA/QIDP to ensure that the Self-Administration Assessment is completed. When possible, it is recommended that a second observer be present to ensure results are indicative of the person's capacity to safely self-administer or not.
  - The person completing the assessment needs to have detailed information about the currently prescribed medications/treatments/health-related activities, including medication name, dose, route, time, purpose and basic side effects.
  - If the medication/treatment/route is one that requires nurse delegation, a nurse must do the assessment.

- The assessment for self-administration of Medications, Nutrition, Fluids per G/J Tube must be completed by a licensed nurse. If the nurse does not know the person well, then it is recommended that a second observer who does and who is also familiar with the person's mode of communication be present to ensure the results are indicative of the person's capacity to safely administer the medication, nutrition or fluids.
  - If the delegating nurse did not complete the assessment for Medications, Nutrition, Fluids per G/J Tube for the person, the nurse should review the assessment prior to delegation to ensure the nurse is not delegating more supports than is needed.

- The assessment for Insulin/Metabolic Glycemic Disorder medications must be completed by a licensed nurse. If the nurse does not know the person well, then it is recommended that a second observer who does and who is also familiar with the person's mode of communication be present to ensure the results are indicative of the person's capacity to safely administer the medication.
  - If the delegating nurse did not complete the assessment for Insulin/Metabolic Glycemic Disorder medications for the person, the nurse should review the assessment prior to delegation to ensure the nurse is not delegating more supports than is needed.

Important Considerations:

- ✓ People have an inherent right to self-administer (Ohio Administrative Code 5123:2-6-02). The assessment form is used to prove the need to override that right.
- ✓ The person being assessed may not be able to state medical terminology but relaying content/intent in their own words or phrases is enough.
- ✓ The person may not be able to state specific side effects, but the ability to report health issues is how potential side effects will be recognized by prescriber/healthcare professional/family/caregiver.
- ✓ People with I/DD have the right to do as many steps of self-administration as they can do, either independently or with support, even if they are not assessed to be able to self-administer with or without assistance.
- ✓ Support providers must be legally qualified for whatever support they provide.
- ✓ The team must follow the appropriate processes associated with rights restrictions if a person has been assessed as having the knowledge and skill to self-administer, but has demonstrated unsafe behaviors, and is therefore not able to self-administer (Ohio Administrative Code 5123:2-2-06).

(Important Considerations continued):

- ✓ Multiple Self-Administration Assessments may be needed for a person if their knowledge and skills vary with different medications/treatments/circumstances. Separate Self-Administration Assessment forms should be used to document variable abilities with different medications/treatments and circumstances. For example: if a person is not able to self-administer multiple medications at 8 a.m., but can self-administer one or more medications at 12 p.m., or can apply their topical medications independently, then different assessments should be completed to confirm the different outcomes.
- ✓ If two people do not agree with the assessment based on safety concerns, a third team member should be consulted.
- ✓ Complete the specific Self-Administration Assessment Form as designed for: Oral and Topical Medications; Inhaled Medications; Oxygen Administration; Health-Related Activities such as obtaining temperature or blood pressure; Glucometer; Medications, Nutrition, Fluids per G/J Tube; Insulin/Metabolic Glycemic Disorder Medications.
- ✓ The form is a basic assessment tool. If the outcome on this form is "unable to self-administer with or without assistance" the team needs to assess in more detail to determine what steps of medication administration the person can do and plan only to provide the necessary support for other steps.

Using the form:

The assessment is the first part of the form; followed by the assessment outcome.

A. Answer every assessment question on the form; questions are answered with a "Yes", "No" or "N/A".
B. Document the outcome of the assessment. One of the 3 possible outcomes will be determined based on the assessment:
    1. Able to Self-Administer
    2. Able to Self-Administer with Assistance
    3. Unable to Self-Administer with or without assistance

Other mitigating factors are then addressed in the "Other Considerations" section of page 2 regarding the assessment outcome.

Processing the Assessment results:

Once the assessment is completed, the ISP should specify how medications/treatments/health-related activities will be completed.

The ISP will state one of the three possible outcome results:

- able to self-administer without assistance
- able to self-administer with assistance or
- unable to self-administer with or without assistance

If the outcome is "able to self-administer with assistance"

- the ISP should clearly identify which of the three types of assistance is needed and who will provide that assistance (OAC 5123:2-6-02(F))

If the outcome is "unable to self-administer with or without assistance" (Ohio Administrative Code 5123:2-6-02):

- the ISP should clearly identify what steps of medication/treatments/health-related activities the person can do, and who will provide the other steps of the medication administration process

The SSA/QIDP shall ensure the results of the self-administration assessment appear in the ISP.

The current DODD approved assessment forms are on the DODD website.

Use of Pill "Caddies" or Pill "Minders" (pre-packaging medications in any container)

- A person who can fill and use their own pill caddy has the right to do so.
- Only a **licensed** healthcare professional can fill a pill caddy for a person who cannot fill it for themselves.
- Only the person whose medications are in the pill caddy may take the medication from the caddy, that has been prepared for them.
- **Unlicensed personnel may not ever fill a pill caddy** unless at the direction of a person who is self-administering but needs physical assistance (Self-Administration with physical assistance).
- Unlicensed personnel may not ever administer medications from a pre-filled pill caddy.

If a person is not able to independently self-administer (or self-administer with assistance) they may be able to use a pre-filled medication dispenser (pill caddy/minder) to consume their medications.

The person-centered planning team needs to assess a person's ability to safely use this technology as part of the chain of supports put in place for medication administration.

When assessing the ability of a person to safely use a pre-filled medication dispenser, or remote monitoring, the team should consider:

- The person's ability to reliably consume the medication at the correct time or with some type of time reminder, or remote support.
- The person's ability to recognize the presence or absence of the correct medications in the pill caddy (or access to real or remote assistance to confirm the medications in the caddy are correct before taking them).
- The resources and support of appropriately **licensed** personnel to pre-fill the caddy or to fix the contents of the caddy if it spills or if there are any other problems with it.
- The resources and support of a **licensed** healthcare professional to adjust the contents of the caddy if a person has a prescribed medication added, discontinued or changed.
- The resources and support of a properly **licensed** or **MA certified** personnel to administer medication if medications cannot be taken by the person from the caddy.
- How will as needed medications be administered (with or without being in a caddy).
- How will medications that do not fit in a pill caddy be administered (ex. liquids, inhaled, ear, eye, nose and other topicals).
- How will filling and consuming of medications be documented.
- What steps can be achieved with remote monitoring, how, and by whom.

The use of remote monitoring to support medication administration:

- If a person can independently self-administer medications, remote monitoring would not be necessary for medication administration.
- If a person can self-administer with assistance, the remote monitoring can be used for the time reminder and medication confirmation or unlocking assistance. The person providing this assistance does not need to have medication administration certification.
- When a person needs more than the time reminder and medication confirmation or unlocking assistance, then the person providing remote support DOES need to be medication administration certified.
- The MA certified personnel who provide more than self-administration assistance as part of remote supports will need to have a MAR for doing the 3-step check process of medication administration, and to document administration just as if they were with the person.

March 2017

Health and Welfare Alert

Ohio Administrative Code 5123:2-17-02 requires all developmental disabilities employees to review Health and Welfare Alerts released by the department as part of annual training. All previous alerts are listed on the department's website.

Medication Administration #55-3-17

This alert is designed to highlight the importance of safe and effective medication administration practices in order to prevent outcomes resulting in risks to health and welfare. Medication passes are one of the most important support services that are provided to Ohioans with developmental disabilities.

Alex Myers

Alex Myers, a 20-year-old from Hamilton County, enjoyed theater, camp, meeting people, singing in the choir, and spending time with his family. In October 2013, Alex died as a result of a lethal medication error at a group home for people with developmental disabilities.

"You Are Your Brother's Keeper," produced by Alex's family, explains the risks associated with administering medications.

'Rights' of Medication Administration

Administering medications safely involves constant awareness of the risks, creating a system to avoid those risks, and committing to monitoring and maintaining safety standards. People administering medications must be aware of *The 6 Rights* of medication administration.

Right Person - Check the name on the medication order with the person's. Use two ways to identify the person.

Right Medication - Compare the medication label with the Medication Administration Record (MAR) three times.

Right Dose - Compare MAR with medication label three times to assure proper dosage and strength.

Right Route - Confirm patient can take or receive medication by ordered route (e.g., by mouth, eardrops).

Right Time - Confirm when last dose was given. Know how early or how late a medication can be given. Set an alarm.

Right Documentation - Chart the time, route and other information immediately after the medication pass before preparing another person's medication.

Common Medication Errors

- Giving someone the wrong medication
- Giving someone another person's medication
- Giving the wrong dosage of medication
- Giving medication at the wrong time or missing a dose entirely
- Giving medication no longer ordered

Other common issues

- Someone does not have enough support to self-administer medications
- Special instructions are not met for administering medication, such as taking it with or without food, using the proper route, etc.
- System of giving, getting, and documenting medications is flawed
- Prescriptions are not re-filled or new ones are not ordered

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Causes and Contributing Factors

Failure to identify medications with significant risk

- Although any medication can cause serious side effects, medications identified with the strictest warning from the U.S. Food and Drug Administration, or "black box warning," can be lethal if given to the wrong person.
- Review safe medication administration practices to ensure appropriate precautions are in place.

One person is confused for another

- This can happen when multiple people live in the same home, or when staff do not realize that incoming or outgoing staff already administered medications.

Medications are prepared for more than one person at a time

- This practice is forbidden by rule. When medications are placed in cups and prepared for multiple people prior to administration, the risk of error increases exponentially.
- Medications must be prepared for one person at a time while using the Right Documentation.

Distraction or multi-tasking during medication administration

- Medication administration is not a time for completing more than one task. Complete focus must be given to providing the appropriate medication to the Right Person at the Right Time.
- When many people are seeking attention and the environment is hectic, mistakes can be made. It is always best to have a quiet and calm environment when preparing and administering medications.

Tips and Things to Remember

The medication administration system should be clear, consistent, and easily understood

- Have a system that prevents distraction to the person administering the medications.
- Mentor new staff in medication administration in the same environment and conditions that they will actually conduct the administration.
- Remind everyone of the importance of correctly administering medication. Conduct audits and medication monitoring safety checks, noting both positive results as well as opportunities for improvement.
- If for some reason there needs to be a change to the process, make sure that all are aware and the system is detailed well.

Monitor medication administration and step in if there are concerns

- If the person is not acting like himself or herself following a medication pass, take it seriously.
- Be alert to changes in the routine of a person or a group. See the Transitions Health and Welfare Alert for more information.
- Know signs and symptoms of adverse reactions.
- If there is ever doubt, contact 911 immediately.

Over time, a person's support needs, abilities, and medications may change, which can make administration of medication more difficult.

- Dosages and medications may change.
- The person may have relied on a spouse or another for help with medication but now lives on their own.
- Direct support provider schedules and service change.

Other supports that people with developmental disabilities rely on to help them correctly take their medication may not be readily apparent. Assuring appropriate supports are available is key to successful medication administration.

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The Process of Delegation from Licensed Nurse to Certified DD Personnel

A. Definitions:

Delegation: Transferring the authority to perform a specified nursing task or activity in a selected situation to a specific unlicensed person.

Delegator: The delegating nurse is the one who provides the delegation.

Delegatee: The person who receives authority to perform tasks or medication administration from the delegating nurse.

B. Authority for Delegation:

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

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 medications via gastrostomy and/or jejunostomy tube, and/or administration of insulin and other injections for metabolic glycemic disorders to unlicensed MA certified personnel in specified environments.

C. Delegation:

1. All nurse delegation must comply with standards and conditions specified by the OBN in OAC 4723-13.

2. Certification is not the same as delegation. Certain services settings and tasks may require delegation in addition to certification.

3. Developmental Disabilities (DD) personnel who are trained and certified will be selected by the delegating nurse to administer medications and perform health-related activities for settings or activities where delegation is required.

4. DD personnel who are appropriately certified will be selected by the delegating nurse to perform administration of medication through a stable-labeled gastrostomy tube or stable-labeled jejunostomy tube or to administer insulin and other injections for metabolic glycemic disorders at the direction of a licensed nurse.

5. A Registered Nurse (RN) will assess the person to determine if the person's condition and circumstances are stable and that delegation of the medication, health-related activities, or insulin and other injections for metabolic glycemic disorders administration is safe and appropriate.

6. A RN will complete a statement of delegation for each person who requires delegation for their medication administration, performance of health-related activities, administration of medication by stable-labeled gastrostomy or jejunostomy tube and/or insulin and other injections for metabolic glycemic disorders.

7. Certified personnel will receive individual specific training, detailed information and written step by step instructions from the delegating nurse, regarding medication administration, performance of the health-related activities/nursing tasks, administration of medication by stable-labeled gastrostomy tube or stable-labeled jejunostomy tube or insulin and/or other injections for metabolic glycemic disorders.

8. A nurse will observe the skills of certified personnel at least annually or more often as needed. 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.

9. The nurse must provide ongoing supervision of the delegated actions.

Ohio Department of Developmental Disabilities

Effective November 6, 2017

Authority of DD Personnel to Perform Services by Type - Medication Administration Reference Grid (ORC 5123.41-.47 and OAC 5123:2-6-3)

Applicable Setting	County Board (CB) responsibility for Quality Assessment (QA) by RN. See outlined boxes				
	Certification 1	**Certification 1**	**Certification 2**	**Certification 3**	**Delegable Nursing Tasks**
	13-HRAs (Health-Related Activities) (HRAs may be delegable without certification per OAC 4723-13)	**Medication Administation** (Prescribed Oral, Topical, O2 and Inhalers)	**G / J Tube Prescribed Medication Administration**	**Insulin** by Sub-Q Injection & Pump and injectable treatments for metabolic glycemic disorders	**Including 13 HRAs & Administration of Nutrition by G/J Tube**
Adult Services Settings up to 16 people	Without nursing delegation	Without nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation
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 arrangements)	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 arrangements)	Without nursing delegation	Without nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation
Residential Facilities : 1-5 Beds	Without nursing delegation	Without nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation
Early Intervention, Pre-School, School Age	With nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation
Adult Services Settings with 17 or more people	With nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation	With nursing delegation
Residential Facilities : 6 or more Beds	With nursing delegation	With 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	With nursing delegation

As per OBN's Administrative Code Chapter 4723-13, an RN may delegate specific NURSING TASKS to uncertified personnel (following all provisions in OAC 4723-13) . Delegation of MEDICATION requires DODD Certification(s).

Medication Administration (MA) and Health-Related Activities By Medication Administration (MA) Certified Personnel

- MA certified personnel have the responsibility to meet all the requirements set forth in OAC (Ohio Administrative Code) 5123:2-6-06 and comply with procedures as taught in the curriculum for certification.
- MA certified personnel must acquire individual specific training for each person prior to administering medications, treatments or performing health-related activities.
- MA certified personnel must have a directive from a Healthcare Professional prior to administration of any medications or treatment (exceptions are for OTC topical medication for musculoskeletal comfort and the taking of vital signs when illness is suspected).
- **For every medication or treatment to be administered, MA certified personnel have the responsibility to know and understand:**
  - What medication/treatment they are administering
  - Why they are administering that medication/treatment
  - The expected outcome
  - Any special instructions and precautions associated with the medication or treatment that need to be addressed
  - Common potential side effects
  - How to contact or get assistance from a healthcare professional if the person is having problems or the medication or treatment outcome is not as expected

These are crucial elements of Medication Administration and are not exempted by any person, circumstances, employer or delegating nurse. THESE ARE YOUR RESPONSIBILITIES AS PART OF YOUR MEDICATION ADMINISTRATION CERTIFICATION.

IF YOU DO NOT KNOW SOMETHING - ASK

Employer Oversight

The employer is responsible for:

- Assuring IST (individual specific training) for each person is provided to personnel after certification and before medication administration or health-related activities occurs.
- Overseeing medication administration and performance of health-related activities as specified in the Ohio Department of Developmental Disabilities (DODD) law and rule. ORC 5123.42 (D) (4)
- Assuring annual relevant skills check for certified personnel. ORC 5123.45 (D) (4)
- Stopping medication administration and health-related activities performance when there is a question about the skill or activity being performed by the certified personnel.
- Providing ongoing oversight of personnel performing oral and topical medication administration and the 13 health-related activities.
- Assuring nurse delegation for actions that require delegation.

FAMILY DELEGATION

Ohio Revised Code (ORC) 5123.47

When a person's family member lives with them, the family member may provide an **independent provider** with the training, delegation and supervision needed to administer medications and treatments.

- ♦ Prescriptions or directives from a healthcare professional are still required.
- ♦ Detailed written instructions are still required.

Please read ORC 5123.47 for a full explanation of requirements.

Medication Administration Certification is not required when a family delegates to an independent provider.

If services are provided through an agency, family delegation does not apply.

Function of Others Involved in Medication Administration and Performance of Health-Related Activities for People with Developmental Disabilities

A. Physician: Prescribes treatments and medications and determines route, dosage, and frequency for medications. The physician may be consulted if there is question about any treatment or medication.

- **Certified Nurse Practitioners and Licensed Physician's Assistants may also write prescriptions.**

B. Nurse: Where applicable, the licensed nurse delegates duties to MA certified personnel, provides training for medication administration, health-related activities and glucagon. The nurse performs an assessment of the person receiving services and provides ongoing recommendations. The delegating nurse must be contacted for any questions or changes in the health of the person or the delegated activities.

A nurse may be consulted when there are questions regarding medications and/or health-related activities.

The delegating nurse is the only one who can transcribe orders for G/J tube food, fluids, or medications. Orders for insulin and injections for metabolic glycemic disorders must be transcribed by a nurse onto the Medication Administration Record (MAR).

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, side effects or giving medications later than what is indicated on the MAR.

D. Employer: Ensures that **ONLY** 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 healthcare directives may be provided by: Dentists, podiatrists, nurse practitioners, clinical specialists, occupational therapists, physical therapists, speech therapists, and dietitians.

Health Needs

Social Needs

Daily Activity Needs

Training on any equipment

Individual Specific Training (IST)

(OAC 5123:2-6-01)

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

Individual Specific Training is the INITIAL introduction to the person and their healthcare needs and preferences. IST occurs prior to the first-time personnel administer medication or perform health-related activities to any person. Ongoing training continues to be provided as needed.

As a provider, IST is the information you will need to ensure the safest care is provided to a person. **IST must include:**

- ♠ The person's needs (physical, social, and emotional)
- ♠ A summary of the person's relevant health care information

ORC (Ohio Revised Code) 5123.42 makes IST a responsibility shared by the employer and employee. The employer is to ensure personnel receive the training. Certified personnel are not permitted to perform any task presented in Medication Administration Certification training without receiving initial IST for each person.

Daily Schedule/ISP/Agency Policies and Procedures

Paperwork/Documentation

Cognitive abilities
Ability to make decisions
Personal preferences

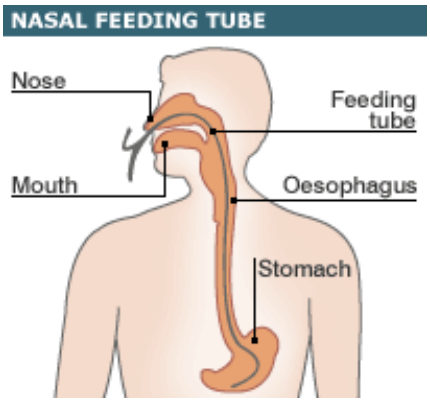
Medications Certified Personnel Are Not Permitted to Apply/Administer

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

EXCEPTIONS for Injections:

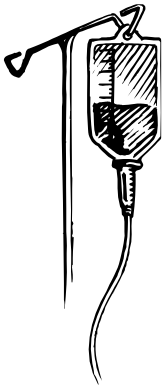
- **Category 1** certified personnel may inject glucagon after a licensed nurse has delegated the task to the certified personnel and the personnel receives Individual Specific Training from the nurse.
- Certified personnel may administer insulin and other injections for metabolic glycemic disorders if they hold a current Category 1 and Category 3 certification and are delegated to do so by a licensed nurse.
- Certified personnel may use an Epinephrine Auto-injector after receiving DODD approved training. **Epinephrine auto-injector is not included in this Category 1 Certification**. See OAC 5123:2-6-05 for information about approved training for the use of an epinephrine auto-injector.

Certified Personnel may NOT Administer

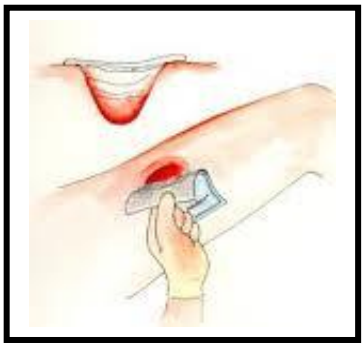


Anything through a Nasogastric (NG) Tube

Parenteral or Intramuscular Injections



IV Medications



Any Debriding Agents

Nasogastric Tube: A tube starting in the nose, passing through the throat and into the stomach.

Parenteral: Delivery of medications by injection.

Debriding: Removal of dead tissue from a wound.

Standard and Universal Precautions

The concept of Universal Precautions presumes that all body fluids are 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 technique for controlling transmission of infections.

Protective measures of personal hygiene are recommended as follows:

1. Keep the body clean.
2. Practice good hand washing (Centers for Disease Control [CDC] advises a minimum of 20 seconds).
3. Don't share used personal items such as medication cups, drinking cups, eating utensils, combs, brushes, etc. without washing them first.
4. Cough or sneeze into arm, sleeve, or disposable tissue.

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

- ♦ Before preparing medications
- ♦ Before and after contact with any person
- ♦ After handling any contaminated equipment
- ♦ Before and after applying topical medications
- ♦ After contact with organic material (i.e. after toileting or assisting with toileting or with hygiene)

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

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

Waterless hand washing products are available for use in situations 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 infection control information.

Sources: www.cdc.gov

What You MUST Know About Any Medication Before Administering It

(Every Medication, Every Time it is Administered)

- What is the purpose of this medication for this person?
- How much should be taken?
- When should it be taken?
- Are there any special instructions?
- Can it be given late if missed? (if yes, how late is too late?)
- What should be done if a dose is missed or if an incorrect dose is given?
- What side effects may occur and who should the suspected side effects be reported to?
- Can anything be done to prevent side effects?
- Will it interact with other medications being taken?
- Should it be taken with food or on an empty stomach?
- Do blood levels need to be checked with this medication?
- If blood work is needed; how often?
- Are there any foods, other medications, supplements, or other things that should not be taken with the medication?

Pharmacist

Information about a specific medication can be obtained from the package insert, a pharmacist, nurse or reputable internet source such as the manufacturer or Drugs.com

Giving or Applying Medication

A. The person giving or applying a medication should <u>always</u> know and consider the following:
- ♦ Why the medication is being given and the expected result
- ♦ Potential side effects, precautions to take, and whom to tell about any concerns

B. **Six rights** of medication administration **(I M DR T D)** (I am Dr. T.D.)

I = Right **I**ndividual (person)
M = Right **M**edication including strength
D = Right **D**ose
R = Right **R**oute
T = Right **T**ime and date **(may be given 1 hour before up to 1 hour after time ordered)**
D = Right **D**ocumentation

C. Stay with the person until the medication has been taken. Be sure medication is taken (swallowed).

D. **Document that you gave the medication(s) IMMEDIATELY AFTER administering.**

E. Medications are to be given and documented by the certified personnel who prepared the dose(s).
- ♦ **NEVER give any medication set up by any other person**
- ♦ **ONLY** give medications **YOU** have set up; this includes medications that you will give to a person who is away from home when you are out with them
- ♦ **DO NOT SET UP medications until you are ready to give them;** prepare and administer medications at the time they are scheduled to be given
- ♦ **Do not** give improperly labeled or unlabeled medications

F. Always keep the original box or bag of the medication that has the label on it. The pharmacy labeling must be able to be read when the medication is being administered.

G. **Only give medications from containers:**
- ♦ That have an intact pharmacy label if it is a prescription medication
- ♦ That have a manufacturer's intact label if it is a non-prescription/OTC medication

H. If giving a medication that the person has never had before, closely observe them for any adverse reactions.

I. Certified personnel must receive **Individual Specific Training** about each person to whom they will be administering medications or treatments before providing medications or treatments.

If the person is not capable of self-administration or self-administration of medication with assistance, then medication may be administered to them as part of their person-centered plan. Personnel administering medications must have a current DODD Category 1 medication administration certification.

PREPARE AND ADMINISTER MEDICATIONS FOR ONLY ONE PERSON AT A TIME

A. Give **FULL ATTENTION** to preparing the medications you will be giving.

B. Make sure the preparation area is clean and well lit.

C. **Check the MAR (medication administration record) to see when the last dose was given and when the next dose will be due. If a medication that should have been given already has not been given, you need to investigate, and report missed medications as Unusual Incidents.**

D. If medications are listed on the MAR for administration at different times, but are all within the same window of time (1 hour before and up to 1 hour after the scheduled time on the MAR), check with a healthcare professional to find out if it is safe to give them together. **Medications may need to be given at separate times because they are not safe or effective when given together.**

Ex: Synthroid scheduled at 7 AM and Lisinopril at 9 AM should NOT be given together at 8 AM.

Scored tablets may be split. Unscored tablets should not be split by medication administration certified personnel.

Scored tablet

Unscored tablet

E. Never place any oral medication (i.e. tablet, capsule, pill) into your own hand.

F. Multiple oral medications for a given person can go into the same cup, unless otherwise specified.

G. Put one medication at a time from its container into the cup in the correct amount. Follow the person's specific instructions to know how many medications to put in a single cup.

If a medication is specified as not crushable, there must be a physician order to crush the medication, if it needs to be crushed.

H. More than one cup may be needed to safely administer multiple medications. Carefully consider a person's ability to swallow multiple medications at one time.

I. Never use unlabeled medications.

J. Never prepare medications before it is time to administer the medications. Never administer medications that have been prepared by someone else; not even if a parent, guardian or nurse has prepared the medications.

Make sure the medication in the pill bottle or docu-dose matches the description from the pharmacy

K. If you have any questions regarding the medications, seek assistance. Resources for medication questions include the person's physician, nurse, or pharmacist. **Unlicensed personnel, including supervisors, may not make independent judgements about medication administration decisions.**

L. Check each person's MAR: Every Medication, Every Page, Every Day.

NEVER prepare medications early for administration later.

(Except as instructed in this manual for administration on outings).

Getting Medication From the Original Container

Getting Medication from a Bottle or Vial Container to the Dispensing Cup

When administering medications from a bottle or vial, certified personnel must be careful not to touch the capsule or tablet with their fingers. The medication is poured from the container into the lid of the container, then from the lid into the dispensing cup.

Pour pill from container into lid of container

Transfer to dispensing cup

Getting Medications from the Blister (bubble) pack to the Dispensing Cup

The packaging for medications placed in compartments for a given month is called a blister pack or bubble pack. The pills are placed in numbered windows.

Put the cup under the correct pills so that you can push the pills from the appropriate window into the dispensing cup.

Check to be sure the medication is in the cup (not stuck in the back of the blister/bubble pack).

Getting Medications from a Multi-Dose Pack to the Dispensing Cup

Multi-dose packs have all the medications for a specific time together in a single pouch. The pharmacy label and description of each medication must be included on the packaging.

Personnel must identify each pill/capsule and compare it to the label and the MAR.

After performing the 2 checks of the MAR personnel put the medication into the dispensing cup.

Medications should be checked the 3rd time after they are put in the cup and they are clearly visible. Try not to destroy the information about each medication while opening the multi-dose packs.

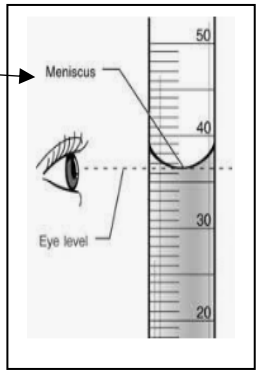
Techniques for Measuring Liquid Medications

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. Pour slowly. Stop when desired level is reached. **Never hold** the measuring cup/device in your hand. **Always place it on a flat surface.**

3. 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 surface at the level of your eyes.

4. When looking at the level of the liquid, the line will look slightly "U" shaped. The bottom of the U is the measuring line of the liquid medication.



5. Use a measuring device that is exact. You may use a calibrated cup, or a syringe designed to draw up medications from a bottle, or an actual measuring spoon. **Never** use a silverware spoon. A silverware "teaspoon" may or may not hold an actual "teaspoon" of liquid or powder.

6. Each person must have their own spoon/cup/delivery device. Wash with soap and water after each use.

Steps for Administering Medication by Mouth (Oral)

If the expiration date is August 10, 2020, the medication may be used up until midnight of August 10, 2020. The medication may not be used on August 11, 2020 or after. If the expiration date is month and year, the medication is good until midnight the last day of the month it expires.

1. Wash hands.

2. Start at the beginning of the medication administration record (MAR) and review, checking for the following:
   a) Individual's name
   b) All medications ordered
   c) Medications to be given now
   d) Confirm that the previous dose was given
   e) Confirm the dose for this time and date has not yet been given
   f) Any allergies
   g) Special instructions for giving the medication

3. Read all the pages of the person's MAR to confirm ALL the medications you will need to prepare for administration. This includes the ***entire* medication name (including strength)**, the dose (amount), and route of each medication you will be giving to the person at this time.

4. Get the medication from the secure storage area.

5. Read the ***entire label*** carefully including the expiration date and special instructions. Make sure the packaging description of the medication matches the medication inside the container.

6. **The first check of the MAR to label**:
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date)

7. **The second check of the MAR to label**:
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date)

8. **If they do not match, do not give the medication until there is clarification** from a healthcare record or healthcare professional regarding the medication. If they do match go to the next step.

9. Using a medication cup, place the medication in the cup without touching the medication with your fingers.

10. **The third check** (done for each medication after it is placed in the cup):
    a) Check medication label against the MAR to confirm the 5 rights
    b) Check the amount of medication in the cup to make sure it matches the label and the MAR
    c) Use optional "dot system" at this step (see "dot system" instructions on page 35)

11. Using steps 5-10 put the next medication into the cup. Repeat until all scheduled oral medications have been prepared.

12. Secure the medication containers before leaving them to go administer medications that have been prepared to give. Never leave prepared medication unattended.

13. Identify the person to receive the medication. Take your time and make sure you are giving the prepared medication to the correct person. Confirm the person's identity with a picture or with another personnel who knows the person.

14. Explain to the person the name and purpose of medication(s) you are giving to them.

15. Be certain the medication is taken (swallowed). Check the person's mouth if uncertain.

16. Leave the person in a safe and comfortable manner.

17. **D**ocument that medication was administered (this is the 6th Right of medication administration). Place your initials on the MAR in the space for the specific **I**ndividual's **M**edication(s), **D**ose, **R**oute and **T**ime/date, **D**ocumenting that you have given the medication **(I M DR TD).**

18. Document any complaints/concerns and action taken.
If the medication is only used as needed, document the need and the response to the treatment.

19. If medication was missed, held, declined or given late, document by circling your initials and explain on the back of the MAR. Write an Unusual Incident Report.

20. Return equipment to the storage area.

21. Make sure your initials, full name, and title are written in a space provided for signatures on the MAR or on a Master Signature Log.

Example: DOCUMENTATION of a problem/complaint

Sue had trouble swallowing her Potassium as a whole pill. I called Accu-dose Pharmacy. Spoke with Jim Smith, R.Ph. He said I could split the scored tablet in half. I split the potassium tablet and Sue took both halves without difficulty.

✓ **Skills checklist to be signed by trainer and trainee are available on the DODD website**

Steps for Administering Medication
MAR Documentation Using the "Dot System" (or method)

Preparing multiple medications for the same administration time requires extra focus and attention to ensure all medications are prepared for administration as ordered.

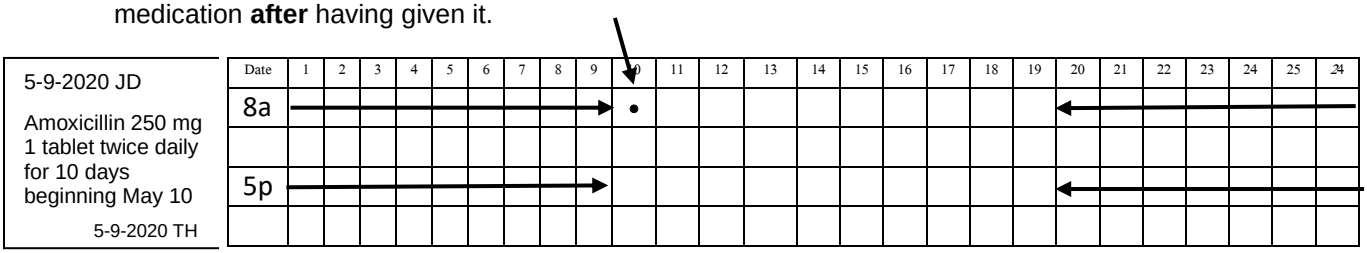
The **"dot system"** provides a means for tracking medications as they are prepared and assists with documentation after administration. The use of the "dot system" is an **optional** addition to the Steps for Administering Medications.

The use of the dot is an additional step following the 3rd MAR check during preparation of medication. To use the "dot system":

- Upon completion of the 3rd MAR check, a dot is placed in the space on the MAR where you will document the administration of the medication on the MAR after having given it.
- The dot indicates that all 3 MAR checks have been done and that the medication was **prepared** for administration.

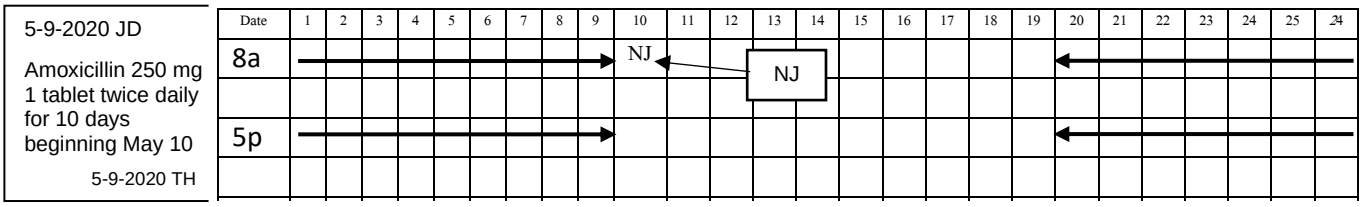
Using the "dot system" as part of the 3rd MAR check:

1. **The third check** (is done for each medication after it is placed in the cup): Check medication label and the MAR to make sure they match exactly with what is in the cup:
   a) Check medication label against the MAR to confirm the 5 Rights
   b) Check the amount of medication in the cup to make sure it matches the label and the MAR
2. Then mark a dot in the space on the MAR where you will document the administration of the medication **after** having given it.



The dot is a visual assist in identification of the prepared and administered medication.

3. **Following administration of the medication(s), certified personnel place their initials in the space for the specific I**ndividual's, **M**edication(s), **D**ose, **R**oute, and **T**ime/date, **D**ocumenting that you have given the medication (**I M DR TD**).



If a medication was prepared, but not administered, personnel document by initialing the MAR, circling initials and writing an explanation on the back of the MAR. Write an Unusual Incident Report.

It is **NEVER appropriate** for certified personnel to place their initials on the MAR before administering a medication. Documentation of medication administration before a medication is given compromises the safety of the person.

Documentation of medication administration before the medication is administered is falsification of a legal document. Falsification of a legal document is a prosecutable offense.

The use of the "dot system" is an **optional** addition to the Steps for Administering Medications.

Special Instructions for Sublingual and Buccal Medications:

***If also administering oral medications at the same time, administer oral medications before sublingual or buccal.**

Medications Given Under the Tongue (Sublingual)

(i.e. Nitroglycerin pills or spray)

1. Sublingual medication is placed under the tongue and kept there until dissolved/melted. This type of medication cannot be chewed or swallowed.
2. Stay with the person until the medication has dissolved.
3. After taking a sublingual medication, have the person wait at least 30 minutes before consuming any food or fluids.
4. Observe the person for any side effects of the medication.
5. Some sublingual medications come with additional instructions. Be sure to follow prescription orders for each medication.

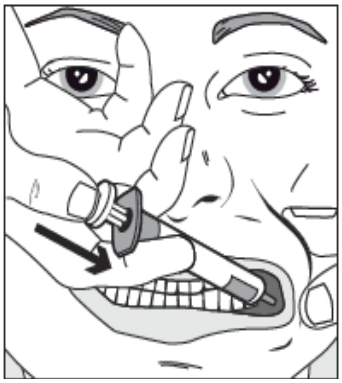
Sublingual Administration of a tablet

Medications Given Between the Cheek and Gum (Buccal)

(i.e. pills, or liquid)

1. Buccal medication is placed between the gums/teeth and cheek and kept there until dissolved/melted.

Buccal administration of a tablet



Buccal administration of a gel

2. Stay with the person until the medication has dissolved.
3. After taking a buccal medication, have the person wait at least 30 minutes before consuming any food or fluids.
4. Observe for any side effects of the medication.
5. Be sure to follow the prescription orders for any special instructions.

Orally Disintegrating Medications

Some medications are designed to dissolve when placed on **TOP** of the tongue. Be sure the person places the orally disintegrating medication in the correct position in the mouth, otherwise the medication will not work effectively.

Steps for Administering Sublingual or Buccal Medication

1. Wash hands.

2. Start at the beginning of the medication administration record (MAR) and review, checking for the following:
   a) Individual's name
   b) All medications ordered
   c) Medications to be given now
   d) Confirm that the previous dose was given
   e) Confirm the dose for this time and date has not yet been given
   f) Any allergies
   g) Special instructions for giving the medication

3. Read all the pages of the person's MAR to confirm ALL the medications you will need to prepare for administration. This includes the ***entire* medication name (including strength)**, the dose (amount), and route of each medication you will be giving to the person at this time.

4. Get the medication from the secure storage area.

5. Read the ***entire label*** carefully including the expiration date and special instructions. Make sure the packaging description of the medication matches the medication inside the container.

6. **The first check of the MAR to label:**
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date)

7. **The second check of the MAR to label:**
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date)

8. **If they do not match, do not give the medication until there is clarification** from a healthcare record or healthcare professional regarding the medication. If they do match go to the next step.

9. Using a medication cup, place the medication in the cup without touching the medication with your fingers.

10. **The third check** (done for each medication after it is placed in the cup):
    a) Check medication label against the MAR to confirm the 5 rights
    b) Check the amount of medication in the cup to make sure it matches the label and the MAR
    c) Use the optional "dot system" at this step (see "dot system" instructions on page 35)

11. Secure the medication containers before leaving them to go administer medications that have been prepared to give. Never leave prepared medication unattended.

12. Put on gloves.

13. Identify the person to receive the medication. Take your time and make sure you are giving the prepared medication to the correct person. Confirm the person's identity with a picture or with another personnel who knows the person.

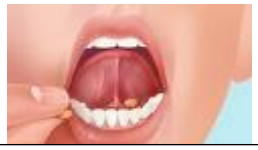
14. Explain to the person the name and purpose of medication(s) you are giving to them.

15. Assist the person into an upright or sitting position and ask them to open their mouth.

16. If the person receives a sublingual/buccal medication on a regular basis, change to different sites under the tongue or buccal/cheek area with each administration.

17. Examine the mucous membrane (under tongue, cheek, gum area) for irritation or sores. If irritation or sores are present, notify a healthcare professional for further instructions before administering the medication.

    If mucous membrane is intact (without sores or irritation):



Sublingual Administration of a tablet

    A. **For sublingual** medication administration:
        1. Ask the person to open their mouth and raise their tongue
        2. Place the tablet, or help the person to place the tablet under their tongue:
            a. If helping the person to lift their tongue, use gauze to help lift the tongue
            b. If administering a sublingual spray, hold the spray about 1 inch away from the site and instruct the person to hold their breath while spraying

    B. **For buccal** medication administration:
        1. Ask the person to open their mouth and expose their cheek/gum area. If helping the person, gently apply downward pressure on the lower lip
        2. Place the tablet between the inner aspect of the cheek and gum or teeth
        3. If administering a liquid medication, insert the syringe into buccal cavity and slowly administer the medication by pushing downward on the plunger

    (Follow specific instructions if half the liquid is to be administered on each side)

Buccal Administration of a tablet

18. Encourage the person to keep their mouth closed until the medication has dissolved. Remind the person not to chew or swallow the medication.

19. Stay with the person until the medication is dissolved.

20. Leave the person in a safe and comfortable manner.

21. Remove gloves and wash hands.

22. **D**ocument that medication was administered (this is the 6th Right of medication administration). Place your initials on the MAR in the space for the specific **I**ndividual's **M**edication(s), **D**ose, **R**oute and **T**ime/date, **D**ocumenting that you have given the medication. **(I M DR TD).**

23. Document any complaints/concerns and action taken. If the medication is only used as needed, document the need and the response to the treatment.

24. If medication was missed, held, declined or given late, document by circling your initials and explain on the back of the MAR. Write an Unusual Incident Report.

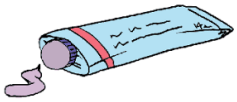
25. Return equipment to the storage area.

26. Make sure your initials, full name, and title are written in a space provided for signatures on the MAR or on a Master Signature Log.

✓ **Skills checklist to be signed by trainer and trainee are available on the DODD website**

Lotions

Creams



Ointments

Categories of Skin Medications

	Examples of Medications	Examples of Side Effects	Related Care
Anti-Infective Used to treat or prevent infections on the skin and mucous membranes	Bactrim® Neosporin® Bactroban®	◂ Temporary dryness in affected areas ◂ Allergic reaction can occur after application	Cleanse area as instructed for the treatment
Anti-fungal Used to treat fungal infection	Nystatin Fungizone® Lotrimin®	See above	See above
Parasite Topical Used to treat head lice and scabies	Nix® Cream Rinse Kwell® Cream, lotion, or shampoo	See above Skin irritation occurs with repeated use	◂ Check other persons for possible infestation ◂ Clean any adaptive equipment used by the person See below for more information

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 person
- ◂ Use a fine-tooth comb to remove nits after application
- ◂ More information can be found at *https://www.cdc.gov/parasites/lice/index.html or https://www.nlm.nih.gov/medlineplus/ency/article/000840.htm*

NOTE: The instructions on the MAR must include the location (the affected area) where the topical product is to be applied.

*****Medications applied to the skin for providing comfort to muscles and bones is presented later in this curriculum.**

Steps for Administering Medications to Skin

1. Wash hands.

2. Start at the beginning of the medication administration record (MAR) and review, checking for the following:
   a) Individual's name
   b) All medications ordered
   c) Medications to be given now
   d) Confirm that the previous dose was given
   e) Confirm the dose for this time and date has not yet been given
   f) Any allergies
   g) Special instructions for giving the medication

3. Read all the pages of the person's MAR to confirm ALL the medications you will need to prepare for administration. This includes the ***entire*** **medication name (including strength)**, the dose (amount), and route of each medication you will be giving to the person at this time.

4. Get the medication from the secure storage area.

5. Read the ***entire label*** carefully including the expiration date and special instructions. Make sure the packaging description of the medication matches the medication inside the container.

6. **The first check of the MAR to label:**
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date); also confirm the location where the medication is to be applied

7. **The second check of the MAR to label**:
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date); also confirm the location where the medication is to be applied

8. **If they do not match, do not give the medication until there is clarification** from a healthcare record or healthcare professional regarding the medication. If they do match go to next step.

9. **The third check** (done before application of medication to skin):
   a) Check medication label against the MAR to confirm the 5 Rights
   b) Check the amount of medication to be used and where to apply
   c) Use the optional "dot system" at this step (see "dot system" instructions on page 35)

10. Put on gloves.

11. Identify the person to receive the medication. Take your time and make sure you are giving the prepared medication to the correct person. Confirm the person's identity with a picture or with another personnel who knows the person.

12. Provide for privacy.

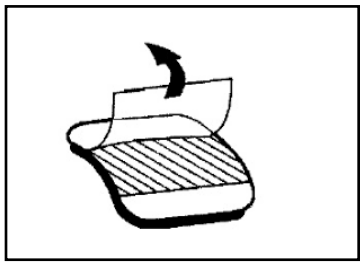
13. Explain to the person the name and purpose of medication(s) you are applying to them.

14. Assist the person into a position that allows for safe application of the medication.
15. Look at the affected area and if ordered, cleanse the area with soap and water, then dry thoroughly.
16. Apply the medication according to directions in the correct amount at the specified location.
17. Leave the person in a safe and comfortable manner.
18. Dispose of application materials as instructed.
19. Remove gloves and wash hands.
20. Return the medication to the secure storage.
21. **D**ocument that medication was administered (this is the 6th Right of medication administration). Place your initials on the MAR in the space for the specific **I**ndividual's **M**edication(s), **D**ose, **R**oute and **T**ime/date, **D**ocumenting that you have given the medication **(I M DR TD).**

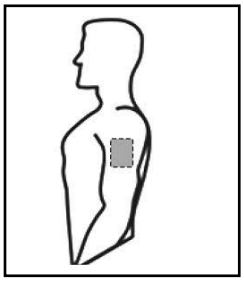
22. Document any complaints/concerns and action taken. If the medication is only used as needed, document the need and the response to the treatment.
23. If medication was missed, held, declined or given late, document by circling your initials and explain on the back of the MAR. Write an Unusual Incident Report.
24. Make sure your initials, full name, and title are written in a space provided for signatures on the MAR or on a Master Signature Log.

✓ **Skills checklists to be signed by trainer and trainee are available on the DODD website**.

Transdermal Medications



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 (i.e. birth control, pain, heart problems, etc.)



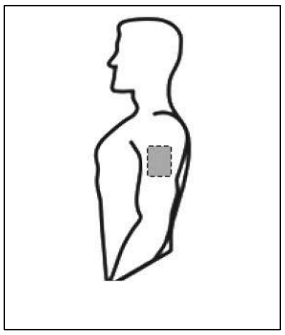
If a transdermal patch is ordered for the person, you must follow the same procedures for assuring correct preparation of this medication, as you do with all medication you administer. Transdermal medications are just as strong as medications given by other routes.

If the person is able, have them wash their hands and apply their own transdermal patch after you have done the 3 MAR checks for the medication.

General instructions for administering transdermal medications:

- Be sure to wear gloves.
- Be sure to reapply daily transdermal medications at the same time every day to ensure a continuous delivery of medication.
- If the person can, have them remove their own patch. If not, carefully remove the patch, so as not to tear the skin covered by the patch.
- For safety, cut up the old patch and put it in a plastic bag for disposal. Carefully clean the scissors to remove any medication left on the blades.
- Clean and dry the skin where the old patch was removed.
- Make sure you know where the person's patch is to be applied. Some patches are applied to the same location every time; others are rotated to different locations. Check with the pharmacist, package insert, physician, or licensed nurse about appropriate sites for applying the person's transdermal patch.
- Do not apply a transdermal patch over scars, calluses, folds or wrinkles in the skin, or on irritated skin.
- Check with pharmacist to see if prescribed patch can be placed over a tattoo.
- Be sure to observe the person for side effects such as skin irritation, rash, dizziness, headache, drowsiness, or any other side effects, or drug interactions.
- Write the current date, time and your initials on the patch if the patch size allows.
- If the patch falls off before it is due to be replaced, notify the appropriate healthcare professional for instructions.

Steps for Administering Transdermal Medication



1. Wash hands.

2. Start at the beginning of the medication administration record (MAR) and review, checking for the following:
   a) Individual's name
   b) All medications ordered
   c) Medications to be given now
   d) Confirm that the previous dose was given
   e) Confirm the dose for this time and date has not yet been given
   f) Any allergies
   g) Special instructions for giving the medication

3. Read all the pages of the person's MAR to confirm ALL the medications you will need to prepare for administration. This includes the ***entire*** **medication name (including strength)**, the dose (amount), and route of each medication you will be giving to the person at this time.

4. Get the medication from the secure storage area.

5. Read the ***entire label*** carefully including the expiration date and special instructions. Make sure the packaging description of the medication matches the medication inside the container.

6. **The first check of the MAR to label:**
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date)

7. **The second check of the MAR to label:**
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date)

8. **If they do not match, do not give the medication until there is clarification** from a healthcare record or healthcare professional regarding the medication. If they do match go to the next step.

9. **The third check** (done before application of medication to skin):
   a) Check medication label against the MAR to confirm the 5 Rights - remove the patch packet from pharmacy labeled box
   b) Confirm that the patch packet matches the order. Check where to apply the transdermal patch
   c) Use optional "dot system" at this step (see "dot system" instructions on page 35)

10. Return the remaining medication supply to secure storage. Never leave the single patch unattended.

11. Put on gloves.

12. Identify the person to receive the medication. Take your time and make sure you are giving the prepared medication to the correct person. Confirm the person's identity with a picture or with another personnel who knows the person.

13. Provide for privacy.

14. Explain to the person the name and purpose of medication(s) you are going to apply.

15. Remove the old patch. Gently wash and dry the area. Observe for skin irritation. Document and report any irritation.

16. Select the correct site. Clean and dry the site if it is a new site (never apply a patch over irritated area, scars, calluses, or folds).

17. Open the sealed wrapper containing the patch. Write the current date, time and your initials on the patch if the patch size allows. Apply the patch according to directions. Follow any special instructions about applying this medicated patch.

18. Leave the person in a safe and comfortable manner.

19. Properly dispose of the old patch according to pharmacy/manufacturer's instructions.

20. Remove gloves and wash hands.

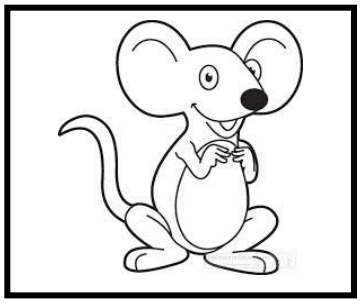
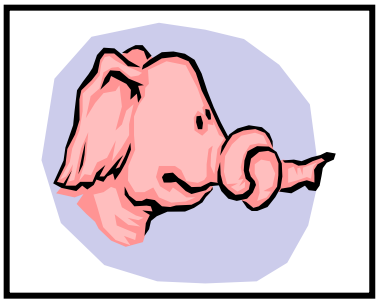
21. **D**ocument that medication was administered (this is the 6th Right of medication administration). Place your initials on the MAR in the space for the specific **I**ndividual's **M**edication(s), **D**ose, **R**oute and **T**ime/date, **D**ocumenting that you have given the medication **(I M DR TD).**

22. Document any complaints/concerns and action taken. If the medication is only used as needed, document the need and the response to the treatment.

23. If medication was missed, held, declined or given late, document by circling your initials and explain on the back of the MAR. Write an Unusual Incident Report.

24. Make sure your initials, full name, and title are written in a space provided for signatures on the MAR or on a Master Signature Log.

✓ **Skills checklists to be signed by trainee and trainer are available on the DODD website**.

Eye, Ear and Nose Medications

This section includes information on the procedures for administering eye, ear and nose medications. This section does not include all medications that may be prescribed. Certified personnel are expected to learn about each person's specific medications before administering.

It is important to know what the medication is expected to do. If the person's condition does not improve or gets worse, notify the prescribing healthcare professional.

In the table below is an overview of uses of eye, ear, and nose medications. Make sure you know what each medication is being used for with the specific person.

	USES	Helpful Information
Eye (Ophthalmic) Medications	**USES:** ♥ Relieve pain ♥ Treat allergies ♥ Treat or prevent infections ♥ Treat diseases such as glaucoma	**Note:** Be careful to never let the applicator tip touch the eye. **Note:** If using multiple eye medications wait at least 5 minutes between different medications.
Ear (Otic) Medications	**USES:** ♥ Treat infection ♥ Relieve pain ♥ Soften wax	**Note:** Before instilling ear drops you need to straighten the person's ear canal by grasping the center of the outer ear and gently pulling back and up. If 2 years or under, pull ear back and down.
Nose (Nasal) Medications	**USES:** ♥ Relieve pain ♥ Treat allergies ♥ Treat infections ♥ Relieve congestion	**Note:** Have the person blow their nose to clear the nasal passages before instilling nasal medication. Assist as needed and have them wash their hands when finished.

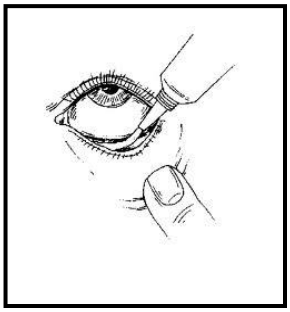
NOTE: When administering more than one medication in an ear, eye or nose make sure the MAR clearly states the order the medications should be administered (1st, 2nd, 3rd, etc.) and how much time between each medication. If you have questions, contact a healthcare professional to clarify the correct administration.

Note to Trainers: The nasal Versed® curriculum can be found in the appendix. The material is optional and may or may not be relevant for the group being taught. Use the manufacturer's instructions for diazepam nasal spray training.

Note to students: Do NOT administer Nasal Versed® (midazolam) for seizure care or Valtoco® (diazepam nasal spray) until you have had specialized training.

Categories of Eye Medications

(Categories of Ophthalmic Medications)

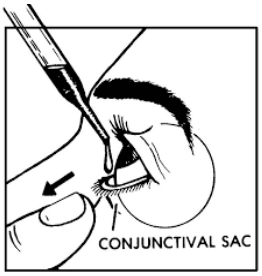


	Examples of Medications	Examples of Side Effects	Related Care
Antibiotics Used to treat infections of the eye	**Name** **Brand** — **Generic** Gentacidin® — Gentamicin Tobrex® — Tobramycin Neosporin® — Polysporin	◂ Itching ◂ Blurred vision ◂ Hypersensitivity (increased redness, watering, swelling)	◂ Observe for changes in eyes: document and report ◂ Do not share used towels and washcloths ◂ Encourage the person to keep hands away from eyes
Anti-Inflammatory Used to decrease swelling in or around the eye	**Brand** — **Generic** Pred-Forte® — Prednisolone Acetate Decadron® — Dexamethasone	◂ Blurred vision ◂ Burning, stinging and watering of eyes upon application	◂ Encourage the person to keep hands away from eyes ◂ Observe for changes in eyes: document and report
Miotics Used to treat intraocular pressure	**Brand** — **Generic** Pilocar® — Pilocarpine Isopto Carpine® — Pilocarpine Timoptic® — Timolol	◂ Stinging, itching, burning and watering of eyes upon application ◂ Sweating, nausea, dizziness and weakness	◂ Tell the person 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 **
Lubricants Used to relieve burning and irritation from dryness of the eye and prevent further irritation	**Brand** — **Generic** Tears Naturale II® — Lubricant eye drops Murine Plus® — Lubricant eye drops	◂ No known side effects	◂ Do not use solution if discolored or cloudy ◂ Report any eye pain, changes in vision, continued redness or irritation to a healthcare professional

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

DO NOT TOUCH THE TIP OF ANY EYE MEDICATION TO ANY SURFACE INCLUDING THE EYE.

Steps for Administering Eye (Ophthalmic) Medications



1. Wash hands.

2. Start at the beginning of the medication administration record (MAR) and review, checking for the following:
   a) Individual's name
   b) All medications ordered
   c) Medications to be given now
   d) Confirm that the previous dose was given
   e) Confirm the dose for this time and date has not yet been given
   f) Any allergies
   g) Special instructions for giving the medication

3. Read all the pages of the person's MAR to confirm ALL the medications you will need to prepare for administration. This includes the ***entire* medication name (including strength)**, the dose (amount), and route of each medication you will be giving to the person at this time.

4. Get the medication from the secure storage area.

5. Read the ***entire label*** carefully including the expiration date and special instructions. Make sure the packaging description matches the medication inside the container.

6. **The first check of the MAR to label:**
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date); confirm in which eye(s) the medication is to be administered

7. **The second check of the MAR to label:**
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date); confirm in which eye(s) the medication is to be administered

8. **If they do not match, do not give the medication until there is clarification** from a healthcare record or healthcare professional regarding the medication. If they do match go to the next step.

9. **The third check** (done before putting medication in eye(s)):
   a) Check medication label against the MAR to confirm the 5 Rights
   b) Confirm which eye and how much medication
   c) Use optional "dot system" at this step (see "dot system" instructions on page 35)

10. Put on gloves.

11. Identify the person to receive the medication. Take your time and make sure you are giving the prepared medication to the correct person. Confirm the person's identity with a picture or with another personnel who knows the person.

12. Explain to the person the name and purpose of medication(s) you are giving to them.

13. If required, cleanse the affected eye with a clean cloth, or cotton ball/pad. Wipe from the inner corner of their eye outward just once.

14. Position the person with their head back and looking upward. Gently pull down the lower lid.

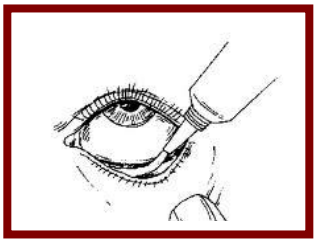
15. Approach the eye from below with the applicator tip remaining outside the person's field of vision.

16. Do not make contact with the eye. Use extra caution to not touch the eye with your fingernails.

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

IF OINTMENT:
Apply ointment in a thin layer along the inside of the lower lid. Apply the amount of ointment prescribed (usually about a ½ inch long "ribbon" of ointment). Break off the ribbon of ointment from the tube by relaxing pressure on the tube and moving the tube away from the eye. Do not use your fingers.



To prevent contamination, do not touch the end of the applicator tip on any part of the eye.

17. Allow the eye to gently close. Encourage the person to keep their eye closed for at least fifteen (15) seconds.

18. Wipe excess medication from their eye with a clean cloth or cotton ball/pad using separate ball/pad for each eye.

19. If both eyes need medication, **change gloves between eyes** to avoid transferring contamination from one eye to the other.

20. Repeat steps 13-18 for the second eye.

21. Leave the person in a safe and comfortable manner.

22. Dispose of cotton balls or put cloth(s) in laundry.

23. Remove gloves and wash hands.

24. Return medication to secure storage.

25. **D**ocument that medication was administered (this is the 6th Right of medication administration). Place your initials on the MAR in the space for the specific **I**ndividual's **M**edication(s), **D**ose, **R**oute and **T**ime/date, **D**ocumenting that you have given the medication **(I M DR TD).**

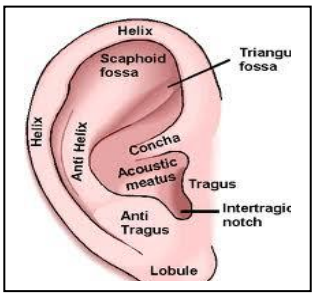
26. Document any complaints/concerns and action taken.
If the medication is only used as needed, document the need and the response to the treatment.

27. If medication was missed, held, declined or given late, document by circling your initials and explain on the back of the MAR. Write an Unusual Incident Report.

28. Make sure your initials, full name, and title are written in a space provided for signatures on the MAR or on a Master Signature Log.

✓ **Skills checklists to be signed by trainer and trainee are available on the DODD website**.

Categories of Ear (Otic) Medications



Uses for Ear Medications	Examples of Medications	Examples of Side Effects	Related Care
Antibiotics Used to treat infections of the ear	**Brand Names:** Cortisporin® Otobiotic®	◂ Stinging ◂ Burning	◂ Observe ears for changes and document ◂ Encourage the person to keep their hands away from their ears ◂ Never place a Q-tip® inside the ear canal ◂ Encourage use of a shower cap to keep water out of ears
Ear Cleansers Used to dissolve and remove ear wax build-up	**Brand Name:** Debrox®	◂ No known side effects ◂ Not recommended for use with ear tubes in place	◂ Consult with a healthcare professional if the person has a suspected ear infection ◂ Encourage the person to keep hands away from ears
Corticosteroids Used to control inflammation and edema in the ear	**Brand Names:** Medrol® Cortame® Otall®	◂ May mask an underlying infection	◂ Hold medication and call a healthcare professional if there is any drainage noted ◂ May be used concurrently with an antibiotic

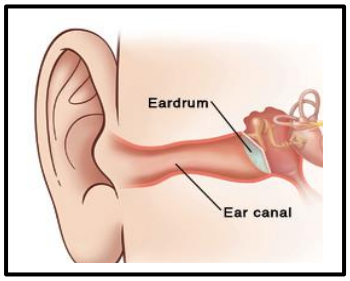
NOTE: It is best to not insert a cotton ball. After administering ear medications encourage the person to remain with their ear to the side for several minutes before becoming active. This should eliminate any need for a cotton ball to be inserted in the ear. If the person insists on a cotton ball, loosely place it in the outer ear for no longer than 15 minutes.

Warming Medications

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

Never place medication container in the microwave or in hot water. You may accidentally change the chemical composition of the medication, or injure the person, if you get it too warm.

Steps for Administering Ear (Otic) Medications



1. Wash hands.

2. Start at the beginning of the medication administration record (MAR) and review, checking for the following:
   a) Individual's name
   b) All medications ordered
   c) Medications to be given now
   d) Confirm that the previous dose was given
   e) Confirm the dose for this time and date has not yet been given
   f) Any allergies
   g) Special instructions for giving the medication

3. Read all the pages of the person's MAR to confirm ALL the medications you will need to prepare for administration. This includes the ***entire* medication name (including strength)**, the dose (amount), and route of each medication you will be giving to the person at this time.

4. Get the medications from the secure storage area.

5. Read the ***entire label*** carefully including the expiration date and special instructions. Make sure the packaging description of medication matches the medication inside the container.

6. **The first check of the MAR to label**:
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date); confirm in which ear(s) the medication is to be administered

7. **The second check of the MAR to label**:
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date); confirm in which ear(s) the medication is to be administered

8. **If they do not match, do not give the medication until there is clarification** from a healthcare record or healthcare professional regarding the medication. If they do match go to the next step.

9. **The third check** (done before putting medication in ear(s)):
   a) Check medication label against the MAR to confirm the 5 Rights
   b) Confirm which ear(s) and how many drops
   c) Use optional "dot system" at this step (see "dot system" instructions on page 35)

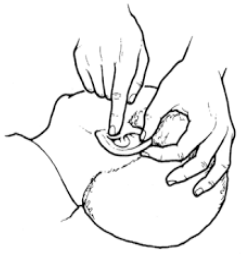
10. Put on gloves.

11. Identify the person to receive the medication. Take your time and make sure you are giving the prepared medication to the correct person. Confirm the person's identity with a picture or with another personnel who knows the person.

12. Explain to the person the name and purpose of medication(s) you are giving to them.

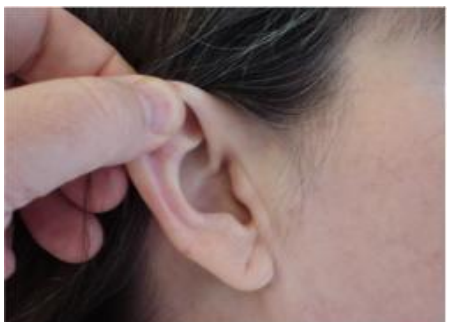
13. Position the person by having them lie down or sit in a chair, tilting head sideways until their ear is as horizontal as possible.

14. Cleanse the entry to their ear canal with a clean cloth or cotton ball/pad.



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 ear.
17. Encourage the person to stay with their head to the side for 2 minutes or per manufacturer's instructions.
18. If both ears need medication, change gloves between ears to avoid transferring contamination from one ear to the other.
19. Repeat steps 13-17 for the second ear.
20. Leave the person in a safe and comfortable manner.
21. Dispose of cotton balls/pads or put cloth(s) in the laundry.
22. Remove gloves and wash hands.
23. Return the medication to secure storage.
24. **D**ocument that medication was administered (this is the 6th Right of medication administration). Place your initials on the MAR in the space for the specific **I**ndividual's **M**edication(s), **D**ose, **R**oute and **T**ime/date, **D**ocumenting that you have given the medication (**I M DR TD).**

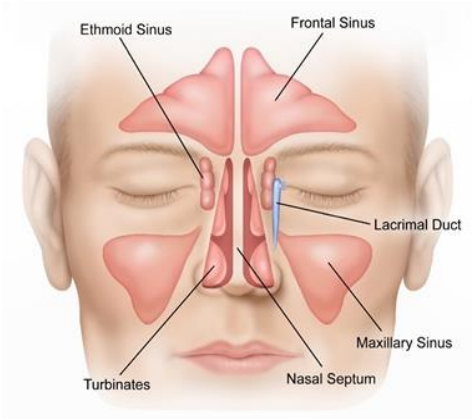
25. Document any complaints/concerns and action taken. If the medication is only used as needed, document the need and the response to the treatment.
26. If medication was missed, held, declined or given late, document by circling your initials and explain on the back of the MAR. Write an Unusual Incident Report.
27. Make sure your initials, full name, and title are written in a space provided for signatures on the MAR or on a Master Signature Log.



To open ear canal, pull mid-outer ear back and up. Be sure to wear gloves.

✓ **Skills checklists to be signed by trainee and trainer are available on the DODD website**.

Categories of Nose (Nasal) Medications



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

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

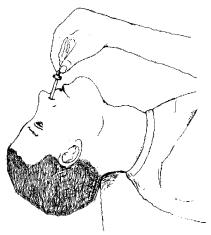
	Examples of Medications	Examples of Side Effects	Related Care
Anti-Inflammatory and Decongestants Used to clear nasal passages	**Brand Names:** Flonase® Nasonex® Veramyst®	◂ Dry, irritated throat ◂ Abnormal sense of taste ◂ Nasal burning or bleeding	◂ Not recommended for prolonged use ◂ Store at room temperature ◂ Do not exceed recommended dose

NOTE: Have the person use disposable tissues rather than cloth handkerchiefs to blow their nose and advise the person to wash their hands after blowing their nose.

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

NOTE: If the person develops a nosebleed, have the person lean **forward** and pinch the end of their nose firmly. Use a towel or bowl to catch any blood. Place a cooled washcloth on the back of their neck. If bleeding does not stop within 10 minutes, seek medical attention.

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



When instilling nose drops, tilt head back. Check manufacturer's instructions when administering sprays.

Steps for Administering Nose (Nasal) Medications

1. Wash hands.

2. Start at the beginning of the medication administration record (MAR) and review, checking for the following:
   a) Individual's name
   b) All medications ordered
   c) Medications to be given now
   d) Confirm that the previous dose was given
   e) Confirm the dose for this time and date has not yet been given
   f) Any allergies
   g) Special instructions for giving the medication

3. Read all the pages of the person's MAR to confirm ALL the medications you will need to prepare for administration. This includes the ***entire* medication name (including strength)**, the dose (amount), and route of each medication you will be giving to the person at this time.

4. Get the medication from the secure storage area.

5. Read the ***entire label*** carefully including the expiration date and special instructions. Make sure the packaging description of medication matches the medication inside the container.

6. **The first check of the MAR to label**:
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date)

7. **The second check of MAR to label**:
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date)

8. **If they do not match, do not give the medication until there is clarification** from a healthcare record or healthcare professional regarding the medication. If they do match go to the next step.

9. **The third check** (done before putting medication in nose):
   a) Check medication label against the MAR to confirm the 5 Rights
   b) Confirm which nostril and how many sprays/drops are to be administered
   c) Use optional "dot system" at this step (see "dot system" instructions on page 35)

10. Put on gloves.

11. Identify the person to receive the medication. Take your time and make sure you are giving the prepared medication to the correct person. Confirm the person's identity with a picture or with another personnel who knows the person.

12. Explain to the person the name and purpose of medication(s) you are giving to them.

13. Provide tissues for the person.

14. Position the person according to manufacturer's instructions.

15. Instill medication per manufacturer's instructions.

16. Instruct the person not to blow their nose for at least 15 minutes after instilling medication.

17. Leave the person in a safe and comfortable manner.

18. Wipe off the container, including the tip. Return medication to secure storage.

19. Remove gloves and wash hands.

20. **D**ocument that medication was administered (this is the 6th Right of medication administration). Place your initials on the MAR in the space for the specific **I**ndividual's **M**edication(s), **D**ose, **R**oute and **T**ime/date, **D**ocumenting that you have given the medication **(I M DR TD).**

21. Document any complaints/concerns and action taken. If the medication is only used as needed, document the need and the response to the treatment.

22. If medication was missed, held, declined or given late, document by circling your initials and explain on the back of the MAR. Write an Unusual Incident Report.

23. Make sure your initials, full name, and title are written in a space provided for signatures on the MAR or on a Master Signature Log.

✓ **Skills checklists to be signed by trainee and trainer are available on the DODD website**.

Categories of Inhaled Medications

Respiration is the act of breathing in and out. Inhaled medications are medications that are taken into the lungs through the nose or mouth. They are also called pulmonary medications.

- Some inhaled medications are prescribed as "**rescue"** medications. These medications are for sudden wheezing or shortness of breath. If the person is in distress, use the rescue inhaler only as needed for symptoms as prescribed.
- Some are **"maintenance"** medications that are used routinely to prevent the occurrence of distressing respiratory symptoms. Maintenance inhalers should be used in the prescribed manner, for example, twice daily.

Commonly Used Inhaled Medications, Side Effects, and Related Care

Category	Examples of Medications	Examples of Side Effects	Related Care
Bronchodilators Used to relax airway muscles making breathing easier; given by nebulizer or inhaler. Can be short acting "rescue" medications, or long-acting "maintenance" medications.	**Rescue** Albuterol Proventil® Ventolin® Duoneb® **Maintenance** Atrovent® Spiriva® Serevent® Foradil® Brovana®	◂ Tremors ◂ Agitation ◂ Dizziness ◂ Hyperactivity ◂ Increased pulse ◂ Bad taste in the mouth ◂ Nausea, vomiting **Atrovent® and Spiriva® side effects** ◂ Dry mouth ◂ Constipation ◂ Difficulty passing urine	◂ Observe breathing and secretions for changes and contact a healthcare professional if breathing does not improve as expected ◂ People may not share a nebulizer or an inhaler ◂ Encourage the person to rinse their mouth and spit, or brush their teeth after use ◂ Clean inhaler after each use
Steroids* Used for maintenance treatment for breathing problems associated with chronic obstructive pulmonary disease [COPD]. COPD can include both chronic bronchitis and emphysema.	**Maintenance** Advair® Symbicort® Dulera® Breo® QVAR® AeroSpan® Flovent® Pulmicort Respules® Pulmicort Flexhaler® Asmanex® Alvesco®	◂ Thrush in the mouth (white coated tongue needing medical attention) ◂ Hoarse voice ◂ Cough	◂ Observe breathing and secretions for changes. Contact a healthcare professional if breathing does not improve as expected ◂ Ask prescriber or pharmacist if a spacer is appropriate for this medication or person ◂ Encourage the person to rinse their mouth and spit, or brush their teeth after use ◂ Use a delivery device specific to the medication for that person

◆ Bronchodilators are generally prescribed before steroids because of serious side effects from steroids.

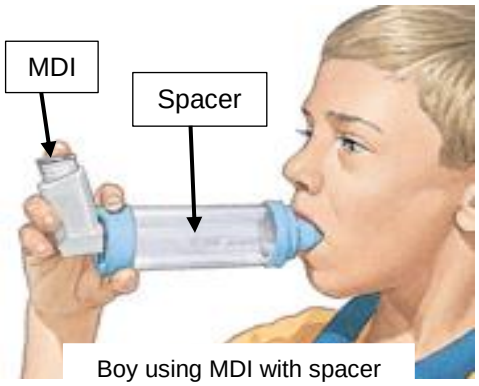
◆ **If both bronchodilators and steroids are prescribed, administer the bronchodilator before the steroid to open the lungs and help the steroid be more effective.**

INHALERS

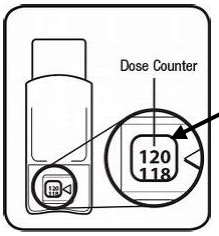
Short-acting medications relax and open the breathing tubes in the lungs. These are called rescue inhalers. Long-acting inhalers are used daily. They help control asthma and prevent symptoms from occurring. These are called maintenance inhalers. Maintenance inhalers do not work to treat sudden symptoms.

Metered Dose Inhaler (MDI)

- Like a mini-aerosol can; pushes out a pre-measured spray of medication.
- When the person pushes down on the aerosol container, a measured "puff" of medication is released.
- May be used with a spacer or holding chamber to make it easier to use.
- The spacer eliminates the need to closely coordinate "puff" from the canister with the inhaling of the medication.
- Aerosol inhalers have a built-in dose indicator window or counter that shows how many doses of the medication are left. Be sure to view this each time medication is administered to assure refills are obtained before needed.



Boy using MDI with spacer



Aerosol inhaler dose indicator

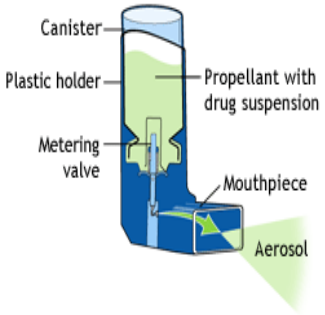
Dry Powder Inhaler (DPI)

- Delivers medication in a powder form.
- Does not spray out the powder.
- User must do more of the work, inhaling the powdered medication quickly and forcefully.

Nebulizer

- Used when a larger amount of medication is needed or when the person is not able to use the inhaler.
- Electric or battery powered machine that turns liquid medication into a fine mist that is inhaled into the lungs.
- The user breathes in the mist through a mouthpiece or facemask.

Steps for Administering Metered Dose Inhalers



1. Wash hands.

2. Start at the beginning of the medication administration record (MAR) and review, checking for the following:
   a) Individual's name
   b) All medications ordered
   c) Medications to be given now
   d) Confirm that the previous dose was given
   e) Confirm the dose for this time and date has not yet been given
   f) Any allergies
   g) Special instructions for giving the medication

3. Read all the pages of the person's MAR to confirm ALL the medications you will need to prepare for administration. This includes the ***entire* medication name (including strength)**, the dose (amount), and route of each medication you will be giving to the person at this time.

4. Get the medication and equipment from the secure storage area. Clean equipment if dirty.

5. Read the ***entire label*** carefully including the expiration date and special instructions. Make sure the packaging description of medication matches the medication inside the container.

6. **The first check of the MAR to label**:
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date)

7. **The second check of the MAR to label**:
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date)

8. **If they do not match, do not give the medication until there is clarification** from a healthcare record or healthcare professional regarding the medication. If they do match go to the next step.

9. Put on gloves.

10. Identify the person to receive the medication. Take your time and make sure you are giving the prepared medication to the correct person. Confirm the person's identity with a picture or with another personnel who knows the person.

11. Assist the person to a comfortable sitting position.

12. Explain to the person the name and purpose of medication(s) you are giving to them.

13. The **third check** of the MAR is done before preparing the canister/inhaler (before use of inhaler):
   a) Check medication label against the MAR to confirm the 5 Rights
   b) Confirm the medication and dose in the canister/inhaler matches the medication and dose listed on the MAR. Confirm how many puffs are to be administered
   c) Use optional "dot system" at this step (see "dot system" instructions on page 35)

14. **If the canister is new and never used, you will need to prime it** to ensure the canister contains medication and is operating properly. If the canister is used daily, you do not need to prime it. If the canister has not been used in the last 3 days or per manufacturer's instructions, prime it before use:
    1. Remove cap, invert the canister, and shake the canister well
    2. With mouthpiece pointing into the air, away from everyone, press once on the canister base
    3. Continue to prime the canister the number of times per manufacturer's instructions

15. **(A) If using a spacer:**
    1. Hold the canister in an inverted position; shake the canister well and then remove the cap
    2. Insert canister into end of the spacer
    3. Have the person exhale
    4. Bring the spacer's mouthpiece to the person's mouth and have them close their lips around it
    5. Press the top of the canister once
    6. Have the person breathe in very slowly until they have taken a full breath and inhaled a puff of the medication from the spacer
    7. Remove mouthpiece and have the person hold their breath as long as they can up to 10 seconds, or as directed on the medication packaging
    8. Then have the person exhale slowly

15. **(B) If not using a spacer:**
    1. Hold the canister in an inverted position; shake the canister well and then remove the cap
    2. Have the person exhale
    3. Bring the canister to the person's mouth and have them close their lips around the mouthpiece
    4. Have the person breathe in very slowly as you press the top of the canister once until they have taken in a full breath, inhaling a puff of the medication from the canister
    5. Remove the mouthpiece and have the person hold their breath as long as they can up to 10 seconds, or as directed on the medication packaging
    6. Then have the person exhale slowly

15. **(C) If you are using a dry powder inhaler:**
    1. Remove the inhaler cap and load the dry medication in the inhaler chamber as directed by the manufacturer
    2. Have the person tilt their head back a little and breathe out slowly and completely
    3. Bring the device to the person's mouth, and have them close their lips around the mouthpiece
    4. Have the person breathe in quickly and deeply for 2-3 seconds, inhaling a puff of the medication from the device
    5. Take the inhaler out of their mouth. Have the person hold their breath for as long as they can up to 10 seconds, or as directed on the medication packaging
    6. Then have the person breathe out slowly through pursed lips

16. If more than 1 puff is ordered for a single medication, wait 1 minute before giving the next puff. Then repeat steps 15 A, B, or C for the next puff, until the prescribed amount has been given.

17. Replace the protective cap on the inhaler. Have the person rinse their mouth with water and then spit it out. Be sure the person does NOT swallow the rinsing water because they will get a systemic effect if they swallow the rinsing water. Or, if they choose, they can clean medication from their mouth by brushing their teeth.

18. Leave the person in a safe and comfortable manner. Observe for results.

19. Clean the equipment and return medication and equipment to storage.

20. Remove gloves and wash hands.

21. **D**ocument that medication was administered (this is the 6th Right of medication administration). Place your initials on the MAR in the space for the specific **I**ndividual's **M**edication(s), **D**ose, **R**oute and **T**ime/date, **Documenting** that you have given the medication **(I M DR TD).**

22. Document any complaints/concerns and action taken. If the inhaler is only used as needed, document the need and the response to the treatment.

23. If medication was missed, held, declined or given late, document by circling your initials and explain on the back of the MAR. Write an Unusual Incident Report.

24. Make sure your initials, full name, and title are written in a space provided for signatures on the MAR or on a Master Signature Log.

25. If another inhaled medication is ordered, wait at least 5 minutes before administering the 2nd inhaled medication and repeat steps 1-23.

✓ **Skills checklists to be signed by trainee and trainer are available on the DODD website**.

Steps for Administering Nebulizer Treatment

1. Wash hands.

2. Start at the beginning of the medication administration record (MAR) and review, checking for the following:

   a) Individual's name
   b) All medications ordered
   c) Medications to be given now
   d) Confirm that the previous dose was given
   e) Confirm the dose for this time and date has not yet been given
   f) Any allergies
   g) Special instructions for giving the medication

3. Read all the pages of the person's MAR to confirm ALL the medications you will need to prepare for administration. This includes the ***entire*** **medication name (including strength)**, the dose (amount), and route of each medication you will be giving to the person at this time.

4. Check equipment and clean if dirty. Get the medication from the secure storage area.

5. Read the ***entire label*** carefully including the expiration date and special instructions. Make sure the packaging description of medication matches the medication inside the packaging.

6. **The first check of the MAR to label**:
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date)

7. **The second check of the MAR to label**:
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date)

8. **If they do not match, do not give the medication until there is clarification** from a healthcare record or healthcare professional regarding the medication. If they do match go to the next step.

9. The **third check** of the MAR is done before placing the pre-measured ampule dose of medication into the nebulizer's dispensing chamber (before use of nebulizer):
   a) Check medication label against the MAR to confirm the 5 Rights
   b) Confirm the medication and dose in the ampule(s) to be added to the nebulizer matches the medication and dose listed on the MAR. Remove ampule from packaging.
   c) Use optional "dot system" at this step (see "dot system" instructions on page 35)

10. Return the package of remaining ampules to secure storage. Never leave the single ampule unattended.

11. Identify the person to receive the medication. Take your time and make sure you are giving the prepared medication to the correct person. Confirm the person's identity with a picture or with another personnel who knows the person.

12. Assist the person to a comfortable sitting position.

13. Explain to the person the name and purpose of medication(s) you are giving to them.

14. Give the person tissues to wipe their face/mouth as needed.

15. Plug in the nebulizer.

16. Put on gloves.

17. Open the ampule and instill the liquid into the dispensing chamber.

18. Have the person place the mouthpiece in their mouth having them use their lips to form a tight seal on the mouthpiece. If the person uses a mask instead of a mouthpiece, be sure the mask is positioned to make a tight seal around the mouth and nose.

19. Turn the machine on. Encourage the person to breathe normally during the treatment.

20. Follow MAR instructions for taking the person's pulse and respirations during and after the treatment.

21. Continue the treatment until the medication dispensing chamber is empty.

22. Remove the mouthpiece or mask.

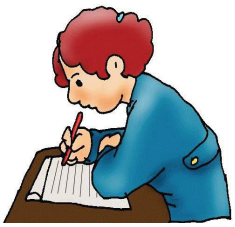
23. Help the person to wipe their face, rinse their mouth, and to apply lip balm if needed.

24. Leave the person in a safe and comfortable manner.

25. Clean the equipment and return to storage area.

26. Remove gloves and wash hands.

27. **D**ocument that medication was administered (this is the 6th Right of medication administration). Place your initials on the MAR in the space for the specific **I**ndividual's **M**edication(s), **D**ose, **R**oute and **T**ime/date, **D**ocumenting that you have given the medication **(I M DR TD).**



28. Document any complaints/concerns and action taken. If the nebulizer is only used as needed, document the need and the response to the treatment.

29. If medication was missed, held, declined or given late, document by circling your initials and explain on the back of the MAR. Write an Unusual Incident Report.

30. Make sure your initials, full name, and title are written in a space provided for signatures on the MAR or on a Master Signature Log.

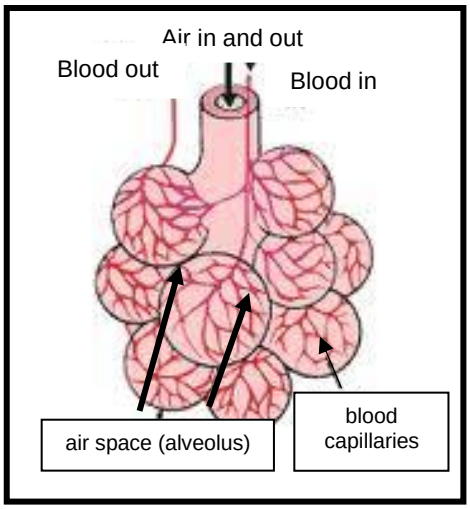
✓ **Skills checklists to be signed by trainee and trainer are available on the DODD website**.

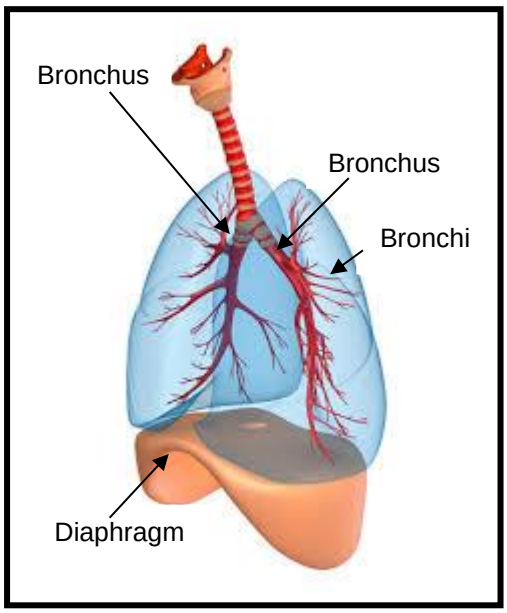
OXYGEN ADMINISTRATION

Vocabulary:

Alveoli: Tiny balloon-like sacks at the end of bronchioles.

Bronchioles: Smaller and smaller branches of the bronchi that connect to the alveoli.





Bronchi: Smaller air passages originating from the bronchus in each lung. There are many of these.

Bronchus: One main air passage into each lung. Originates at the end of the trachea.

Capillaries: Very tiny blood vessels in the wall of the alveolus that absorb oxygen that is then distributed to the body.

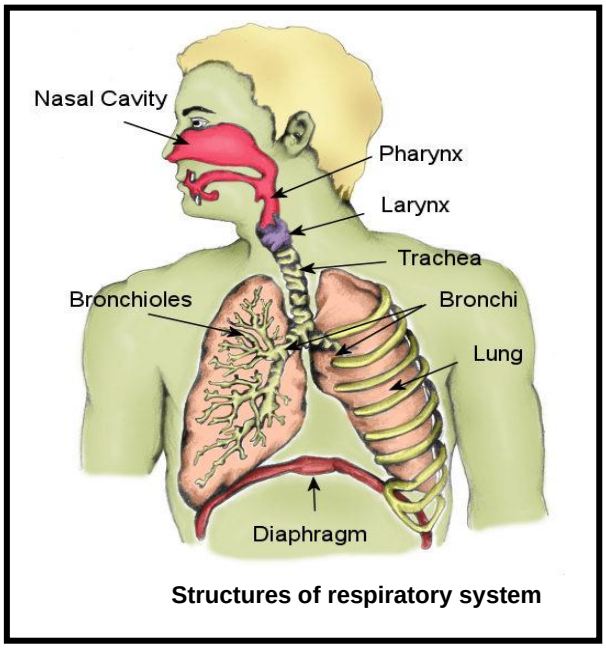
Diaphragm: Dome shaped muscle separating the chest from the abdomen. It is the muscle that makes breathing happen.

Lungs: Main organ for the respiratory system. Contains 5 lobes: 2 on the left and 3 on the right. They supply oxygen to the body as well as eliminate carbon dioxide from the body.

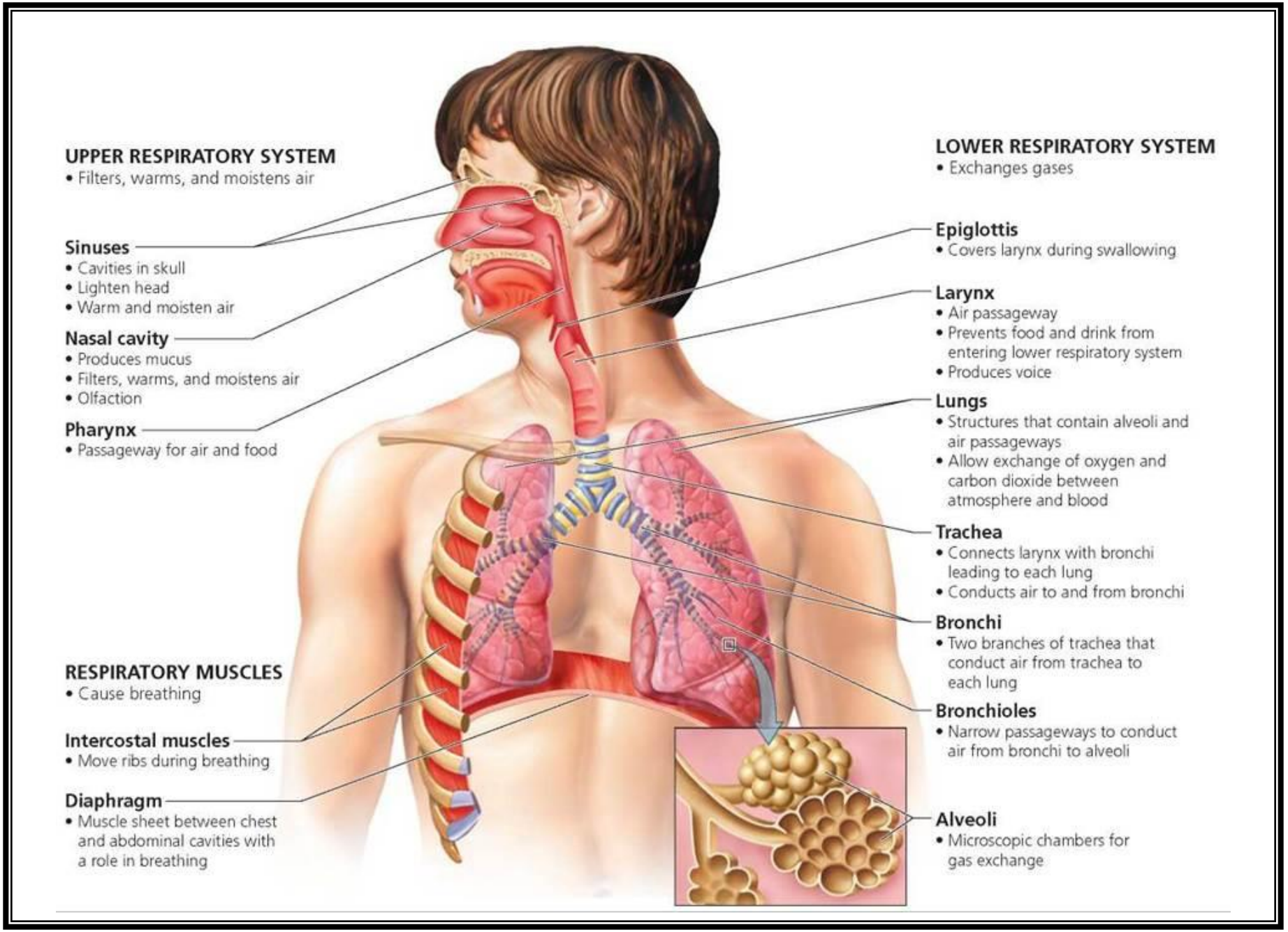
Epiglottis: A flap of cartilage at the entrance of the trachea. It closes over the trachea to prevent food and fluid from entering the windpipe and lungs.

Trachea: Windpipe. Tube that allows air to pass from the back of the mouth into the lungs.

Pleura: Thin membrane with 2 layers around the lungs. Fluid between these 2 layers provides for lubrication allowing for smooth, uniform expansion and contraction of the lungs during breathing.



Structures of respiratory system


UPPER RESPIRATORY SYSTEM
• Filters, warms, and moistens air
Sinuses
• Cavities in skull
• Lighten head
• Warm and moisten air
Nasal cavity
• Produces mucus
• Filters, warms, and moistens air
• Olfaction
Pharynx
• Passageway for air and food
RESPIRATORY MUSCLES
• Cause breathing
Intercostal muscles
• Move ribs during breathing
Diaphragm
• Muscle sheet between chest and abdominal cavities with a role in breathing
LOWER RESPIRATORY SYSTEM
• Exchanges gases
Epiglottis
• Covers larynx during swallowing
Larynx
• Air passageway
• Prevents food and drink from entering lower respiratory system
• Produces voice
Lungs
• Structures that contain alveoli and air passageways
• Allow exchange of oxygen and carbon dioxide between atmosphere and blood
Trachea
• Connects larynx with bronchi leading to each lung
• Conducts air to and from bronchi
Bronchi
• Two branches of trachea that conduct air from trachea to each lung
Bronchioles
• Narrow passageways to conduct air from bronchi to alveoli
Alveoli
• Microscopic chambers for gas exchange

Administration of Oxygen (O_2)

Oxygen:
O_2 is a colorless, odorless gas. It is essential for life. O_2 in the air is absorbed through the lungs and into the blood where it binds to the hemoglobin in red blood cells. It is the circulating red blood cells that distribute oxygen throughout the body.

Why O_2 is used
- To restore O_2 blood levels to normal.
- Decrease shortness of breath and fatigue.
- Improve sleep in those with sleep apnea.
- Increase life span of some people with COPD (chronic obstructive pulmonary disease).

Regulator on oxygen tank

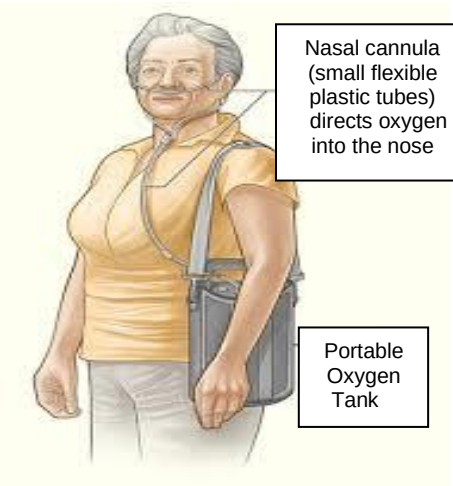
Oxygen tank on a transporter

How O_2 can be given
- By nasal cannula
- By mask

A person may use a **concentrator** that extracts oxygen from the air;

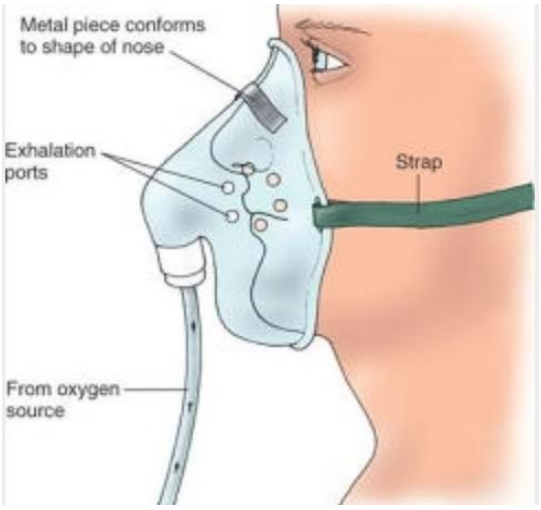
OR

A person may use oxygen supplied from an **oxygen tank**



Woman with portable O_2 tank

Person wearing O_2 mask



Man using oxygen concentrator

OXYGEN THERAPY

Oxygen is an inhaled medication that requires a prescription.

Oxygen is a medication administered in the form of an inhaled gas. As with any medication, you are expected to follow orders precisely as written on the MAR. The dose (amount) is the **flow rate and is indicated as liters per minute.** The flow rate must be set only at the prescribed rate. Example: 2 liters per minute.

Time frames for receiving oxygen

Depending on the needs of the person the prescription for oxygen may be to administer as needed, intermittently, or continuously.

Transportation

Anyone transporting a person on oxygen needs to know how to shut off the tank if it is hissing or there is an accident.

Side Effects of Oxygen Therapy

- Fatigue (tiredness)
- Morning headaches
- Dry and/or bloody nose
- Skin irritation from face mask or nasal cannula

Care for a person on oxygen

- Protect the person's nose, face and ears from irritation caused by the nasal cannula or face mask. Use a water-based lubricant where the mask or cannula rub the face, nose or ears. Vaseline® or petroleum jelly is NOT a water-based lubricant.
- Be sure to strictly follow safety measures to prevent a fire or explosion.
- Provide frequent opportunities for the person to keep their mouth and throat moist.

Responsibility for ordering more supplies

Getting more supplies is everyone's job.

Call the equipment provider for refills when you see supplies are getting low. Document and communicate with others that you have reordered supplies.

The Equipment supplier must be available by phone 24/7. The contact information should be maintained in an easily accessible location that everyone knows.

Call the supplier for questions about equipment functioning, and safety questions.

Signs of receiving too little oxygen

- Confusion
- Headache
- Restlessness
- Blurred vision
- Tunnel vision
- Cyanosis (bluish tint to the lips, earlobes, and/or nail beds)
- Rapid heart rate
- Elevated blood pressure
- Rapid breathing
- Shortness of breath
- Excessive tiredness

Signs of receiving too much oxygen

- Slow respiratory rate < 8 breaths/minute
- Difficult to wake up

When to call a healthcare professional (HCP)

- If you see any signs of receiving too much or too little oxygen (see boxes to left)
- For any of the side effects listed on page 65
- If the equipment is not working right
- If the person is declining oxygen therapy or insisting you change the number of liters given
- If the person is having trouble sleeping because they cannot breathe well

Cleaning the oxygen equipment

Oxygen Concentrator

- Clean at least once a week. The outside of the concentrator can be wiped down with a damp cloth and a mild dish detergent. Never spray the cleaner directly onto the machine.
- The oxygen concentrator may have exterior filters that need to be cleaned at least once a week. They can be easily removed and placed under warm running water. Excess water should be squeezed out and the filters should be left out to air dry.

Cannula/Mask

- Clean daily; if visibly soiled; or after intermittent use.
- Use mild dish detergent and rinse.
- Towel or air dry.
- Replace every 2 (two) weeks.

Tubing

- Replace monthly.

Water Trap

- Empty as needed.
- Remove at least twice a week and clean with mild dish detergent and rinse.

Distilled white vinegar

Distilled Water

Humidifier Bottle

- Use only distilled or sterile water.
- Empty daily and replace with fresh distilled or sterile water.
- Clean and disinfect at least twice a week. First wash with mild dish detergent and rinse well; then soak in 1 part water and 1 part distilled white vinegar. Rinse thoroughly.

Safety Tips for Use of Oxygen in the Home

- Below is a listing of precautions you MUST take when oxygen is in use. These precautions are arranged in categories. If you have questions about the safe storage and use of O_2 contact the O_2 supplier.

Smoking Precautions

- **No one should be smoking** when oxygen is in use. If the person using oxygen insists on smoking, they will need to remove their mask/cannula. Turn off the oxygen, remove mask/ cannula from their face and body. Then, wait 10 minutes after turning the oxygen off before smoking. Anyone else in the house that insists on smoking, must go outside when oxygen is in use.
- **In homes where a variety of support persons or visitors come and go, posting "No smoking" signs in every room where oxygen is stored or in use will remind everyone to not smoke around the oxygen.**

Precautions while working in the kitchen

- When the stove is in use and the person is in the kitchen, turn off their oxygen and remove their mask/cannula. If the stove or appliances are not in use oxygen can remain on. If the person must always have oxygen, there may be times when it is not safe for them to be in the kitchen.
- When using electrical devices such as can openers, mixers, blenders, knives, or skillets while the person using oxygen is in the kitchen, turn off the oxygen and remove their mask/cannula.
- A person wearing a mask or cannula must be at least 10 feet away from the stove or active electrical appliances. Tanks must be at least 10 feet from the stove or electrical appliances in use, even if the O_2 is turned off.

Precautions with use of health, hygiene and beauty products

- Products containing oil or grease, such as body oil and some moisturizers can easily ignite. Keep oils and grease away from where oxygen is in use. This includes petroleum products such as some lip balms and nail polish remover (acetone).
- Aerosol sprays containing combustible materials (i.e. hairspray, air fresheners) should not be used while the oxygen is in use.
- Electric razors or hairdryers should not be used while oxygen is on. Battery powered razors and hairdryers can be used when oxygen is on.
- Appliances that have a control switch (i.e. heating pad, vibrating devices, electric blankets, electric toothbrushes) should not be used when oxygen is on because the control switch could generate a spark.

Precautions while working with projects/crafts

- Petrol, solvents, thinners, cleaners, adhesives, paints, waxes and polishes, combustible liquids, or anything in an aerosol can should not be used while oxygen is on.

(precautions are continued on the next page)

Oxygen Tank Precautions (the tank contains compressed oxygen gas)

- Keep oxygen tanks at least 10 feet away from a heat source (heater, gas stove), open flame or electrical devices.
- Store oxygen tank upright in a well-ventilated area away from flame, heat source or direct sunlight. Do not cover the tank with cloth or plastic. Do not store in closets, behind curtains, near outlets, or other confined spaces. Secure tank on a stand with a strap to hold it in place.
- Handle the tank gently to avoid damaging it.
- If transporting an oxygen tank, do not lay it down in the bed of a truck or trunk of a car. Place it carefully on the back seat of the car. Secure it so it does not roll around and stays in place.
- Be sure to use the correct pressure gauge and regulator.
- When the tank is almost empty, close the valve and mark the tank as empty. Do not store full and empty tanks together.

Oxygen Concentrator Precautions (concentrators filter nitrogen out of the air, providing almost pure oxygen)

- Be sure the concentrator is plugged into an electrical outlet. Never use an extension cord or power strip.
- Keep concentrator away from curtains or drapes and place in a well-ventilated area.
- Do not keep concentrator in a closet or other confined space when in use.
- Be sure the concentrator is inspected and serviced per the supplier's instructions.

General Precautions

- Be sure all electrical equipment near the oxygen is properly grounded.
- Be sure you have smoke alarms in the home.
- Avoid materials that cause static electricity. Use cotton blankets.
- Candles, matches, wood stoves and sparking toys can serve as ignition sources. Keep these items out of the home.
- Keep oxygen equipment clean and dust free.
- Help people to stay at least 10 feet away from an open flame if oxygen is flowing. This includes fireplaces, wood burning stoves and gas stoves.
- Avoid build-up of static electricity by using a humidifier in the winter when the heat is on and the air tends to be dry. Encourage the person to wear cotton. Avoid wool and nylon as these fabrics attract static electricity.
- Be aware to keep oxygen tubing from dragging on the floor to prevent falls, tangles or disconnections.

Steps for Administering Oxygen (O_2)

1. Wash hands.

2. Start at the beginning of the medication administration record (MAR) and review, checking for the following:
   a) Individual's name
   b) All medications ordered
   c) Medications to be given now
   d) Confirm that the previous dose was given
   e) Confirm the dose for this time and date has not yet been given
   f) Any allergies
   g) Special instructions for giving the medication

3. Read all the pages of the person's MAR to confirm ALL the medications you will need to prepare for administration. This includes the ***entire*** **medication name (including strength)**, the dose (amount), and route of each medication you will be giving to the person at this time.

4. The **first check of the MAR**. Read the MAR for the oxygen order to assure the 5 Rights (**I M DR T**):
   1) **Individual's name**
   2) **Medication:** Oxygen
   3) **Dose:** Flow rate (liters per minute) and length of time
   4) **Route:** Inhaled using cannula or mask
   5) **Time** & date**:** When to administer (ex: pulse oximeter reading of 92 or below)

   If any part of the order is not clear and the person's pulse oximeter reading is 92 or below, proceed with administering oxygen at a flow rate of 2 liters per minute and contact a healthcare professional IMMEDIATELY.

5. Get oxygen supply and equipment from storage. Clean equipment if dirty.

6. Confirm the tank supply level is adequate for the O_2 administration. Note when the tank level will need to be rechecked if prior to the required 2-hour check. If using a concentrator, make sure it is plugged in and away from the wall.

7. The **second check of the MAR**. Read the MAR for the oxygen order to assure the 5 Rights (**I M DR T**):
   1) **Individual's name**
   2) **Medication:** Oxygen
   3) **Dose:** Flow rate (liters per minute) and length of time
   4) **Route:** Inhaled using cannula or mask
   5) **Time** & date**:** When to administer (ex: pulse oximeter reading of 92 or below)

8. Identify the person to receive the medication. Take your time and make sure you are giving the oxygen to the correct person. Confirm the person's identity with a picture or with another personnel who knows the person.

9. Explain the safety precautions that need to be followed while the oxygen is being administered.

10. Connect the nasal cannula or mask to the oxygen source.

11. Turn on the oxygen and adjust flow rate as directed on the MAR.

12. Without touching the cannula or mask, use your hand to check that the oxygen is flowing from cannula or mask.

13. Place the cannula in the person's nostrils and loop the tubing over their ears or place the mask on the person's face.

14. Adjust the cannula or mask as necessary for the person's comfort.

15. Instruct the person using a cannula to breathe through their nose with their mouth closed.

16. The **third check of the MAR**. Read the MAR for the oxygen order to assure the correct amount of oxygen is being administered according to the 5 Rights (**I M DR T**):
    1) **Individual's name**
    2) **Medication:** Oxygen
    3) **Dose:** Flow rate (liters per minute) and length of time
    4) **Route:** Inhaled using cannula or mask
    5) **Time** & date**:** When to administer (ex: pulse oximeter reading of 92 or below)

17. Note the time to recheck pulse oximeter reading or end O_2 administration.

18. Leave the person in a safe and comfortable manner.

19. **D**ocument that oxygen administration was initiated. Place your initials on the MAR in the space for the specific **I**ndividual's **M**edication(s), **D**ose (# of liters per minute), **R**oute (mask or cannula) and **T**ime/date, **D**ocumenting that you have started the O_2 (**I M DR TD**).

20. Document any complaints/concerns and action taken, including any comfort measures initiated. If the oxygen is being used as needed, document the reason for the need and the response to the treatment.

21. If oxygen was missed, held, declined or given late, document by circling your initials and explain on the back of the MAR. Write an Unusual Incident Report.

22. Make sure your initials, full name, and title are written in a space provided for signatures on the MAR or on a Master Signature Log.

23. Recheck flow rate, oxygen supply, and flow from cannula at least every 2 hours and before and after transition to different activities and locations. Document findings and actions taken.

24. Check pulse oximeter reading as directed on the MAR. Document the outcome. Continue or discontinue oxygen as prescribed.

25. Document the time when oxygen administration was ended, the pulse oximeter reading if taken, and the response to the treatment.

26. When the oxygen gauge is near or at the red zone, change the tank by repeating steps 5-21.

27. The cannula/mask should be removed and cleaned if oxygen is not flowing or if it is visibly soiled.

✓ **Skills checklists to be signed by trainee and trainer are available on the DODD website**.

Rectal Medications
(Suppositories and Enemas)

	Examples of Medications	Examples of Side Effects	Related Care
Antiemetic Used to relieve nausea and vomiting	Phenergan® Tigan® Compazine®	◂ Sedation ◂ Dizziness ◂ Blurred vision ◂ Dry mouth ◂ Increased risk of sunburn	◂ Advise the person not to drink alcoholic beverages while taking the medication ◂ Driving while taking this medication may be unsafe ◂ Encourage the use of sunscreen
Analgesic / Anodyne Used to relieve pain	Aspirin Motrin® Tylenol®	◂ Tinnitus (ringing in the ears) ◂ GI upset, nausea, vomiting, diarrhea	◂ Check with physician if the person is on blood thinning medications such as Coumadin®
Antipyretic Used to reduce elevated body temperature	Aspirin Motrin®/Advil® Tylenol®	◂ Tinnitus (ringing in the ears) ◂ GI upset, nausea, vomiting, diarrhea	◂ Encourage rest ◂ Encourage fluids ◂ Administer with food
Laxative Used to relieve chronic constipation by stimulating intestinal action, or softening the waste products	Glycerine Dulcolax® Fleets® (enema)	◂ Nausea and vomiting ◂ Abdominal cramps	◂ Do not give at meal time ◂ Discourage frequent or prolonged use ◂ Encourage fluids and fiber intake of at least 25 grams per day
Hemorrhoidal Used to relieve burning and itching from hemorrhoids	Preparation H® Proctofoam®	◂ Redness ◂ Burning ◂ Allergic reaction ◂ Rectal bleeding	◂ Keep rectal area clean ◂ Carry disposable wet wipes to use when away from home ◂ May need to wear a pad to protect clothing

Note: suppositories, enema tips and fingers must always be lubricated before inserting into the rectum. Only use **water-based lubricants** (not petroleum jelly). To apply lubricant, use a single-use packet or put a single portion of lubricant on gauze or paper towel and insert the tip of the suppository, gloved finger, or enema tip into the lubricant.

Steps for Administering Rectal Suppositories

1. Wash hands.

2. Start at the beginning of the medication administration record (MAR) and review, checking for the following:
   a) Individual's name
   b) All medications ordered
   c) Medications to be given now
   d) Confirm that the previous dose was given
   e) Confirm the dose for this time and date has not yet been given
   f) Any allergies
   g) Special instructions for giving the medication

3. Read all the pages of the person's MAR to confirm ALL the medications you will need to prepare for administration. This includes the ***entire* medication name (including strength)**, the dose (amount), and route of each medication you will be giving to the person at this time.

4. Get the medication from the secure storage area.

5. Read the ***entire label*** carefully including the expiration date and special instructions. Make sure the packaging description of medication matches the medication inside the container.

6. **The first check of the MAR to label**:
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date)

7. **The second check of the MAR to label**:
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date)

8. **If they do not match, do not give the medication until there is clarification** from a healthcare record or healthcare professional regarding the medication. If they do match go to the next step.

9. **The third check** (done before inserting the suppository):
   a) Check medication label against the MAR to confirm the 5 Rights
   b) Confirm administration time and that suppository in package matches the order. Remove the single wrapped suppository from the package.
   c) Use optional "dot system" at this step (see "dot system" instructions on page 35)

10. Return the package of remaining suppositories to secure storage. Never leave the single suppository unattended.

11. Put on gloves.

12. Gather tissues or toilet paper.

13. Identify the person to receive the medication. Take your time and make sure you are giving the prepared medication to the correct person. Confirm the person's identity with a picture or with another personnel who knows the person.

14. Provide for privacy.

15. Explain to the person the name and purpose of medication(s) you are giving to them.

16. Position the person on their left side unless directed otherwise. Bend their top knee and move it toward the chest.

17. Unwrap the suppository and lubricate the tip; also lubricate tip of the gloved finger to be used to insert suppository.

18. Lift upper buttock to expose rectal area.

19. Slowly insert suppository into rectum well beyond the muscle at the opening (sphincter), pushing gently with your gloved, lubricated finger.

20. After slowly withdrawing your finger, press a folded tissue or piece of toilet paper against the anus and hold the buttocks together until the urge to expel the suppository goes away.

21. Encourage the person to continue to lie down in a comfortable position for 20 minutes providing supervision as needed.

22. Leave the person in a safe and comfortable manner.

23. Dispose of materials appropriately.

24. Remove gloves and wash hands.

25. **D**ocument that medication was administered (this is the 6th Right of medication administration). Place your initials on the MAR in the space for the specific **I**ndividual's **M**edication(s), **D**ose, **R**oute and **T**ime/date, **D**ocumenting that you have given the medication (**I M DR TD**).

26. Document any complaints/concerns and action taken. If the suppository was used as needed, document the need and the response to the treatment.

27. If medication was missed, held, declined or given late, document by circling your initials and explain on the back of the MAR. Write an Unusual Incident Report.

28. Return equipment to storage area.

29. Make sure your initials, full name, and title are written in a space provided for signatures on the MAR or on a Master Signature Log.

✓ **Skills checklists to be signed by trainee and trainer are available on the DODD website**.

Note: Request additional training from a healthcare professional and follow manufacturer's instructions for administration of enemas.

Vaginal Medications

Vaginal medications are given for birth control, infection, and comfort. They come in the form of suppositories, creams, gels, ointments, and douches. When administering a medication vaginally, it is important to provide privacy and remind the woman she may need to remain still for as long as 30 minutes after instillation of the medication. It may be helpful for her to use the restroom or take care of any other personal priorities prior to administering the medication.

	Examples of Medications	Examples of Side Effects	Related Care
Anti-fungal Used to treat overgrowth of yeast inside the vagina (Yeast infection is a common side effect of oral antibiotic treatment)	Gyne-lotrimin® Monistat 7® Mycostatin® Terazol 7®	◂ Burning, itching, stinging	◂ Provide protective panty-liner to prevent staining of clothing ◂ May need to remain on her back or side for as long as 30 minutes after installation. Be sure bladder is emptied before instillation of medication ◂ Place protective pad on bed or provide person with a peri-pad while she is waiting to get up
Anti-infective Used to treat infections of the vaginal walls (internal mucous membranes)	Metronidazole Clindamycin	◂ Burning, itching stinging	◂ See above ◂ Pregnant women should use oral treatment not vaginal treatment
Hormone Used to treat vaginal thinning and dryness	Estrogen Cream	◂ Nausea, breast tenderness, headache ◂ Weight changes, vaginal itching	◂ See above

Steps for Administering Vaginal Medications

1. Wash hands.

2. Start at the beginning of the medication administration record (MAR) and review, checking for the following:
   a) Individual's name
   b) All medications ordered
   c) Medications to be given now
   d) Confirm that the previous dose was given
   e) Confirm the dose for this time and date has not yet been given
   f) Any allergies
   g) Special instructions for giving the medication

3. Read all the pages of the person's MAR to confirm ALL the medications you will need to prepare for administration. This includes the ***entire* medication name (including strength)**, the dose (amount), and route of each medication you will be giving to the person at this time.

4. Get the medication from the secure storage area.

5. Read the ***entire label*** carefully including the expiration date and special instructions. Make sure the packaging description of medication matches the medication inside the packaging.

6. **The first check of the MAR to label**:
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date)

7. **The second check of the MAR to label**:
   a) Place the medication container beside the name of the medication on the MAR
   b) Make sure the package/container label and the MAR match exactly
   c) Confirm the first 5 Rights (**I**ndividual's name, **M**edication name - including strength, **D**ose, **R**oute, **T**ime & date)

8. **If they do not match, do not give the medication until there is clarification** from a healthcare record or healthcare professional regarding the medication. If they do match go to the next step.

9. **The third check** (done before inserting vaginal medication):
   a) Check medication label against the MAR to confirm the 5 Rights
   b) Confirm administration time and that medication in package matches the order. Remove the single use medication and applicator from the package.
   c) Use optional "dot system" at this step (see "dot system" instructions on page 35)

10. Return the package of remaining medication to secure storage. Never leave the single dose of medication unattended.

11. Put on gloves.

12. Identify the woman to receive the medication. Take your time and make sure you are giving the prepared medication to the correct woman. Confirm the woman's identity with a picture or with another personnel who knows her.

13. Remind the woman that she will be laying down for 30 minutes and ask if she needs to urinate (pee) or take care of other personal tasks before the medication is administered. Assist as needed.

14. Go with the woman to a private location. Explain to the woman the name and purpose of medication(s) and how and where you will be giving the medication.

15. Place towel or protective pad so that it will be under her buttocks.

16. Position the woman on her back with knees bent and legs separated unless contraindicated or another position is recommended by the woman's physician or nurse. Provide additional privacy with a sheet or blanket over her bent knees.

17. Place medication in applicator (if not prefilled).

18. Separate the labia with one hand and gently insert the applicator into the vagina with other hand. Angle applicator slightly downward toward tail bone. It will usually go in about 2 inches. **DO NOT FORCE IT.**

19. Push the plunger of the applicator in while holding the barrel of the applicator still.

20. Remove the applicator and encourage her to remain lying down for 30 minutes. Provide supervision and support as needed.

21. Provide with a protective pad for under wear if needed.

22. Leave her in a safe and comfortable manner.

23. Clean equipment and return equipment to storage area.

24. Dispose of other materials appropriately.

25. Remove gloves and wash hands.

26. **D**ocument that medication was administered (this is the 6th Right of medication administration). Place your initials on the MAR in the space for the specific **I**ndividual's **M**edication(s), **D**ose, **R**oute and **T**ime/date, **D**ocumenting that you have given the medication (**I M DR TD**).

27. Document any complaints/concerns and action taken. If the vaginal treatment is used as needed, document the need and the response to the treatment.

28. If medication was missed, held, declined or given late, document by circling your initials and explain on the back of the MAR. Write an Unusual Incident Report.

29. Make sure your initials, full name, and title are written in a space provided for signatures on the MAR or on a Master Signature Log.

✓ **Skills checklists to be signed by trainee and trainer are available on the DODD website**.

Receipt and Transcription of Medication Orders:

A. Only personnel 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). MA certified personnel = personnel with current category 1 medication administration certification.

B. **Information about medications may be transcribed only from the pharmacy label onto the MAR. MA certified personnel may NOT add any NEW medication to the MAR from a written or verbal order.** There are 3 exceptions to this rule:

   1. **Changes in dose, frequency, or a time of administration of a medication already prescribed** and dispensed by a pharmacist.

   2. A **medication that can be purchased without a prescription that** has been **prescribed** for MA certified personnel to administer (i.e. a prescribed medication purchased over-the-counter).

   3. Performance of any of the 13 legally authorized Health-Related Activities taught as part of category 1 certification (or changes to previously ordered health-related activities).

C. If the pharmacy supplies a self-stick label with information, certified personnel can attach that label to the MAR as the transcribed order.

D. MA certified personnel must transcribe medication instructions onto the MAR as soon as possible after receiving the dispensing container from the pharmacy.

E. The transcribed entry must be dated and initialed by the MA certified personnel. Accuracy of transcribed orders must be checked by the next available certified personnel, ideally at the time of transcription. This accuracy check must be initialed and dated by the MA certified personnel performing the check.

F. When orders are transcribed onto a new MAR for the next month, the transcription must be checked against the label and confirmed by a second MA certified personnel when transcribed. Orders need must be confirmed against the previous MAR again, before using the new MAR at the start of the month.

G. In settings that require delegation of the Category 1 activities, the delegating nurse(s) must indicate if MA certified personnel may transcribe onto the MAR.

(H. through O. continued on the next page)

H. **MA 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 or injectable treatments for metabolic glycemic disorders.** Only the **delegating nurse** may receive and transcribe physician's orders for food and/or prescribed medication administered by gastrostomy/jejunostomy tube. Orders for administration of **insulin** or injectable treatments for metabolic glycemic disorders **must be transcribed by a nurse.**

I. **MA certified personnel are prohibited** from receiving and **transcribing** orders for medications which require them to calculate dosage based on body weight.

J. The prescribing healthcare professional must give an EXACT **dosage** for MA certified personnel to be able to receive and transcribe orders. The order should never give a range (ex: "1-2 tablets" this is not an exact dosage).

K. MA certified personnel may accept verbal orders only as taught in this curriculum and **only when it is impractical for the orders to be given in a written manner.**

L. A dated and signed hard copy of any verbal order must be obtained within seven (7) days.

M. Any questions regarding a verbal order or written order must be referred to the prescribing healthcare professional.

N. The only times when orders that are different from the pharmacy label can be transcribed on to the MAR are when:

- There are **changes to the dose, frequency, or a time of administration of a medication already prescribed** and dispensed by a pharmacist.
- A **medication that can be <u>purchased</u> without a prescription that** has been **<u>prescribed</u>** for MA certified personnel to administer (i.e. a prescribed medication that has been purchased over-the-counter).
- There is an order for any of the 13 legally authorized Health-Related Activities taught as part of category 1 certification (or changes to previously ordered health-related activities).

O. Agency specific procedures for receiving and transcribing written and verbal orders must be included in personnel training.

Procedure for
Transcribing Orders from a Dispensing Container

A. Check the pharmacy dispensed medication <u>package or typed information provided by the pharmacy</u> for the following:

1. Date of the dispensing (ex. 3-18-2XXX)
2. Individual's name (ex. John Doe)
3. Medication name and strength of medication (ex. Topiramate 250 mg)
4. Dosage of medication (ex. 1 tablet)
5. Route the medication needs to be given (ex. by mouth, on the skin, in the eye, etc.)
6. Description of what the medication looks like
7. Times the medication needs to be given (ex. once a day, three times a day, at bedtime, etc.)
8. Special instructions (ex. give one hour before eating; mix with "X"; do not mix with "X"; do not eat grapefruit; give with/without food; do not crush, etc.)
9. Length of treatment (ex.10 days)

B. You need to find out **the reason for the medication** (ex. to control seizures). This may be listed somewhere other than pharmacy label (ex. on the appointment report).

C. Transcribe the required information **onto the MAR** as directed:

- ✓ Transcribe the name of the **I**ndividual, the **M**edication including strength, the **D**ose, the **R**oute, and the **T**imes and dates to be given
- ✓ Transcribe special instructions and any specific start/stop times and dates

D. Transcribe in **black or dark blue ink only.** Be sure your **transcribed information, initials and signature are readable.**

E. **<u>Check the pharmacy label against the MAR three times.</u>** Confirm **I. M. D. R. T.** (**I**ndividual, **M**edication including strength, **D**ose, **R**oute and **T**ime/date) with each check.

F. As soon as possible, **have another MA certified personnel check the transcribed medication order** with the pharmacy label **to confirm the transcription is correct**.

G. Do NOT use abbreviations when transcribing orders.

H. If there is a **question or concern** regarding the order, **contact a healthcare professional.**

NOTE: Assure that the description of the pill on the outside of the medication package or attached information sheet matches the pill inside the package.

Pill Identification website: www.drugs.com

Procedure for Receiving Verbal Orders

Remember, **you may only receive verbal orders for:**

1. Change in frequency or dose of an already prescribed medication
2. Performance of or change in frequency of a health-related activity
3. Over-the-counter (OTC) medications that need prescriptions to be administered (i.e. all OTC oral medications, and topical treatments for conditions that must be diagnosed by a healthcare professional before treating)

A. If possible, have second certified personnel listen to the verbal order along with you.

B. **Write all the information** down. Do not use abbreviations.

C. 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 and write it down.

D. Ask the healthcare professional with prescriptive authority to:
   1. State the health-related activity (HRA) or spell the name of the medication and specify the strength
   2. State the dose of the medication to be given
   3. State the time the medication or health-related activity is to start
   4. State the frequency for the medication or health-related activity (ex. every 4 hours up to 6 doses in 24 hours)
   5. State the route for giving the medication (ex. by mouth, apply to specific skin location, etc.)
   6. State the length of time the medication is to be given or the HRA is to be done (specify the number times or doses; or specify continue until the order is changed)
   7. State the reason for giving the medication or doing the treatment
   8. State the specific, observable symptoms or behaviors that indicate when the as needed medication or HRA is to be administered
   9. Tell you what reading to expect as the range of an HRA, and what to do if the result is outside the expected range (ex. if blood glucose, O_2 saturation, BP, pulse or respirations are higher or lower than the specified range)
   10. Tell you about any side effects of the medication/HRA and state what to do if side effects are observed

E. Read back what you wrote down to assure accuracy of the order you wrote and to confirm that you wrote it correctly.

F. Tell the person giving you the verbal order that you need a hard/written copy of the verbal order within 7 days. **A written copy of all verbal orders must be kept.**

G. Transcribe the order information on to the MAR or TAR. After transcribing, verify the accuracy of the transcription. Check what you transcribed on the MAR with the order you received.

H. Have another certified personnel check what you copied onto the MAR/TAR from the order you were given, as soon as possible.

I. Do not use abbreviations for medication orders on the MAR or the TAR.

J. Call the healthcare professional back if you have any questions or concerns about the order you transcribe.

K. Plan to get a signed written order within 7 days. If you do not have a written order within 7 days, contact the prescriber for direction of what to do next.

When the Medication in the Container Does Not Match Either:

- **the Medication Description on the Container or**
- **the Medication Insert from the Pharmacy**

Whatever you do, DO NOT give any medication until you are certain about what you are giving, and that it matches exactly what is written on the MAR (Medication Administration Record).

It is more important to give a correct medication late than to give a wrong medication on time.

◆ Contact a healthcare professional right away about the discrepancy (nurse, doctor, pharmacist)

◆ Call the pharmacy and ask to speak with a **pharmacist.**

◆ Call poison control. Describe the markings, shape, size, and color and they can identify the medication.

◆ The following websites offer descriptions of medications:

www.rxlist.com

www.drugs.com

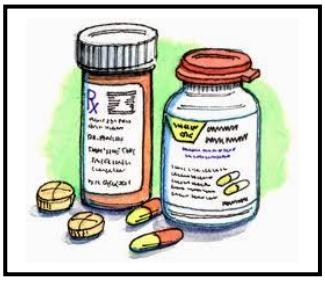
Rules for As Needed Medications

(often referred to as PRN medications)

As needed medications are used for the relief of symptoms such as headache, vomiting, itching, or upset stomach. Unlicensed personnel are only authorized to administer medications that are prescribed. Over-the-counter as needed medications that can be purchased without a prescription require **written orders from a healthcare professional to be administered by unlicensed personnel.**

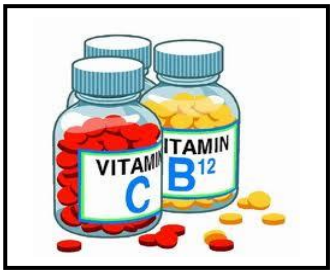
NOTE: A person may be able to self-administer as needed medications even if they are unable to self-administer all routine medications.

Any prescribed as needed medication must be transcribed onto the MAR before personnel can administer it.



Prescription medications must be written on the MAR before they can be given

A HCP must write an order for any oral OTC medication certified personnel administer



Vitamins, minerals and other supplements require a written order from a HCP before before personnel can give them

Rules for As Needed Orders

Personnel are **NOT ever permitted to use independent judgement to decide how or when to use as needed medications.**

The prescribed order directs what medication to use and when to use it. The order must include clear, objective observable parameters.

As needed orders must be written specifically so that certified personnel know exactly how much to administer and when to administer without using personal judgement.

♦ Order must specify medication, strength and dose (ex. Acetaminophen 500mg 1 tablet; Acetaminophen liquid 500mg per 15 ml - give 15 ml)

The order cannot read: *"Acetaminophen give 1-2 tablets"* or; *"give Albuterol 2-3 puffs"*

♦ Order must specify dosing interval (ex. every 6 hours)

The order cannot read: "*give Acetaminophen 500mg 1 tablet every 4-6 hours"*

♦ Order must specify the reason for giving the medication; the reason for an as needed medication must be stated in the order. The reason must be clear, objective and observable. (ex. as needed for a temperature above 100^0 F; as needed for cough lasting more than 15 minutes)

The order cannot read: ***"****for a fever" or; "for a cold"*

♦ Orders for two as needed medications must clearly state which medication should be used for what specific symptom. (ex. Acetaminophen 500mg 1 tablet for complaint of headache; if headache not relieved within 2 hours, administer Ibuprofen 600mg 1 tablet)

The order cannot read: "*Ibuprofen 600mg 1 tablet for complaint of headache"* and another order stating, *"Acetaminophen 500mg 1 tablet for complaint of headache"*

*If you discover that the person has more than one as needed medication ordered for a specific symptom contact a healthcare professional for clarification.

Rules for As Needed Medications (continued)

As needed medications are given for specific symptoms at designated intervals. The window of time for administration of routinely scheduled medications/treatments (1 hour before or 1 hour after the scheduled time) does not apply to as needed medications.

Example: “every 4 hours for complaint of headache” means the medication can be administered again no sooner than four hours after the last dose and if there is a complaint of headache.

Following the Administration of an As Needed Medication:

- The observed indication of need, medication, strength, dose, route, date, time, and initials of the person giving the medication must be documented on the MAR when an as needed medication is given.
- The effectiveness of the medication must be documented on the MAR after the medication has had time to help. Thirty (30) minutes after administration of any as needed medication the effectiveness of the medication should be observed, and the outcome documented on the MAR if it was effective. If the medication is not effective yet, wait another 30 minutes then document outcome and take action if still not effective.
- If an as needed medication does not relieve the symptom it is used for, call a healthcare professional.
- If symptoms worsen, call a healthcare professional.
- If symptoms go away then continue to return over a 72-hour time period, notify a healthcare professional.

Certified Personnel CANNOT EVER:

Make judgments about what as needed medication to give without orders that adhere to the rules for administering as needed medication. When in doubt call a healthcare professional for guidance.

NOTE: As needed medications need to be specific for each person. As needed medications paid for from one person’s funds or insurance, cannot be used for another person who has the same symptom, even though the other person may have an identical as needed order, but is currently out of that medication. Agencies may pay for a stock of medication that multiple people may use. People may choose to share the cost of having stock of as needed medications if they want to.

Documentation of As Needed Medications:

If a medication is given on an as needed basis:

1. Initial on the MAR/TAR indicating the date and time it was given.
2. Document the reason it was given, and the effectiveness/outcome of the medication/treatment.

Examples of Correctly Written Orders for As Needed Medications

Example #1

Acetaminophen 325mg, give 1 tablet by mouth every 4 hours as needed for complaint of headache, or temperature of 100^{O}F or above.

The medication would need to be provided for the person in this strength (325mg). Personnel cannot use tablets of a different strength to get to 325mg. For example, personnel cannot substitute four 81mg tablets for a 325mg tablet.

This order allows any brand of Acetaminophen to be given for a headache or a temperature of one hundred degrees Fahrenheit or above.

Generic substitutions may be given by unlicensed personnel ONLY with the written authorization of an appropriate healthcare professional.

Example #2

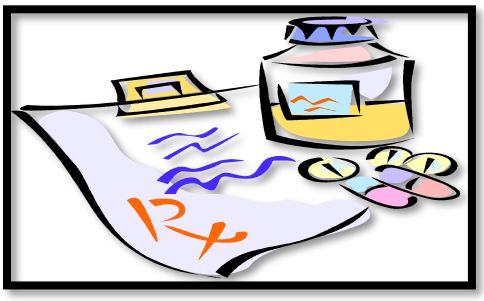
Loperamide 2mg, give 2 tablets by mouth as needed after the first loose stool; give 1 tablet by mouth after each subsequent loose stool. Do not exceed 4 tablets in 24 hours.

Example #3

Acetaminophen 500mg, give 1 tablet by mouth every 6 hours as needed for complaint of headache or symptom of headache as evidenced by hitting head with heel of hand. If headache is not resolved within 2 hours, use Ibuprofen 600mg, give 1 tablet by mouth.

If headache returns after 6 hours after the initial Acetaminophen administration, the medication order begins again with Acetaminophen.

In this example an alternate medication is available if the first medication is not effective. No judgement is needed.



Example #4

Pepto-Bismol® 262mg, give 2 tablets by mouth every hour as needed for complaint of stomach upset, not to exceed 16 tablets in 24 hours.

Example #5

Lorazepam 1mg, give 1 tablet by mouth every 6 hours as needed for symptoms of anxiety due to Autism as evidenced by head banging or skin picking or crying or rocking in a fetal position.

An order for "increased agitation" is not specific enough.

Medication used for treatment of specific symptoms associated with a diagnosed (DSM) condition may be considered medical treatment not a chemical restraint.

Medication used strictly for control of behavior is considered a chemical restraint.

The definition of, and specification for use of a Chemical Restraint are addressed in OAC 5123:2-2-06 and 5123-17-02.

Example #6:

Ambien® 5mg, give 1 tablet by mouth at bedtime, as needed for insomnia, as evidenced by being awake 40 minutes after going to bed.

Example #7

Give Tylenol® 500 mg, 1 tablet by mouth as needed for temperature of 101 degrees Fahrenheit or above. Recheck temperature in 2 hours. If temperature is still 101 degrees Fahrenheit or above, give Ibuprofen 200 mg, 1 tablet by mouth as needed. Alternate Tylenol® and Ibuprofen every 2 hours as needed until temperature is below 100. Do not give more than 6 Tylenol® tablets and 6 Ibuprofen tablets in a 24-hour period. Contact a healthcare professional if fever lasts more than 24 hours.

Note: Alternating medications to treat the same symptom is a complete order. It is not an order for 2 medications for the exact same symptom, it is a single order that alternates medications for a single symptom.

Example #8

Use the FLACC scale* to determine the pain level and treat as ordered.

Give Ibuprofen 800 mg 1 tablet by mouth every 6 hours as needed for fracture related pain level between 3-5.
OR
Give Percocet® 5/325, 1 tablet by mouth every 6 hours as needed for fracture related pain level between 6-10.

Assess pain 30 minutes after giving Ibuprofen and every hour thereafter. If at any time during the 6 hours after giving Ibuprofen the pain level is 6 or above, give Percocet® as ordered.

If Percocet® was given first, assess pain level 30 minutes after giving Percocet® and every hour thereafter. If pain is between 3-5 administer Ibuprofen as ordered. If pain is still between 6-10 thirty minutes after giving Percocet®, contact the healthcare professional.

Note: the remedy given depends on the person's determined pain level. One remedy (Ibuprofen) works sufficiently for lower levels of pain, the other (Percocet®) may be needed to control higher levels of pain.

If the pain is not controlled by the prescribed dosage of the stronger medication, a healthcare professional should be contacted to adjust the prescription for optimal pain control.

It is more difficult to get pain under control than to keep it under control. By treating pain promptly, it can often be managed more effectively.

If you do not understand how to follow the orders as written, contact the healthcare professional for clarification.

***see samples of pain scales on page 106**

Rules for Documenting

DO:

- ♦ Write legibly
- ♦ Avoid spelling errors
- ♦ Keep documentation current
- ♦ Correct documentation errors immediately
- ♦ Spell out words or use only approved abbreviations listed in the key or legend of abbreviations
- ♦ Write new documentation for each day/event (even if the information is the same as a previous entry)
- ♦ Document with non-erasable dark 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
- ♦ Make sure your signature is legible

DO NOT:

- ♦ Use pencil
- ♦ Use correction fluid (white-out)
- ♦ 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 a person's health records as a place to air grievances or criticize other caregivers or administrators
- ♦ Use abbreviations unless there is a legend or key present (for narrative documentation only; no abbreviations are to be used on MAR/TAR)
- ♦ Document for another person
- ♦ Guess or provide opinions

Remember: you are painting a word picture with what you write down. Describe, describe, describe. No opinions. No conclusions. Simply objectively describe what you have observed.

Documentation of Medications Administered and Health-Related Activities Performed

Certified personnel must document all medications administered as well as all health-related activities and tasks completed. **Remember, if it is not documented on the MAR/TAR, it was not done.**

Documentation of medication administration shall be done according to the rules for medication administration (Ohio Administrative Code 5123:2-6-07). Electronic MAR/TAR and other healthcare documentation must follow these same rules. Personnel will need to be trained how to use electronic records to complete required documentation.

A. **A medication administration record (MAR) or treatment administration record (TAR) for each person must include:**
   1. Individual's Name
   2. Medication Name (including strength)
   3. Dose of medication to be given
   4. Route of medication
   5. Time to administer the medication
   6. Month and Year
   7. Allergies
   8. Special Instructions: (ex. take pulse before giving; give with food; etc.)

Identification of personnel initialing entries in the record may be on the MAR or a Master Signature Log.

B. After the medication is given or health-related activity is performed, the certified personnel who gave the medication or performed the health-related activity will initial the appropriate date and time space on the MAR or the TAR or as instructed when using an electronic MAR.

C. If a medication is given on an as needed basis:
   1. Initial on MAR/TAR indicating the date and time it was given
   2. Document the reason it was given, and
   3. The effectiveness/outcome of the medication/treatment

If a medication or treatment is not given or is not taken:

- Initial the appropriate time space on the MAR
- Then circle the initials and
- On the back of the MAR/TAR document the reason for the circled initials
- When using an electronic MAR/TAR document per system instructions

If a documentation error is made:

- Draw a single line through the word (so original words can still be read)
- Write the word "void" or "error" above the wrong words
- Place your initials and date above the wrong words
- Write the correct entry

Never document for anyone else. All MARs including electronic MARs are legal documents. Documenting for others is falsifying a legal record.

Never leave a blank space for late entries. If there is a blank on a MAR/TAR it should be circled and an explanation written on the back of the MAR/TAR. An undocumented medication is a medication error (OAC 5123:2-6-01); a UIR must be written.

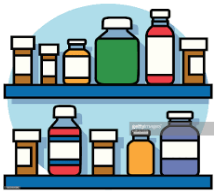
An Unusual Incident Report (UIR) must be written for any late, missed or declined (refused), or undocumented medications/treatments. There will be variations of employer procedures for processing Unusual Incident reporting; such as communicating about UIRs to appropriate persons and for identification of patterns and trends.

NOTE: If medications, or health-related activities are administered away from where they are usually given, there must be documentation on the MAR/TAR to explain where they were administered (such as on vacation, or at work).

Storage and Care of Medications

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

Medication Storage and Preparation Areas



Storage and preparation areas must be functional and provide:

1. Adequate space for storage.
2. Accessible hot and cold running water.
3. Adequate lighting so that labels can be clearly seen.
4. A clean and orderly space for preparation and storage.
5. Cupboards/containers that are secure.
6. Adequate, uncluttered countertop or table space to prepare medications.
7. Ability to separate oral medications from medications given by other routes. Each route must have its own clearly labeled storage (bins, bags, shelves, drawer, etc.).

Medications Stored in the Refrigerator

If possible, a separate refrigerator used only for medications is ideal. If this is not possible, medications stored in the refrigerator must have a dedicated space in the refrigerator for their storage. Place refrigerated medications inside a plastic container with a lid to protect them and keep them from getting misplaced or contaminated by food/beverages. Remember, medications stored in the refrigerator must also be appropriately secured.

Maintaining potency (effectiveness) of medications

- Follow the instructions provided by the pharmacy.
- Keep away from direct light sources (windowsill, beneath a light).
- Keep away from heat sources (stove, top of refrigerator, window ledge, microwave).
- 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
- Have missing labels
- Have unreadable labels
- Are missing the original dispensing label
- Are expired (past expiration date)

If the expiration date is August 10, 2020, the medication may be used up until midnight of August 10, 2020. The medication may NOT be used on August 11, 2020 or after. If expiration date is a Month/Year, the medication can be used until midnight the last day of the specified month.

Disposal of Medications

✓ **Before destroying any medication, document the amount of medication(s) to be destroyed (name, strength and amount)**

Medications that are expired, contaminated, declined, or discontinued must be disposed of safely. Medications may be returned to the person's pharmacy for disposal if that is an option. Contact your local department of health or police for other disposal options.

US FDA (US Food & Drug Administration) guidelines for the disposal of medications include:

- ♦ Mixing medication with something that will hide it or make it unappealing, such as kitty litter or used coffee grounds, then placing the mixture in a container such as a sealed plastic bag and throwing the container into the household trash.

To protect the person's identity and protect their privacy, be sure to remove and destroy the label from the original container before throwing the container in the trash.

Additional information can be found at:
https://www.fda.gov/consumers/consumer-updates/where-and-how-dispose-unused-medicines

MEDICATIONS SHOULD NOT BE FLUSHED

Do Not Flush Medications

Mix medication with Kitty Litter. Seal in a container and put in the trash.

Mix medications with used coffee grounds. Seal in a container, and put in the trash.

Disposal of Medications

Medications that are being disposed of need to be documented. Document the medication name, strength, amount of medication and method used for disposal. Have a witness document that the medication was disposed.

Remember: When a person dies; **DO NOT** dispose of their prescription medication(s) until a law enforcement officer, the coroner, or the investigative agent from the ICF or County Board of DD indicates that it is okay to do so. Prior to disposing of any medication, it must be counted to ensure the correct count at the time of death. Schedule II, III, IV drugs must be counted by two different people at the same time.

NOTE: Specialty products such as Deterra® can also be obtained and used for safe medication disposal.

Preventing or Reducing Occurrences of Medication Theft

Medications must be secure. Whether medications are locked or not will depend on the person and the situation. Medication should be secured as directed in the person's plan or as directed by the delegating nurse, or agency policy. In some instances, medications may need to be kept in locked storage, in other situations medications may be safely kept in a dedicated place that is secure. Note: the need to have medications locked for security does not prevent self-administration.

Misappropriation (theft) is a Major Unusual Incident (MUI).

Adverse consequences of stolen medications:	**Stealing, borrowing, or other misappropriation of medications can result in serious outcomes for personnel such as:**
♦ Not receiving medications as prescribed ♦ Prolonged illness or delay in progress ♦ Unnecessary pain/discomfort ♦ Drug withdrawal or disease relapse ♦ Financial hardship	♦ Criminal charges ♦ Revocation of certification ♦ Termination of employment ♦ Listing on the DODD Abuser Registry

Helpful hints to assist with proactively preventing medication thefts:

♦ Document security procedures and practices

♦ Track who administers medications

♦ Establish an effective accounting system for all medications

♦ Provide for a safe/secure storage area with limited access

♦ Report and address medication errors immediately

♦ Store only those medications necessary to have on-hand (avoid overstocking)

♦ Train all personnel on the importance of proper medication administration and storage

♦ Conduct an inventory of medications routinely so that problems can be quickly identified and investigated

♦ Monitor the administration of medication routinely

♦ It is important to have a tracking system to look for problems over time. Resolve any identified problems as soon as possible

Safe Practices:

♦ Secure medications

♦ Provide adequate oversight of all medication administration

♦ Place each person's medications in a separate bin or storage unit

♦ Account for medications regularly to assure medication administration procedures are being followed

♦ Keep on hand only the amount of medications needed: do NOT overstock for the sake of convenience

♦ Be alert for signs of drug abuse and report suspicions to the appropriate personnel immediately

♦ Stay alert to signs that a person may not be getting their medications and report this immediately

♦ Even people who live alone need to keep medications secure from children and any other visitors

***** Observe for signs of medication effectiveness. If medication is not effective, the person may not be receiving the medication as ordered. Report signs of ineffectiveness immediately to an appropriate healthcare professional. Request tests for blood level of medications that do not seem to be working.

Medication Errors

If you make or discover a medication error, report it and follow-up immediately.

**** Get medical care if a person is showing any symptoms from the medication error or any time a person takes medications that were not prescribed for them**.

Per OAC (Ohio Administrative Code) 5123-17-02(C) (25), a medication error must be reported as an Unusual Incident.

Types of Medication Errors Include (OAC 5123:2-6-01 (Z)):

- Giving medication to the wrong **I**ndividual
- Giving the wrong **M**edication
- Giving the incorrect **D**ose of the medication
- Giving medication by the wrong **R**oute
- Giving medication at the wrong **T**ime
- Not **D**ocumenting medication administration directly following the administration
- Administering medication or treatment without nurse delegation when delegation is required
- Giving expired (outdated) medication
- Giving medication without a physician order
- Omitting a medication
- Giving contaminated medication
- Giving medication when not currently certified
- Giving medication that was improperly stored (potency may have been affected)

Why Medication Errors Happen

Do NOT multi-task when preparing and administering medications.

1. Not checking the label against the MAR 3 times during preparation
2. Reading the label or MAR incorrectly
3. Preparing medications for more than one person at a time
4. Not waiting for the person to swallow the medication
5. Not documenting immediately that a medication was given
6. Error in transcription onto the MAR
7. Not having transcription verified by a second person
8. Incorrect documentation of medication given
9. Multi-tasking while setting up medication: not giving the task your full attention
10. Environmental distractions (ex. noise, talking to other people while setting up medications, cluttered work area)

Documentation

- ◆ If a medication is not given or not taken or, a health-related activity is not completed, initial the appropriate time space on the MAR/TAR, then circle the initials and note the reason on the back of the MAR/TAR
- ◆ If you accidently document in the wrong space, correct your error immediately
- ◆ Do not ever correct someone else's documentation error
- ◆ A missed medication requires a UIR to be written, no matter what the reason
- ◆ Failure to document medication administration is a medication error and requires a UIR

Preventative Measures to Reduce Medication Errors:

- ♦ Consistent supervision and oversight of medication administration
- ♦ On-going training/education of personnel certified to give medications
- ♦ Evaluation of employer's policies and procedures
- ♦ Identify and evaluate system issues that may contribute to medication errors

Missed Medications

1. When a medication is held, missed, not taken, or not given on time find out what to do from the package insert or by following the instructions of a pharmacist, nurse, or physician.

2. Document missed medications on the MAR by
   - Initialing in the space for the dose/time
   - Circling your initials and
   - Writing an explanation on the back of the MAR; the explanation should be brief and refer to the Unusual Incident Report

   If using an electronic MAR, document missed medications as directed.

3. A missed, late or incorrect medication is always documented on an Unusual Incident Report. Include details on the UIR about:
   - Who was consulted
   - What was reported
   - What directions were given
   - What actions were taken

   Incident reports should result in action to understand the cause and develop preventative measures.

4. For missed medications/treatments that are delegated, notify the delegating nurse.

Common Reasons Medications are Not Given or Taken:

- The person declines to take the medication
- The person responsible for giving the medication forgot
- The medication has an unpleasant taste or consistency
- The person does not like the way the medication makes them feel
- The medication is not transcribed onto the MAR
- There is confusion about how or when to give the medication
- The prescription or refill was not called in, filled, or picked up in a timely manner

If a person repeatedly or routinely declines to take prescribed medications or treatments, the person-centered planning process must try to determine why and mitigate the cause. If the person (or guardian) declines a prescribed medication or treatment entirely, the prescriber needs to be notified and alternate treatments pursued.

Repackaging Pharmacy Dispensed Medication for Leave Away from Home

Adapted from Ohio Board of Nursing's article in Momentum (Winter, 2011), 9:1, Pg. 10-11

…..”re-packaging” dispensed medication is regulated by the Board of Pharmacy. Pharmacy Board staff recently informed the [Nursing] Board that the Pharmacy Board reaffirmed its policy concerning nurses re-packaging residents' medications while the resident is away from a long-term care or residential care setting. Excerpts of the Pharmacy Board's September 2010 meeting related to the Pharmacy Board's action are provided below:

Excerpts from the Minutes of the September 13-15, 2010 *Meeting of the Ohio State Board of Pharmacy* Monday, September 13, 2010

R-2011-071 Reaffirmation of an existing policy created January 22, 1985, concerning mental health and pick-up stations. The Board discussed circumstances in which residents in nursing homes or small group homes for the mentally disabled need to take medication while on a temporary leave or when absent during the day from the facility where they reside.

The Board noted that in each of these instances, the medications had been dispensed by a pharmacist for administration by the patient themselves, or by personnel of the facility where the patient resides.

The Board further noted that the facility where the patient resides maintains custody of the drugs for the patient and in providing nursing or custodial care of the patient, is responsible for administration of the medicine as prescribed.

The problem faced by these facilities is the repackaging of the medication for administration at a site other than the facility where they reside and by individuals who are not employees or agents of the facility. The repackaging of the medication in smaller amounts for self-administration, or administration by someone other than an employee of the facility is not considered to be dispensing.

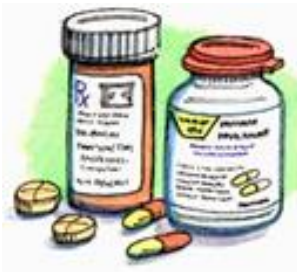
If the medication has already been dispensed by a pharmacist in accordance with state and federal laws and delivered to the facility responsible for the care of the patient, any competent employee of the facility could legally prepare the medication for administration by another competent individual who has temporary custody and is responsible for the patient's well-being during his/her absence from the facility.

In order to ensure the medication is administered as prescribed, an amount necessary to cover only the duration of drug therapy should be repackaged and labeled with:

- The facility's full name and address;
- The patient's full name;
- Directions for use;
- Any cautionary statements required for the safe and effective use of the drug;
- Full name of the drug; and the
- Date the drug was packaged for administration

In order to avoid confusion and prevent errors in administration, each package should contain only one medication to be administered. A record of the person responsible for repackaging the drug should be maintained in the facility, as well as the date and amount removed from the patient's prescription container for administration at a location other than the facility where he/she resides.

In some instances, if not all, it may also be in the best interest of the patient and the facility if an administration record form accompanied the package of medication that is to be administered when the patient is absent from the facility. This form could be maintained with the patient's records in the facility and provide a continuous record of drug therapy and the person's responsible for the patient's care during such therapy.



Place each medication in a separate labeled envelope to administer at the appropriate time

The following medication information is a general overview. It is your responsibility to read and understand information provided by the pharmacy or other reputable source and be certain you understand "What you must know about any medication before administering it" (on p. 28).

Things to Know About Medications

Alzheimer Medications (To treat mild to moderate symptoms of Alzheimer's Disease)

Examples: **Aricept®** **Cognex®** **Exelon®** **Namenda®** **Razadyne®**

These medications should not be stopped suddenly. Changes in stool color should be immediately reported to the doctor. Liver function studies may be ordered periodically.

Analgesics (To relieve pain)

Ex: **Aspirin** **Acetaminophen** **Demerol®** **Morphine** **Percocet®**

May cause stomach upset; do not give on an empty stomach (give with a meal or snack).

Be sure to document effectiveness of medication by asking the person 30 minutes after dosing if pain is better. If not, call a healthcare professional.

Antacids (To control heartburn or "sour stomach")

Examples: **Pepto Bismol®** **Pepcid AC®** **Tagamet®** **Reglan®**

May cause constipation. Monitor bowel function.

Can interfere with absorption of other medications. Give 2 hours after, or 1 hour before other medications.

Pepto Bismol® contains aspirin. Should not be given with anticoagulants (blood thinners) or to people with aspirin allergies.

Anti-anxiety (To calm the nerves)

Examples: **Klonopin®** **Luvox®** **Tranxene®** **Valium®** **Xanax®**

Tolerance can develop when these medications are taken over time and they may be less effective. If it appears their effectiveness is decreasing notify the prescriber.

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

These medications should not be combined with alcohol. Death can result.

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

Antiasthmatics (To treat asthma)

Examples: **Albuterol** **Proventil®** **Symbicort®** **Singulair®**

May cause stomach upset; do not give on an empty stomach (give with a meal or snack).

Be aware that the pulse may increase after giving the medication. Report heart rate above 100 to a healthcare professional.

May interfere with sleep. If that is a problem, schedule medication several hours before bedtime.

Antiarrhythmics (To regulate heartbeat)

Examples: **Calan®** **Sotalol®** **Toprol®**

You may need to check the person's pulse before administering these medications. The prescriber's directions will tell you when to check the pulse and hold the medication if pulse is too low (usually below 60 beats per minute).

Notify a healthcare professional if heartbeat is irregular.

Antibiotics (To treat bacterial infections)

Examples: Amoxicillin Ceclor® Penicillin

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

Pay attention to how the medication frequency is specified.

Give all the pills in the container until completely gone to avoid developing an antibiotic resistant infection in the future.

Be aware that antibiotics can affect the way seizure medication, birth control pills and other medications work. Read the pharmacy information carefully.

Encourage 6-8 eight-ounce glasses of fluid intake daily while taking these medications.

Anticonvulsants* (To control seizures)

Examples: Depakote® Dilantin® Keppra®**
Lamictal® Neurontin® Tegretol®

Read all instructions carefully. Some of these medications cannot be taken with food (i.e. Dilantin®).

Always use seizure precautions with anyone taking these medications.

Be aware of signs of toxicity.

*These medications may also be used for mood stabilization.

**Routine blood ammonia levels need to be checked for persons taking Depakote.

Antidepressants (To treat depression)

Examples: Celexa® Cymbalta® Effexor®
Prozac® Lexapro® Zoloft®

Any person 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 people wear sunscreen and sunglasses when outdoors, even in the winter.

These medications can take as long as 4-8 weeks before the person experiences therapeutic effects.

Dry mouth can be a huge problem. Keep water, hard candies and juicy fresh fruits available.

These medications must NOT be suddenly discontinued, they need to be withdrawn slowly.

Anticoagulants (To thin the blood)

Examples: Coumadin® Warfarin

Report bleeding gums to nurse or physician.

Avoid foods high in vitamin K (green leafy vegetables).

Do NOT give aspirin or aspirin containing products unless directed to do so by a physician.

Other medications (such as vitamins, cold medications, sleeping pills, antibiotics, herbal supplements) can increase or decrease effectiveness of this medication.

Know when blood tests are to be done to monitor effectiveness of this medication. Be sure to adjust the dose as ordered.

Use caution with sharp items while taking this medication.

Use electric razors, do not use blade razors.

Notify the physician immediately if:

- The person's gums bleed
- There are blood blisters and/or bruising
- The person complains of headache or stomach pain
- There is more bleeding than normal during a menstrual period
- The person gets sick, feels weak, faint or dizzy
- Stool is red, very dark brown, or black
- Urine is dark brown or red
- Injury resulting in swelling that might possibly contain blood or be painful

Anti-Diarrheals (To treat diarrhea)

Examples: Imodium AD® Lomotil®
Loperamide

Be sure rectal area is clean after each stool.

Notify a healthcare professional if stools continue beyond specified time.

Document color, consistency, number of stools.

Provide for a bland diet for as long as diarrhea persists.

Antihistamines (To alleviate allergy symptoms)

Examples: **Benadryl®** **Zyrtec®** **Claritin®** **Singulair®**

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

Encourage people to be careful if riding a bike or using other equipment requiring coordination.

Antiparkinsons (To treat Parkinson-like symptoms or side effects of other medications)

Examples: **Akineton®** **Artane®** **Cogentin®** **Levodopa** **Sinemet®** **Stalevo®**

People on these medications are at risk for falls. Be very aware of anything in the environment that could cause a fall.

The need for assistance walking should be addressed in the person-centered planning.

Antipyretic (To reduce fever)

Examples: **Naproxen** **Aleve®** **Aspirin** **Acetaminophen** **Ibuprofen**

Be sure the person drinks plenty of fluids to prevent dehydration.

Give these medications with food to avoid stomach upset.

Be sure the prescriber knows if the person is on anticoagulant therapy (on Coumadin®) because blood can get too thin.

Antitussives (To control coughs)

Example: **Benylin®** **Codeine** **Delsym®** **Robitussin®**

If cough does not improve, have the person evaluated by a healthcare professional.

Take only as prescribed. Usually the recommended dose is taken up to 4 times a day.

Antihypertensives (To control high blood pressure)

Examples: **Cardizem®** **Catapres®** **Coreg®** **Lisinopril** **Minipress®** **Verapamil®**

You may be asked to monitor a person's BP. Use an automated device.

The doctor or MAR will tell you parameters for BP and when to contact a healthcare professional.

Lisinopril can cause a persistent cough. Report coughing to prescriber.

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

Sometimes people get lightheaded or dizzy when going from lying/sitting to standing. Encourage people to stand up slowly.

Antipsychotics (Neuroleptics)
(To treat mental illnesses)

Example: **Abilify®** **Clozaril®** **Geodon®** **Haldol®** **Risperdal®** **Seroquel®**

It is not unusual for people taking these medications to eventually develop diabetes. Be aware of signs of diabetes and seek medical care early.

Be aware of signs of life-threatening Neuroleptic Malignant Syndrome: fever, rigid muscles, sweating, renal failure, muscle wasting, pallor. Call 911.

Photosensitivity can be a problem. Be sure people use sunscreen and wear sunglasses when outdoors, even in the winter.

Birth Control (To prevent pregnancy; regulate menstrual cycle)

Examples: **Depo-Provera®** **Estradiol** **Ortho Novum®** **Yasmin®**

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

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

Smoking increases the risk of blood clots.

Decongestants (To reduce nasal congestion or stuffy nose)

Examples: Sudafed® Comtrex®
Chlortrimaton D®
Afrin Nasal Spray®

Can cause ▪drowsiness ▪dry mouth ▪dizziness ▪restlessness ▪sleeplessness ▪agitation

Can raise blood pressure and should not be used by people being treated for high blood pressure. Ask prescriber for an alternative treatment for people with high blood pressure.

Afrin® should not be used for more than 3 consecutive days.

Diuretics (To increase the release of extra water from the body)

Examples: Aldactone®
Hydrodiuril®
Lasix®
Zaroxolyn®

Check weight routinely as ordered by a healthcare professional.

Be aware of urinary output (or lack of).

Observe for decrease or increase in swelling in ankles, lower legs, and hands.

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

Hormones (To treat hormone imbalances)

Examples: Estrogen Prempro®
Levothyroxine

Take 1 hour before eating for maximum absorption.

Avoid taking antacids within 2 hours of a hormone.

Oral Diabetes Medications (To control blood sugar)

Examples: Glyburide Metformin®

Monitor the person's blood glucose level as instructed.

Infection can raise a person's blood sugar.

Stress can raise a person's blood sugar.

Know the person's typical glucose levels. If glucose level is outside the person's typical range, follow the healthcare professional's instructions or contact a healthcare professional for further instructions.

Expectorants (To get secretions out of the lungs)

Examples: Benylin®
Congestac® Humabid®
Mucinex®

Encourage the person to drink at least 6-8 eight-ounce glasses of water during waking hours.

Have the person cough and deep breathe as instructed.

Observe and document frequency and intensity of coughing.

Laxatives (To relieve constipation; promote peristaltic action in the intestines)

Examples: Cascara® Colace®
Metamucil® Miralax®
Senna®

Give after meals.

Be sure fluid intake throughout the day is adequate. Encourage 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.

Preferably these are short-term treatments, some people need them for long-term use.

Mood Stabilizers (To treat mood swings)

Examples: Depakene® Lithium® Tegretol®

Watch for signs of toxicity which will be listed on the medication information sheet.

Report lethargy, trouble walking, ringing in the ears, and severe vomiting to a healthcare professional immediately; **these can be life-threatening symptoms.**

Prevent medication buildup in the body leading to toxicity by encouraging adequate fluid intake throughout the day; at least 6-8 eight-ounce glasses of water during waking hours.

Osteoporosis Medications (To prevent bone loss; prevent osteoporosis)

Examples: Boniva® Fosamax®

Must remain upright for 1 hour after taking the medication.

Take 1 hour before breakfast unless otherwise specified.

These medications must always be taken at the same time on the same day of the week. If the medication is delayed for any reason, the future schedule must be changed to be exactly 7 days later.

Proton Pump Inhibitors (To treat GERD or acid reflux and prevent erosion of the esophagus)

Examples: Aciphex® Nexium® Prevacid® Prilosec® Protonix®

If taken for more than 1 year, the risk of developing osteoporosis increases.

These work best if taken in the morning and if taken 30-60 minutes before eating.

Nutritional Supplements (To treat vitamin and mineral deficiencies in the body)

Examples: Vitamins Herbs

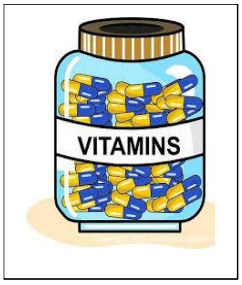
A directive from a healthcare professional is required for unlicensed personnel to administer supplements. They can be dangerous and interfere with other medications.

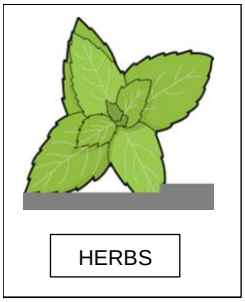
Potassium may be needed if the diet is inadequate or if a person is taking a diuretic which can deplete the body of potassium. Apples, oranges, potatoes, bananas, and raisins are good sources of potassium.

Calcium intake is often insufficient. Adults need at least 1200 mg of calcium per day. Caffeinated beverages deplete the body of calcium. Limiting soda intake to only one 12 ounce can per day or less is best for bone health.

Many Americans are deficient in fiber intake. Whole grains, fruits, and vegetables are excellent sources of fiber.

Iron pills can upset the stomach. Give with food and monitor for constipation. Iron is found in red meats, poultry, eggs and dark green leafy vegetables. Stools may be black in color.





Sedatives/Hypnotics (To promote sleep)

Examples: **Ambien®** **Lunesta®** **ProSom®** **Rozerem®** **Sonata®** **Nytol®**

Can cause dizziness. Be careful of falls.

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

Should be scheduled to allow for 8 hours of sleep.

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

Stimulants (To treat Attention Deficit Disorder)

Examples: **Adderall®** **Caffeine** **Ritalin®**

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

Some people lose weight on these medications. Be aware of weight and report changes to a healthcare professional.

If the desired effect is not apparent, report to a healthcare professional.

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

Skeletal Muscle Relaxants (To treat muscle spasms and pain from injury to the body)

Examples: **Baclofen®** **Dantrium®** **Flexeril®** **Norflex®** **Skelaxin®**

Can cause dizziness and drop in blood pressure.

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

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

Can cause respiratory depression in older or debilitated people.

Be aware of decreased urinary output. Kidney dysfunction can be a problem.

Urinary Tract Infection Medications
(To treat and relieve symptoms of bladder and kidney infections)

Examples: **Bactrim®** **Cipro®** **Pyridium®** **Septra®** **Unasyn®**

Pyridium turns the urine orange which can stain clothing.

These medications should be taken with food to avoid stomach irritation.

The person needs to drink a lot of fluids to keep their bladder flushed. Offer 8 ounces of fluid every hour.

The physician may order a clean catch urine to test for the presence of bacteria.

Psychotropic Medications Overview

Medications prescribed to improve a person's mental health, or their behavioral symptoms of mental illness are referred to as psychotropic medications. Antidepressants, antipsychotics, mood stabilizers, anti-anxiety agents, sleep agents, stimulants, antiparkinsonian and anticholinergic agents are such medications.

Anticonvulsant and cardiac medications may also be considered psychotropic medications if used for mental health treatment.

Individual's Rights

All people have the right to choose not to take medications including people with diagnoses of mental illness and IDD.

Support providers must always recognize the right of the person with IDD 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 medications that may cause serious adverse effects. It is named for the black border that surrounds the text of the warning.

If administering a medication that has a black box warning, obtain immediate medical treatment for serious signs and symptoms of possible medication side effects.

Commonly Used Psychotropic Medications with a Black Box Warning

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

What to do:

- Be informed about the black box warning
- Obtain immediate medical treatment for signs and symptoms of possible medication side effects

Observation and Reporting of Side Effects

A person who is taking psychotropic medications may be unable to adequately verbalize symptoms or medication side effects. Therefore, it is important for others to be observant for possible side effects that need to be reported to a healthcare professional.

Examples of Side Effects Common to Psychotropic Medications include:

- Dry mouth
- Drowsiness
- Change in sex drive
- Sensation of thirst or increased need for fluids
- Unusual bruising or bleeding
- Yellowing of the eyes or skin
- Abnormal posture, movements, or gait (walking)
- 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 heartbeat (slow, fast, irregular) or blood pressure (high or low)
- Fainting or dizziness, especially with changes in position (ex. going from sitting to standing)
- Repetitive motor movements (such as with hands, eyes, legs, lip-smacking, etc.)
- Allergic reaction (difficulty breathing, swelling of lips/face/tongue, rash, or fever)

Medications used only for controlling behaviors with no corresponding psychiatric diagnosis are considered chemical restraints. These medications must be identified as a chemical restraint in the person's support plan and reported as restraints according to rules.

Scheduled Drugs

The FDA classifies drugs on a Schedule of 1-5 (I, II, III, IV, V).
Schedule II and III drugs are highly restricted due to their potential for abuse or addiction. Schedule I drugs have no legally established medical use.

Schedule II, III & IV Drugs:

- Schedule II and III drugs require special precautions due to the potential for addiction and abuse.
- All schedule II, III & IV drugs are highly regulated and must be carefully tracked. If a schedule II, III & IV drug is being administered, you will need to keep careful records to account for each dose. Follow your agency's procedure for securing and tracking these drugs.
- Schedule II & III drugs will have an additional warning on the label that reads:
  CAUTION: Federal Law prohibits the transfer of this drug to any other person than the patient for whom it was prescribed.

Schedule II, III, & IV drugs include:

Narcotics (Used to treat severe pain)

Examples: Morphine
Demerol®

Can be broken down into two groups:

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

Stimulants (Used to treat hyperactivity)

Examples: Adderall®
Ritalin®

- ♦ Includes amphetamines
- ♦ May be used to treat depression and narcolepsy

Depressants (Used to induce sleep, sedation and combat anxiety).

Examples: Barbital®
Nembutal® Seconal®
Ambien® Lunesta®

- ♦ Includes barbiturates and tranquilizers such as Valium® and Librium®
- ♦ These medications are addicting and if combined with alcohol can lead to death

Food and Drug Administration (FDA) Scheduled Drugs

Additional documentation may be required for medications that have the potential for addiction or abuse. It is recommended that agencies have a policy and procedure regarding **safeguarding ALL medications** and should include counting or monitoring medications that are schedule 2, 3 or 4 (II, III, IV). Such procedures are important to ensure that a person receives the prescribed amount of a medication and to ensure that the medication is not being stolen and used by others.

Licensed facilities must follow Ohio Board of Pharmacy laws and rules related to medications and dangerous drugs.

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 personnel have the responsibility to recognize and report the first potential signs/symptoms of problems that may be noted through observations during baths/showers, mealtimes and recreation periods. Things to think about when observing a person: facial expression, vocal sounds, body position and behavior. Be alert to changes and notice if there is unusual touching, tapping or otherwise focusing on a certain part of the body.

*** **<u>Whenever you see anything that is not typical for the person, arrange for the person to be assessed by a healthcare professional.</u>**

Examples of common signs and symptoms which will require further evaluation and should be called to the attention of a healthcare professional for evaluation are listed below:

A. General Body Symptoms

- ❑ Shaking or chills
- ❑ Loss of appetite
- ❑ Increased thirst
- ❑ Eating problems
- ❑ Rapid weight gain
- ❑ Persistent low energy
- ❑ Weight loss without dieting
- ❑ Frequent or severe headache
- ❑ Swelling in any part of the body
- ❑ Abnormal posture, movement or gait

B. Skin

- ❑ Burns
- ❑ Too dry/moist
- ❑ Yellow color
- ❑ Rash, moles, open sores

- ❑ Tenderness to touch
- ❑ Pale or reddened
- ❑ Unusual bruising or bleeding
- ❑ Unusual redness and warmth
- ❑ Wounds or sores that do not heal

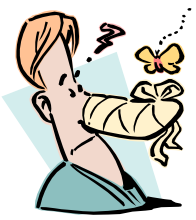
C. Eyes

- ❑ Profuse tearing
- ❑ Discharge or bleeding
- ❑ Suspected decrease in vision
- ❑ Redness or swelling of eyes or eyelids
- ❑ Twitching, sensitivity to light
- ❑ Dullness, dark circles
- ❑ Pupils dilated (big) or contracted (small)
- ❑ Foreign body in the eye (scratchy feeling in the eye or eye pain)
- ❑ Change in color of the white part of the eyes to look red, bluish or yellowish

D. Ears

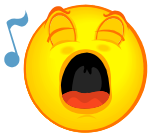
- ❑ Loss of hearing
- ❑ Discharge or bleeding
- ❑ Pain in ear or back of ear
- ❑ Profuse hardened ear wax
- ❑ Foreign body in ear (do not attempt to remove)

E. Nose



- ❑ Sneezing
- ❑ Repeated nosebleeds
- ❑ Congestion/stuffy nose
- ❑ Runny nose

F. Mouth

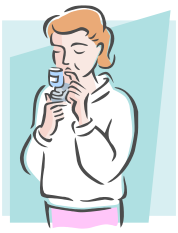


- ❑ Hoarseness
- ❑ Tongue: coated, red or pale
- ❑ Swollen, cracked, peeling lips
- ❑ Teeth: sharp, broken, toothache
- ❑ Difficulty in swallowing or talking
- ❑ Gums: swelling, bleeding, sores that do not heal
- ❑ Rash or blisters in mouth or throat, sore throat
- ❑ Coughing or gagging when drinking or eating
- ❑ Jaw drooping on one side
- ❑ Jaw swelling

G. Neck

- ❑ Stiffness or pain in neck
- ❑ Swelling or lumps in neck
- ❑ Holding the neck at an odd angle

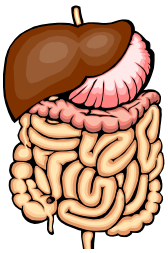
H. Chest



- ❑ Blood-tinged mucus
- ❑ Lump in breast or under arm
- ❑ Persistent or congested cough lasting longer than 1 week

*Women and men should do a self-breast exam monthly. If unable to do a self-breast exam, the plan should include a breast exam by a healthcare professional at least annually or as recommended.

I. Abdomen



- ❑ Hard abdomen
- ❑ Nausea or vomiting
- ❑ Pain in the abdomen
- ❑ Any swelling or lumps in abdomen or groin*

***Do NOT press on any lumps or bumps in the abdomen. Notify a healthcare professional if a lump or bump is found.**

J. Arms and Legs

- ❑ Varicose veins
- ❑ Lumps, bruises
- ❑ Swelling or pain
- ❑ Limping or change in walking (gait)
- ❑ Changes in ability to move limb(s) or any complaints of pain

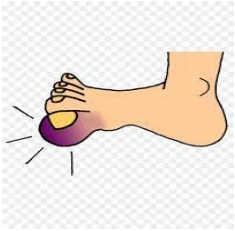
K. Genitals and Urine

- ❑ Itching
- ❑ Redness
- ❑ Swelling
- ❑ Discharge
- ❑ Pain or difficulty in urination
- ❑ Change in color or odor of urine
- ❑ Unable to void; voids frequently
- ❑ Incontinence if unusual for this person

L. Rectum

- ❑ Hemorrhoids
- ❑ Bleeding or drainage from rectum
- ❑ Loose or liquid bowel movement (stools)
- ❑ Bowel movement (stools) with blood, mucus, or worms
- ❑ Black or clay colored stools
- ❑ Constipation (dry, hard stool) or no bowel movement in 2 days

M. Feet



- ❑ Deformities
- ❑ Swelling, pain
- ❑ Corns or bunions
- ❑ Ingrown toenails
- ❑ Peeling, cracked skin
- ❑ Thick, discolored nails
- ❑ Changes in color (red, pale or blue) or temperature (too hot or too cold)

***If a person is diabetic, sensitivity in their feet may be decreased. Inspect feet daily.**

N. Mental State

- ❑ Fatigue
- ❑ Agitation
- ❑ Sudden change in behavior
- ❑ Drowsiness, change in alertness
- ❑ Irritability
- ❑ Sadness or not enjoying things previously enjoyed
- ❑ Withdrawn
- ❑ Unusual comfort seeking

O. Pain

How to tell if someone is in pain:

- ❑ The person tells you
- ❑ Facial grimaces
- ❑ Wincing
- ❑ Bracing
- ❑ Unusually resistant
- ❑ Self-injurious behavior
- ❑ Restlessness
- ❑ Aggression
- ❑ Rating on a pain scale*
- ❑ Rubbing an area
- ❑ Groaning, moaning
- ❑ Unable to get the person's attention (or not able to focus as usual)
- ❑ Stiff or avoiding movement of a body part
- ❑ A person's unique expression of pain as identified in the person-centered plan
- ❑ Verbalizations such as: Ouch! Don't touch me! Stop! That hurts!

***If a pain rating scale is used, all personnel should use the same scale for that person.**

PAIN PAIN PAIN PAIN PAIN PAIN

Achy, sharp

Throbbing, hurts

According to the U.S. Department of Health and Human Services pain is

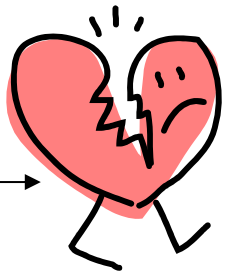
- ♦ An uncomfortable feeling that something may be wrong in your body
- ♦ A way of sending a warning to the brain that something is not right

www.ahrq.gov (Agency for Healthcare Research & Quality)

How people describe pain

- ♦ Dull
- ♦ Aches
- ♦ Sharp
- ♦ Constant
- ♦ Throbbing
- ♦ Stabbing
- ♦ A different feeling
- ♦ Comes and goes
- ♦ Broken heart
- ♦ Sad
- ♦ Nervous/anxious
- ♦ Hurts

A change in the person's behavior can signal pain. A change in appetite or energy level can signal pain or that something is wrong in the body or emotions (i.e. depression)



Broken hearted, sad

Tense, irritable, change in behavior

Causes of Physical Pain

- ♦ Non-visible injuries
- ♦ Chronic medical conditions
- ♦ Untreated dental problems
- ♦ Ill-fitting shoes or clothing that rubs
- ♦ Emotional and interpersonal problems
- ♦ Inactivity
- ♦ Having the body in poor alignment for long periods of time

A Change in Behavior May Signal Pain Especially for:

- ♦ Infants and young children
- ♦ People with cognitive disabilities
- ♦ People with expressive language disorder
- ♦ Anyone with chronic pain

Young child

Person with cognitive or expressive language disorder

"High pain tolerance" is a condition where an injury or illness that would typically be painful for most people is not noticed as painful to a person with high pain tolerance.

Watch very carefully for any movements, behavior or actions that could be a sign of injury or illness that needs to be reported.

Pain

♣ Pain signals that something is wrong

♣ **Being as pain free as possible is a person's right**

♣ Anytime a person verbalizes being in pain, or acts like they may be in pain, provide treatment as ordered or contact the appropriate healthcare professional

♣ Document:

- ♦ Time
- ♦ Date
- ♦ Who you notified
- ♦ What you were instructed to do
- ♦ What you did
- ♦ When you did it

Wong-Baker FACES® Pain Rating Scale

0	2	4	6	8	10
No hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

FLACC Scale - A Pain Assessment Tool

Although originally designed to be used with children between ages 2 and 7, this scale can also be used with adults unable to verbally communicate about their pain.

How to use a FLACC scale

In patients who are awake: observe for 1 to 5 minutes or longer. Observe legs and body uncovered. Reposition patient or observe activity. Observe body for tenseness and tone. Initiate consoling interventions if needed.

In patients who are asleep: observe for 5 minutes or longer. Observe body and legs uncovered. If possible, reposition the patient. Touch the body and observe for tenseness and tone.

Face (F)

0 - No expression or smile

1 - Occasional grimace or frown, withdrawn, disinterested

2 - Frequent to constant quivering chin, clenched jaw

Legs (L)

0 - Normal position or relaxed

1 - Uneasy, restless, tense

2 - Kicking, or legs drawn up

Activity (A)

0 - Lying quietly, normal position, moves easily

1 - Squirming, shifting back and forth, tense

2 - Arched, rigid or jerking

Cry (C)

0 - No cry (awake or asleep)

1 - Moans or whimpers; occasional complaint

2 - Crying steadily, screams or sobs, frequent complaints

Consolability (C)

0 - Content, relaxed

1 - Reassured by occasional touching, hugging, or being talked to, distractible

2 - Difficult to console or comfort

Each category is scored on the 0-2 scale and added together for a total score of 0-10.

Total Score Indicates:

0: Relaxed and comfortable

1-3: Mild discomfort

4-6: Moderate pain

7-10: Severe discomfort or pain or both

Record score here: _____

Health-Related Activities (HRAs)

In some settings, the personnel will be performing health-related activities under nurse delegation and in other settings they will provide these services as MA certified DDP while being supervised by whomever normally supervises them without the oversight of delegated nursing.

Only these 13 specific HRAs are authorized for MA certified personnel in settings without nursing delegation. Refer to the chart on page 22 in this manual for further details.
In any setting, all other prescribed health-related activities must be taught AND delegated by a nurse according to Ohio Board of Nursing OAC (Ohio Administrative Code) 4723-13.

The 13 HRAs Include:

1. Taking vital signs
2. Application of clean dressings that do not require health assessment
3. Basic measurement of bodily intake and output
4. Oral suctioning
5. Use of glucometers
6. External urinary catheter care
7. Emptying and replacing ostomy bags
8. Pulse oximetry reading
9. Use of continuous positive airway pressure machines, including biphasic positive airway machines (CPAP & BiPAP)
10. Application of percussion vests
11. Use of cough assist devices and insufflators
12. Application of prescribed compression hosiery
13. Collection of specimens by noninvasive means

- ✓ **After this class, you may not be able to competently do all these skills without additional training and practice.**
- ✓ **Be sure you have an opportunity to practice and be comfortable with these skills before doing them independently.**
- ✓ **You can ask for instructions or assistance from a licensed healthcare professional if you need additional training or clarification.**
- ✓ **Make sure you understand the specific details of how these tasks should be done for the person including personal preferences, equipment, special instructions and personal parameters for when to act based on outcomes.**
- ✓ **If the Health-Related Activity requires equipment, make sure that you handle, clean and store the equipment properly so it does not get damaged.**

✓ **Skills checklists to be signed by trainee and trainer are available on the DODD website**.

Taking Vital Signs

Sometimes a single vital sign will be ordered to be done routinely or in relation to a medication or treatment. Follow the orders or directives of the HCP on the MAR.

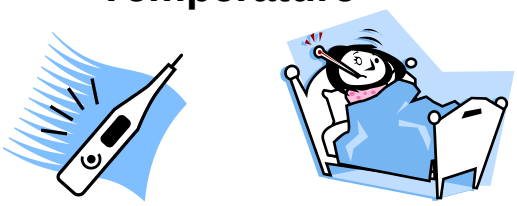
When someone is ill, or you think there may be something wrong all their vital signs should be checked.

Taking a Temperature (T)

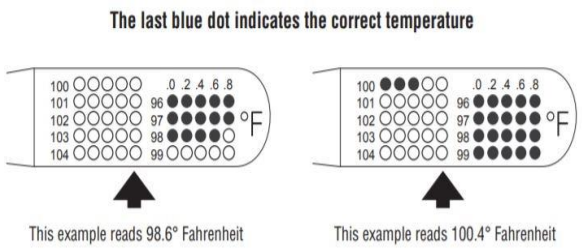
(Wear disposable gloves)

- ♥ Do not use a mercury thermometer. Dispose of old mercury thermometers at your health department.
- ♥ Using an oral/axillary (arm pit) device:
  - ♣ If oral
    - Turn on the device
    - Insert under tongue
    - Remove when beeps
  - ♣ If axillary (arm pit)
    - Turn on device
    - Insert in armpit
    - Remove when beeps
- ♥ A protective sleeve should be used if thermometers are shared by more than 1 person.
- ♥ If using another device, follow manufacturer's instructions.
- ♥ A person should not smoke, eat, or drink for at least 10 minutes before taking an oral temperature. These activities alter the temperature of the mouth and you will get an inaccurate body temperature reading.
- ♥ Document which part of the body was used when the temperature was taken.
- ♥ Normal temperature range is between 97 and 99.8 degrees Fahrenheit. Report any reading outside this range or the range specified for the person.

Steps for Taking a Temperature



1. Wash hands and put on gloves.
2. Gather supplies and equipment.
3. Cleanse the thermometer if necessary or use a disposable protector.
4. Identify the person and explain the procedure.
5. Place the thermometer according to manufacturer's instructions and wait the specified time.
6. Remove thermometer and read according to manufacturer's instructions.
7. Remove gloves and wash hands.
8. Document the temperature, time, date, the type of thermometer used, and where it was placed on the body.
9. Clean the thermometer according to manufacturer's instructions.



Temp Dot

Temporal

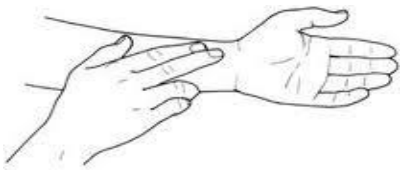
Ear thermometer

<u>Blood Pressure, Pulse and Respirations should be taken together</u>. The heart and lungs work together so all 3 readings are needed at the same time. Together they give a more complete picture about what is going on in the body. A healthcare professional will need all 3 results to decide what to do. When taking all the vital signs at once gather all your equipment before starting.

Taking the Pulse (P)

(No gloves needed)

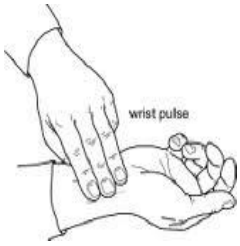
- ♥Radial pulse is located on the thumb side of the wrist where the wrist bends.
- ♥Never use your thumb to take a pulse. Your thumb has a pulse and you will be feeling your own pulse, not the person's pulse.
- ♥Place your index and 3rd finger on this location and you will feel the pulse.



- ♥Count the pulse for at least 1 full minute. Note if the pulse is strong/weak, regular/ irregular.
- ♥Document the pulse rate, strength and rhythm.
- ♥Normal pulse range is 60-100. Report any pulse outside this range to a healthcare professional.

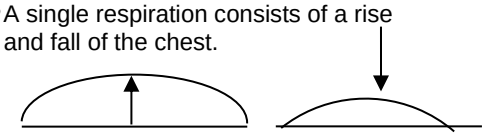
Steps for Taking a Pulse

1. Wash hands.
2. Get the watch or clock you will need to track the time when counting the pulse.
3. Identify the person and explain the procedure.
4. Locate pulse and count rate for one full minute.
5. Then count respirations for one full minute while keeping your hand on the wrist. When people know you are watching them breathe, they may change their breathing rate.



Counting Respirations (R)

- ♥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 the person you are counting respirations, just count them.
- ♥Respirations should be slow and easy and should range between 12-20 per minute. If respirations are less than 8 or more than 25 per minute, call 911 immediately.
- ♥If the person is struggling to breathe, has pain with breathing, is turning blue, or if breaths are shallow or irregular, call 911 immediately. This is respiratory distress.

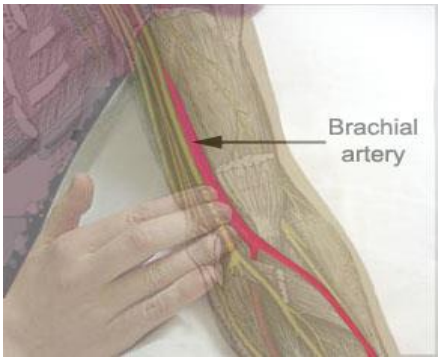
Steps for Counting Respirations

1. Start by taking the person's pulse.
2. After counting the pulse rate, observe and count respirations for one full minute.
3. Watch the chest and abdomen for the rise and fall with each inhalation/exhalation (counted as one breath).
4. Document the time, and date the vital signs were taken:
   - Document the pulse rate and note if it is strong or weak, and regular or irregular.
   - Document the respiration rate and note if breathing is deep, shallow, easy or difficult, regular or irregular.

Blood pressure (BP) is the pressure exerted by circulating blood on the walls of blood vessels. It is usually measured at a person's upper arm but can be measured with a wrist monitor. There are many models of BP devices available to use. Read the manufacturer's instructions on how to use the available cuff for best results.

Taking the Blood Pressure (BP)

- Use an automated device and follow manufacturer's instructions.
- Encourage the person to sit quietly for at least 5 minutes before taking the BP.
- Ask the person to uncross their legs while BP is being taken. Crossed legs increase the BP.
- Ask the person not to sing, hum, talk or make any sounds while BP is being taken. These activities alter the BP.
- Be sure to use the properly sized BP cuff. Measure the upper arm circumference halfway between the elbow and the shoulder and follow manufacturer's instructions for proper cuff size.
- Take the BP device to the doctor's office at least annually to check its accuracy compared to the office equipment.
- Apply cuff snuggly to the upper arm at least 1 inch above the bend in the arm at the elbow. If properly applied, you can slide no more than 1 finger under the edge of the cuff.
- 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 at or just above bend in the arm (palm facing up).



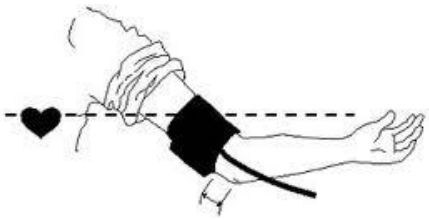
- A blood pressure reading is two numbers written one over the other (Ex: 120/80). Systolic is the top number. Diastolic is the bottom number.
- Normal BP range (systolic/diastolic) is generally between 90/60 up to 140/90. Follow the healthcare professional's direction for reporting BP outside this range.

Steps for Taking a Blood Pressure (with an arm cuff)

1. Wash hands (no gloves needed).
2. Gather equipment.
3. Identify the person and explain the procedure.
4. Find the brachial artery.
5. Correctly wrap cuff around the upper arm (1 inch above bend in the arm at the elbow).
6. Activate the BP device according to the manufacturer's instructions.
7. Read the result.
8. Document the outcome including date, time, top number and bottom number, which arm was used, and what type of BP monitor was used.

If possible, always use an automated cuff.

Get additional training and practice if you need to use a manual cuff.



Proper placement of BP cuff on the arm is with the tubes over the brachial artery and the cuff placed at the level of the heart. Have the person rest their arm on a table so their arm can be fully relaxed with the cuff at the level of the heart.

When applying the cuff to the arm:

● Put cuff over thin clothing sleeve or ● Remove thick clothing sleeve or layers

DO NOT ROLL OR PULL SLEEVE UP

Taking the Blood Pressure Using a Wrist Monitor

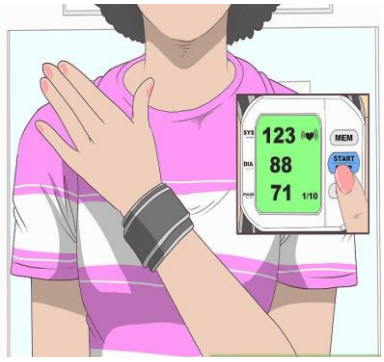
Using a Wrist BP Monitor:

Follow Manufacturer's Instructions:

- Always keep the instructions that were provided by the manufacturer with the monitor. Store the instructions with the device
- Follow the instructions for proper placement of the wrist cuff
- Use pictures with instructions to assure proper placement
- When taking the reading the cuff must be kept over the heart. This means the person bends their elbow to hold their wrist over their heart
- Ask the person to relax their wrist and hand, and not to bend their wrist forward or backward
- Ask them not to clench their fist

The manufacturer's instructions will explain the proper use in more detail.

Consult a healthcare professional for assistance if needed.



Application of a Clean Dressing

- If a wound needs assessment for the dressing change, the assessment and the dressing change must be done by a healthcare professional.
- This certification allows you to change a dressing using “clean” techniques, not “sterile” techniques. Sterile techniques require a healthcare professional to do the dressing change.
- You will follow simple steps for changing a clean dressing.
- **It is very important to report to a healthcare professional promptly IF:**
  - the wound is not getting better or is getting worse
  - you notice drainage
  - you see increasing redness
  - the person complains of pain
  - the wound is getting bigger not smaller
  - you see red or blue lines or streaks on the skin by the wound
  - the wound smells
- In most cases, the dressing is used to protect the wound and to keep it clean.
- You may be applying a prescribed anti-infective medication to the wound.
- If you have First-Aid certification that taught you to put an over-the-counter anti-infective on minor abrasions and cuts, you may do that.
- Even if the wound has a scab on it you need to wear gloves when cleaning the wound and applying a dressing.
- When removing a bandage pull down on the skin in the opposite direction of the way you are pulling up on the bandage to minimize skin damage and discomfort.

Steps for Application of a Clean Dressing When No Assessment is Required

1. Check the MAR/TAR for the order and the time the dressing change is to be done.
2. Wash hands and put on gloves.
3. Gather the equipment and supplies.
4. Identify the person, provide for privacy, and explain the procedure.
5. Assist the person into a comfortable position for the dressing change.
6. Remove the old dressing and discard in a disposable bag.
7. Take off dirty gloves, wash hands, put on clean gloves.
8. Cleanse the area with gentle soap and water or as directed by a healthcare professional.
9. Open the package of the new dressing material without touching the clean part of the dressing that will touch the wound. Place the dressing, clean side up, on a clean surface.
10. Apply the medication to the pad of the dressing without touching the medication container to the dressing.
11. Place the dressing over the wound and secure it in place.
12. Discard waste supplies, remove gloves, and wash hands.
13. Return unused supplies to the storage area.
14. Document exactly what was done and how the person responded to the procedure.
15. Document and report the following observations to a healthcare professional:
    - ♦ Odors
    - ♦ Change in amount or color of drainage
    - ♦ Pain in or around wound area
    - ♦ Increasing redness around the wound
    - ♦ Red or blue streaks
    - ♦ Other color changes

Remember: ♦ Certified Personnel are prohibited from using a debriding agent or packing or irrigating a wound.

♦ Hydrogen peroxide is not a recommended product for cleansing a wound, unless specifically ordered by a healthcare professional.

Measuring Intake and Output (I & O)

- If I & O measurement has been ordered by a healthcare professional, it is very important to be consistent and accurate in documenting all the fluid intake and output a person has.
- Intake is any fluid a person consumes/drinks. 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.
- Liquids can be measured in cubic centimeters (CC), milliliters (ML) or in ounces (OZ).
- **Measure fluids** the person wants **before they consume them** and **document the amount** the person **consumed** when they are done.
- When measuring output, ask the person to use a urinal, bedpan, or plastic "hat" that can be placed beneath the toilet seat.
- Equipment for collecting and measuring output such as measuring cups, bed pans, urinals and plastic "hats" that go on the toilet can be purchased at a drug store.
- When feces is mixed with urine, it will cause inaccurate measurement. Be sure to note the presence of the feces in the documentation if that occurs.
- If the person vomits, document the frequency and color of the vomit, and estimate the amount.
- Before documenting the weight of a person's incontinence briefs, the dry weight of the brief should be subtracted from the weight when wet.
- Empty ostomy or catheter urine collection bags into a measuring container to determine the output amount.
- Report the results of I & O to a healthcare professional as directed.

See DODD website for a sample form for documenting only Intake, and a form for documenting Intake & Output.

Urine collection "hat" placed between rim and seat

Steps for Basic Measuring of Bodily Intake and Output

Intake:

1. Check MAR/TAR for I & O orders.
2. Wash hands and put on gloves.
3. Gather supplies and equipment.
4. Identify the person and explain the procedure.
5. Measure the liquids to be consumed before giving them to the person.
6. Remove gloves and wash hands.
7. After they finish consuming as much as they want, wash hands and put on gloves.
8. Measure the remaining amount of liquid. Subtract the remaining amount from the original amount to determine how much was consumed.
9. Clean all equipment appropriately.
10. Remove gloves and wash hands.
11. Document the amount of intake.

Output:

1. Check MAR/TAR for I & O orders.
2. Wash hands and put on gloves.
3. Gather supplies and equipment.
4. Identify the person and explain the procedure.
5. Measure liquid output before flushing or disposing of appropriately.
6. Clean all equipment appropriately.
7. Remove gloves and wash hands.
8. Document the output measured.

Oral Suctioning

Yankauer®: a type of suction catheter inserted into the mouth

Portable suction machine

- People who cannot handle the amount of secretions in their mouth, may need to have suctioning of the secretions.
- A small plastic suction catheter is placed in the mouth to remove secretions and prevent choking and aspiration.
- Never suction for longer than 15 seconds. **Excessive suction can be dangerous and painful.**
- Always keep the catheter in motion in the mouth so it will not stick to the oral mucosa and injure the tissue.
- If any bleeding is noted during suctioning or the person has trouble breathing during suctioning, call 911.

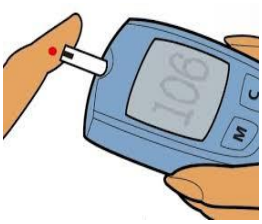
Steps for Oral Suctioning

1. Check MAR/TAR for directions and when to suction.
2. Wash hands and put on gloves.
3. Gather equipment and supplies including a cup of water for clearing the tubing during the suctioning.
4. Identify the person and explain the procedure.
5. Assist the person into a comfortable position for the suction treatment.
6. Connect tubing to the outlet port on the lid of the collection container.
7. Attach the suction catheter device to the other end of the tubing.
8. Turn on the suction machine and check for suction pressure level. Follow manufacturer's instruction for how to set and how to check the correct amount of suction indicated for the person.
9. Insert the suction catheter into the person's mouth, placing tip of the device along the lower gum outside of the bottom teeth. Using a circular motion move the catheter around in their mouth; keep the catheter moving to not touch oral surfaces. Suction for no longer than 15 seconds at one time. Count to 15 as you suction. After suctioning to a count of 15, remove the catheter, wait 15 seconds and repeat step 9 if excess secretions remain.

If the person starts to cough or gag, take the catheter out until the person recovers before continuing.

NEVER SUCTION FOR LONGER THAN 15 SECONDS AT ONE TIME

10. After suctioning the person's mouth, suction clean water through the suction catheter until the catheter and tubing are clean. Watch the container fill limit line and **NEVER ALLOW THE FLUID LEVEL IN THE COLLECTION CONTAINER TO RISE ABOVE THE FILL LIMIT LINE** (empty container and suction more clean water if more cleaning is needed).
11. Turn machine off.
12. Empty collection container and clean thoroughly. Put equipment away.
13. Remove gloves and wash hands.
14. Document the person's response.
15. Notify a healthcare professional if anything is different than what is typical for that person and document the notification.



Use of a Glucometer

- Follow the instructions provided by the manufacturer for proper use and care of the glucometer and lancets used by the person.
- Manufacturer's directions for operation of the glucometer and use of the lancet pen must be available near where the glucometer is stored.
- Follow the manufacturer's instructions for routine calibration of the glucometer.
- If using the finger as a blood sample collection site, be sure to apply the lancet to the side of the finger, **never the fingertip pads**.
- Rotate finger sites to avoid formation of calluses. Any redness, bruising, or calluses requires choosing another site for sample collection and needs to be reported to a healthcare professional.
- Be sure to have access to a properly labeled or color-coded sharps container for disposal of lancets.
- With some glucometers, sites other than the side of the finger may be used.
- Be sure to document the finger site used.
- The glucometer and lancet pen can only be used by the person for whom it was purchased.
- Alcohol wipes should not be used to clean the finger prior to testing. If no soap and water is available, clean with a non-alcohol-based cleanser such as a baby wipe.

*****Each person should have parameters listed for what glucometer readings are acceptable for them specifically. Contact a healthcare professional when blood sugar/glucometer readings are higher or lower than the normal parameters for that person.**

Steps for Using a Glucometer to Monitor Blood Sugar

1. Check MAR/TAR for scheduled testing.
2. Wash hands and put on gloves.
3. Gather equipment and supplies.
4. Identify the person and explain the procedure.
5. Have the person wash their hands thoroughly with soap and water. Assist as needed. Be sure the finger to be used is dry before inserting the lancet to get the blood sample.
6. Place lancet in pen, if a pen is part of the procedure for this person.
7. Turn glucometer on, insert strip if needed.
8. Stick the side of finger with the lancet (never stick the finger pad).
9. Point the finger downward and gently massage to get an adequate blood sample. Hold the strip to the side of the drop of blood (the strip will absorb the blood).
10. Use a paper towel, tissue, or cotton pad to wipe the finger and then hold it in place, applying gentle pressure until the bleeding stops.
11. Read and document the result.
12. Clean the equipment and dispose of used supplies appropriately. Lancet must be disposed of in a sharps container.
13. Remove gloves and wash hands.
14. Report results to a healthcare professional when results are outside the parameters specified for the person.

Use of a CGM (Continuous Glucose Monitoring) system is not authorized by this Category 1 certification. Contact a nurse for training and delegation to use a CGM.

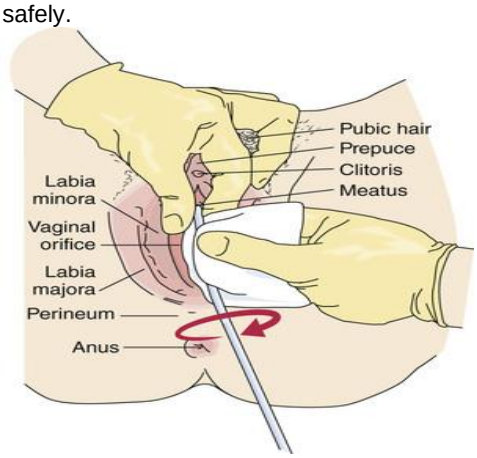
External Urinary Catheter Care

- 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.
- Indwelling catheters may be placed into the urinary bladder through the urethra (Foley®), or surgically inserted through an incision in the lower abdomen (suprapubic).

Indwelling Foley® Catheter

Condom Catheter

- The tubing that enters the body as well as the entry site must be cared for and cleaned to prevent infection and the transmission of bacteria into the urinary tract and bladder.
- To clean the entry point and tubing, use a disposable personal cleansing wipe or a wet soapy cloth. Soap must then be rinsed off with a clean wet cloth.
- Indwelling catheters are attached to drainage bags that must be emptied at specified times.
- Unless specifically directed to do so DD personnel should not 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 person's orders require the tubing to be disconnected from the bag to change bags, personnel need specific training for how to do that safely.



Steps for External Urinary Catheter Care

1. Check MAR/TAR for schedule of catheter care.
2. Wash hands and put on gloves.
3. Gather equipment and supplies.
4. Identify the person, provide privacy, and explain the procedure.
5. Position the person on their back exposing only a small area where the catheter enters the body. **Be sure** the **catheter bag is ALWAYS lower than the bladder.**
6. Using a disposable personal wipe or wet soapy cloth, wash the area surrounding where the catheter enters the body. If using a soapy cloth, rinse the cloth well and then wipe the soap off the body.
   If you are working with an uncircumcised male, be sure to retract the foreskin and cleanse well as a part of cleaning the catheter entry site. Be sure to return foreskin to its original position after cleansing.
7. Using a fresh personal wipe or wet soapy cloth, wipe the tube, starting at the point where the catheter enters the body, and move downward. Always wipe away from where the catheter enters the body. Never wipe upward.
   Clean from the catheter entry point to the connection point between the catheter and the tube connecting the catheter to the collection bag. If using a soapy cloth, rinse the cloth well and then wipe the soap off the tubing.
8. 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.
9. Discard disposables. Clean equipment and return it to storage area.
10. Remove gloves and wash hands.
11. Document procedure on MAR/TAR.
12. Report any problems to a HCP.

***Intermittent (straight) catheterization and application of condom catheters are nursing tasks. These tasks require training and nurse delegation (OAC 4723-13). These tasks are not external catheter care activities.**

DOs and DON'Ts of External Urinary Catheter Care

DO:

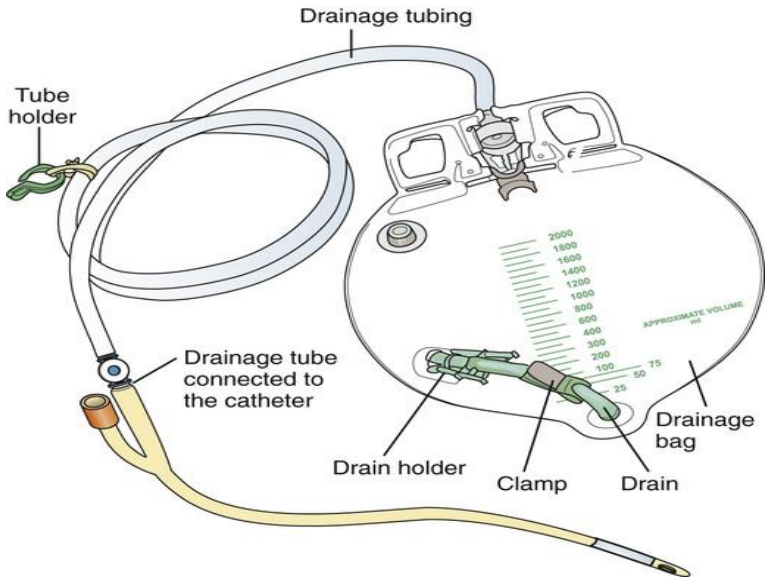
- Anchor the catheter securely to the person's upper leg using a non-tape binder (catheter tube holder) to prevent pulling.
- Be sure the tubing and bag are always below the bladder level.
- Hang the collection bag so it does not touch the floor.
- Encourage the person to drink adequate amounts of fluids daily (about 64 ounces). Monitor and assist as needed.
- Teach the person how to keep a daily record of how much they drink daily. Monitor and assist as needed.
- Teach the person how to keep the catheter tubing free from kinks. Monitor and assist as needed.
- Observe the catheter system for obstruction, sediment, leaking, and irritation or pulling in the genital area and report it to a healthcare professional.
- Report any redness, discharge or irritation in the catheter area to a HCP.
- Have the person change their body position frequently to assist the bladder to empty more completely. Monitor and assist as needed.

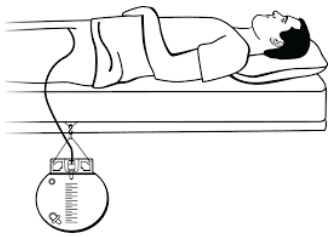
DO NOT:

- Pull on the collection bag or the catheter.
- Disconnect the catheter tubing unless specifically trained and directed to do so. If the tubing and collection bag accidentally come apart, wipe the ends with an alcohol wipe and reconnect. Then immediately report the event to a healthcare professional so tubing can be changed promptly.
- Raise the collection bag and tubing above the level of the bladder. The bag must always be kept lower than the bladder to promote drainage and prevent back flow of urine into the bladder.
- Lay the collection bag on the bed, chair, seat or in the person's lap. That would make the bag as high or higher than the bladder.

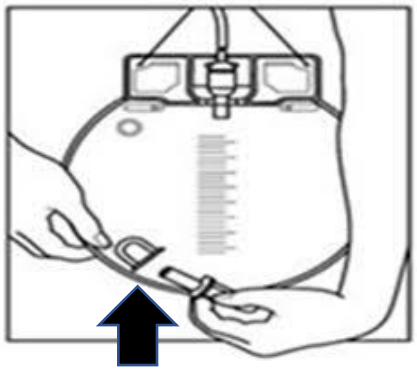
Steps for Emptying the Urine Collection Bag

1. Prepare to empty the bag according to the person's schedule.
2. Wash hands and put on gloves.
3. Gather equipment and supplies.
4. Identify the person, provide privacy, and explain the procedure.
5. Remove the urine bag drain from its holding area and open it over an appropriate container (e.g. urinal, bedpan, beaker). Drain contents of urine bag, being careful not to splatter any urine.
   Always keep collection bag lower than the bladder.
   Never put it on the bed, chair or in the person's lap.
6. Close the drain port to urine bag. Clean and dry the tip of the drain before putting it back into its holder.
7. Measure and discard urine.
8. Clean the equipment and return it to storage.
9. Remove gloves and wash hands.
10. Document the amount of urine if required.
11. Report to a healthcare professional any unusual color or odor, and volume of output that is unusual for this person.





Always hang collection bag lower than the person's bladder



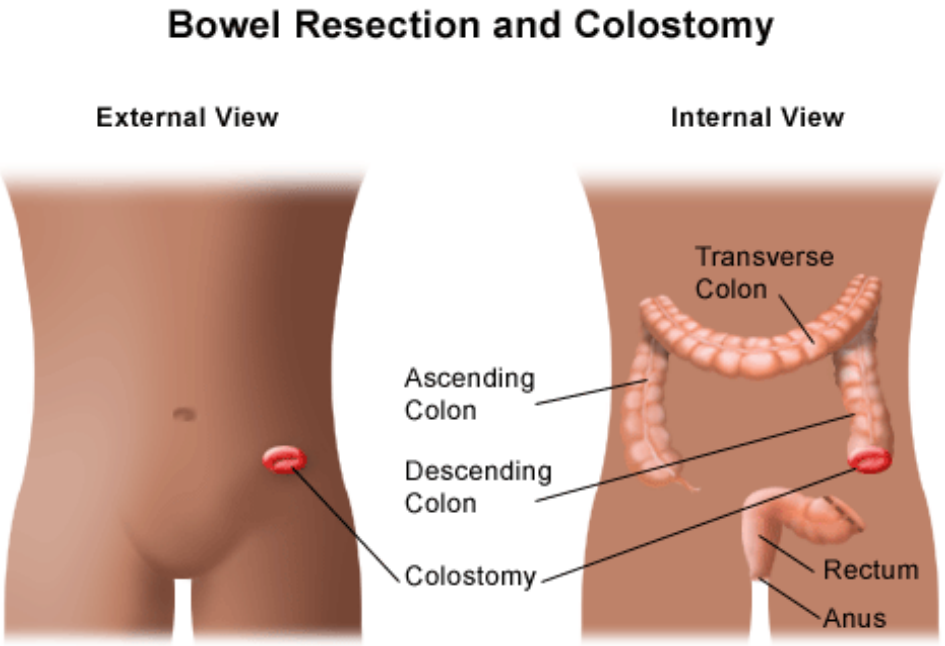
Urine collection bag with drain

Note: Do not detach the urine collection bag from the catheter tubing when draining urine from the bag

Remember: Per OSHA, if you splash any urine on your clothing, that clothing must be replaced by another clean, dry article of clothing. Place the contaminated clothing in a plastic bag and wash it when you get home.

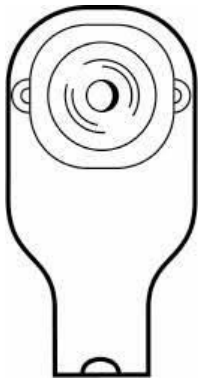
Ostomy Care

OAC 5123:2-6-01 authorizes personnel with Category 1 certification to provide the health-related activity of emptying and replacing ostomy bags. This course specifically addresses only colostomies. Certified personnel MUST get additional training specific to the person's ostomy and ostomy care plan BEFORE providing ANY kind of ostomy/stoma care.



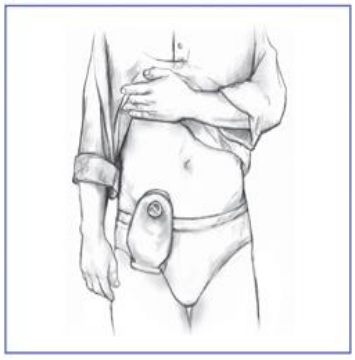
A colostomy is the procedure performed to bring a small piece of the colon to the surface of the abdomen. Bowel waste is carried out of the body through the stoma (the end of the colon that sits on top of the abdomen).

You may be asked to care for the stoma as well as change the bag that collects waste from the bowel. The bag placed over the site to collect the waste is called a colostomy bag. DD personnel may be assigned the task of emptying and replacing the bag on a routine basis.



Colostomy bag

Colostomy bag attached to stoma



Stoma under bag

There are 2 types of colostomy appliances, a one-piece and a two-piece:

- With a one-piece appliance the wafer and the bag are a single unit. Because the wafer sticks directly to the skin with the bag attached, the wafer and the bag are changed at the same time.
- The two-piece appliance has a wafer that is left on the skin when the bag is changed. The wafer is not changed as often as the bag. With the two-piece appliance there is less skin irritation from taking the wafer off with every change.

Certified personnel must get detailed training on the person's appliance and all the details of their ostomy/stoma care products and how to use them.

General Tips for Managing a Colostomy

*Refer to the person's ostomy care instructions for details of their personal plan.

General Tips

- Eat a well-balanced diet daily
- Drink at least 6-8 eight-ounce glasses of fluid daily
- Avoid chewing gum, smoking, and drinking from a straw
- Consuming yogurt or buttermilk may help reduce gas
- Refrain from eating after 8pm
- If gas is a problem, consult a healthcare professional about gas relief
- Weight gain or loss can affect the way the pouch fits, and the equipment may need to be changed

Colostomy Care

- If able, perform colostomy care in the bathroom
- Be sure the skin is clean, dry and smoothed out before putting on a new wafer
- Cleanse the stoma per the person's healthcare professional instructions
- Holding the wafer in place for a period of time according product directions, helps the wafer stick better

Traveling

- Carry a squirt bottle for rinsing the pouch while away from home
- Carry wet wipes or tissues to use in public bathrooms
- Carry an extra pouching system
- Never store colostomy supplies in the glove compartment of a car
- Keep ostomy supplies handy. Do not keep in a bag or suitcase that you might not have access to

The Pouching System

- Do not use toxic chemicals or agents in the pouch that may harm the stoma
- Change the pouch as often as indicated in the person's ostomy care plan
- Write the date on the pouch indicating when the pouch was changed

Bathing/Showering

- Bathing or showering can be done with the bag/pouch on or off

Wearing the pouch

- Pouch can be worn inside underwear to help support the pouch
- Place a cloth barrier between the pouch and skin to protect the skin

Reducing Odor

- Use air deodorizers in the bathroom
- Rinse pouch 1-2 times after you empty it
- Adding odor eliminating drops or sprays to the pouch may be part of the person's plan
- Limiting odor causing foods such as broccoli, fish, cabbage, onions, garlic may 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 a healthcare professional if a person experiences any of the following symptoms:

- Purple, black, or white stoma
- Skin irritation or ulcers
- Bulging or other changes in the abdomen
- Cramps lasting more than two hours
- Pulling inward of the stoma below the skin level
- Swelling from the stoma to more than ½ inch larger than usual
- Unusual watery discharge from stoma lasting more than 6 hours
- No output from colostomy for three days
- Bleeding from the stoma

Personnel must receive training specific to the person, their supplies, equipment and person-specific procedure before emptying or changing a person's ostomy bag.

Steps for Emptying and Replacing a Colostomy Bag

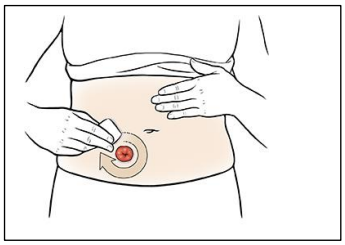
Emptying a Colostomy Bag

1. Prepare to empty the bag according to the person's schedule.
2. Wash hands and put on gloves.
3. Gather equipment and supplies.
4. Identify the person, provide privacy, and explain the procedure.
5. Assist the person into a comfortable position where the bag can be emptied into a toilet or receptacle.

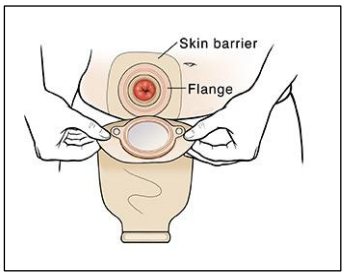
6. Remove the clip, empty the contents of the bag, rinse the bag and clean the outside and inside of the pouch tail with toilet paper.
7. Close and re-seal the bag.
8. Clean up supplies and discard disposables.
9. Remove gloves and wash hands.

Replacing a Colostomy Bag

Confirm change date on MAR/TAR; perform steps 1-6 above, then



10. Gently remove the soiled colostomy bag from the stoma site and place in a trash bag; place that trash bag in a second trash bag (double bagging) before putting it in the garbage.
11. Remove wafer if indicated.
12. Clean and dry the site, apply a new wafer as indicated in the person's ostomy care plan. Be careful to not allow the wafer to rub against the stoma.



13. Apply a new bag being careful to not allow bag or wafer to rub against the stoma.
14. Clean up supplies and discard double bagged disposables in the trash.
15. Remove gloves and wash hands.
16. Document the date and time the procedure was performed on the MAR/TAR. Document observations and the person's response to the procedure.

Pulse Oximetry

Definition of Terms

Capillaries: Very small blood vessels close to the surface of the skin.

COPD: Chronic Obstructive Pulmonary Disease. A general term used to describe progressive diseases of the lungs including emphysema, bronchitis, and asthma.

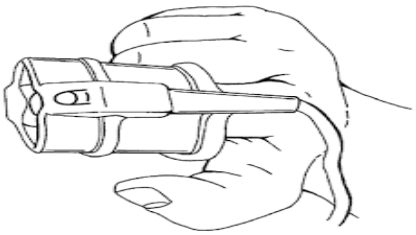
Hemoglobin: An iron rich protein in red blood cells that carries oxygen throughout the body.

Non-invasive: A procedure that does not cause a break in the skin or contact with body mucosa or an internal body cavity; does not require making an incision (cut) into the body or removing any body tissue.

Oxygen Saturation (O_2 saturation): The percentage of oxygen bound to hemoglobin in the blood.

Oxygenation: The process by which oxygen increases within the body. It may require the use of oxygen therapy.

Pulse oximeter: A clip-on device or adhesive wrap placed on the finger used to monitor the percentage of oxygen in the person's blood. Follow the manufacturer's instructions for which finger/site to use.



SpO_2: The peripheral capillary oxygen saturation obtained by pulse oximetry.

- Normal SpO_2 reading is 95% or higher.
- SpO_2 reading of 92% or below is generally abnormal. Contact a healthcare professional unless the person's specific orders direct otherwise (such as treat with O_2).
- SpO_2 reading of 89% or below requires urgent care. If a person does not have an order to administer oxygen for low SpO_2, **call 911 if SpO_2 is 89% or lower.**

Important to Remember:

If the person is having trouble breathing or has decreased alertness, call 911 even if the oximeter reading is in the normal range.

If the person looks okay, but the reading is low, check the radial pulse to see if the pulse rate matches the rate on the pulse oximeter. Reposition the probe to get a more accurate reading. If the reading is still low, contact a healthcare professional immediately for further directions.

SpO_2 level is considered a type of vital sign and may be checked along with other vital signs any time a person seems unwell.

Pulse oximetry

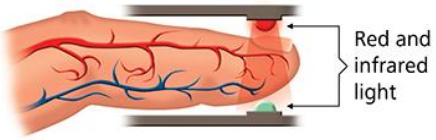
A non-invasive method for monitoring the amount of oxygen in the person's blood. Pulse oximetry may be used to **monitor the oxygen level in persons with sleep apnea, COPD, or who are on oxygen therapy.**

Why pulse oximetry is used

Pulse oximetry may be used on an as needed basis to determine if or when oxygen therapy is needed. Tracking SpO_2 levels helps the healthcare professional determine if the amount of oxygen prescribed is too little or too much. It may be used as needed to get additional information if a person is ill or having symptoms of breathing difficulties.

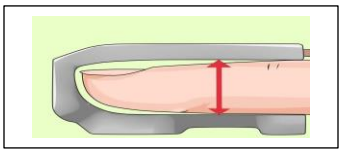
How a pulse oximeter works

The oximeter is designed to measure the amount of oxygen in the person's blood by shining two beams of light into capillaries in the finger. The light beams reflect the amount of oxygen in the blood.



The risks of using pulse oximetry

An accurate reading is important for the person to get the right care. The biggest risk with using a pulse oximeter is getting an inaccurate reading. It is important to place the oximeter correctly on the finger to ensure an accurate reading.



Care and Storage of a Pulse Oximeter

- Keep the probe clean. Dirt and dust can block light emitted by the oximeter, leading to a faulty reading. Clean the probe with a damp paper towel to remove dirt; use an alcohol swab to remove germs from the probe.
- Keep the manufacturer's instructions with the pulse oximeter.
- Keep a supply of replacement batteries available.

Orders for use of a pulse oximeter must include:

1. Specific indications for when to take the reading. These can be based on the time of day or by signs and symptoms.

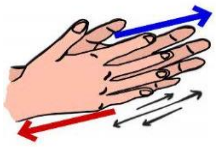
2. Specific parameters for what actions to take based on the oxygen reading.

Example: Check SpO_2 every 4 hours while awake; give oxygen as indicated in O_2 orders.

Issues that should be considered when using pulse oximetry

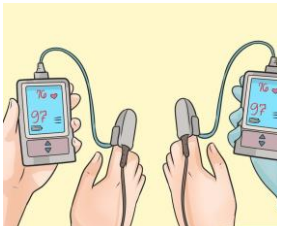
- **Choose a sensor** appropriate to the person's age, size, weight, and where it will be placed.
- **Allergies** to adhesives should be address by using a clip-on probe sensor.
- **Smoking** affects the oxygen levels in the blood. A higher level of oxygen may be reported than is present because smoking increases carbon monoxide in the blood and the oximeter does not distinguish between oxygen and carbon monoxide.
- **Dark nail polish and artificial nails** can interfere with the oximeter's ability to accurately detect the level of oxygen in the blood. Encourage the person to remove nail polish before using an oximeter.
- **Dark pigment** on the finger can alter the strength of the light beam through the finger.
- **Cold hands** can decrease the flow of blood to the capillaries in the finger. Help the person warm their hands before applying the oximeter to the finger.
- **Dirt on the hands** can interfere with the functioning of the oximeter. Help the person wash their hands before using the oximeter.
- **Bright light** can interfere with getting an accurate reading. Do not use the oximeter in bright sunlight and turn bright lights away from the oximeter. Make sure the clip or wrap does not allow external light to enter the sensor.
- **Moving around** while the oximeter is measuring the person's oxygen level can cause an inaccurate reading. Encourage the person to sit still while the oximeter is reading the oxygen level.
- **Improper fit of oximeter** will give an inaccurate reading.
- **If there is an order for an "off oxygen" SpO_2 for a person who has been on oxygen,** the person must be taken off oxygen for at least 15 minutes before an "off oxygen" reading is taken.
- **The home oximeter** reading should be checked for accuracy during a doctor's appointment. Take the person's oximeter to the doctor's appointment to check its accuracy against the readings obtained by the doctor's office equipment.

Remove Nail Polish



Warm cold hands

Wash hands to remove dirt



Check your readings against readings of doctor's device

Universal Precautions

It is not necessary to wear gloves when measuring oxygen levels using a pulse oximeter.

Be sure to wash your hands before and after the procedure. Be sure to use an alcohol swab on the finger probe to kill any germs on the probe after every use.

Steps for Using a Pulse Oximeter (Pulse Oximetry)

1. Check the MAR/TAR for order to use pulse oximeter. May also be used as one of the vital signs measured for signs of potential illness, respiratory discomfort/distress.
2. Wash hands.
3. Gather supplies and equipment.
4. Identify the person and explain the procedure.
5. Clean and dry the site that will be used for the reading.
6. If using an adhesive wrap, remove the protective backing and wrap around appropriate finger.
7. Attach the probe per the manufacturer's instructions.
8. Follow the manufacturer's instructions for taking a SpO_2 reading.
9. Remove the probe sensor and turn off the oximeter when monitoring is no longer necessary.
10. Document the reading and report to a healthcare professional any results that are outside of normal ranges or outside of the person's specified parameters.
11. Follow the orders on the MAR for administering oxygen to the person if pulse oximetry is used to determine the need for oxygen.

CPAP/BiPAP

Definition of Terms

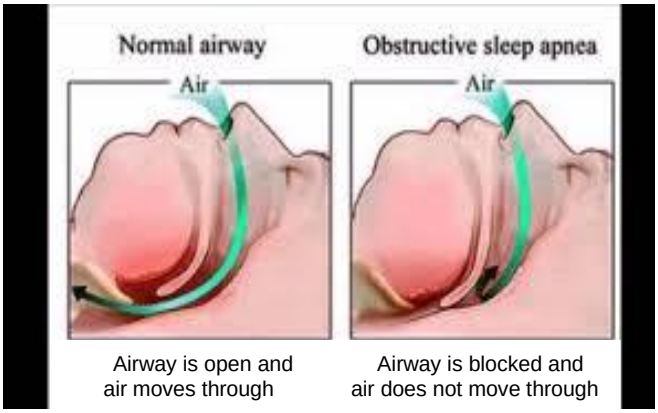
Airway: The passage through which air passes to the lungs and carbon dioxide (CO_2) passes out of the lungs. It consists of the nose, mouth, throat, trachea, and lungs.

Apnea: Involuntary pauses in breathing that usually happen while sleeping.

CPAP/BiPAP: Devices for preventing sleep apnea by delivering pressurized air to the lungs. (**C**ontinuous **P**ositive **A**irway **P**ressure) (**Bi-**level **P**ositive **A**irway **P**ressure)

Blood oxygen levels: The amount of oxygen in the blood at any given time.

Obstruction: A blockage.



Obstructive sleep apnea: Involuntary pauses in breathing during sleep caused by changes in the position of the upper airway when laying down.

Sleep Apnea: Involuntary pauses in breathing during sleep due to the brain's signals to the sleeping muscles.

Normal **Snoring** **Obstructive Sleep Apnea**

CPAP/BiPAP - COMMON TREATMENTS FOR SLEEP APNEA

Obstructive sleep apnea affects thousands of people every night. The most common symptom people have is daytime sleepiness. At night, the person stops breathing for periods of time, resulting in poor quality sleep. Because the person is asleep, they do not know that they are not breathing for periods of time. If untreated, sleep apnea can lead to irregular heartbeats, and increase the risk of heart attack, stroke, high blood pressure, diabetes, and accidents causing injuries.

The most common treatment for sleep apnea is use of either a BiPAP or CPAP machine that delivers positive air pressure through a face mask or other device during sleep. Room air is usually used, but some people may require oxygen to be delivered through the CPAP/BiPAP.

Be sure to follow the specific instructions for the person and their equipment. If the person has difficulty adjusting to their sleep apnea device, contact the equipment supplier for assistance. Be sure that hoses and masks or other face equipment is replaced when in disrepair.

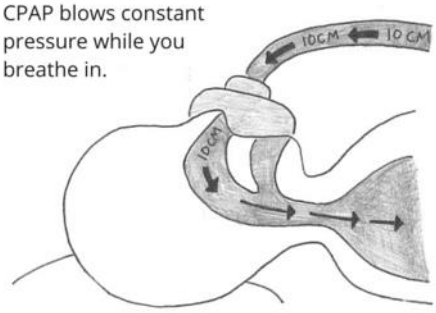
- The CPAP delivers continuous air pressure when the person breathes in and out.
- The BiPAP delivers higher pressure when the person breathes in then reduces the pressure when the person breathes out.

The pictures below show the subtle difference in how the CPAP and BiPAP delivery systems work.

CPAP

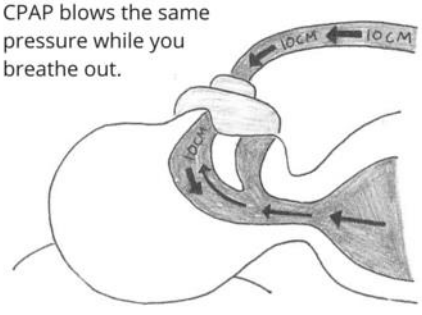
Inhalation (breathing in)

CPAP blows constant pressure while you breathe in.



Exhalation (breathing out)

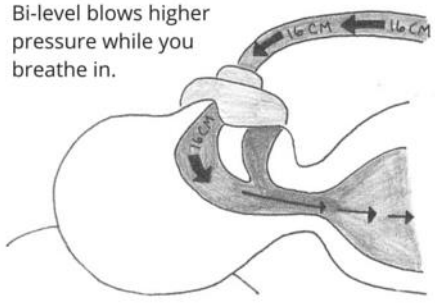
CPAP blows the same pressure while you breathe out.



Bi-Level PAP (BiPAP)

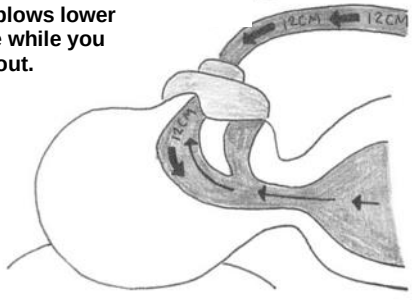
Inhalation (breathing in)

Bi-level blows higher pressure while you breathe in.



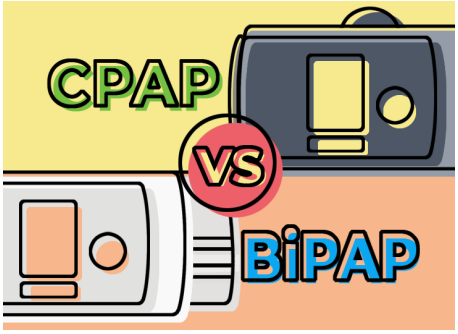
Exhalation (breathing out)

Bi-level blows lower pressure while you breathe out.



Risk factors for sleep apnea

- Being male
- Family history of sleep apnea
- Having a thick neck
- Being overweight
- Having diabetes
- Aging



Who uses CPAP and BiPAP

A sleep study may be done on anyone with a history of snoring, waking up gasping for air, excessive day time sleepiness or who stops breathing for periods of time during the night. If the person is diagnosed with sleep apnea the doctor may prescribe one of the PAP (positive air pressure) devices to treat the problem. The pressured air is delivered through a face mask or other devices such as nose pillows or nose mask.

How the devices work

- The devices are programmed by a respiratory therapist to deliver air under the right amount of pressure to keep the person's airway open during sleep.
- The pressurized air is delivered through a face mask or other device such as nose pillows or a nose mask to prevent episodes of sleep apnea and allows the person to get restful sleep. The face or nose device must fit snuggly to allow pressurized air to enter the airway.
- The machine pushes the air through water to deliver moist air that prevents drying out the airway.
- All machine settings are preprogrammed by the equipment supplier. Certified personnel will not be making any adjustment to the machine settings.
- Some people may require oxygen delivered through the machine instead of using just room air. **Oxygen is an inhaled medication. All procedures for the administration of oxygen must be followed.**

Nose pillow with head gear

Benefits of using CPAP/BiPAP

- Elimination of snoring
- Improved quality of sleep
- Elimination of daytime sleepiness
- Decrease in or prevention of high blood pressure

Potential side effects from using CPAP or BiPAP

Some people may experience:

- Sneezing
- Runny nose
- Nasal congestion
- Abdominal bloating
- Dry nose and sore throat
- Irritation of the eyes and the skin on the face
- Increased dreaming when first using the device
- Interrupted sleep from improperly fitting mask or other face devices
- TMJ disorders (Temporomandibular joint pain; pain in the jaw joint)
- Respiratory infections from improperly cleaned and dried hoses and other equipment parts

Potential problems with CPAP/BiPAP

- Interruption in air flow from a clogged air filter
- Fire hazard or electrical shock from frayed electrical cords
- Mineral deposits in the system from failure to use distilled water in the humidifier well
- Growth of bacteria from improper cleaning of the component parts that could lead to respiratory infections
- Odor and growth of bacteria or mold in hoses that are improperly cleaned, dried or stored
- Irritated skin from an improperly fitting mask or other face devices
- Machine malfunctions
- Oxygen Fire Hazards: If the person is receiving oxygen and removes their own mask or nose piece during the night without immediately turning off oxygen
- Assistance needs: The person-centered plan should indicate if the person needs periodic checks through the night to assure the face device and machine are functioning properly

How to clean and maintain the CPAP/BiPAP

- Follow the manufacturer's instructions
- Hang the hose over a hook to allow air to freely flow through it; do not coil it when not in use
- Wipe the outside of the machine daily with a damp cloth to keep it dust free
- Clean the mask or other face equipment daily as directed by the manufacturer
- Replace any worn or non-working parts as directed by the manufacturer

- **ONLY use distilled water** NOT tap water in the water well
- Empty the water well daily, wash it and let it air dry
- Change the filter per supplier's instructions
- Contact the equipment supplier for assistance with any problems with the equipment

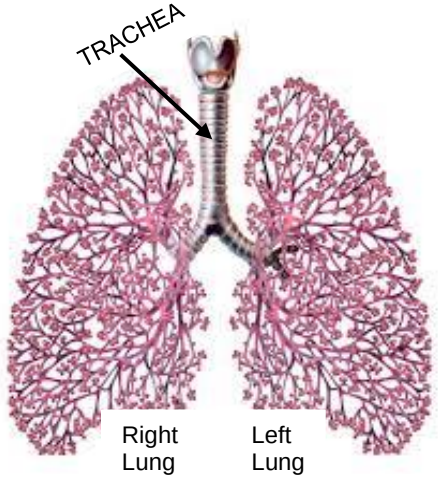
Steps for use of CPAP/BiPAP Machine

1. Check MAR/TAR to confirm the treatment order.
2. Wash hands.
3. Gather the supplies and equipment.
4. Identify the person and explain the procedure.
5. Place the machine on a level surface near the bed.
6. The machine must be lower than the level of the bed so any accumulation of water will drain back toward the machine, not the mask.
7. Place the machine at least 12 inches away from anything that could block the vents (curtains, bedspread, etc.).
8. Plug the machine into an outlet. Do NOT use an extension cord.
9. Fill the water well with distilled water. Do not fill above fill line. Never use tap water.
10. Place the water well into the machine per the manufacturer's instructions.
11. Put on gloves.
12. Position face piece (mask, nose pillow, etc.) on the person's face.
13. Fasten/adjust headgear on the person's head so that the face device fits snuggly.
14. Put the hose of the face device into the hose port on machine.
15. Turn the unit on**. If using oxygen**, **turn on CPAP/BiPAP unit first, before turning on oxygen flow.**
16. Have the person breathe deeply until pressured air begins to flow.
17. Have the person breathe normally once pressured air is flowing. Make sure air is not leaking out of the mask or nasal pillows. Readjust the mask or nasal pillows and headgear to stop leaks.
18. Remove gloves and wash hands.
19. Document application of CPAP/BiPAP on MAR/TAR.
20. When the person awakens in the morning, turn off the machine. **If using oxygen, turn off oxygen first before turning off the machine.**
21. Wash hands and put on gloves.
22. Remove or assist with removing mask or nose pillows and headgear.
23. Clean the face gear per supplier's instructions.
24. Clean the machine, and hose per supplier's instructions and hang hose to dry.
25. Remove gloves and wash hands.
26. Document removal and cleaning of equipment.
27. Document and report any complaints, problems or concerns.

Percussion Vest

Definition of Terms

Airway clearance: Movement of mucus out of the lungs by coughing or other techniques to reduce airway obstruction, prevent the likelihood of infection and improve lung function.



Chest wall oscillation: Application of an external vibration device to the chest to help clear airways of mucus.

Chronic: Persistent, long-lasting, difficult to get rid of.

Hemoptysis: Coughing up blood.

Lung airways: The passages in the lungs by which air enters and leaves. These passages consist of the trachea and bronchial tree.

Percussion vest: A device worn over the chest area to vibrate the chest to loosen mucus from the airways.

Respiratory Distress: Difficulty breathing. Symptoms include:

- Agitation
- Increased respiration rate
- Difficulty waking up
- Increased pulse rate
- Complaint of “air hunger” or difficulty breathing
- Increased effort to breathe (gasping)
- Changes in skin color (pale, gray)
- Face or lips become pale, blue, or gray

Sputum: Mixture of saliva (spit) and mucus coughed up from the respiratory tract.

Trachea: Windpipe; 4-6 inch tube connecting the back of the throat to the lungs.

Why a person would use a percussion vest

There are more than 35 million people in the United States with debilitating diseases that affect their ability to clear their airways of mucus build-up. Using a percussion vest to vibrate the chest is a way to **loosen mucus in the airways so it can be cleared**. This helps the lungs expand and improves air movement and oxygen absorption.

The percussion vest assists the movement of mucus (phlegm) from the smaller parts of the lungs to the larger airways, so the person can more effectively cough up mucus from their airways. A person who cannot cough effectively may need oral suctioning with this treatment.

Diagnoses often associated with the need for percussion vest assistance include:

- Cystic fibrosis
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic asthma
- Muscular Dystrophy (MD)
- Paraplegia or quadriplegia (limited body mobility)

Considerations when using percussion vest therapy

- If the vest causes itching, have the person wear thicker clothing under the vest.
- It is best to do the treatment before eating or to wait at least one hour after eating to avoid stomach problems.
- If the person has an upset stomach, nausea or vomiting, hold the treatment and contact a healthcare professional.
- Do not use the vest if a person has broken ribs, is coughing up blood, or has a head or neck injury. Hold the treatment and contact a healthcare professional.
- If the person has fallen or been in an accident, hold the treatment and contact a healthcare professional.
- At least once a year, the person, the vest and the machine must be evaluated to assure proper fit of the vest and proper functioning of the machine.

Potential side effects with percussion vest therapy

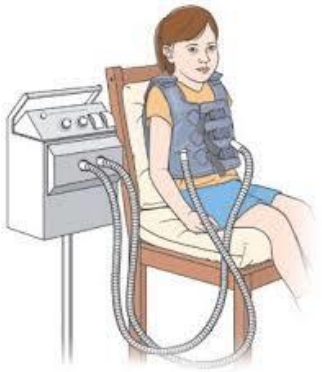
The person may experience:

- Vomiting
- Bronchospasms (wheezing, shortness of breath)
- Decrease in oxygenation or signs of respiratory distress that do not go away
- Pulmonary hemorrhage (coughing up blood)

If any of the above side effects are observed, stop the therapy:

- Call 911
- Document what was observed and reported

How to use the percussion vest



- Be sure the vest fits correctly. It should be placed over a tee shirt or other thin layer of clothing. Be sure that the clothing is not bunched up under the vest.
- Be sure the shoulder straps (if applicable) are the proper length to allow the vest to cover the upper chest without causing pressure on the armpits due to it being too short.
- The bottom of the vest should come to just above the hip bones.
- Adjust the fasteners so that when the person takes a deep breath, there is room for a hand to fit between the vest and the chest.
- Connect the tubing to the generator and the ports on the vest.
- Assist the person to sit upright if possible, or make sure the head of the bed is elevated.

- Turn on the machine's main power switch. **DO NOT change frequency, pressure, or time settings when starting the machine. The settings are preset for each person by the supplier.**
- As the vest inflates, firmly grasp the vest at the bottom and pull down to prevent it from riding up.
- The person's speech should be "choppy" indicating the set pressure is effective in creating airway vibration.
- **Stay with the person and watch them during the treatment for signs of discomfort or distress.**
- Let the machine run for as long as it is set to run. Turn off the machine when it stops.
- Stop the machine if the person voices or shows signs of discomfort. Contact a healthcare professional immediately.
- After the machine is turned off, have the person cover their mouth (assist as needed), and have them cough to clear their airway. Follow the person's plan for how long the person should try to cough.
- You may be instructed to perform oral suctioning instead of or in addition to having the person cough.
- After the treatment, remove hoses and vest. Clean the equipment as instructed.
- Have the person wipe their face and clean their hands after the treatment. Assist as necessary.
- Report any problems to the person's healthcare professional promptly.

Report to the person's healthcare professional right away:

- Any unusual coughing
- If the treatment was not completed for any reason (such as declined by the person, illness, vomiting, diarrhea, mechanical problems, etc.)

Steps for using a Percussion Vest

1. Read the MAR/TAR to confirm the entire percussion vest order. Read the entire order carefully including special instructions.
2. Wash hands.
3. Gather supplies and equipment. Plug in the machine. The duration, pressure and Hz settings on the machine are pre-set and cannot be changed.
4. Prepare percussion vest equipment. Prepare suction machine if suction will be used.
5. Identify the person and explain the procedure.
6. Encourage the person to relax, breathe normally and cough when they feel like it.
7. Place the vest on the person and check the fit of the vest. The vest should be snug but allow a hand to be inserted between the vest and chest during an inhalation. Check that the bottom of the vest is above the hip bones.
8. Help the person into a comfortable position of their choice with their upper body elevated.
9. Connect the tubing to the vest and generator per supplied instructions.
10. Begin the treatment by pressing the start button.
11. As the vest inflates, firmly grasp it at the bottom and pull it down.
12. Stay within visual range and monitor the person throughout the treatment. Stop the treatment immediately if the person is upset, in pain, vomits, or exhibits other signs of distress.
13. When the treatment is nearly completed, wash hands and put on gloves.
14. When the treatment is completed assist the person to cover their mouth and cough, or suction as instructed by their plan.
15. Have the person clean their face and hands after coughing or suctioning. Assist with these as needed.
16. Remove gloves and wash hands.
17. Document the completed treatment on the MAR/TAR. Document any problems or concerns. If the treatment could not be completed circle your initials on the MAR and write a UIR and notify the appropriate healthcare professional immediately.
18. If the treatment is only used as needed, document the need and the response to the treatment.
19. Clean the vest and machine using a disposable sanitizing wipe at least weekly or more often if visibly soiled.

Cough Assist Insufflator-Exsufflator

Definition of Terms

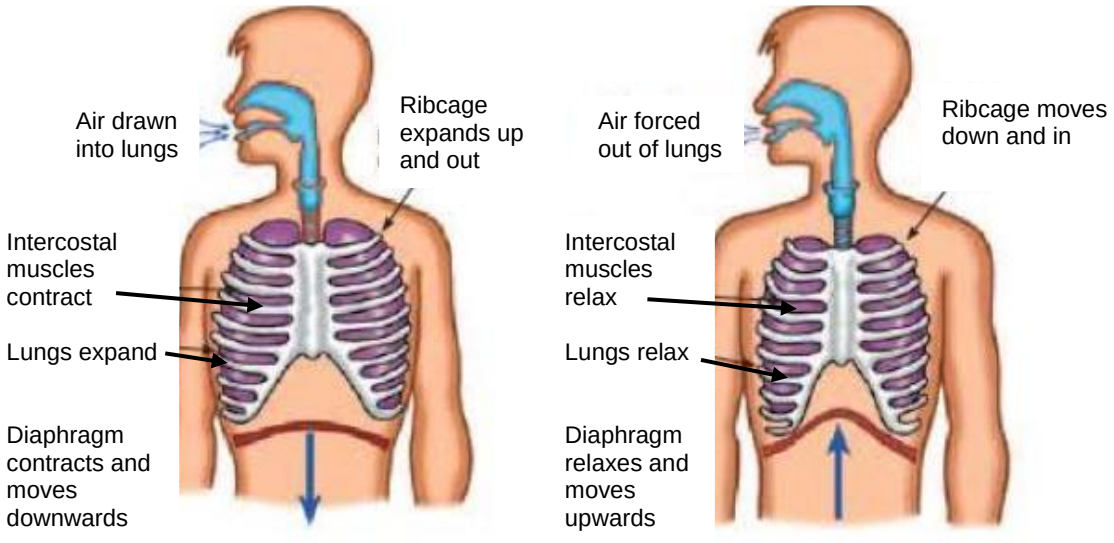
Airway: The route by which air reaches the person's lungs; it consists of the nose, mouth, throat, trachea (windpipe) and bronchial tree.

Airway clearance: Movement of mucus out of the lungs by coughing or other mechanical techniques. This reduces airway obstruction, prevents the likelihood of infection, and improves lung function.

Cough Assist Insufflator-Exsufflator Machine: This device forces pressurized air into the lungs on inhalation to help a person breathe deeper and then applies negative pressure on exhalation to pull any loose secretions into the mouth and upper airway.

Breathing Cycle: 1 Inhalation + 1 Exhalation = 1 Breathing cycle.
A normal rate of breathing should be 12-20 times per minute. If breaths at rest are fewer than 8 or more than 25 breaths per minute, CALL 911.

Illustration of a Breathing Cycle



- Inhalation: ribs lift up and out, volume of lungs increases, diaphragm contracts, air pressure drops, air is pulled in.
- Exhalation: ribs lower, volume of lungs decreases, diaphragm relaxes, air pressure increases, air is pushed out.

(Definition of terms continued)

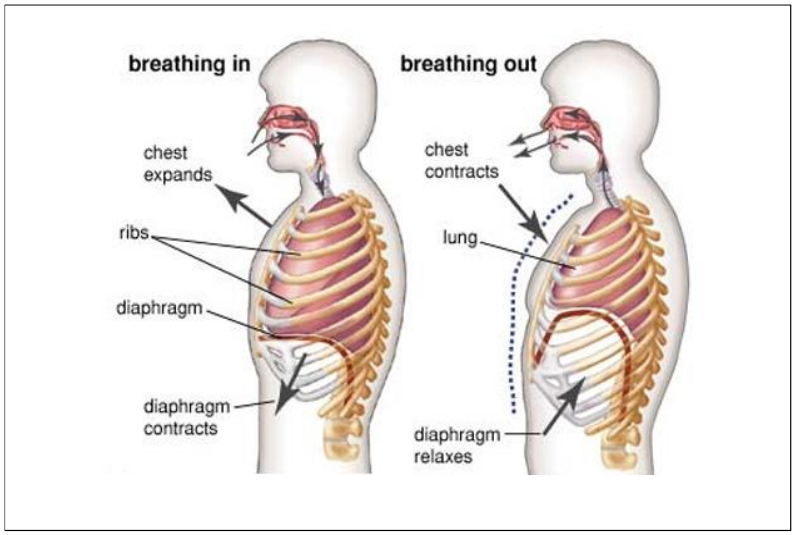
Expiration/Exhalation: Movement of air out of the lungs; chest falls during expiration.

Exsufflation: Mechanical application of negative pressure to pull air out of the lungs for help with expiration/exhalation.

Inspiration/Inhalation: Taking a breath in; chest rises during inspiration.

Insufflation: Mechanical application of positive pressure to push air into the lungs and help with inspiration/inhalation.

Mode: The machine may be operated by manual or auto mode. Auto mode allows the device to automatically function on pre-set settings. **Unlicensed personnel may never use manual mode.**



Secretions: Mucus is produced by glands lining the airways to keep its structures moist and lubricated. If the mucus becomes too thick and sticky, or builds up, it makes it difficult for the person to breathe properly.

Sputum: A mixture of saliva (spit) and mucus coughed up from the respiratory tract.

Treatment Cycle: One cycle is when the machine pushes air into the lungs **and** pulls air out of the lungs.

Coughing is an important body function

Coughing is essential to life. The mucous layer in the airways traps dirt and bacteria. Coughing allows the airways to expel this mucus and prevents infection.

What a cough assist insufflator-exsufflator does

It is a machine that helps people with a weak or ineffective cough bring up mucus so that air can move freely in and out of the lungs. This helps reduce the need for hospitalization. The insufflator-exsufflator machine helps people with weak chest muscles get:

- a deep breath
- a simulated strong cough

Weak chest muscles can be caused by spinal cord injuries, cerebral palsy, muscular dystrophy, and other debilitating diseases.

This machine simulates a natural cough by gradually delivering a large volume of air when the person breathes in. Once the lungs are inflated (expanded), the machine quickly reverses the positive pressure in the lungs to a negative pressure to pull mucus out of the airways.

The treatment prescription specifies the number of cycles. A push of air in plus the pull of air out is one cycle.

With the assistance of the machine, the person's cough is stronger and more effective at removing built up mucus that has collected in the airways.

Regular use of the cough assist insufflator-exsufflator machine reduces the likelihood of pneumonia caused by infection in the lungs.

To obtain and use a cough assist insufflator-exsufflator

- A physician or Advanced Practice Registered Nurse (APRN) must order the cough assist insufflator-exsufflator.
- When the physician/APRN indicates that an insufflator-exsufflator is needed, a respiratory therapist evaluates the person's need and provides directions for settings and usage.
- Directions will include machine settings to be set by the equipment supplier.
- Directions will specify use with a mouthpiece, mask, or tracheostomy tube adapter.
- Directions for certified personnel will include the number of cycles per treatment and the number of treatments per day.
- Certified personnel may **NEVER** adjust the machine settings.
- If there is any problem with the settings or the equipment, call the equipment supplier immediately to address the issue. They are on call 24 hours a day.

Safety precautions

- Check ports for airflow to ensure they are open and working.
- Check all settings before each treatment. The machine should always be in auto mode.
- Allow the person to rest and recover between cycles.
- Keep the machine away from curtains, blankets or any heat-generating device.
- Do not attempt to repair the machine yourself: contact the supplier.
- Use a grounded outlet only.

<u>Never use the machine until you have received proper training and fully understand how to use it. Be sure to follow the prescription information precisely.</u>

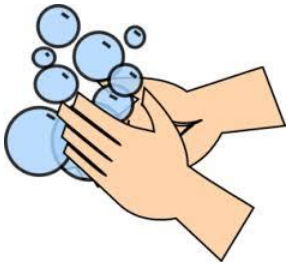
Cleaning and maintenance of a cough assist insufflator-exsufflator

Be sure to follow the manufacturer's directions for cleaning and maintenance

- Always keep cleaning instructions with the equipment
- Contact the supplier if you notice any worn, torn or broken supplies or equipment
- Do **NOT** wash the bacterial filter. Leave it in place if it is not blocked by mucus or trapped moisture. It is never washed and reused, it is only replaced

DO NOT EVER ATTEMPT TO USE THIS DEVICE WITHOUT DIRECT TRAINING WITH THE PERSON WHO WILL BE GETTING THIS TREATMENT AND HAVING YOUR SKILLS VERIFIED BY A PERSON WHO KNOWS HOW TO DO THE TREATMENT

Steps for use of Cough Assist Insufflator-Exsufflator



1. Check MAR/TAR for current order.
2. Wash hands.
3. Gather supplies and equipment.
4. Identify the person and explain the procedure.
5. Plug electrical cord into power socket and into back of machine.
6. Put on gloves.
7. Insert the tubing into the cough assist machine.
8. Attach the face mask to the other end of tubing.
9. If oral suctioning will be required, prepare the oral suction machine and supplies.
10. Help the person to a comfortable sitting/upright position as instructed.
11. Turn on the cough assist machine using the power switch.
12. Check the pressure by putting your hand over the mask. Check the pressure gauge to ensure pressures are registering on the gauge for both inhalation & exhalation.
13. Check to be sure the machine is in auto mode.
14. Make sure the person is comfortable and ready for the treatment.
15. At the end of exhalation or just at the start of inhalation, seal the mask firmly around the person's mouth and nose.
16. Instruct the person to take a deep breath in with the machine during the inhalation and to cough strongly during exhalation if they are able.
17. After each **cycle** (inhalation and exhalation) pause the machine and remove the mask.
18. Instruct the person to spit out any secretions or orally suction if needed.
19. Allow the person to recover.
20. Repeat steps 14-19 for the prescribed number of cycles.
21. Turn off machine at the switch.
22. Remove gloves, wash hands, and put on clean gloves.
23. Unplug the machine and clean machine, mask, and tubing according to specific instructions for that person's equipment.
24. Remove gloves and wash hands.
25. Document the procedure on MAR/TAR and document the person's response to the treatment.
26. If the treatment is only used as needed, document the need and the response to the treatment.

Remember, it will be difficult for the person to take a normal breath while the insufflator is cycling air in and out. If the person is distressed by this, remove the mask promptly and start again when the person is calm and ready.

Application of Compression Hose

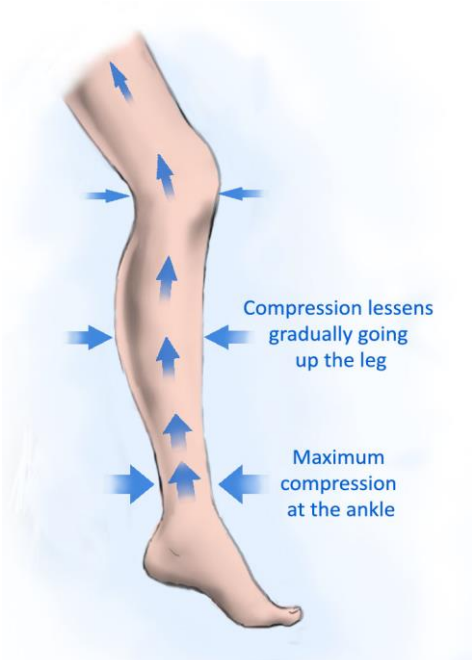
Definition of Terms

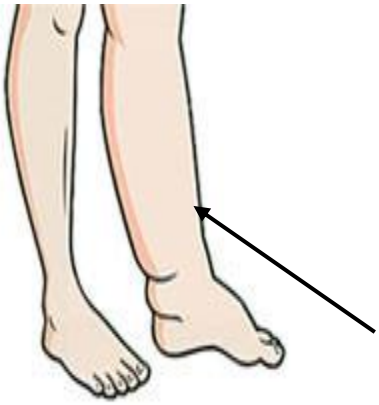
Compression: To squeeze; to place a device on the leg to squeeze the muscle against the veins.

Compression hosiery: Elastic socks/stockings worn on the leg to compress the tissues in the leg to promote upward movement of blood through the veins. This helps increase circulation and prevents blood clots, phlebitis, edema.

Deep Vein Thrombosis (DVT): Blood clot found in the deep veins in the lower legs.

Edema: Swelling from fluid collecting in an area. Most often found in the hands, lower legs and feet.

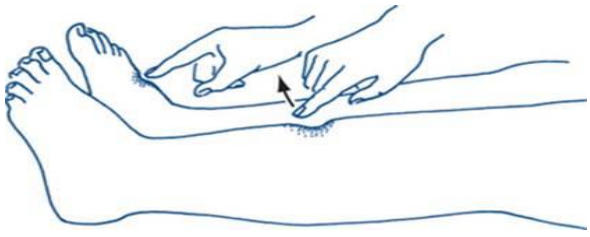




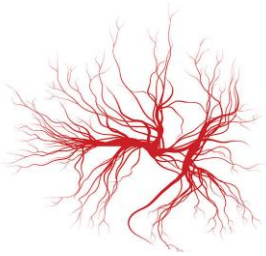
Lymphatic System: A network of tissues and organs that help rid the body of toxins, waste, and other unwanted materials.

Lymphedema: Faulty draining of fluids into the tissues due to inability of the lymphatic system to drain excess fluids from the tissues.

Phlebitis: Inflammation of the walls of a vein.



Pitting edema: A significant collection of fluid in a body area that looks like an impression in the skin that stays after pressure has been applied.



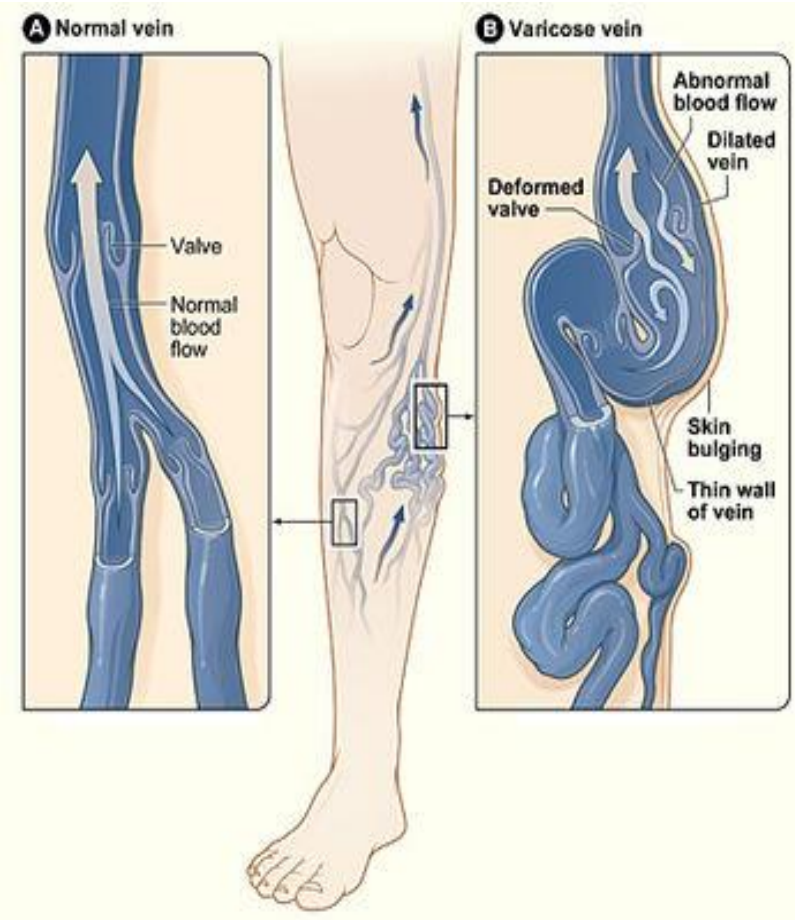
Spider veins: Visible capillaries just beneath the skin.

(Definition of Terms cont.)

Thrombosis: A blood clot in a vein or an artery.

Thromboembolism: A blood clot that has detached from the wall of a blood vessel and travels through the circulatory system. It can get stuck in another blood vessel in the body. Depending on where the clot gets stuck it can block blood flow and be life threatening.

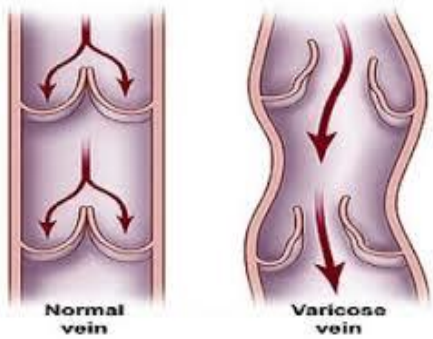
Valve: The mechanism in a blood vessel that allows for fluid/blood to travel through the circulatory system. Valves in the veins allow for blood and other fluids to flow upward toward the heart. As fluid is pushed upward by the muscles squeezing the veins, valves in the veins close to keep blood from flowing backward.

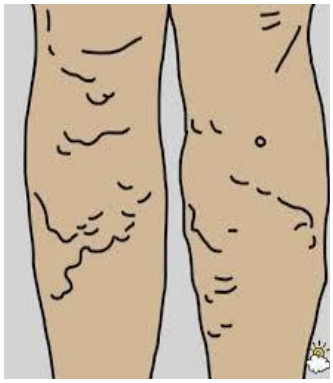


Veins: The system of branching blood vessels or tubes that carry oxygen-depleted blood from various parts of the body back to the heart and lungs to get more oxygen.

Venous insufficiency: The failure of the veins to adequately circulate blood, especially from the lower limbs.

Varicose veins: Veins that have become enlarged and twisted from backflow of blood.





Application of Compression Hose

Compression hose (TED® hose) and what they do

Compression hose are a special kind of prescribed elastic socks or stockings designed to squeeze the legs to help move blood upward. This prevents swelling and potential blood clots. Compression hose are tightest at the ankles, becoming less tight as they go up the leg.

Why compression hose are worn

Compression hose may be prescribed if a person has a condition that causes poor blood flow from their legs back up to the heart and lungs.

Use of compression hose

Compression hose are generally worn when a person is out of bed. They are applied first thing in the morning, preferably before the person gets out of bed, before fluid has had a chance to accumulate in the tissues. If the person has been up already, encourage them to lay down for 15 minutes with leg(s) raised before applying the compression hose.

Care of compression hose

Hand wash daily. Do not put in a dryer. Follow the manufacturer's instructions for care. Most people have 2 pair of compression hose so that while one pair is drying, the other pair is available for use. **Do NOT put wet or damp hose on a person.**

Putting on compression hose

Do not put the hose on wet skin. The hose will go on easier if the person is laying down with their legs raised. Compression hose can be difficult to get on because they are made to fit snuggly. Special devices are available to assist the person to put on their compression hose.

Potential problems associated with wearing compression hose

If improperly applied, compression hose can cause tissue damage, circulation problems, worsen edema, or cause a superficial clot to travel. If compression hose are too small, they can cut off blood flow in the legs. If the hose are too loose they cannot apply the pressure needed to squeeze the leg muscles enough. If the fit of the hose changes to be noticeably more tight or loose, notify a healthcare professional.

Unless directed by a healthcare professional, compression hose should NOT be used if the person:

- has any wounds on the leg
- has a skin infection
- has a lack of feeling in the limb
- is unable to get out of the bed and move around

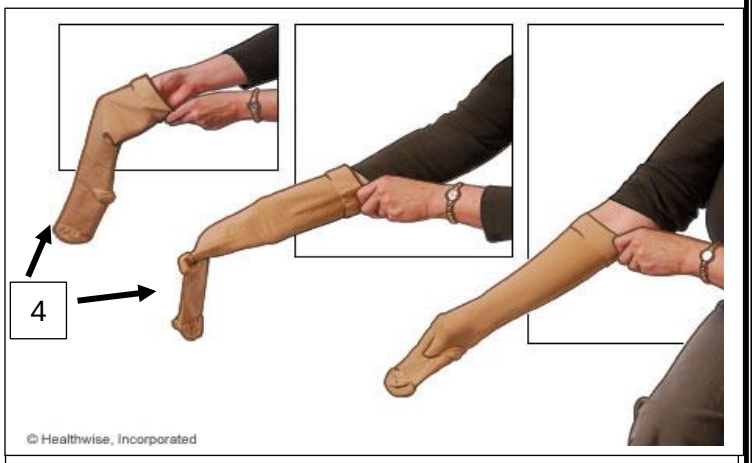
Notify the appropriate healthcare professional if the person cannot or will not wear the hose as prescribed.

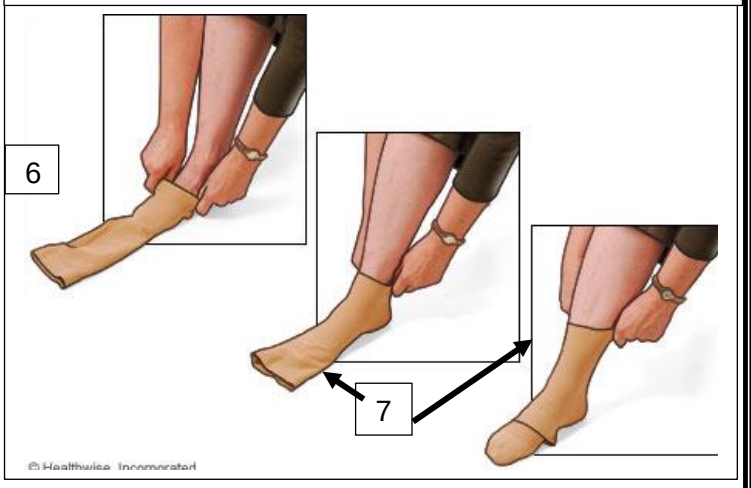
Never fold the top of the hose down.
This will cause harm to the person's circulation.

Contact the prescriber if hose cannot be applied correctly for any reason.

How to Apply Compression Hose

1. Help the person to recline on the bed.
2. Ensure the person's feet and legs are clean and dry.
3. Place your hand in the top of clean hose.
4. Pull hose up your arm until your hand is in the foot of the hose.
5. Roll the hose inside-out, down over your arm to your hand, while keeping a grip on the inside of the toe.
6. Grasp edges of the hose and place the person's foot into the toe of the hose. Be sure the toe and heel of the hose are in place.
7. Grasp the top of the folded hose; roll the hose up and over the ankle with a back and forth twisting motion. Continue rolling the hose up the leg avoiding stretching or creating creases in the hose.
8. Ensure the top of hose is 1-2 inches below the crease at the back of the knee; **NEVER** roll the top of the hose down.
9. **If thigh length**, roll the hose over the knee and over the thigh until it is 1-3 inches below the buttocks. Make sure the hose has no wrinkles or creases at the back of the knee. **NEVER** roll the top of the hose down.
10. Ensure the hose fits smoothly over the skin with **NO wrinkles or creases**. If there are wrinkles or creases, roll the hose back to below the wrinkle/crease, and re-work the hose back up the leg until it fits smoothly.





Steps for Application/Removal of Compression Hose

1. Check MAR/TAR for current order. Note any special instructions on the MAR/TAR.
2. Wash hands.
3. Gather the equipment you need. Make sure the hose are dry.
4. Identify the person and explain the procedure and assist them to recline on the bed or on a chair.
5. Be sure the person's feet and legs are clean and dry and there are no open sores, skin infections or other signs the hose should not be applied. Put on gloves if the person has toe fungus.
6. Place your hand in the top of clean hose.
7. Pull hose up your arm until your hand is in the foot of the hose.
8. Roll hose inside-out, down over your arm to your hand, while keeping a grip on the inside of the toe.
9. Grasp edges of the hose and place the person's foot into the toe of the hose.
10. Put the foot of the hose over the person's foot. Be sure the toe and heel of the hose are in place.
11. Grasp the top of the folded hose; roll the hose up, rolling them over the ankle with a back and forth twisting motion. Continue rolling the hose up the leg avoiding stretching or creating creases in the hose. Ensure the hose has no wrinkles or creases.
12. Be sure the hose top is 1-2 inches below the crease behind the knee or 1-3 inches below the buttocks.
13. Be sure the hose fits smoothly over the skin. Assure there are no wrinkles or creases in the hose. If there are wrinkles or creases, roll the hose back to below the wrinkle and re-roll the hose back up the leg.
14. Repeat steps 5-13 for the opposite leg if hose are ordered for both legs.
15. Remove gloves if worn and wash hands.
16. Document application of hose on the MAR/TAR.
17. Document any complaints, problems or concerns and report them to a healthcare professional.

18. When getting ready for bed, help the person remove the hose by rolling them back down the legs. Wash them by hand and hang to dry. Document removal and washing.

Collection of Urine Specimens by Non-Invasive Means

If a urine sample is needed for testing, personnel may be assigned the task of obtaining the specimen using a clean catch procedure.

To keep the sample clean and uncontaminated, it is important that the person be clean before attempting to obtain a clean catch urine sample.

If the person is not able to clean him or herself adequately, personnel will need to perform this task. **Wipe females from front to back.**

Do not lay the lid of the container face down on a surface or touch:

- the inside of the collection cup
- underside of the lid
- top rim of the cup

Do not touch the outside of the transportation bag with dirty gloves. Set the bag up in advance so that the container can be placed in the bag without touching it. After putting the container in the bag, take off your gloves and wash hands then seal the bag closed. It is important to keep the bag clean since other people will be handling the bag.

If unable to take the specimen to the lab or physician's office immediately, store the specimen as directed by a healthcare professional.

Steps for Collection of Clean Catch (Mid-Stream) Urine Sample

1. Wash hands and put on gloves.
2. Gather equipment and supplies.
3. Identify the person, provide privacy, and explain the procedure.
4. If the person is unable to clean their own genitals, assist them to thoroughly clean using disposable wipes. Remind females to clean from front to back.
5. Have the person begin to urinate. After stream has begun, insert specimen cup into the stream. After desired amount of specimen is obtained, remove specimen cup from stream as the person continues to empty their bladder.
6. If the person is unable to do step 5 above, have the person urinate into a urine hat or urinal which has been thoroughly cleaned with bleach water or another appropriate solution. Pour the sample collected into the specimen cup.
7. Remove gloves and wash hands.
8. Document the date and time of collection and delivery of specimen.

Requirements for Training/Authorizations for Over-the-Counter (OTC) Medications

ALL ORAL MEDICATIONS REQUIRE A PRESCRIPTION FOR CERTIFIED DDP TO ADMINISTER EVEN IF THEY CAN BE PURCHASED OTC			
Types of OTC Medications	**Prescription**	**Medication Administration Certification**	**DODD Stand-Alone Training**
OTC Topical Musculoskeletal	Not required	REQUIRED	Not Applicable
OTC Topical for cleaning, protection or comfort of intact skin, hair, nails, teeth, or oral surfaces	Not required	Not Applicable: Not authorized by category 1 certification	REQUIRED
ALL other OTC medications Oral and Topical	**REQUIRED**	**REQUIRED**	**Not Applicable**

Topical OTC Medications For Musculoskeletal Comfort

Topical treatments for musculoskeletal comfort contain medication that the FDA calls "drugs" and will list "Drug Facts" on the label. Examples include:

- Icy Hot®
- Aspercreme®
- Biofreeze®
- Blue Emu®
- Penetran Plus®
- BenGay®

Can be used for: •arthritis •bursitis •muscle strain •muscle sprains

What Certified DD Personnel MAY DO:

DDP who have a current **Category 1 Certification** may administer topical OTC products for musculoskeletal comfort without a prescription **ONLY when:**

- Applying to intact skin
- Using for sore muscles and joints such as backache or soreness after exercise
- Treating on-going muscle and joint conditions that have already been diagnosed by a healthcare professional

What Certified DD Personnel MAY NOT DO:

- Apply to open wounds
- Use longer than the package recommends unless otherwise directed by a HCP
- Use for a new condition that needs to be evaluated by a HCP
  - new swelling
  - new injury

Terminology

Active ingredient: The functional part or component of the medication that produces the desired outcome. For example, in Icy Hot® Pain Relieving Cream: menthol 10% and methyl salicylate 30% are the active parts of the product that provide temporary pain relief.

Analgesic: Something that relieves pain.

As needed: Using an OTC topical medication only when there is a reason for using it.

Brand Name: Products with a registered trademark ® name. The name represents the active ingredient or combination of active ingredients in the product by that manufacturer.

Diagnosis: Refers to a disease or condition that must be identified based on an assessment by a physician or Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA). By assessing and analyzing the combination of symptoms, a PA, APRN, or physician can identify and diagnose the health condition the person is experiencing. Examples can include arthritis, bursitis, chronic musculoskeletal pain, muscle strain and muscle sprain.

Drug: A product defined and classified by the US Food and Drug Administration (FDA). On every OTC product that contains a "drug" the word "drug" and the drug's name will be on the label. **For example:** menthol 10% and methyl salicylate 30% are the "drugs" in Icy Hot® Pain Relieving Cream.

Generic products: Products that have the same active ingredient as a brand name product. Some brand name products also have additional inactive ingredients. Generic products cost less for the same amount of active ingredient(s). Example: CVS® Health Extra Strength Cold and Hot Pain Relieving Cream also has menthol 10% and methyl salicylate 30%. It would be the generic equivalent for Icy Hot® Pain Relieving Cream.

Intact skin: No breaks, scrapes, cuts or openings in the skin.

Manufacturer's label and instructions: Information found on the topical OTC product packaging. It will always include the name and strength of the drug that is in the product.

Over-the-Counter (OTC) medication: Any drug (medication) that can be purchased without a prescription.

Prescription: A written order from a physician, APRN or PA for a drug/medication.

Signs: Observable evidence that something is wrong. Signs of musculoskeletal discomfort may include such things as swelling, decreased range of motion, redness.

Storage: The protection and proper handling of a medication to assure it retains its ability to do what it is supposed to do. Be sure to follow manufacturer's instructions. Always store topical medications separately from oral medications. Keep medications safe from misuse or theft.

Symptom: What the person experiences; what the condition feels like. Examples include complaints of aches, or pain.

Requirements for Use of OTC Topical Medications

- **Person-Centered Purchasing:** Products ***should be chosen by the person*** with assistance from DDP, as needed, to choose the right product for the right use. The person's personal preferences must be considered when assisting with choices. This includes preferences of scent/smell, texture, price, packaging, etc. A pharmacist can also help the person with product choices.
- **Documentation:** OTC topical medication documentation must include

  - the person's name
  - allergies
  - product name
  - date
  - time
  - reason used
  - where applied
  - effectiveness
  - certified personnel's name

***See sample documentation form on the DODD website**

✓ People who can self-administer these types of OTC medications do not need certified DD personnel to administer for them.

Allergy: When a person has an undesirable reaction to any product or substance. Examples of undesirable reactions include such things as sneezing, itching, rash, hives, swelling of the face, tongue, lips, or throat.

◈ **Before using any OTC product, personnel must know what the person's allergies are and be certain that the OTC product does not contain ANY of the substances the person is allergic to. Certified DD personnel must check each person's allergies every time before a product is used.**

If not absolutely certain that an OTC product is safe for the person, personnel must ask a licensed healthcare professional before using the product.

Note: Products containing Salicylic Acid should not be used by people who are allergic to Aspirin or Acetylsalicylic Acid (ASA).

On the next page, is an example of information found on the label of Icy Hot®, an over-the-counter musculoskeletal pain reliever.

Information about this product gives no manufacturer contact phone number. Any questions you have about any product that does not include a manufacturer's contact number, must be referred to a pharmacist or the person's physician or other licensed healthcare professional.

Understanding the Label on OTC Drug Products

Products that contain drugs have the specific heading "Drug Facts" on their label. Special attention must be given to all information under "Drug Facts". Over-the-Counter products that do not list "Drug Facts" may be used as the label directs without a prescription or special medication certification.

Always keep the original box or bag of the purchased product. The label must always be available when the product is being used. ■ **To assure the product is used correctly and safely, *THE LABEL MUST BE READ* by anyone using the product *BEFORE EVERY USE*.** ■ ***CHECK THE EXPIRATION DATE BEFORE EACH USE.*** ■**Do NOT use products after the expiration date.** ■ **Compare the person's allergy list to ingredients on the label.** ■ **Keep all medications out of reach of children or others who might swallow them.**

Example: ICY HOT® Pain Relieving Cream

Drug Facts

Active Ingredient **Purpose**
Menthol 10% ……. Topical analgesic
Methyl salicylate 30%..... Topical analgesic

Uses
Temporarily relieves minor pain associated with: •arthritis •simple backache •muscle strains • sprains •bruises

Warnings: For external use only

Allergy alert: If prone to allergic reaction from aspirin or salicylates, consult a doctor before use

When using this product
■ use only as directed ■ do not bandage tightly or use with a heating pad ■ avoid contact with eyes or mucous membranes ■ do not apply to wounds or damaged, broken or irritated skin

Stop use and ask doctor if:
■ condition worsens ■ symptoms last more than 7 days or clear up and occur again within a few days ■ redness is present ■ irritation develops

Drug Facts Continued

If pregnant or breast feeding: ask a health professional before use.
Keep out of reach of children. In case of accidental ingestion, get medical help or contact a Poison Control Center right away.

Directions
Adults and children over 12 years: ■ apply generously to the affected area ■ massage into painful area until thoroughly absorbed into skin ■ repeat as necessary, but no more than 4 times daily **Children 12 years or younger:** ask a doctor

Inactive ingredients: carbomer, cetyl esters, emulsifying wax, oleth-3 phosphate, stearic acid, triethanolamine, water (245-110)

ACTIVE INGREDIENT(S): is the drug in the product and is listed on the drug facts label. For each active ingredient there is a purpose listed. The purpose of all active ingredients is the reason the drug is being used.

USES: Make sure to use the product only for the right purpose as listed on the label and allowed by law.

WARNINGS: Follow all warnings exactly, (such as "Do not get in eyes"). Pay attention to warnings about when to stop using the product and when to ask a doctor about using the product. You **MUST** stop using the product and contact the doctor as instructed on the label.

DIRECTIONS: These tell you where, when, how much, and how often to use the product. Directions also state when you can use the product again if still needed. **DO NOT USE MORE of the product than recommended OR MORE OFTEN THAN THE LABEL STATES.**

OTHER INFORMATION: Includes instructions such as proper storage.

INACTIVE INGREDIENTS: These are ingredients in the product that contribute to the delivery, stability, texture, and smell of the product. **It is very important to make sure that NONE of the inactive ingredients are chemicals the person is allergic to.**

QUESTIONS? There is often a number on the label for calling the manufacturer for questions about the product. ***Questions about the person's health or condition must always be directed to their licensed healthcare professional.***

Steps for Administering OTC Topical Medications for Musculoskeletal Comfort

Purchasing/choosing the OTC topical medication for musculoskeletal comfort:

1. Assist the person with choosing their topical non-prescribed OTC medicated product(s) to be used for providing comfort to muscles and joints.
2. Confirm allergies before assisting with purchase and before every use, every time**.**
3. Identify the following from the product label:
   - When to use
   - Where to use on the body
   - How to use
   - How much to use
   - When to repeat use
   - When to stop use and call doctor
   - Warnings
   - Expiration date
4. Create the OTC topical musculoskeletal medication treatment record (or confirm the product to be used matches the current treatment record).

Use of the OTC topical medication for musculoskeletal comfort:

1. Before application of the medication, check to determine if the medication is needed/wanted by the person. Verify:
   - When to use
   - Where to use on the body
   - How to use
   - How much to use
   - When to repeat use
   - When to stop use and call doctor
   - Warnings
   - Expiration date
2. Check the documentation sheet to determine when was the last time the medication was used.
3. Wash hands and put on gloves.
4. Apply the correct amount by following manufacturer instructions.
5. Remove gloves and wash hands.
6. Return the medication to secure storage.
7. Document application time, where on the body the topical medication was applied, and the person's response to treatment.
8. Report any problems to the person's healthcare professional.

When to Seek Assistance:

CALL 911 FIRST, then notify others per your agency policy

Examples of When to Call for an Ambulance or Call 911

- ♦ Poisoning
- ♦ Sudden loss of vision
- ♦ Severe, constant abdominal pain
- ♦ Uncontrolled bleeding; bleeding heavily
- ♦ Choking
- ♦ Fainting, loss of consciousness, or won't wake up
- ♦ Person appears very ill; sweating, skin looks blue or gray
- ♦ Possible stroke; new weakness, loss or change in speech
- ♦ Severe or large area of burned skin
- ♦ Repeated vomiting/diarrhea not responding to treatment
- ♦ BP:
  - ∗ Below 90 for upper number
  - ∗ 220 or higher for upper number
  - ∗ Below 60 for the lower number
  - ∗ 120 or higher for lower number
- ♦ Chest pain
- ♦ Cardiac arrest (loss of heartbeat)
- ♦ Pulse rate is less than 40 or more than 140
- ♦ Difficulty breathing and/or loud wheezing
- ♦ Respiratory failure (stops breathing)
- ♦ Severe allergic reaction
- ♦ Symptoms develop suddenly; the person stops their usual activity or starts to act unusually
- ♦ Hypoglycemia (low blood sugar that does not respond to nutritional intervention)
- ♦ First time seizure
- ♦ Seizure lasting longer than is typical or as specified in the person's plan; or one seizure right after the other
- ♦ The person does not wake up after the seizure; unable to arouse from a seizure within 20 minutes
- ♦ The person does not start breathing normally after the seizure stops
- ♦ Foreign object embedded in any body part
- ♦ Fractures of the long bones of the arms or legs
- ♦ Vomit/diarrhea that is bloody or looks like coffee grounds
- ♦ Crushing injury of the head, chest, or abdomen
- ♦ A hit to the head comparable to being hit with a baseball bat or falling on a concrete floor

Persistent abdominal pain

Strong blow to the head

Trouble breathing

Change in gait (stroke)

For the following injuries, KEEP THE PERSON WARM, DO NOT MOVE THEM (unless the scene is unsafe). CALL 911

- ♦ A fall with limb deformity (bone sticking out, swelling, unusual position of arm, or leg)
- ♦ A fall with a head injury or with a change in level of consciousness
- ♦ A fall and the person is unable to get up on their own when they normally would be able to do so, or the person is in a lot of pain when lying still or trying to get up

CALL 911 for:

♦ Severe Allergic Reaction (sometimes called anaphylactic reaction). Symptoms may appear right away or up to many hours after exposure to allergen. A severe allergic reaction is often characterized by:

♣ Massive hives ♣ Difficulty breathing ♣ Swelling of the throat, tongue, lips or mouth

If the person has an Epinephrine Auto-injector use it immediately then call 911

Examples of When to Take a Person to the ER/Urgent Care

- ♦ Eye injury
- ♦ Burn with blisters including sunburn
- ♦ Shaking and chills with or without fever
- ♦ Body temperature of 96 or lower or 103 or higher
- ♦ Repeated vomiting/diarrhea over 12 hours
- ♦ New onset of confusion for no known reason
- ♦ Fall with complaints of pain or cannot walk normally
- ♦ 24 hours of poor appetite and fluid intake and/or decreased urination
- ♦ Moderate bleeding that does not stop after 5 minutes of direct pressure, the laceration may need sutures; continue to **apply pressure while transporting**

Examples of When to Call a Healthcare Professional

- ♦ New rash
- ♦ Fever of 101-102.9 F
- ♦ Earache or sore throat
- ♦ New onset incontinence
- ♦ Increase in seizure numbers, type or duration
- ♦ Burns that are reddened or blistered, including sunburn
- ♦ Repeated vomiting/diarrhea more than 6 hours but less than 12 hours
- ♦ Other times as designated in the person-centered plan

When to Call Poison Control

- Ingestion of toxic substances
- Ingestion of the wrong medication and unable to consult with a local healthcare professional
- Ingestion of the wrong amount of prescribed medication and unable to consult with a healthcare professional
- The number for poison control is: **1-800-222-1222**

American Association of Poison Control Centers: www.aapcc.org

Examples of Situations to Be Reported to a Healthcare Professional

- Suspected adverse reactions to medications
- Changes in mental or physical functioning
- Repeatedly choosing not to take prescribed medications or treatments
- Any concerns personnel have regarding the person's mental or physical health

If you think there may be a health problem:

- Call or talk to a healthcare professional
- **Document:**
  - Date reported
  - Time reported
  - Person to whom you reported symptoms
  - Symptoms you reported
  - What you were instructed to do
  - What you did and when you did it
  - Who else you notified

- **IF YOU THINK THE PERSON'S LIFE IS IN DANGER, CALL 911 IMMEDIATELY**

Quick Overview of Selected Emergency Situations:

Status Epilepticus

Prolonged Seizure

Hypoglycemic Reaction

Symptoms of low blood sugar

Condition and Actions to Take:

Condition	Action to Take
Status Epilepticus A seizure that is longer than typical or more than 1 seizure in a specified time period	♦ Give **Diastat® or other medication** as ordered if a seizure goes beyond the specified time limit ♦ Keep the person's airway open ♦ Protect the person from injury ♦ Stay with the person ♦ Call 911 if Diastat® or other as needed medication does not stop the seizure within 15 minutes ♦ Call 911 if seizure lasts longer than 5 minutes, and no emergency medication is ordered, and if their plan does not specify something different ♦ Call the nurse/doctor as directed in the person's seizure care plan
Hypoglycemic Reaction Low blood sugar	♦ Administer **glucagon in any form;** as ordered **and delegated** ♦ Call 911 ♦ Stay with the person ♦ Call the delegating nurse

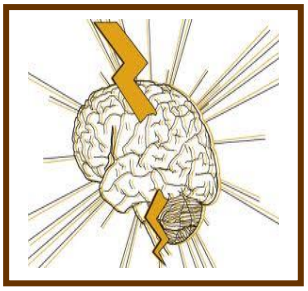
It is important for you to recognize each of these serious situations and know how to assist the person to recover as quickly as possible, preventing medical complications and possible death. Additional information is presented on the following pages.

*****At the beginning of every shift locate the emergency medication, check the expiration date and check the medication against the MAR 3 times: confirm the medication and dosage that will be given if/when the emergency medication is needed.**

Nasal Versed® (midazolam) is authorized by this Category 1 Medication Administration Certification because it is a nasal medication. **Before administering midazolam, certified personnel MUST receive the additional DODD appendix training material AND receive training specific to the person's use of the medication.**

Seizures

A seizure is sudden, uncontrolled electrical disturbance in the brain. It can cause changes in a person's behavior, movements, feelings, and in the levels of their consciousness.



What Happens During a Seizure

- The person may experience a warning (aura) that the seizure is about to happen
- Seizures are individual specific. You MUST become familiar with what behavior(s) the person exhibits during seizures. Common behaviors exhibited during a seizure can include:
  - Sudden falling
  - Clenched teeth
  - Eye movements
  - Grunting and snorting
  - Temporary halt in breathing
  - Loss of bladder or bowel control
  - Drooling or "foaming" from the mouth
  - Uncontrollable muscle spasms with twitching and jerking limbs
  - Brief blackout (staring into space) followed by confusion for a period of time
  - Unusual behavior such as sudden anger, sudden laughter, or picking at one's own clothing

IF THE PERSON'S SEIZURE IS DIFFERENT FROM PREVIOUS SEIZURES, CALL 911.

What can bring on a seizure (triggers)

- Fever
- Bright sunlight
- Medication errors
- Tired/not enough rest
- Getting too hot (hot tubs, sauna, strenuous exercise, and hot weather)
- Flickering lights (TV, strobe lights, fireworks, rotating ceiling fans)

Auras

- An aura is a warning that a seizure is about to occur and is individual specific
- Auras can include (but not limited to):
  - A smell
  - Fear
  - A noise
  - Headache
  - Anxiety
  - Nausea
  - Confusion
  - A feeling or sensation

Duration of a seizure

- From seconds to minutes

BECOME FAMILIAR WITH HOW LONG THE PERSON'S SEIZURE TYPICALLY LASTS.

Report the seizure to a healthcare professional:

- If the seizure lasts longer than a typical seizure as specified in the person's plan
- If a person has a seizure after having been seizure free for 6 months or longer

Frequency of seizures

The frequency varies from person to person.

You MUST know how often the person typically has seizures. Some people have seizures daily, others once a month, others once or twice a year. Some people's seizures are well controlled, and they go years without a seizure.

IF THE PERSON'S SEIZURES OCCUR MORE OFTEN THAN IS TYPICAL FOR THEM REPORT TO THE APPROPRIATE HEALTHCARE PROFESSIONAL.

Website: www.epilepsy.com

Safety considerations for people with seizure disorders

- Always be aware of environmental hazards
- Wear a life jacket while swimming
- Adjust the water heater to avoid burns if a seizure occurs in the shower
- Use a shower chair or bench to avoid falling if a seizure occurs in the shower
- Avoid the risk of drowning by taking showers rather than a tub bath

During a seizure DO NOT

- Restrain the person
- Place anything (including your fingers) in the person's mouth
- Move the person unless they are in danger or near something hazardous
- Give the person anything by mouth until the seizure has stopped and the person is fully awake and alert
- Try to make the person stop convulsing; they have no control over their seizures

Individual Specific Training about a person with a seizure disorder should include:

- Typical duration of the seizure
- What the seizure looks like
- Frequency of seizure activity
- Any emergency medication (Diastat®/Ativan®/nasal Versed®/nasal diazepam)
- Prescriber's specified parameters for administering emergency medications
- Any procedures or actions for supporting the person who has seizures
- Documentation and reporting of seizures

Care during a seizure

Stay with the person and provide for their safety:

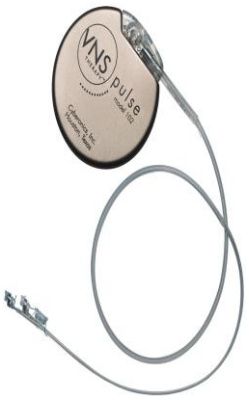
- Assist the person to the floor if standing
- Support the person to prevent falling from a chair or bed
- Position the person on their side if possible to maintain the airway and prevent aspiration if the person vomits
- Provide a cushion for the person's head
- Move furniture or other items that could cause injury if arms/legs are moving

Call 911 if:

- The person stops breathing
- This is the first seizure the person has ever had
- The person sustains an injury during the seizure
- The person remains unconscious more than 20 minutes after the seizure ends
- The person has a seizure after being seizure free for 12 months or more
- This is NOT the person's typical seizure (appearance/duration/frequency)
- The person has multiple seizures one after another

Vagus Nerve Stimulator (VNS)

Some people with a seizure disorder may have an implanted VNS. This is a device that can help prevent and stop seizures.

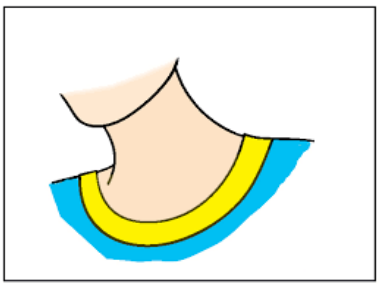


***This category 1 training does NOT authorize use of a VNS magnet:**

If the person you are supporting has a VNS, you need to have the DODD approved training. Online self-directed training is available in My Learning. The written DODD approved curriculum is available for training by a nurse or a MA certified personnel.

First Aid for Seizures: What To Do

Note the time. You need to know how long the seizure lasts.



Be sure there is nothing tight around the person's neck.

Turn the person on their side to prevent choking or aspiration if vomiting occurs and cushion the head to prevent injury.

Place nothing in the person's mouth during a seizure.

DO NOT: Try to hold the person down.

DO: Move any obstacles that could cause harm out of the way.

Offer comfort, reassurance and whatever assistance is needed when the seizure is over.

Call 911 if:

- The person stops breathing
- This is the first seizure the person has ever had
- The person sustains an injury during the seizure
- The person remains unconscious more than 20 minutes after the seizure ends
- The person has a seizure after being seizure free for 12 months or more
- The seizure is different than the person's typical seizures (appearance/duration/frequency)

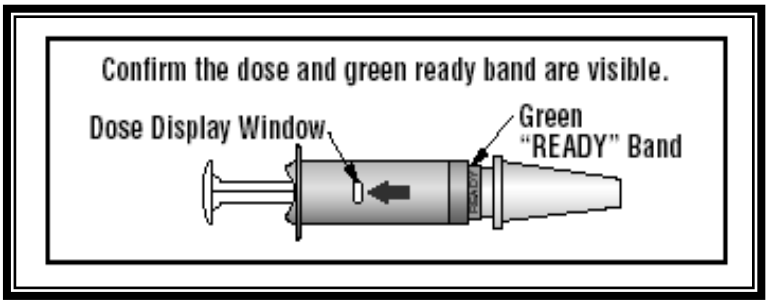
Treatment of Repetitive or Prolonged Seizures with Diastat®

Some people with a 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 medication that can be administered rectally while the person is still having a seizure.

Diastat® is a prescribed medication and is only used when ordered for that specific person by a physician or another healthcare professional with prescriptive authority. Prescriptions for Diastat® must be specific about when to use (ex. when seizure lasts more than five minutes).

Diastat®

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



Administering Diastat®

Diastat® is prescribed to be be given for repetitive seizures or for seizures that last longer than specified.

What to expect after giving Diastat®

Seizures usually stop within 15 minutes. If seizures continue longer than 15 minutes, follow the person's seizure care plan for giving additional Diastat® or calling 911.

Diastat® storage and care

Diastat® is transportable. It can be taken anywhere and given anywhere the person is. It does not need to be refrigerated. 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.

When Diastat® is used, the person still needs to take their other seizure medications

Diastat® is an emergency medication to be used only as directed by the prescriber. It does NOT take the place of other seizure medications. Do NOT stop giving other medications without first asking the person's healthcare professional.

Be respectful of the person's privacy

Ask others to leave the area. Cover the person with a blanket, sheet or other available drape to maintain privacy.

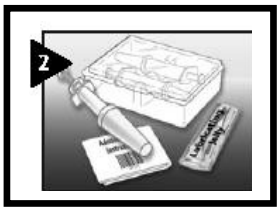
Be safe

If Diastat® is needed in a specific setting or situation that puts the person or you at risk, hold the Diastat® and call 911. Discuss with the prescriber if there are routine situations that may prevent administration, such as during transportation or at public places. The person's seizure first-aid plan should include how to handle those routine situations.

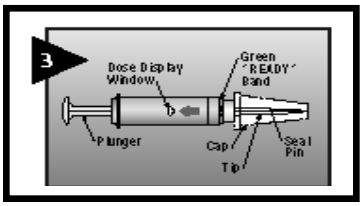
Valtoco® (diazepam nasal spray) is authorized by this Category 1 Medication Administration Certification because it is a nasal medication. **Before administering diazepam nasal spray certified personnel MUST receive additional training with the manufacturer's instructions and receive training specific to the person's use of the medication.**

Steps for Administering Diastat®

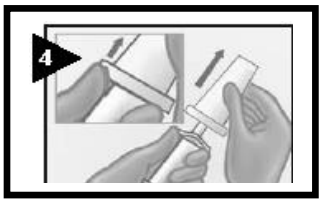
Place person on their side where they cannot fall



Get the medication

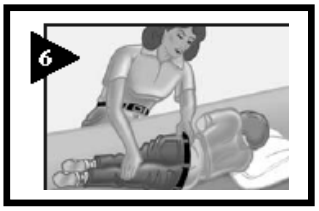


Get syringe. **NOTE:** Seal Pin is attached to the cap

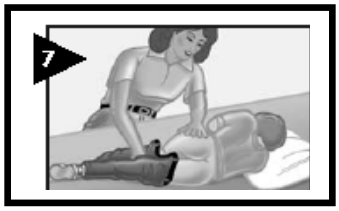


Push up with thumb and pull to remove cap from syringe **Be sure Seal Pin is removed with the cap**

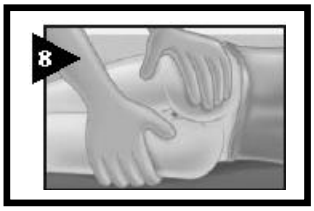
Lubricate rectal tip with lubricating jelly



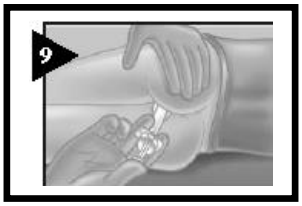
Turn person on side facing you



Remove clothing from lower body



Bend upper leg forward to expose rectum



Gently insert tip into rectum **NOTE:** Rim should be snug against rectal opening

Slowly count to 3 while gently pushing plunger in until it stops

Slowly count to 3 before removing syringe from rectum

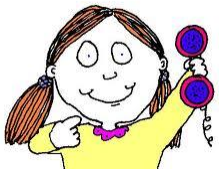
Slowly count to 3 while holding buttocks together to prevent leakage

Keep person on side facing you, note time given and continue to observe

Disposal Instructions:
Follow manufacturer's or pharmacist's instructions for discarding any unused Diastat®. Document medication disposal as taught in this curriculum.

Call for emergency help (911)

- If seizure behavior is different from other episodes
- If seizures lasts more than 15 minutes after giving Diastat® or another emergency medication
- According to person specific orders/plan



Steps for Administering Diastat®

(Locating the Diastat®, checking the expiration date and doing the 3 checks on the MAR were done at the beginning of the shift to be prepared to administer quickly in this situation)

1. Recognize that the seizure requires administration of Diastat® according to the parameters on the MAR.
2. Put the person on their side in a location where they cannot fall.
3. Get the medication.
4. Put on gloves.
5. Get the syringe from the package.
6. Push the cap up with your thumb and pull to remove cap from syringe. Make sure seal pin is removed with the cap.
7. Lubricate the rectal tip with the lubricating jelly in the package.
8. Turn the person on their side **facing you** and pull-down clothing to expose the buttocks.
9. Bend their upper leg forward to expose the buttocks.
10. Separate the buttocks to expose the rectum.
11. Gently insert the syringe tip into the rectum. Rim should be snug against the rectal opening.
12. **SLOWLY** count to three while gently pushing the plunger in until it stops.
13. **SLOWLY** count to three again before removing the syringe from the rectum.
14. **SLOWLY** count to three while holding the buttocks together to prevent leakage.
15. Keep the person on their side facing you. Note the time the Diastat® was given and continue to support and observe the person until seizure activity stops.
16. Assist the person to a safe and comfortable position.
17. Remove gloves and wash hands.
18. Document the administration of Diastat® on the MAR. Document the seizure details and the person's response to the treatment.
19. Dispose of any unused Diastat® and the Diastat® syringe according manufacturer's or pharmacist's instructions. Document medication disposal as taught in this curriculum.
20. Immediately make arrangements to replace the used Diastat® with a new supply.

Diabetes Mellitus

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 United States is increasing rapidly, everyone should be aware of this potentially fatal disease. Complications may be reduced by early detection and treatment.

Risk Factors

- Family history
- Inactive lifestyle
- Obesity
- Some types of medications

Symptoms of Diabetes

- Hunger
- Fatigue
- Blurry vision
- Extreme thirst
- Frequent urination
- Unexplained weight loss
- Sores that do not heal
- Frequent infections

Complications

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

Prevention of Complications

- Exercising regularly
- Eating a healthy diet
- Maintaining a healthy weight
- Taking medication as ordered
- Keeping blood sugar under control
- Monitoring blood glucose as directed
- Inspecting skin, especially feet, at least daily
- Wearing shoes or slippers on feet when walking to prevent cuts and other foot injuries that could lead to infection and possibly amputation

Screening Exams

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

Website: www.diabetes.org
Resource website of The American Diabetes Association

Recommendations for People with Diabetes

- Get recommended dental checks
- Never put lotion between toes
- Eat meals and snacks as scheduled
- Always wear shoes or slippers when up
- Engage in some physical activity daily
- Wash and examine feet daily and dry thoroughly between the toes
- Have toenails cut only by a healthcare professional
- If lesions are found anywhere on the body, contact a healthcare professional for an evaluation
- Take all medications exactly as prescribed
- When checking blood sugar use the side of the finger, never the pad, and rotate finger sites to avoid callus formation

When blood sugar is too high it is called **HYPERGLYCEMIA.** When blood sugar is too low it is called **HYPOGLYCEMIA.** Signs and symptoms for Hyperglycemia and Hypoglycemia are listed in the boxes below. If a person is diagnosed with diabetes, it is important to know what their normal blood sugar levels are, and when to take action for high or low blood sugar levels.

Signs of Hyperglycemia (High blood sugar)

- ♦Feel weak
- ♦Drowsy, sleepy
- ♦Pain in abdomen
- ♦Nausea, vomiting
- ♦Dehydration, dry mouth and skin
- ♦Decreased alertness
- ♦Skin flushed, red and warm
- ♦Slow, lethargic movements
- ♦Rapid respirations

Onset is slow: Call 911
Know the person's normal glucose range. Test blood sugar. If glucose is higher than normal for that person, call 911.
Hyperglycemia is a medical emergency.

The **onset of hypoglycemia is rapid,** and the person can quickly deteriorate (go into a coma). It is essential to recognize these symptoms and act quickly. 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.

Physical Symptoms of Hypoglycemia (low blood sugar) can include:

- ♦ Nausea
- ♦ Headache
- ♦ Fast pulse
- ♦ Feeling hungry
- ♦ Blurred vision
- ♦ Unsteadiness
- ♦ Feel too hot/cold
- ♦ Tremors, shakiness
- ♦ Dizziness/lightheaded
- ♦ Pounding heartbeat
- ♦ Excessive sweating
- ♦ Slurred speech
- ♦Tingling in hands, feet or face

When a person is having symptoms of high or low blood sugar, but you cannot test to be sure, treat it as low blood sugar and give a sugar source.

Quick action is important to prevent a coma and possibly death.

Mental Symptoms of Hypoglycemia can include:

- ♦ Inability to follow directions
- ♦ Sleepiness or drowsiness
- ♦ General weakness
- ♦ Difficulty concentrating or slow thinking
- ♦ Feeling that something is not quite right
- ♦ Confusion or being disoriented: not knowing where they are, what time it is, or not recognizing the people they usually know

Emotional Symptoms of Hypoglycemia can include:

- ♦ Anger
- ♦ Irritability
- ♦ Looking frantic
- ♦ Changes in typical behavior
- ♦ Inappropriate giggling
- ♦Sudden crying
- ♦ Feeling anxious

Treatment for Hypoglycemia (low blood sugar)

People diagnosed with Diabetes Mellitus (DM) who take medication to lower blood sugar (glucose) can be at risk for hypoglycemia. It is important to know the specific blood sugar parameters for people who have diabetes and make sure there are written instructions to follow when the person's blood sugar is too high or too low.

Causes of hypoglycemia include:

- Stress
- Illness
- Taking too much medication
- Not eating on a regular schedule
- Increased activity

If the person's blood sugar reading on the glucometer is below their specified range, you need to take immediate action to get the blood sugar up to the specified range. In most cases, an episode of hypoglycemia is easily reversible when treated quickly. Follow the persons specific treatment plan.

**** Any time a person becomes sleepy, passes out, or has a seizure while experiencing low blood sugar, CALL 911 IMMEDIATELY.**

<u>If the blood sugar is below 45 call 911 and proceed with their treatment plan</u>

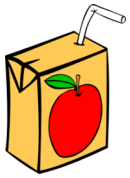
If a person does not have a specific plan for treating low blood sugar, follow these guidelines if their blood sugar level goes below 70.

1. If the glucometer reading is below 70 (69 or less) and the person is ♦ alert ♦ awake & ♦ can follow your instructions:
   a) **Note the time.**
   b) **Do NOT leave the person alone until the blood sugar is back up above 70.**
   c) **Give the person any <u>one</u> of the sugar sources listed (or one listed in their plan);** each sugar source is a fast-acting carbohydrate and should help to raise the blood sugar within 15 minutes.
2. **15 minutes after** eating/drinking one of the sugar sources check the blood sugar again. <u>Note the time.</u>
   a) If the reading is the same or rising, but is still below 70, and the person is **still alert**, **awake**, and **can follow your instructions, give another sugar source**.
   b) If the blood sugar is rising but is still below 70, and the person is having **decreased alertness** or **difficulty speaking or following directions, CALL 911**.
   c) **If the blood sugar has dropped lower even after eating the first sugar source,** and the person is alert, awake, and can follow your instructions, **give one more sugar source <u>AND then</u> Call 911.**
3. **15 minutes after** eating the 2nd sugar source check the blood sugar again. **Call 911 if the reading is still below 70.**
4. When the episode has resolved or after EMS has arrived, notify the appropriate people.

Give only one source at a time

Sugar Sources:

- 1 tablespoon of sugar, honey, or corn syrup (3 tsp = 1 TBSP)
- ½ cup fruit juice
- ½ cup soda pop, NOT DIET POP
- 1 tablespoon jelly, jam, or pancake syrup
- 1 tube glucose gel or instant glucose
- 1 small tube cake decorating gel or frosting
- 4 glucose tablets



***Anything given by mouth must be liquid, gel or melt easily. Choking is always a risk when blood sugar is low.**

After the blood sugar is above 70:

a. If a meal or snack time is within 1 hour, have the person eat his or her planned meal or snack.

b. If a snack or mealtime is not going to occur within 1 hour, give the person some food that will provide protein and fat and will be slowly digested such as:
   - a soft protein snack bar
   - a slice of cheese with 6 crackers
   - 1 cup of milk

   This will help keep the blood sugar stable until the next meal.

*** Any food given must comply with diet texture orders**

Document the episode of hypoglycemia on an Unusual Incident Report form and take information about all hypoglycemic episodes to the next appointment for review by the person's physician or APRN.

CALL 911 if at any time while experiencing a low blood sugar reaction, the person exhibits any of the following:

- symptoms getting worse
- loss of consciousness/passes out
- problems with breathing
- difficulty swallowing
- becomes less alert
- has a seizure

While you wait with the person for EMS to arrive, DO NOT give them anything to eat or drink and protect them from falling or hitting their head on anything.

Documentation of a Hypoglycemic Episode Should Include Each of the Following and the Time Each Occurred:

- ♦Symptoms exhibited by the person (e.g. sweating, irritable, dizzy, etc.)
- ♦All glucometer readings, along with the time of each reading
- ♦Treatment provided (food/beverage given, injection of glucagon)
- ♦Response of the person to the treatment (stated feeling better; became confused and drowsy)
- ♦Who was notified (nurse, supervisor, emergency services personnel)

Glucagon

Glucagon 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.

Remember: <u>glucagon, in any form, MUST be delegated in all settings</u>. If a person has an order for glucagon, personnel must be certified and be delegated by a nurse before being alone to care for that person in an emergency.

If glucagon has been prescribed for the person, inject the glucagon first, then contact emergency medical services and notify the delegating nurse.

The order of treatment steps is:

1. Administer glucagon
2. Call 911
3. Stay with the person until EMS arrives
4. Call the delegating nurse

Information About Glucagon

- **It is a hormone** given by nasal spray or injection for hypoglycemic (low blood sugar) emergencies <u>only</u>.
- It is **given <u>only</u>** if prescribed by a healthcare professional and is listed on the MAR.
- It should **only** be **used when** the person is **unable to chew, drink, or swallow** food.
- When injected, it releases glucose stored in the liver into the blood stream and raises the level of glucose (sugar) in the blood quickly.
- Glucagon comes in a Glucagon Emergency Kit® with all the supplies needed to administer it by injection. The kit contains a vial of glucagon powder and a syringe filled with liquid to dissolve the powder in the vial. The powder and liquid are premeasured so there is no danger of giving too much.
- **Glucagon cannot be prepared ahead of time. It must be prepared at the time of the emergency.**
- Follow the delegating nurse and manufacturer's instructions for nasal administration of nasal glucagon powder.

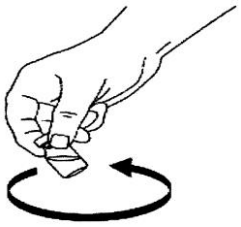
General Instructions for Use of Emergency Glucagon

NOTE: USE OF GLUCAGON MUST BE DELEGATED. The delegating nurse will provide instructions for use of glucagon as part of the delegation process for each person.

- As part of the delegation process, the delegating nurse will make sure you are familiar with what is in the person's kit so you will know what to do if you ever need to administer it. Not all glucagon emergency kits are the same. One person's kit may be different from another person's kit.
- The glucagon kit should be located at the beginning of each shift, expiration date confirmed and compared to the MAR 3 times for current orders. If the expiration date is near, make arrangements to replace the kit before it expires.
- Properly store the kit by following the manufacturer's or pharmacist's instructions.
- Do NOT prepare the glucagon for injection UNTIL you need it.
- Glucagon injection is given in the thigh, back of the arm, abdomen or buttocks. Nasal glucagon powder is administered in the nose.
- Some people vomit when given glucagon. If the person is laying down, turn the person on their side to prevent choking if they vomit.
- **AFTER administration, call 911.**
- If the person does not become responsive after the glucagon administration: Maintain an open airway. Be prepared to perform CPR if needed, while you wait for emergency personnel to arrive.
- As soon as emergency personnel arrive, be sure to let them know you gave glucagon and hand them the empty vial, so they know you gave it.

Guidelines for Preparing the Glucagon Emergency Kit®

- ☐ Wash your hands.
- ☐ Carefully remove the flip seal from the glucagon powder vial. Avoid touching the rubber stopper.
- ☐ If you accidently touch the rubber stopper, wipe the stopper with an alcohol pad.
- ☐ Carefully remove the needle cover from the sterile water filled 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 swirl* the vial with your other hand until powder is dissolved (solution will be clear). If the solution is not clear after powder is dissolved, you cannot administer it. Call 911 immediately.
- ☐ When the powder is dissolved to a clear liquid, reinsert needle into the vial. Turn the vial upside down and draw the entire contents from the vial into the syringe.
- ☐ Remove the needle from the vial and recap the needle, being careful not to contaminate it or stick yourself.
- ☐ Take the prepared glucagon to the person.
- ☐ Administer per Steps for Administering Glucagon by Injection on pages 167-168.



*Swirling the vial prevents the formation of air bubbles in the vial. Do not shake the vial.

Steps for Administering Glucagon by Injection

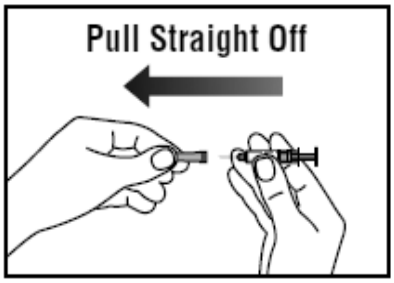
Nurse delegation is required for glucagon administration in ALL settings. The delegation needs to occur before certified personnel are alone with a person who has a glucagon order.

- **Locating the glucagon, checking the expiration date and doing the 3 checks on the MAR were done at the beginning of the shift to be prepared to administer quickly in this situation.**

Preparing the Glucagon

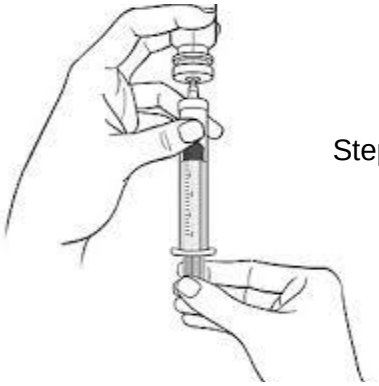
1. Recognize that the blood sugar level requires administration of glucagon according to the parameters on the MAR.
2. Wash hands.
3. Get the Glucagon Emergency Kit® from secured storage area.
4. Remove elements of the Glucagon Emergency Kit® from the package and place on a clean, dry work surface.
5. Carefully remove flip seal from vial containing the glucagon powder.
6. Remove the needle protector from fluid-filled syringe.
7. Insert needle into rubber stopper of vial; inject all the fluid from the syringe into the glucagon vial.
8. Remove the needle. Hold the syringe above the level of your waist with the needle upright. With your other hand gently swirl vial until glucagon powder is dissolved into a clear liquid. (swirl; do not shake).
9. Reinsert the needle into the rubber stopper; turn the vial and syringe upside down; draw up all the solution from vial into the syringe by pulling back gently on the syringe plunger.
10. Once all the solution is drawn into the syringe, remove the needle from vial and carefully recap the needle.
11. Place filled syringe in a safe, but accessible place close to the person.

Step 5



Step 6

Step 7



Step 9

Giving the Injection

12. Put on gloves then locate the injection site. (thigh, back of arm, abdomen, or buttocks).
13. Clean the site with alcohol. Make sure site is clean and dry before injecting.
14. Pick up the syringe and remove the cap from the needle.
15. Hold the syringe in your dominant hand (hand you write with).
16. With your other hand place thumb and forefinger about 2 inches apart on either side of the injection site. Pinch up the skin creating a mound at the injection site.
17. With a darting motion of the wrist, quickly insert needle at a **45-degree angle** into the pinched up skin between the thumb and forefinger. Insert the needle all the way into the skin.
18. Keeping thumb and forefinger on the skin, slide thumb and forefinger apart, releasing the mound of skin. Keep the thumb and forefinger on either side of the injection site while holding the syringe in place with your dominant hand.
19. **SLOWLY** push down on the plunger until all of the glucagon is injected. Hold the needle in place and count slowly to five before removing the needle.

Removing the needle from the injection site

20. Quickly pull the needle straight out. If there is bleeding at the site, use a gauze pad, cotton ball or bandage to apply gentle pressure until bleeding stops.

After the injection is completed

21. As soon as the injection is completed, and the needle has been removed, dispose of the glucagon syringe in a sharps container.
22. Turn the person on their side to help prevent choking if vomiting occurs.
23. Call 911.
24. Remove gloves and wash hands.
25. Do not attempt to give the person food or leave the person alone while waiting for emergency responders.
26. Give the empty vial of glucagon to emergency personnel when they arrive.
27. Only give food or beverage as directed by emergency medical responders or the on-call nurse.
28. Document administration of glucagon, and the person's response to treatment. Write an Unusual Incident Report.
29. Notify the delegating nurse.
30. Promptly arrange for a replacement supply of Glucagon Emergency Kit®.

✓ **Skills checklists to be signed by trainee and trainer are available on the DODD website**.

Proper Disposal of Sharps

Acceptable Sharps Containers must be:

- Closeable
- Leak proof
- Puncture resistant
- Properly labeled or color coded
- Used only for sharps disposal

Unacceptable Sharps Containers Include:

- Soft plastic soda or water bottles and plastic bags
- Milk or water containers
- Any cardboard containers
- Glass jars

When away from home carry a small puncture-resistant container with you, such as an empty pill bottle for disposal of sharps.

- **Sharps are NEVER put in the trash until they are placed in an appropriate sharps container.**
- **The sharps container should be labeled with the word SHARPS on all sides of the container in big BLOCK letters.**
- **Contact your waste management district to see if they collect sharps from your house.**
- **Do not put your home-made sharps container in the recycle bin.**

www.epa.state.oh.us

Thick Puncture Resistant Container
** Test to see if product container is really puncture resistant.

Biohazard Container
These can be obtained from a pharmacy.

How to Prevent Accidental Puncture Wounds from Sharps

- Never recap or bend a used needle
- Never place your hand INSIDE or UNDER a trash bag for any reason
- Never put fingers or hands inside a sharps container, always drop the sharp into the container
- Alert a supervisor if the location has no acceptable sharps container
- Give full attention to what you are doing when handling a sharp; no multi-tasking
- Know the location of the sharps disposal container before using sharps
- Have a replacement container on hand when the one in use is 1/2 full
- Never fill a sharps container more than 3/4 full
- Never shake a sharps container

If possible, use safety lancets and safety syringes.

If You Receive a Puncture Wound from a Contaminated Sharp

- Run warm water over the area immediately.
- Wash the area thoroughly with soap and warm water or a skin disinfectant.
- Rinse well, allowing water to flow downward toward your fingertips.
- Report the incident to your employer immediately. Follow your employer's policy about who to notify and what to do for a workplace exposure incident.
- Seek immediate medical attention.
- The person whose body fluid you were exposed to may need to be tested also.
- Complete an exposure incident report to document the incident. You may need special medical care to protect you from communicable diseases.

For more detailed information about worker safety and exposure incidents go to https://www.osha.gov

Summary

- This course is for DODD Category 1 Medication Administration Certification.
- The certification is issued by the Ohio Department of Developmental Disabilities to DD Personnel who meet the qualifications.
- Attending class, demonstrating skills and passing the test are required but those actions DO NOT EQUAL Certification. Certification is only current and valid when qualifications have been submitted and approved by DODD. Certification registration must be visible on the DODD public registry of Medication Administration Certifications dodd.ohio.gov.
- The certification is registered to the MA certified personnel, not the employer.
- Personnel MUST confirm current certification dates on the DODD website or mobile page BEFORE administering medication.
- Employers and delegating nurses must also verify each personnel's current certification on the DODD website BEFORE assigning any personnel to administer medications.
- Certification is valid for 1 year. MA certified personnel may not administer medications after the date the certification is expired.
- Personnel may renew certification beginning 180 days prior to expiration.
- Personnel whose certification has expired have an additional 60 days to renew certification after expiration. Personnel may not administer medications, treatments or health-related activities during the time when the certification is expired.
- When the certification has been expired more than 60 days, personnel must repeat the entire Initial Certification Course to become certified.
- After certification and before administering medications, treatments and/or health-related activities to anyone, the MA certified personnel must receive initial Individual Specific Training for every person to whom they will administer medications, treatments and/or health-related activities. After the initial Individual Specific Training, personnel should routinely be kept up to date on the person-centered plan and healthcare needs.
- MA certified personnel are only authorized to administer medications and treatments in the way that they are taught in this manual and only for the routes of administration taught in this manual. Short cuts or failure to follow the step-by-step methods specified in this course can put people's lives at risk and can lead to revocation of certification and/or listing personnel on the DODD Abuser Registry.

- MA certified personnel are never authorized to make medical judgements. Questions and clarifications must be directed to a healthcare professional; never to another unlicensed person.

- With this certification the only over-the-counter medications that can be administered without a prescription are topical medications for musculoskeletal comfort.

- Additional DODD approved stand-alone training must be obtained for personnel to administer over-the-counter topical medications for comfort, cleansing, and protection of intact skin, nails, hair, teeth and oral surfaces (see Ohio Administrative Code 5123:2-6-03 and 5123:2-6-05).

- Additional DODD approved stand-alone training must be obtained for personnel to administer an epinephrine auto-injector.

- Additional DODD approved stand-alone training must be obtained for personnel to use a VNS magnet.

- If MA certified DD personnel do not have the necessary knowledge, skill or ability to act safely and accurately they must obtain additional training before attempting to provide prescribed medications, treatments and/or health-related activities.

- MA certified personnel are responsible to know the purpose, expected outcome, and potential problems for every medication and treatment administered to every person, every time it is administered.

- If a task or setting requires MA certified personnel to have nurse delegation to authorize medications, treatments and/or health-related activities, the personnel may only provide that care at the direction of the delegating nurse. The delegating nurse must provide step-by-step instructions, individual specific training, and be available to address questions or concerns while the task is being completed.

Medications are hazardous substances. MA certified personnel are administering these medications only to people who do not have the necessary knowledge, skill or ability to administer for themselves. This means MA certified personnel have the responsibility to protect the person receiving the medication from potential harm caused by inaccurate administration. That is done by following the instructions in this manual and directing all questions and concerns to healthcare professionals.

Optional Training Materials and Sample Forms

These and other resources can be found on the DODD website:
dodd.ohio.gov

1. Nasal Versed®
2. General Documentation Examples
3. How to Document Use of As Needed Medications
4. Extrapyramidal Side Effects (EPSE) Associated with Psychotropic Medications
5. Psychotropic Medication Side Effects
6. Recommendations for Managing Diabetes
7. Suggestions to Follow When Calling a Pharmacy
8. Watching for Adverse Drug Reactions
9. Individual Specific Training Form (sample form)
10. Intake Record (sample form)
11. Intake and Output Record (sample form)
12. Medication/Treatment Administration Record (MAR/TAR) (sample form)
13. Nursing Statement of Delegation (sample form)
14. Verbal Order Form (sample form)
15. Steps for Administering Medications by Mouth (Oral) from a Blister/Bubble Pack

Ohio | Department of Developmental Disabilities
Medication Administration