MEDICATION ADMINISTRATION MANUAL

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I. INTRODUCTION

This manual is designed to prepare ABLED, Inc. employees and subcontractors to meet the requirements of the Medication Aide Act and to assume the role and responsibility of the medication aide.

The Medication Aide Act (Nebraska Revised Statutes Sections 71-6718 to 71-6742) provides for the medication aide to participate in the administration of medications. Medication administration includes three components; 1) providing medications according to the Five Rights, 2) recording medications provided and 3) observing, monitoring, reporting, and taking appropriate actions regarding desired effects, side effects, interactions, and contraindications associated with the medication. The purpose of the law is to "ensure the health, safety and welfare of the public by providing for an accurate, cost-effective, efficient and safe utilization of medication aides to assist in the administration of medications."

I. MEDICATION AIDE

The medication aide is a position that has been created by the Nebraska legislature (Nebraska Law Title 172 NAC 95). A medication aide means an individual who has met all requirements for registration and is listed on the Medication Aide Registry operated by the Department of Health and Human Services.

The purpose of this position is to provide a safe way for individuals other than licensed health care professionals (M.D., Physician Assistant, Nurse Practitioner, R.N., L.P.N., and pharmacist) to provide medications to participants who are not able to take medications by themselves.

A. REQUIREMENTS

To become a medication aide for ABLED, Inc. you must:

- Be at least 19 years of age and of good moral character.
- Understand and demonstrate the Ten Basic Competency Standards of Medication Provision as established by the Department of Health & Human Services.
- Be assessed as competent to administer medications through direct observation by a licensed healthcare professional (LHCP) to determine whether an individual understands and can actually demonstrate the basic competencies. No one will be allowed to administer medications without passing a competency assessment. A first time or renewing medication aide applicant must complete the ABLED, Inc. competency assessment which includes Medication Administration Training, pass the Medication Administration Demonstration, and pass the Medication Aide Competency Exam. Initial registration for an applicant will have a 30-day grace period in which they may administer medications after their competency assessment is completed. During this time, the State registers the individual on the Medication Aide Registry.
- Submit to the Department of Health and Human Services:
    - A completed application including applicant's name, address, birth date, Social Security number, alien number (if you are a qualified alien under the Federal Immigration and Nationality Act)
    - Identification of any felony or misdemeanor conviction along with date of occurrence and county and state in which the conviction occurred;
    - Copies of all charges, amended charges, pleas, sentencing and probation orders for convictions;
    - An explanation of the events leading to the conviction, such as what, when, where, and why, and a summary of actions that the applicant has taken to address the behaviors or actions related to the

conviction;
  - A letter from the applicant's probation officer addressing the terms and current status of the probation, if the applicant is currently on probation;
  - To aid in the evaluation of an applicant's drug or alcohol related convictions, an applicant may submit evaluations and discharge summaries where drug or alcohol treatment was obtained or required. Evaluations and discharge summaries must be submitted by the provider directly to the Department;
  - All records, documents or information requested by the Department of Health and Human Services. If you get a request for additional information from the State, you will not be listed on the Medication Aide Registry as a medication aide until that information is provided to the State. The Department of Health and Human Services will act within 30 days upon the completed application for registration. It is your responsibility to provide the requested information. It is advised that you also inform the ABLED Executive Team regarding the delay.
  - An official record documenting demonstration of competency as specified in regulations (the LHCP will complete this at the time of the competency assessment).
  - The required non-refundable fee as specified in regulation (paid by ABLED, Inc for SLPs & DSPs).
- Be registered on the Medication Aide Registry.
- Renew registration every 2 years. Competency must be retested, and the renewal form completed, and registration fee paid.
- If a person's medication aide registration is expired, they must be assessed competent, reapply to the State, and may not administer medications until they are posted as current on the Medication Aide Registry.
- Failure to maintain competencies or demonstrated incompetence may be reported to the State of Nebraska and can result in revocation of registration.

All records will be maintained at the ABLED, Inc. main office.

B. RESPONSIBILITIES

As a medication aide there are several key duties in providing medication support. You must be able to:

- Use safe practices in monitoring and managing of medications
- Respond to the specific needs of the participant being supported
- Follow laws, rules, regulations, policies, and guidelines that apply in your situation
- Assist people in taking medications correctly
- Find additional information regarding medications when necessary
- Communicate effectively with the participant, family, health care provider, pharmacist and your ABLED, Inc. representatives.

C. DIRECTION AND MONITORING

Medications may be provided by a medication aide only when direction and monitoring is provided and documented. State Regulations define direction and monitoring as the acceptance of responsibility for observing and taking appropriate actions regarding any desired effect, side effects, interactions and contraindications associated with the medication. A medication aide may not provide direction and monitoring but may participate in observing and

reporting. Acceptance of responsibility to provide direction and monitoring must be in writing and must be provided by one of the following:

Competent Recipient

A competent recipient (participant) may direct their own health services if they are competent to do so and state so in writing. This means they fully understand their own health requirements and are capable of communicating when any changes occur. They must have the capacity and capability to make informed decisions about their medications, to refuse medications, and at no time be forced to take medications. See Section G for Self-Administration and the Self-Administration of Medication Assessment at the end of this manual.

Recipient Specific Caretaker

A caretaker means a parent, foster parent, family member, friend, or legal guardian who provides care for a participant. A caretaker is a competent person who understands the health care needs of the participant and is willing to assume responsibility in writing. See the Caretaker Acknowledgement Form of this manual. In this instance, it is the caretaker that the medication aide contacts for authorization of PRN medications or questions regarding a participant's medical care.

Licensed Health Care Professional (LHCP)

As part of the job description, the Staff Nurse assumes responsibility for the direction and monitoring of medications administered by ABLED, Inc. staff. This allows for a medication aide to administer medications under the Staff Nurse's nursing license. This applies to all participants supported by ABLED, Inc., except those participants who are capable of directing their own health care needs, and those participants where responsibility has been assumed by a caretaker or other LHCP.

D. TEN BASIC COMPETENCY AREAS AND STANDARDS

The Nebraska Department of Health and Human Services has developed the following ten competency areas that a medication aide needs to show understanding and capability. During your medication competency the Staff Nurse will ask questions relating to or directly observe understanding of these competencies.

1. Maintain Confidentiality

Do not share confidential information except when it affects the recipient's care and is to the appropriate person(s).

Federal law protecting health information privacy is known as HIPAA (Health Insurance Portability and Accountability Act). It is against Federal statute to reveal any health-related information to persons or organizations without proper authority.

Participants receiving support from ABLED, Inc. have the right to personal privacy. All information about the participant is confidential. This includes any information about identity, diagnosis, medication, health care, payment of services and medical therapies. All information of this nature may be shared only with appropriate persons on a "need to know" basis.

For example, if a participant supported has hepatitis B, it is important for the ABLED Executive Team and those persons working with him to know this information. ABLED, Inc. personnel that do not work with this participant do not need to know this personal information. On the other hand, if the staff person has hepatitis B, it is important that the participant supported, his family/guardian, the ABLED Executive Team and fellow staff know this information. Again, it is on a "need to know" basis. Does someone need to know this information to safely interact with this participant? Contact the ABLED Executive Team if you have questions or concerns about this.

Never discuss a participant's behavior, conditions, medications, or other information where others can hear the conversation. Be aware of this particularly when out in the community or in social settings. When discussing information in the presence of the supported participant, advise them of what you are doing and why and ask their permission to discuss it with another "need to know" person.

What can you share about a participant without breaking confidentiality? How do you introduce one friend to another?

Talk about talents, hobbies, personal interests, job skills, certain likes. Anything that is "public knowledge" is not confidential but not everything that is "public knowledge" is appropriate to share.

2. Complying with a Recipient's Right to Refuse Medication

Do not force recipients to take medication. Use appropriate measures to encourage taking of medications when directed for recipients who are not competent.

A participant receiving support has the right to be informed about all aspects of the medication he or she is taking.

The participant has the right to refuse to take medication. As the person providing support, your job is to provide the best care possible, and this care usually involves administering prescribed medication. Never force a participant to take their medication.

If the participant is refusing their medication, try to determine why. Is this a bad time for that participant? Wait and offer later. Does it taste bad? Offer a choice of yogurt or applesauce. Does it cause unpleasant side effects? The physician may be able to change the time of dosing or offer remedies to help. Other staff can be very helpful in

suggesting ideas that may help - she prefers butterscotch to chocolate pudding, or he likes his meds in his blue bowl. This information can be listed on the medication administration record under special instructions.

The right time for administering a medication is one hour before to one hour after the assigned time listed on the medication administration record. You have a two-hour window in which a medication can be correctly administered.

If a participant refuses their medication, you must try at least three attempts to get them to take it. Be respectful during medication administration. Medication aides must respect the personal space of participants they assist. Intimidation by physical presence is not an acceptable method of getting someone to take their medication, nor is physically touching someone, unless that is the method desired by the participant supported. Be respectful by not getting in their face, give them a little time, offer preferred tastes, try other staff's suggestions, suggest an outdoor activity, and try to not offer only sugar-filled treats. If after all your efforts, the medication is refused; contact a pharmacist or physician for recommendations regarding what to do, potential reactions to anticipate or recommendations for adjusting the next scheduled dose.

Refusal of a medication needs to be documented on the medication administration record and a General Event Report (GER) on Therap Services. Documenting a refusal on the medication administration record will be discussed later, see section for General Event Report (GER)s. The refusal, efforts you tried, and any advice given you by the pharmacist (include pharmacist's name) need to be documented on a General Event Report (GER) on Therap Services.

If refusals occur frequently or you start to see a pattern of refusal, notify the ABLED Executive Team. The situation needs to be reviewed by the ISP team.

Any medication used for behavioral control is a rights restriction and does require review. Due process includes review by the Individual Support Plan (ISP) and the ABLED, Inc. Rights Review Committee.

3. Maintaining Hygiene and Current Accepted Standards for Infection Control

You must utilize appropriate infection control principles when providing medications.

a. Universal Precautions

Universal precautions assume that all human and all human body fluids are infectious and should be handled with appropriate protective measures. These protective measures include:

- Hand washing.
- Wearing protective equipment - gloves, eye protection.
- Proper disposal of needles and sharps.
- Decontamination of surfaces that come in contact with blood by cleaning with a mixture of 1:10 bleach to water solution.
- Washing clothes that are contaminated with blood in hot water and detergent. Bleach may be added as an additional disinfectant measure.

b. Hand Washing

Hand washing is the single most important way to prevent the spread of infection. The importance of good hand washing cannot be underestimated. When providing medications to multiple participants, wash hands between each participant's administrations unless no contact was made with the participant or anything the participant may have touched.

Hand sanitizers can be a great alternative when soap and water are not available. After using hand sanitizer, wash your hands as soon as possible. Good old hand washing with soap and water is still the best.

Proper Hand Washing:

1. Prepare a paper towel
2. Using warm water, wet your hands before applying soap
3. Rub your soapy hands together for 10 - 20 seconds
4. Rinse your hands thoroughly of soap with fingers pointing downward
5. Turn water off with a paper towel
6. Dry hands with a clean paper towel
7. When leaving a public restroom, use the paper towel to open the door handle

c. Gloves

For some procedures, disposable gloves may be worn. They should be worn anytime there is a chance of coming in contact with body fluids. This might happen if you need to put medication in someone's mouth or when applying a cream or ointment. Never touch another participant's medication with your bare hands, only the recipient can touch the medication bare handed. Gloves are not a substitute for good hand washing. Wash hands before and after using gloves.

To remove used gloves properly:

1. Pinch the palm of the first glove and pull toward the fingertips and off the hand.
2. Continue to hold the first glove while removing the second glove. Place fingertips of the first hand between the skin of the wrist and glove. Pull second glove toward the fingertips, turning the glove inside out. The first glove will be inside the second glove.
3. Dispose of gloves. Wash your hands.

4. Documenting Accurately and Completely.

You must accurately document all medication provided including the name of the medication, dose, route, and time administered and any refusal of medication, and spoilage.

When documenting, remember:

- A medication administration record (MAR) is a legal document.
- ABLED, Inc. utilizes electronic medication administration records (MARs) via Therap.
- Do not leave blank spaces on a medication administration record (MAR).
- Document only what is observed, not an interpretation or an opinion of what is observed.
- Document administration of medication immediately after the medication is given. Do not document prior to administration. Documentation means that you have already done it.
- When the electronic Medication Administration Record (MAR) is not available a hard copy (paper copy) MAR should be documented on.

5. Providing Medications According to the Five Rights

You must provide the right medication, to the right person, at the right time, in the right dose, and by the right route. To safely provide medications, a Medication Aide must observe the "Five Rights of Medication Administration".

These Five Rights are the basis for medication administration. You must give the Right Medication, to the Right Person, the Right Dose, at the Right Time by the Right Route. You must get all five right, if even one "Right" is missed, it can result in a medication error and may result in serious harm to the participant.

When removing the medication from the locked storage compartment compare the prescription label to the medication listed in the medication book to assure you have the right medication. If a generic medication is received from the pharmacy, then the generic name should be listed on the medication administration record. The photograph and the name listed in Therap identifies the right participant.

Call the participant by name. Prepare medication for one participant at a time and complete paperwork before going on to the next participant.

Always check the proper amount or the right dose. Know the abbreviations for tablespoon (Tbsp. or T.) and teaspoon (tsp. or t.) and use calibrated medication cups.

The right time for administering a medication is one hour before to one hour after the assigned time listed on the medication record. An exception is a medication that must be given 30 minutes before (ac) or after (pc) a meal. These drugs should be given as close to the specified time as possible.

The right route is how the medication is to be taken. Is it taken orally, under the tongue, applied topically?

When removing the medication from the locked storage, read the label to be sure you have the right medication, right person, right dose, right time, and right route. When setting up the medication compare the prescription label and the medication record to double check that you are providing the right medication, to the right person, at the right dose, at the right time and by the right route. Never administer any medication without checking and double checking the Five Rights of Medication Administration. The participants we support are depending on us to accurately administer medications. This is no time for short cuts.

Violation of these Five Rights of Medication Administration may impact a medication aide's employment. Do this right every time!

1. **Right person.**
2. **Right medication.**
3. **Right dose.**
4. **Right time.**
5. **Right route.**

6. Having the Ability to Understand and Follow Instructions

You must comprehend written and oral directions.

Being safe with medications is the Medication Aide's number one concern when assisting with providing medications to another person. Safety with medications includes the ability to understand and follow directions.

a. Abbreviations

Many abbreviations are used when administering medications. To be safe when providing medications, a medication aide needs an understanding of these abbreviations. Although physicians are discouraged from using many of these

abbreviations, you will still see them used and you need an understanding of what they mean. Below is a list of frequently used abbreviations.

ac = before meals

pc = after meals

bid = twice a day*

po = by mouth

c = with

prn = as needed*

d/c = discontinue

q = every*

h = hour

qd = every day

hs = at bedtime*

q4h = every 4 hours

OD = right eye

qid = four times a day*

OS = left eye

qod = every other day

OU = both eyes

stat = immediately

OTC = over-the-counter*

tid = three times a day*

*memorize this information

b. Measures

In order to provide medications safely, the Medication Aide must also understand measurements and how medications are measured.

- Always use the correct measuring device to give the correct dose.
- All liquid and powdered medications are measured in a calibrated medication cup.
- Always measure liquid medications by putting the med cup on a flat surface and bringing your eye down to the cup to see exactly how much you are pouring.
- Measure thin liquids using the lowest point of the meniscus or the lowest curve of the liquid. A thick liquid is measured using the highest point of the meniscus or the highest curve of the liquid.
- Never pour liquids back if you poured out too much, pour excess into another medication cup to be destroyed.

Listed below are common abbreviations and common equivalences:

cap = capsule

gtt = drop

gtts = drops

mcg = microgram

mg = milligram

ml = milliliter

oz = ounce

tab = tablet

t = teaspoon

tsp = teaspoon

T = tablespoon

Tbsp = tablespoon

Common Equivalences:

1 cc = 1 ml

1 teaspoon = 5 cc or 5 ml

1 tablespoon = 15 cc or 15 ml

3 teaspoons = 1 tablespoon

1 ounce = 30 cc or 30 ml

Note: a milligram (mg) does not equal a milliliter (ml) 12

An understanding of abbreviations and measurements will help with your ability to understand and follow a medical provider's orders.

7. Practicing Safety in Application of Medication Procedures

You must store and handle all medication in accordance with entity policy, intervene when unsafe conditions of the medication indicate a medication should not be provided, and provide medication to recipients in accordance with their age and condition.

a. Medication Storage

- All medications are stored in the original container (including the original prescription label) in which they are dispensed by the pharmacy. An original container may be a pill bottle, a blister pack, or a cassette. If the prescription label is attached to the box (e.g., inhaler, insulin), keep the medication within the original box.
- All prescription and non-prescription medications administered by staff are stored in a locked cabinet (or a locked box within a refrigerator if needed).
- Each participant supported must have their own medication storage container within a locked cabinet to separate their medications from other participants' medications. This will help prevent giving the wrong

medication to the wrong person.

- Medications taken orally are stored separately from externally applied medications. Keeping ointments and creams separated in a zip-lock bag will prevent contamination of medications taken orally.
- Keep refill medications labeled, inventoried, sealed, and locked until they are needed. The key to the locked medication storage cabinet must be in a secure location. Do not leave the key in the lock of a file cabinet. Only participants who can administer medications can have access to the keys.
- If a participant administers their own medication, a locked drawer or box may be provided. At the very least, the participant should keep the meds in a private area, within their bedroom or bathroom. It is always good idea to store medications in a locked area if children are present.
- Medications for emergency purposes should be more easily accessible than other medications.

These are questions to consider in determining general unsafe conditions of medications:

1. Is the medication past its expiration date?

Over time, most medications become ineffective, some liquid medications can become more potent as they evaporate, and a few medications become unsafe after the expiration date. Expiration dates may especially be a concern with PRN prescription medications and OTC medications that are not given routinely. If there is no expiration date listed, consider a PRN/OTC medication expired one year after it is opened.

2. What is the condition of the medication?

Check for medications that have a cracked coating, an odor, or have a color change. Do not give broken or crumbly tablets. If a solution/liquid changes color, becomes cloudy, or has a sediment, this may represent a deterioration of the medication. A change in the consistency of a liquid could indicate possible tampering. When medications are received from the pharmacy immediately inspect to see that they are all present and in good condition, call the pharmacy for replacements if needed.

Are the tablets the same color as last month's? A different generic equivalent may have been substituted; the pharmacy needs to inform you of these changes. If the participant says it does not look like one they usually take; check.

3. Is the prescription label legible?

If a medication is unlabeled or the label becomes illegible (e.g., cough syrup spilled on the label) do not administer. Take it to the pharmacy to have it relabeled by a pharmacist.

If in doubt about the safe condition of a medication:

a. Review medication information sheets for any information regarding storage and unusual appearance.
b. Contact a pharmacist for guidance in determining if a medication is safe to administer.
c. If medication is deemed unsafe, dispose of it by turning it into the pharmacy for proper destruction.

We need to be alert and sensitive to the differing needs of the participants we support. Do they have difficulty swallowing? Do they receive some medications orally and others through a g-tube? How are ear drops instilled in an adult versus a child? We will discuss these issues in the medication administration routes section of the manual.

8. Complying with Limitations and Conditions Under Which a Medication Aide or Medication Staff may Provide Medications

You must be competent and have been assessed, always comply with the five rights of provision of medications, record all medication provided or refused, and have additional competencies to provide additional activities.

Only medication aides who are listed on the Department of Health and Human Services Medication Aide Registry can administer medications to our participants supported. If you are not already registered or your license has expired, you must complete ABLED, Inc.'s Medication Administration Training, pass the Medication Administration Demonstration and pass the Medication Aide Competency Exam performed by the Staff Nurse who is a licensed healthcare professional (LHCP).

The Medication Administration Demonstration and Medication Aide Competency Exam are direct observations in which the Staff Nurse observes a medication pass and a written assessment related to the Ten Basic Competency Standards. During the Medication Administration Demonstration and the Medication Aide Competency Exam, the Staff Nurse determines if you are competent to administer medications.

If you are currently registered as a medication aide through another agency, you are invited to attend ABLED, Inc.'s Medication Administration Training. At the minimum you must understand ABLED, Inc.'s expectation of medication aides and be able to accurately complete documentation. The Staff Nurse will monitor your documentation to identify whether competency should be reassessed.

Always comply with the Five Rights of Medication Administration: You must give the **(i) right medication** to the **(ii) right person,** at the **(iii) right dose,** at the **(iv) right time** by the **(v) right route.** You must get all five right. If even one "right" is missed, it can result in a medication error and may result in serious harm to the participant.

Document administration of medication immediately after the medication is given. Do not document prior to administration. Documentation means that you have already done it. If a medication is refused after three attempts, document the refusal on the medication administration record, complete a General Event Report (GER) on Therap Services, and notify the pharmacist or the physician of the refusal.

The Medication Administration Act provides for a medication aide to give medications according to the "Five Rights of Medication Administration," administer by routine routes (oral, topical, inhalation, and instillation into the eye, ear, or nose), and appropriately document once medication is given.

It also makes provisions for additional activities. These are:

- Giving medications by routes other than routine routes (e.g., rectal suppository, medication by gastrostomy tube, insulin injection).
- Performing nursing related duties (e.g., glucometer testing, oral suctioning, gastrostomy feeding).
- Participation in monitoring.
- Providing PRN medication.

To administer a medication by a route other than routine or perform a nursing related duty, a medication aide must be:

- Trained by a licensed health care professional (LHCP). Staff cannot train other staff.
- There must be written direction for each additional activity that is recipient specific.
- There must be a written statement by a LHCP that the medication aide can competently perform the activity and that it is safe for the recipient to receive the additional activity. This statement of training is kept in the staff's personnel file.

Training for additional activities should be done only if the medication aide is expected to perform the task in the workplace. Once a medication aide has been trained on an activity, follow-up monitoring will be done by the LHCP to assure continued competence. The responsibility for the safety of the recipient and the accurate performance of the activity lies with the medication aide, the employer, and the LHCP who trains, supervises, and directs the activity.

To participate in monitoring, specific instructions from a LHCP need to be available for what the medication aide is to observe and report. Instructions should include timelines for observing and reporting and shall identify the person to be notified. An example may be that you notice a reddened area on a participant's heel. An LHCP may tell you to keep the area clean and keep pressure off the heel for the next 2 days. The LHCP may then advise that if there is no improvement or if you notice an increase in redness or a blister develops, to report this to the physician.

To provide a PRN (as needed) medication, the medication aide should be given specific directions that list the reason the medication is to be given, how often it can be given, results to expect after receiving it, and to whom to report observations. This will be discussed more fully under the heading PRN medications.

9. Having an Awareness of Abuse and Neglect Reporting Requirements

You must identify the occurrences of possible abuse or neglect of a vulnerable adult/child. You must report this information to the appropriate person/agency as required by the Adult/Child Protective Services Act.

10. Complying with Every Recipient's Right to be Free of Physical and Verbal Abuse, Neglect, and Misappropriation or Misuse of Property

You must not misuse the participant's property or cause physical harm, pain, or mental anguish.

Treating people with dignity and respect requires that they be are from abuse and neglect. As part of ABLED, Inc. you are required to comply with the Nebraska law regarding the reporting of abuse/neglect of vulnerable people.

a. Reporting Abuse/Neglect

Any person who observes abuse/neglect or has reasonable cause to believe that it has occurred must either report or cause a report to be made to the Nebraska office of either Adult Protective Services (APS) or Child Protective Services (CPS).

Reporting may be done by any ABLED, Inc. subcontractor or employee or the ABLED Executive Team. If a subcontractor or employee makes any direct report to an outside agency, the subcontractor or employee must also notify the ABLED Executive Team. Knowledge of abuse or neglect that is not reported is a criminal offense according to Nebraska statute. If a person is in immediate danger, law enforcement should be contacted immediately. To report suspected abuse or neglect, call The Abuse/Neglect Hotline 1-800-652-1999.

b. Abuse

Abuse is defined as any knowing, intentioned, or negligent act or omission which results in physical injury, unreasonable confinement, cruel punishment, sexual abuse, exploitation, or denial of needed services to a vulnerable participant. This definition now includes self-abuse by the participant.

Some examples of abuse:

1. Physical: hitting, slapping, pushing, hair pulling, kicking, overmedicating, withholding personal care, medical care or food, pulling someone out of bed, keeping a participant awake, driving recklessly, forcing the participant to eat, drink or take medications and unreasonable confinement.

2. Sexual: verbal harassment, unwanted sexual touching, unwanted display of sexual parts, exposure to pornography, tricking or manipulation into sexual activity, sexual assault and rape or any sexual relationship between staff and participant supported.
3. Psychological: denial of right to make a decision, threats to harm the participant or his/her pets or their property, isolating the participant from family and/or friends, humiliation, to cause fears and isolation.
4. Exploitation: misuse or theft of financial resources, taking of money, taking of personal property, failure to pay the participant a legal wage for work performed or the unauthorized use of digital social media.
5. Denial of essential services: not protecting a participant from abuse, failure to provide sufficient food and clothing, inadequate supervision, failure to intervene to protect someone, failure to utilize available adaptive devices (e.g., hearing aids, communication equipment, wheelchairs, etc.) and/or repair such devices.
6. Verbal: making demeaning remarks, making fun of, treating in a patronizing way, threats to deny essential services, swearing, talking baby talk to participants, name calling – telling them they are stupid, worthless, a moron, dumb, bad.

c. Neglect

Neglect occurs when someone is negligent or omits or fails to provide a needed service to a vulnerable participant. This may include denial of food, clothing, shelter, not working assigned hours, withholding medications or necessary treatments, leaving a participant in one position, on the toilet for an extended period of time or in soiled clothing for long periods of time, extended ignoring, inadequate supervision.

d. Ten Performance Standards to Prevent Abuse

1. Speak to all people politely, as you would like to be spoken to.
2. Include people in conversations; speak with them, not about them.
3. Use positive verbal and non-verbal communication; avoid being negative.
4. Give explanations so that people can understand. Observe how they receive the information.
5. Encourage people to participate by asking questions rather than giving commands.
6. Teach people to do as much as possible for themselves rather than doing for them.
7. Include people in decision making by providing them information and encouraging the participant's choice. Do not be bossy.
8. Respect differences and personal desires, needs, and values.
9. Respect the participant's right to say no.
10. If involved in a disagreement, listen to each other's point of view, if upset, DO NOT allow it to affect your behavior.

E. MEDICATION PACKAGING

Medications given throughout ABLED, Inc. may be in several types of packaging.

Pill bottle

- The medication aide removes the correct amount of medication from the bottle and returns the bottle to the

storage area.

- Medications are poured into the lid of the container and then into a med cup or a gloved hand.
- A clean counting tray or a clean saucer and knife are used to count the inventory.

Blister Pack (e.g., Bubble Pack, Med Cup Packaging)

- The pharmacist packages medications for each participant dose in a blister on a card.
- Medications are removed from the packaging by pressing it through the foil on the back side of the packet.
- The day's date corresponds to the number printed next to the medication blister. The first day of the month starts a new blister packet and the tablet/capsule in the #1 blister is administered.
- If a medication is ordered three times a day (tid), there will be a separate blister packet for each administration time.
- Inventory is easy in that you count all medications remaining in the blister packets.

Cassette

- A 3X4 inch plastic container with individual sections for holding tablet/capsule. The top of the cassette is clear and slides open to expose one section at a time.
- The cassette may either be marked with days of the week (Mon., Tues., Wed., etc.) or the day's date (1, 2, 3, etc.).
- After the top is slid open, the medication can be poured into a med cup or a gloved hand.
- Inventory is easy since you can see at a glance how many tablets/capsules are left in the cassette.

F. MEDICATION ADMINISTRATION ROUTES

Administration by the Oral Route

The oral (by mouth) route is the most frequently used method of medication administration. When giving a medication orally, have the recipient in an upright position. Have a glass of water available and encourage a drink prior to and after giving the medication.

a. Tablet or capsule

- Wash your hands. Wear gloves if you will be touching the medication.
- Read label as you remove medication from the locked storage container.
- Check label on medication against the med record. Review any special instructions.
- Place the prescribed amount of medicine in a med cup.
- Offer recipient a drink of water.
- Ask the recipient to place tablet/capsule on the back of their tongue and swallow with a mouthful of water.
- Observe the recipient taking the medication. Do not leave the medication with the participant to take at a later time. Do not leave the medication unattended. A medication cup left at the dinner table may be missed,

contaminated, or taken by the wrong participant.

- Document administration of the medication immediately after it has been administered.
- Inventory according to ABLED, Inc. policy.

NOTE:

1. Capsules should be swallowed whole. Check the medication information sheet or call the pharmacist to determine if a capsule can be opened or dissolved. If a participant is unable to swallow a capsule whole, open capsule with a gloved hand and put contents on a spoonful of applesauce, yogurt, etc. Make notation on med record under “Special Instructions” if medication is to be crushed and place in a bite of applesauce, yogurt, etc.
2. Tablets that are scored can typically be broken in half for ease in administration. If a half tablet is ordered, the pharmacy will be responsible for splitting the tablet.
3. Children or participants with difficulty swallowing may need to have medication broken or crushed.
    - Large tablets may be broken in half with gloved hands.
    - Pill cutters are available for splitting pills.
    - Tablets can be crushed between two spoons and mixed with pudding, applesauce, etc.
    - Pill crushers are available at most pharmacies. A preferred crusher has the threads on the outside of the crusher. Wash the crusher daily.
    - If a participant is having trouble swallowing, always check their position. By repositioning, such as sitting upright or adjusting head position, the medication may be easier to swallow.
    - If a participant has a weak side, give meds on the stronger side of the face.
4. Besides crushing and mixing in food, other ideas for participants having difficulty swallowing medication include dissolving in liquid or placing in food (cookie, pudding, etc.). If these measures are used, make this notation under Special Instructions to better assist other staff in administering the medication.
5. Enteric coated means a tablet is coated so it does not dissolve until it reaches the intestine, thus protecting the stomach. An enteric coated tablet must be swallowed whole not broken or chewed.
6. Do not crush time-released tablets (medication name may be followed by initials such as SR- sustained release, CR-controlled release, or LA-long acting) as this affects its absorption.
7. Sublingual (SL)/Buccal medications
    - Sublingual (SL) and buccal medications are placed next to the mucous membrane in the mouth. The medication is absorbed through the mucous membrane into the bloodstream.
    - Sublingual medication may be dispensed in a darkened bottle (nitroglycerin) or packaged in an individual foil packet. Caution when opening these packets. The medication crumbles easily if pushed through the packet; it is preferable to peel the packet apart.
    - Sublingual medications are placed under the tongue. The participant should not eat or drink until the medication is completely dissolved.
    - Buccal medications are placed between the cheek and gums. The participant should not eat or drink until the medication is completely dissolved.

- Do not swallow sublingual or buccal medication.

b. Liquid form

This route is most preferred for children or participants having difficulty swallowing. Again, if the participant is having difficulty swallowing, reposition. It can also be helpful to put liquid medication in the side of the mouth to aid in swallowing.

1. Wash your hands.
2. Read label as you remove medication from the locked storage container.
3. Check label on medication against the med record. Review any special instructions
4. Place a paper towel down so you have a clean surface to work on. Remove lid and place top side down on the clean surface.
5. Measure the correct dosage. Liquid medication should be measured in a teaspoon or a calibrated medication cup. Put the med cup on a flat surface and bring your eye down to the cup to see exactly how much you are pouring. Protect the label with the palm of your hand and pour away from the label to prevent dripping onto the label and making it messy and difficult to read.
6. Administer medication and observe the participant swallowing medication.
7. Document administration immediately after medication has been given.
8. Inventory according to ABLED, Inc. policy.

NOTE:

1. Some liquids are suspensions and should be shaken first to mix.
2. Frequently liquid medication tastes bad so follow it with fruit juice or a favorite drink.
3. Syrups have a coating effect so avoid giving liquids immediately after giving syrup.
4. Never pour liquids back if you poured out too much, pour excess into another medication cup to be destroyed.
5. A syringe may be helpful for drawing up a specific dose e.g., 12cc.

Topical Application

Topical application is applying medication to the skin. Topical medication may be used to treat skin lesions, lubricate, or protect the skin. Most topical medications are not absorbed through the skin and their action is locally or to the skin. Some topical medications (e.g., Nitroglycerin) are absorbed through the skin for a systemic effect (action is throughout the whole body). Topical medications that have a systemic effect may be in the form of a patch.

a. Lotions, Creams, Ointments, and Gels

1. Wash your hands and apply gloves.
2. Read label as you remove medication from the locked storage container.
3. Check label on medication against the med record. Review any special instructions. The physician may write special instructions for the application of a topical medication, for example: apply sparingly and rub in well. These instructions are important because medication action depends on correct administration. The biggest problem with topical medication is that too much is applied. Small dabs are usually sufficient.

4. To avoid applying too much medication, put a small amount of topical medication to the back of gloved hand near your thumb. Then use your finger to apply dabs from this supply of topical medication. Topical medication may also be applied with gauze or a tongue blade.
5. Observe the skin. Look for open areas, redness, drainage, swelling, and note the color of the skin.
6. Document administration immediately after the medication has been applied.
7. Inventory according to ABLED, Inc. policy.

NOTE:

a. Lotions may be applied liberally and rub in easily. If the lotion is non-medicated it may be applied without gloves as the participant might appreciate the human touch.
b. Creams are white and rub in easily while ointments are clear, oily and absorb more slowly. Both should be applied sparingly.
c. If both a cream and ointment are ordered, apply the cream first.
d. If you need to apply a cream/ointment to several areas, use different fingers.
e. If you are applying a topical medication and the recipient cannot see you, tell them what you are doing.
f. Applying cream/ointment on a dressing then placing on a wound or tender area may be more comfortable for the recipient.

Patches (Transdermal Medication)

1. Wash your hands. Apply gloves. Gloves will prevent the medication from being absorbed into your skin.
2. Read label as you remove medication from the locked storage container.
3. Check label on medication against the medication record. Review any special instructions.
4. Open patch and use the packaging as a clean surface to work on. On the non-sticky side of patch, write the date, time, and your initials.
5. Apply patch by removing the adhesive cover and placing the patch on a non-hairy spot of the skin and applying pressure to all the edges. Hold hand over the patch for 60 seconds to seal the patch. You may need to clip hair to ensure that the patch will stick. Do not place the patch in the exact same spot as it may be irritating to the skin. Different patches may require different placement, follow the physician's recommendation.

   Suggested sites:

Pain patches - chest, upper back, or upper arm

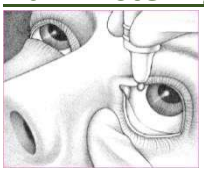
Hormone patches - lower abdomen or buttocks

Nitroglycerin patch – upper chest

Nicotine – upper arm

1. Document administration immediately after application.
2. Disposal: Use gloves to remove a used patch. Used skin patches should be folded on sticky sides together. Place it in a sealed container or designated disposal bag. Dispose of it in the trash according to local regulations or turn it into a pharmacy medication disposal bin.
3. Inventory according to ABLED, Inc. policy.

Administering Medication by Instillation or Inhalation



Instillation means applying medication directly into the eye, ear, or nose.

a. Eye Medication Instillation

Eye medication may be used to lubricate the eye, to treat medical conditions such as glaucoma, or oftentimes used to treat an infection such as pink eye (conjunctivitis).

Before administering eye medication (drops or ointment):

1. Read label as you remove medication from the locked storage container. Make sure the medication is marked “ophthalmic use only” (for the eye).
2. Check label on medication against med record. If the prescription label is on the box, keep the drops in the box. Review any special instructions.
3. Check for the expiration date. Observe solution for color changes or sediment, this may mean solution is decomposing. Do not use if it appears abnormal.
4. Double check to see which eye(s) gets the medication. OD = right eye, OS = left eye, OU = both eyes.
5. If the participant has discharge or crusting of the eye, make sure the eyelid and lashes are clean before administering the eye medication. Using gloves, moisten gauze/cotton ball with warm water. Place gauze/cotton ball on closed eye for a minute and gently wipe once from inner to outer eye. Discard after one wipe. Continue to moisten gauze/cotton ball and wipe eye until clean. If a washcloth is used to cleanse the eye, make sure different areas of the washcloth are used and the cloth is immediately put in the laundry. This will prevent cross-contamination.

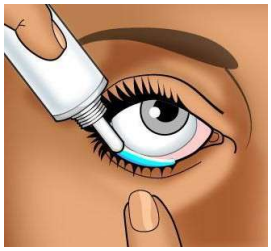
Instillation of Eye Drops:

1. Wash your hands. Apply gloves.
2. Have recipient sit or lie down and ask them to tilt head back and look upward.
3. Pull down the lower lid with your ring finger of your least dominant hand to form a pocket. This will prevent unnecessary pulling on delicate tissue.
4. Instill the prescribed number of drops in the pocket (usually 1 or 2). This feels better than putting drops directly on the eyeball.
5. Take care not to touch the eye with the dropper tip to prevent contamination of the dropper or injury to the eye.
6. Ask recipient to gently shut, not squeeze eye and then blink.
7. Use a clean tissue to remove excess fluid. Wash your hands.
8. If administering two different kinds of drops, wait at least 5 minutes between drops.
9. Document eye drop administration immediately after instillation.
10. Inventory according to ABLED, Inc. Policy.

NOTE:

If a participant is especially resistant to having drops placed in the eye, wash the closed eye with Baby Shampoo, rinse and let dry. Apply the drop(s) to the inner canthus (close to the nose) of the closed eye and ask the participant to open the eyelid allowing the drop(s) to fall into the eye.

Instillation of Eye Ointment:



1. Wash your hands. Apply gloves.
2. Have recipient sit down and ask them to tilt head back and look upward.
3. Pull down the lower lid with your ring finger of your least dominant hand to form a pocket. This will prevent unnecessary pulling on delicate tissue. Within this pocket, squeeze a small ribbon (1/4-1/2”) of ointment from the inner canthus (close to the nose) and move outward with a twist and pull movement to lay down the ointment.
4. Take care not to touch eye or eyelid with tip of the tube.

5. With eye closed, gently massage eye with a tissue to distribute over the eyeball.
6. Use a clean tissue to remove excess ointment. Wash your hands.
7. If applying two different kinds of ointments, wait at least 10 minutes between ointments.
8. If drops and ointment are ordered, instill drops first, wait 5 minutes, and then administer ointment.
9. Document eye ointment administration immediately after application.
10. Inventory according to ABLED, Inc. Policy.

NOTE:

If a participant is especially resistant to having ointment placed in the eye, wash the closed eye with Baby Shampoo, rinse and let dry. Apply the ointment to the base of the lashes of the upper eyelid of the closed eye and ask the participant to open the eyelid allowing the ointment to reach the eye.

b. Ear Medication Instillation

Ear drops may be used to treat infection, to relieve pressure and congestion, or to soften ear wax.

Instillation of Ear Drops:

1. Wash your hands.
2. Read label as you remove medication from the locked storage container
3. Check label on medication against the med record. Review any special instructions.
4. Drops are most comfortable when warmed to body temperature. This prevents dizziness and nausea. The best way to warm ear drops is to warm the bottle in the palm of the hand, let the medication sit out to room temperature or place in a glass of warm water. If the medication is a suspension (cloudy), shake the bottle well.
5. The recipient should lie down on their side with the ear to be treated facing up.
6. For an infant or child (See B below), gently pull up and out from center of outer ear. For an adult (See A below), gently pull top of the ear up and back. This will straighten the ear canal and ensure the drops will have their maximum effect.

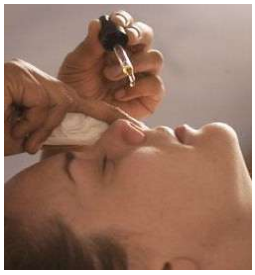
7. Draw up medication in the dropper and slowly place prescribed number of drops into the ear canal from one inch away. Do not touch the dropper to any surface.
8. Keep the recipient in the same position at least two minutes to allow drops to enter ear completely. You may loosely tuck a small piece of cotton ball in the ear.
9. If drops are ordered for the other ear, wait five to ten minutes before turning to the opposite side and then repeat procedure.
10. Wash your hands. Wipe tip of dropper off with a clean tissue.
11. Document administration of the medication immediately after it has been administered.
12. Inventory according to ABLED, Inc. policy.

c. Nasal Medication Instillation

Nasal medications are instilled by means of drops or spray. Drops are more often used for infants and young children. Nasal medications may be used for participants with allergies to relieve nasal congestion by shrinking swollen membranes.

Instillation of Nose Drops:

1. Wash your hands. Apply gloves.
2. Read label as you remove medication from the locked storage container.
3. Check label on medication against the med record. If the prescription label is on the box, keep the drops in the box. Review any special instructions.
4. Ask recipient to blow nose and then sit down with the head tipped back.
5. Draw medication up into the dropper. Tilt recipient's head slightly towards you and close the other nostril.
6. Ask recipient to breathe in and out of the mouth. Aim dropper upwards towards the eye as you instill the prescribed number of drops (usually 2-3) into each nostril. Take care not to touch the sides of the nose with the dropper to prevent contamination of the dropper.
7. Ask recipient to keep head tilted back for a few minutes after instillation of the drops. Do not sniff or medication will go down the back of the throat.
8. Document administration of the medication immediately after it has been administered.



Instillation of Nasal Spray:

1. Wash your hands.
2. Read label as you remove medication from the locked storage container.
3. Check label on medication against the med record. If the prescription label is on the box, keep the spray in the box. Review any special instructions.
4. Shake bottle gently and remove the cover. It is necessary to prime the pump into the air the first time it is used, or when the spray has not been used in a week or more. To prime the pump, press downward on the shoulders of the spray bottle. Press down and release several times into the air until a fine spray appears.
5. Ask recipient to blow nose and then sit down with the head tilted slightly forward.
6. Close one nostril. Keep bottle upright as you insert nasal applicator into the other nostril.
7. Ask recipient to breathe in through the nose and while breathing in, press down firmly and quickly once on the applicator's shoulder. Ask recipient to breathe out through the mouth. After spray, lean head backwards for a few seconds. Do not sniff or medication will go down the back of the throat.
8. If ordered, spray the nostril again then repeat procedure with the other nostril. Avoid blowing nose for 15

minutes after using spray.

9. Wipe applicator with a clean tissue and replace cover. Wash your hands.
10. Document administration of the medication immediately after it has been administered.

d. Administration of Medication by Inhalation

Administration of medications by inhalation includes inhalers, nebulizer, and oxygen therapy.

Use of Metered Dose Inhaler

Metered dose inhalers (MDIs) are used to treat asthma or other lung diseases. The inhaler delivers medication directly to the lungs, where it can be absorbed quickly and completely at the site where it is needed. MDIs are designed to deliver an exact amount, or metered dose, to the lungs each time they are used. A metered dose inhaler can be used alone, or it may be attached to a spacer device before inhaling. Incorrect administration means the medication is wasted and the participant may not benefit from the medication.

1. Wash your hands.
2. Read label as you remove medication from the locked storage container.
3. Check label on inhaler against the med record. If the prescription label is on the box, keep the inhaler in the box. Review any special instructions.
4. Shake the inhaler well. Remove the cap from the mouthpiece. Make sure the metal canister is fully inserted into the actuator (colored plastic inhaler).
5. Instruct recipient to breathe out fully through the mouth, expelling as much air from the lungs as possible. Place the mouthpiece fully into the mouth, holding the inhaler in an upright position and closing the lips around it.

6. While the recipient is breathing in deeply and slowly through the mouth, fully depress the top of the metal canister with your index finger.
7. Instruct recipient to hold his/her breath for 10 seconds and then exhale slowly.
8. Wait one minute to repeat if more than one puff is ordered.
9. Document administration of the medication immediately after it has been administered.

NOTE:

If the inhaler contains a cortisone medication, the mouth should be rinsed out with water, without swallowing, after inhaling the dose. This will prevent thrush, a yeast infection of the mouth that is common with inhaled cortisone.

Spacing Devices Used with Inhaler

A spacing device attached to the inhaler can be helpful for children and participants having trouble coordinating the pressing of the inhaler with the breathing-in motion. A spacer is actually a holding chamber that is attached to the inhaler. When the inhaler is pushed, the medication first goes into the spacer, and then inhaled into the mouth. The spacer helps to direct the medication past the tongue and back of the throat directly to the trachea and down into the lungs.

Use of Diskus

Another way to deliver asthma medication is with a diskus.

1. Wash your hands.
2. Read label as you remove medication from the locked storage container.
3. Check label on diskus against the med record. If the prescription label is on the box, keep the diskus in the box. Review any special instructions.
4. Hold the diskus in one hand and put the thumb of your other hand on the thumb grip. Push your thumb away from you as far as it will go, until the mouthpiece appears and snaps into position.
5. Hold the diskus in a level position. Slide the lever away from you as far as it will go, until it clicks. The diskus is now ready for use. Every time the lever is pushed back, a dose is ready to be inhaled. This is shown by a decrease in numbers on the dose counter.
6. Tell the recipient to breathe out fully through the mouth. Never breathe out into the diskus.
7. Put the mouthpiece to the lips. Instruct the recipient to breathe in quickly and deeply through the diskus, not through the nose.
8. Remove the diskus from the mouth and ask participant to hold their breath for 10 seconds. Breathe out slowly.
9. Document the administration of the medication immediately after it has been administered.

NOTE:

The mouth should be rinsed out with water, without swallowing, after inhaling the dose. This will prevent thrush, a yeast infection of the mouth that is common with inhaled cortisone.

Use of a HandiHaler

A way to deliver Spiriva, a medication for COPD (chronic obstructive pulmonary disease), is with a HandiHaler.

1. Wash your hands and apply gloves.
2. Read label as you remove medication from the locked storage container.
3. Check label against the medication record. If the prescription label is on the box, keep the Handihaler in the box. Review any special instructions.
4. Open dust cap by pulling upwards. Then open the mouthpiece.
5. Immediately before use, remove a Spiriva capsule from the blister and place it in the chamber. Use a gloved hand if you need to touch the capsule.
6. Close mouthpiece firmly until you hear a click, leaving the dust cap open.
7. Hold the HandiHaler with the mouthpiece upwards and press the green button completely in once, and release. This makes holes in the capsule and allows the medication to be released when breathed in.
8. Ask the participant to breathe out completely. Important: Avoid breathing in mouthpiece at any time.

9. Raise the HandiHaler to the participant's mouth and have them close lips tightly around the mouthpiece. Have participant keep their head in upright position and have them breathe in slowly and deeply but at a rate sufficient to hear the capsule vibrate. Ask the participant to breathe until their lungs are full and then hold breath as long as comfortable and at the same time take the HandiHaler out of the mouth.
10. Open the mouthpiece again. Tip out the used capsule and dispose in the trash. Close the mouthpiece and dust cap for storage.
11. Document the administration of the medication immediately after it has been administered.

Use of a PulmoMate Nebulizer

A nebulizer may be used to relieve bronchial spasms, reduce swelling in the bronchial tract and help thin mucous and secretions. The nebulizer directs air under pressure through a solution of drug, producing a mist for inhalation. Nebulizers produce a continuous mist, so the participant does not have to coordinate breathing with the action of the nebulizer. Proper usage of the nebulizer is necessary so that the drug can reach the airways.

1. Wash your hands.
2. Read label as you remove medication from the locked storage container.
3. Check label on medication against the med record. If the prescription label is on the box, keep the medication in the box. Review any special instructions.
4. Place PulmoMate on a level surface. A towel placed under the nebulizer will prevent it from "walking off" the counter. With switch off, plug into outlet.
5. Connect one end of tubing to the air-outlet connector.
6. Unscrew cap on nebulizer chamber and add prescribed medication through a dropper or a premeasured dose container (prefill). Place the cap on the chamber and turn clockwise until snug.
7. Assemble mouthpiece and insert into the top of the nebulizer cap. If using an aerosol mask, insert the bottom part of the mask directly into the top of the nebulizer cap.
8. Attach tubing to air-inlet connector at bottom of the nebulizer chamber. Turn switch on to start the compressor. Check to see if there is adequate misting.
9. Place mouthpiece in the mouth and instruct participant to breathe in and out of mouth normally. The participant may take a deeper breath every so often. If using an aerosol mask, place mask over nose and mouth. The treatment may last 10-20 minutes until no mist can be seen. At this time, turn the machine off, tap the reservoir and continue the treatment but note that a small amount of medication may remain.
10. Encourage participant to cough and spit out mucous and secretions.
11. Document administration of medication immediately after it has been administered.
12. Inventory according to ABLED, Inc. policy.
13. To clean, disassemble mouthpiece from cap, open chamber and remove baffle. Wash all items except tubing, in hot water/mild fragrance-free dish detergent and allow to air dry. The tubing does not have to be washed because only filtered air passes through it. The reusable nebulizer is dishwasher safe and may be reused for up to one year.

14. The filter should be changed every 6 months or sooner if filter turns completely gray. Remove filter cap by grasping it firmly and pulling out the unit. Remove the dirty filter and discard. Replace with a new filter and push filter cap back into position.

Oxygen Administration

All the cells of the body need oxygen. Too little oxygen makes a person feel short of breath or his/her skin may take on a bluish color (cyanosis), especially the tip of the nose, ear, lips, fingers, or toes. This lack of oxygen can damage tissues, especially those in the brain. A participant who requires oxygen may be suffering from a respiratory, blood, or heart disease. Because of this, oxygen is considered a medication. The vendor who supplies the oxygen tank or oxygen concentrator will assist in the setup of the unit and instruct on filling any needed portable tanks.

Some tanks will make a "clicking" sound when a participant breathes in. This is normal and means the tank is delivering oxygen only when the participant is taking a breath therefore oxygen is not being wasted into the air.

a. Oxygen Tank

1. Wash your hands.
2. Check oxygen order on medical contact form. Oxygen is a prescribed drug. Never adjust or change the flow without a physician's order. Recheck flow rate.
3. Place oxygen cylinder or portable tank in upright position. Check indicator to determine amount of oxygen in tank.
4. Slowly turn hand knob on cylinder clockwise to crank tank open for a brief second to clear opening of tank, then close.
5. Humidification may be used to improve comfort for the participant. If ordered, fill humidifier with sterile distilled water and attach to flow meter.

b. Nasal Cannula

1. Adjust flow of oxygen as ordered by the physician. The flow is usually set at 6 liters per minute or less.
2. Place tips of cannula in participant's nostrils with the tips pointing toward the face. Hook cannula tubing behind participant's ears and under the chin. Slide the adjuster upwards under the chin to secure the tubing. Check for pressure around the ear as it can cause skin breakdown. If needed, pad the tubing, or adjust elastic around the head to take the pressure off and improve the comfort.
3. Oxygen administration is documented on the medication record, and participant may have specific charting for when and how long oxygen was used.

c. Mask

1. Turn on oxygen flow to liters prescribed. The flow is usually set at 5-10 liters per minute.
2. Place participant in upright or semi-upright position.
3. Place mask over recipient's nose, mouth, and chin. Mold flexible metal edge to the bridge of the nose.
4. Adjust elastic band around the head to hold the mask firmly but comfortably over cheeks, chin, and bridge of nose. Check that there are no areas of pressure that could cause skin breakdown and adjust accordingly.
5. Oxygen administration is documented on the medication record, and participant may have specific charting for when and how long oxygen was used.
6. Turn off when not in use.

d. Oxygen Concentrator

An oxygen concentrator is an electrically operated device that draws in room air; strains the air of other gases, then delivers concentrated oxygen.

1. Wash your hands.
2. Check oxygen order on medical contact form. Oxygen is a prescribed drug. Never increase without a physician's order. A standby oxygen tank may be ordered in case of a power failure.
3. If recommended, fill humidifier bottle with sterile distilled water. Attach humidifier bottle.
4. Press the ON/OFF switch to ON position. An alarm may sound until the proper pressure is reached.
5. Adjust the oxygen flow rate by turning the liter control knob until the flow is at the prescribed number.

Nasal Cannula

1. Adjust flow of oxygen as ordered by the physician. The flow is usually set at 6 liters per minute or less.
2. Place tips of cannula in participant's nostrils with the tips pointing toward the face.
3. Hook cannula tubing behind participant's ears and under the chin.
4. Slide the adjuster upwards under the chin to secure the tubing.
5. Check for pressure around the ear and pad tubing for comfort as needed.

Mask

1. Turn on oxygen flow to liters prescribed. The flow is usually set at 5-10 liters per minute.
2. Place participant in upright or semi-upright position.
3. Place mask over recipient's nose, mouth, and chin. Mold flexible metal edge to the bridge of the nose.
4. Adjust elastic band around the head to hold the mask firmly but comfortably over cheeks, chin, and bridge of nose.
5. Oxygen administration is documented on the medication record, and participant may have specific charting for when and how long oxygen was used.

6. Turn off when not in use. May consider leaving the concentrator on if the participant prefers white noise.

There is an increased risk of fire with the presence of an oxygen tank. Oxygen tanks should not be near an open fire, lamp, or radiator. Do not smoke in the same room or near the oxygen tank. Keep a fire extinguisher nearby. Keep the tank upright in a secured position so it will not get accidentally knocked over.

G. MEDICATION DOCUMENTATION

Each participant supported to whom we administer medications will have his/her medication documented on their Medication Administration Record on Therap. The Medication Administration Record will list both active and historical medications. Therap should have a photo of the participant. This photo helps to identify the participant.

Therap Consultation Forms or Medical Contact Forms need to be completed for every visit to the doctor, eye doctor, hospital, medical clinic, dentist's office, etc. ABLED, Inc. uses special forms for annual physicals, dental exams, vision exams, and psychiatry appointments. You will need to take these forms to each respective appointment.

Medical Consent – all signed medical consent forms.

Misc. Health Tracking – may contain charts for blood pressure, weight, blood sugars, physical therapy reports, seizure records, bowel charts, etc.

Physician Orders

All prescription medications administered must have a physician's, physician's assistant's (PA) or Nurse Practitioner's (NP) order. Prescription medications cannot be administered without verbal or written physician's/PA's/NP's orders. Physician's/PA's/NP's orders are usually documented on a medical contact form or occasionally on the physical exam report. The person who typically takes a participant to a medical appointment is the residential staff or guardian. This person will act as the liaison person between the physician and ABLED, Inc., making sure that orders are clear and ensuring that physician's/PA's/NP's orders are received and passed on to the participant's residential and day services staff. If you take the participant to his/her appointment, then it is your responsibility to see that the orders are clear, and the residential and day services locations are notified of the physician's/PA's/NP's orders.

a. Medication Order Process

1. A medical provider (physician, physician's assistant, nurse practitioner) should send the order or medication changes to the pharmacy in order to be filled and added to the Medication Administration Record in Therap.
2. The provider should also clearly write the order or medication changes on a Therap generated Consultation Form or a Medical Contact Form as a cross reference.
3. At the medical appointment, the attending staff must check the order or medication changes for clarity and legibility.
4. It is important to repeat the order at the time of the contact to the medical provider to confirm it is understood. If you do not understand or have a question regarding an order or medication change, ask questions.
5. The attending staff notifies the residence and day service program of the new order. This notification may be by phone, email, text or placing information in an appropriate mail slot or log. Please ensure this is accomplished.

6. If you receive a written order, a copy of the written order should be reported to the pharmacy and ABLED, Inc. immediately in order to be entered into Therap.
7. Verbal orders are only allowed if given directly to ABLED, Inc.'s nurse. Verbal orders are outside the medication aide's scope of practice.
8. When the new medication is received, double check the contact form against the prescription label. Also, double check that it is listed correctly on the Medication Administration Record (MAR) in Therap. Do not give medication until the correct information can be determined.
9. If medication is not received within 24 hours after being ordered, check with the pharmacy. Also, if you receive a medication that you were not expecting, check with the pharmacy.
10. If you take someone to an appointment, be sure to obtain the Consultation Form or Medical Contact Form and notification of changes/instructions and turn it into the ABLED, Inc. office.
11. All staff serving the participant must be aware of the information on the medical contact form. As a Medication Aide, it is your responsibility to read contact forms and be aware of medication orders and changes.
12. The medical contact forms will be on file at the main office of ABLED, Inc. There must be a physician's order for every prescription medication or a contact form with medications listed and signed by the physician.
13. If a medication is discontinued, the medical provider (physician, physician's assistant, nurse practitioner) should contact the pharmacy in order to have the medication removed from the Medication Administration Record in Therap.

Right Documentation

When documenting, remember:

- A medication record is a legal document.
- Document only what is observed, not an interpretation or an opinion of what is observed.
- Document administration of medication immediately after the medication is given. Do not document prior to administration. Documentation means that you have already done it.
- Remember "The Five Rights of Medication Administration". *Right Documentation* has been called the "Sixth Right of Medication Administration".

Medication Administration Record

Medication Administration Records (MARs) are kept on Therap. In Therap, you will record for each day of the month whether the medications were administered.

a. Basic Information

Basic information includes:

- Month and Year
- Participant's Name
- Allergies – this can be found on the general medical information form.

- Pharmacy and its phone number – this information corresponds to the prescription label.
- Primary Physician and office phone number– this is usually a general practitioner or a family practice physician.

b. Administration Section of the Medication Administration Record

All of the information in the administration section is taken from the physician's orders and the prescription label. Do not copy this information from previous medication records.

Enter all medications in the Medication Administration Record tab for the participant in Therap. This is done by the ABLED Executive Team, the pharmacy, or a designated staff member.

1. Enter the right medication from the right prescription label. Enter the medication name as listed on the prescription label. If the generic name is on the prescription, enter the generic name so there is no confusion as to what the medication is. Sometimes the pharmacist will list the generic name followed by the brand name.
2. Prescriber – Enter the name and phone number on the line that says "Prescriber". The name and phone number will correspond to the name on the contact form and the prescription label.
3. Frequency – this information tells you the right dose and the right time.
4. Instruction/Comments – Instructs proper dosage, route, and time. May include additional comments as needed.
5. Medication Name – This is taken from the prescription label, not from a previous medication administration record.
6. Indication/Purpose – This describes the purpose for which the medication was prescribed. This information may be found on the medical contact form as the diagnosis. If you do not have this information, contact the ABLED Executive Team.
7. Scheduled Time Slot(s) – If a physician orders a medication at specific times (8 a.m. and 8 p.m.), these times must be listed. When a specific time is listed, medications must be administered within one hour, either way of that time. Any longer than this time frame is considered a medication error.

   If specific times are not ordered, use designated administration points. Designated administration points correspond to events in daily routines and reflect a participant's personal schedule. Events in daily routine, such as mealtimes, insure consistent administration of medications. Again, medications must be administered within one hour, either way, to the designated administration points. Any longer than this time frame is considered a medication error. An exception is a medication that must be given 30 minutes before (ac) or after (pc) a meal. These drugs should be given as close to the specified time as possible.

   Typically, a "daily", "once a day" or "one qd" medication is given at breakfast. Occasionally a medication may be ordered as "once a day at bedtime" or "one qhs" (hour of sleep).

   - BID (twice a day) is approximately 12 hours apart.
   - TID (three times a day) is approximately 6 hours apart.
   - QID (four times a day) is approximately 4 hours apart.

   If a participant eats breakfast at 6:00 a.m., lunch at 11:30 a.m. and dinner at 5:30 p.m. and goes to bed (H.S – hour of sleep) at 8:30 p.m.:

   - A BID medication would be given at breakfast and dinner.
   - A TID medication would be given at breakfast, lunch, and dinner.
   - A QID medication would be given at breakfast, lunch, dinner, and bedtime (H.S).

Occasionally a medication has to be given at an unusual time that does not correspond with a meal or bedtime. Setting the alarm on a cell phone or clock radio can help you remember to administer the medication.

If you realize that you forgot to administer a medication after the allowed one-hour time, call the pharmacist or Staff Nurse for instructions whether to go ahead and administer or hold medication as directed. This is a Med Error. Complete a General Event Report on Therap Services.

8. The Dates are shown numerically, 1-31 (for 31-day months) with the days of the week below. If a new medication is received on the 5th of the month, start documentation on that date.
9. After administering a medication, document this administration by entering your initials in the box that corresponds to the date and time given.
10. By default, Therap is in the "Quick mode" allowing you to just click the appropriate box that the medication was properly administered. If the medication was not properly administered, you will need to click on the "Detail mode". Then clicking on a scheduled time will open a pop-up box with a drop-down menu. From the menu you can select "Missed", "Refused", "LOA", or "On Hold".
11. Refused – if a participant refuses a medication, wait a little while and try again. At least three attempts should be tried before documenting. In the comment section of the pop-up box indicate the reason and complete a General Event Report on Therap Services. Contact a pharmacist or the Staff Nurse for recommendations regarding what to do, potential reactions to anticipate or recommendations for adjusting the next dose. A pattern of refusal should be brought to the attention of the ABLED Executive Team and may need to be reviewed by the ISP team.
12. LOA (Leave of Absence) – Select from the drop-down menu from the "Detail mode" when the participant is not present for that particular dose. Indicate the reason in the comment section. Possible reasons may include: at day services, visiting parents, or on vacation.
13. On Hold – Select "On Hold" from the drop-down menu of the "Detail mode" box if a medication is discontinued. The reason should be explained in the comment section. The medication aide should return the bubble pack to the pharmacy in order for the bubble pack to be repackaged or if they are able to correctly identify the medication, the discontinued medication may be pulled from the pack and stored in a zip-lock bag until it can be safely turned into the pharmacy for proper destruction.
14. Comments/Observations – It is imperative that staff record pertinent observations regarding the effectiveness of a medication and other related information. It is important to observe a participant carefully, especially the first few weeks after starting a new medication, for desired effects, adverse effects, and behavioral changes.

If a detailed explanation is required, use a General Event Report on Therap Services and/or a daily log format.

Inventory

Residential staff maintain control over the inventory of medications typically in a locked medication box or cabinet. Staff are responsible for working with the pharmacy to ensure adequate supplies of medication are maintained. If a participant is to remain on a prescription, staff should call or fax the pharmacy and order a refill as the supply gets low. Some pharmacies will automatically send a new supply when refills remain on a prescription. Refill information can be found on the pharmacy label.

Staff should reconcile medications to the Medication Administration Record after each refill or medication change to verify accuracy. In the event of a medication change, the best practice is for the medication aide to return the bubble

pack to the pharmacy in order for the bubble pack to be repackaged. The “MED & MAR CHECK” will be listed on the Medication Administration Record. It is not a medication, but an avenue to document reconciling medications to the Medication Administration Record. Staff should acknowledge a reconciliation was completed at least once every month by documenting “administered” on the Medication Administration Record under “MED & MAR CHECK” on the day it was completed. Suggested times are when receiving refills or repackaged medications.

In the event that a medication is discontinue and the medication aide is able to correctly identify the medication, the discontinued medication may be pulled from the pack and stored in a zip-lock bag until it can be safely turned into the pharmacy for proper destruction.

In the event that no expiration date is listed, write the date initially opened directly onto the medication package. Consider it expired one year after it was opened. If the expiration is in question, ABLED, Inc. recommends turning it in along with all other unused or expired PRNs into the pharmacy for proper destruction.

The Staff Nurse or designated staff will periodically review the supply of medications and address any concerns. Any discrepancy will be considered a medication error requiring a General Event Report on Therap Services.

PRN-Controlled Substances

1. The initial drug count for any PRN-controlled substance will be entered in Therap under “Drug Count” upon prescription.
2. Staff will be responsible for updating the drug count after each administration to ensure accuracy.
3. Daily controlled substances will continue to be reconciled under the MED & MAR CHECK and are not affected by the "Drug Count” feature.

Pill Planners

ABLED, Inc. does not recommend the use of pill planners. The best practice is to avoid taking medications out of the package with original labels.

Transfer of Medication

1. A transfer is defined as the movement of medication to a new location of administration.
2. Medications administered regularly at different locations (residence and day services) have separate medications and medication administration records at each location.
3. It is the responsibility of the staff person obtaining refills to let the pharmacist know that separate containers (bottles, cassettes, blister packs) are needed.
4. If separate containers cannot be procured (such as may occur with a short-term medication or eye drops), medications must be transferred from one facility to another in the original container and be in possession of a staff person at all times, do not place the medication in a participant’s lunch box or backpack. In this situation, a single medication administration record should be used and transferred with the medication.
5. Medications should never be transferred from one location to another on a daily basis as this increases the chance of missed administration or loss of medication.

Other Forms

1. Insulin Pen Administration Competency
2. Rectal Suppository/Rectal Gel Competency
3. Self Administration of Medication Competency
4. Emergency Anaphylaxis/EpiPen Injection Competency
5. Blood Glucose Monitoring Competency
6. Subcutaneous Injection Competency
7. VNS Training and Competency
8. Intermuscular Medication Competency
9. Gastric Feeding Tube Competency
10. Medical Contact Form
11. Caretaker Acknowledgment

General Event Report on Therap Services

1. All medication errors are documented by a General Event Report on Therap Services.
2. The medication error may be a discrepancy in the inventory, not documenting administration, or an incorrect administration of medication (wrong time, wrong dose, wrong person, wrong drug, wrong route, or a missed dose).
3. When completing a General Event Report on Therap Services use objective language such as “this recorder,” “he/she stated,” “it was observed.”
4. Be brief but descriptive. If a medication is missed, list the name of the medication and scheduled time of the medication.
5. To complete a General Event Report on Therap Services see ABLED, Inc.’s GER Policy. Also, medication errors should be reported to ABLED, Inc.’s LHCP.
6. Failure to document is a medication error requiring a GER. ABLED, Inc. and/or our Staff Nurse will review policy requirements with staff committing such medication errors.

Self-Administration

The mission of ABLED, Inc. is to provide desired training and supports that promote interdependence and relations within community and lessen reliance on ABLED, Inc. services. Medication administration is a great area in which to get participants involved in their own care. The goal is not necessarily for a participant to become self-administering but for that participant to be as involved in their own care as they are capable. Being aware of what a medication is for or what the color of one’s pill is very valuable information. Many medication errors have been thwarted by a participant saying this is not the medication they usually take.

a. State of Nebraska Self-Administration Requirements

A person must:

1. Be at least 19 years old of age.
2. Have cognitive capacity to make informed decisions about taking medication.

3. Be physically able to take or apply a dose of medication.
4. Have capability and capacity to take or apply a dose of medication according to specific directions for prescribed medications or according to a recommended protocol for non- prescribed medication.
5. Have capability and capacity to observe and take appropriate action regarding any desired effects, interactions, and contraindications associated with a dose of medication.

b. Determination of Self–Administration

A Self-Administration of Medication Assessment is a tool the team considers in determining if a participant can be considered self-administering. It is important to realize that participants and situations change which may make it necessary to reassess one's ability to self-administer.

c. Learning to Self-Administer

For participants who are learning to administer their own medications, staff monitoring must continue until it is clear that the participant can independently administer his/her own medication.

For any participant who is learning to self-medicate:

1. A medication administration record must be maintained.
2. Medications must be kept locked as described in "Medication Storage," unless addressed by the ISP team.
3. ISP team approved supports must be in place, which include procedures and safeguards concerning any deviation from the medication administration procedures.
4. Self-administration of medications means that the participant knows which medication to take, when to take it, how much to take, and requires no staff assistance in decision making.
5. When a participant completes a medication self-administration training program, follow-up monitoring must be done. During the first six months of independent self-administration, follow-ups must be regularly scheduled.

PRN Medications

PRN medications are those given not routinely, but "as needed." For example, a cough syrup is given if needed for a bad cough; a pain medication is given as needed for pain.

A participant may not receive a PRN medication unless it has been approved by a physician/PA/NP. The medication must be listed in the MAR in Therap.

1. Administration of PRN medications is considered an "Additional Activity" by the Medication Administration Act. To provide a PRN medication there must be specific criteria under which a PRN medication may be given, and reporting requirements associated with each PRN medication.
2. The procedure for administering a PRN medication, whether prescribed or over the counter, is the same as with any other medication.
3. Document PRN over-the-counter (OTC) medication on the MAR in Therap.
4. With PRN medications, the administration schedule or dosage may vary "as needed" according to the physician's directions. Contact the prescribing physician if clarification is needed.
5. Before giving a PRN medication, check to see when it was last given. Be certain there has been enough time between each dose of medication.

6. The use of PRN medications is discouraged in ABLED, Inc. settings. If at all possible, a regular schedule of administration should be set by the physician.
7. The use of psychotropic medications as a PRN is regulated by DHHS Provider Bulletin No. 17-17. This Bulletin states that they must be prescribed by a doctor as an approved intervention, after all other interventions have not been successful. PRN medications cannot be utilized in advance of an event or behavior unless directed by the medical practitioner (e.g., seizure prevention)
8. Since a PRN medication may be used infrequently, be sure to check the medication's expiration date prior to administration. If no expiration date is listed, consider it expired one year after it is opened. If the expiration is in question, ABLED recommends turning it in along with all other unused or expired PRNs into the pharmacy for proper destruction.
9. Psychotropic PRNs may only be administered when prescribed, used for the purpose prescribed for, listed on the MAR and after all alternative and less restrictive methods of dealing with a behavior episode as documented in the ISP and BSP have been attempted. See *Provider Bulletin No. 17-17.* Follow these steps when administering a psychotropic PRN.
    1. Document administration on the MAR and report effectiveness in a follow-up comment.
    2. Immediately notify ABLED, Inc., the Service Coordinator, and the Guardian all by phone.
    3. Submit a GER within 24 hours with event type "Psychotropic PRN Use". List all three notifications (Administrator, Case Manager, and Family/Guardian).

Over-the-Counter Medication (OTC)

a. Non-Prescription Medication Authorization/Nursing recommendations

A participant may not receive a PRN non-prescription /over-the counter (OTC) medication unless it has been approved by a physician/PA /NP. The Non-Prescription Medication must be listed in the MAR in Therap.

If a participant receives a PRN non-prescription/OTC medication on a fairly frequent basis, the ABLED, Inc. Staff Nurse can write nursing recommendations which give specific indications and directions that will give the medication aide approval to administer the medication. These specific indications and directions include clear description of when medication may be given, a specific dosage of medication to be given, and instructions of what to do if medication is ineffective (i.e., repeat administration after a specific time period, contact ABLED, Inc. Staff Nurse or call physician).

If you are concerned that a participant might need an OTC medication, (complaining of a headache, slight cough, itchy rash) check the MAR for approved OTC medication. Check to see if there is a nursing recommendation that would allow you to administer an OTC medication. If not, contact ABLED, Inc. Staff Nurse or LHCP for approval prior to giving the medication.

b. Prescribed Over-the-Counter Medications

A physician/PA/NP may prescribe an OTC medication at a specified dosage and administration schedule. For example, one baby aspirin daily for heart health. In this situation, the pharmacy will dispense the baby aspirin with a prescription label, and you will document and inventory the baby aspirin on the medication administration record (MAR) as you would any prescribed medication.

c. Recommended Daily Over-the-Counter Medication

A physician/PA/NP may recommend an over-the-counter medication to be given on a regular basis but advises you to

pick up an OTC supply. An example may be to take one multi-vitamin daily. To ensure daily administration, document the administration on the MAR.

Medication Administration Task Analysis

1. Do not set up medications in advance.
2. Do not multitask while administering medications. Your attention needs to be focused on correct and accurate medication administration.
3. Do not attempt to administer medications to more than one participant at a time.
4. Wash your hands. Gloves may be worn if appropriate for the situation.
5. Read the prescription label as you remove the medication from the properly locked storage container.
6. Make sure you have the right medication. Compare the prescription label with the MAR or the physician's contact form. Double check that this information agrees. If they do not agree, contact the physician's office and/or the pharmacy. If they do agree, continue with the next step.
7. Review any special instructions listed on the MAR.
8. Carefully measure or count the correct dosage and compare the amount with the pharmacy label. Double check to see that you have the right dose.
9. Check and double check that you have the right time. Check the MAR to see if the medication has already been given to avoid double dosing.
10. Check and double check that you have the right route.
11. Provide the medication to the participant.
12. Make sure you have the right participant.
13. Observe the participant taking the medication.
14. Do not leave the medication unattended at the table or with the participant for them to take later.
15. Your careful observation of the Five Rights of Medication Administration is of the utmost importance to the safety of the participants you support.
16. After administration of the medication, immediately document (right documentation) that the medication has been given on the MAR.
17. Track inventory according to ABLED, Inc. policy.
18. Secure medication in a locked storage container.

Medication Errors

Medication administration errors may include:

1. Giving a participant the wrong medication.
2. Giving a medication to the wrong participant.
3. Administering at the wrong time (greater than one hour before or after the scheduled time).
4. Administering the wrong dose.
5. Administering a medication by the wrong route.

6. Forgetting to administer a medication.
7. Administer a medication without a physician's order.
8. Administer a PRN medication without appropriate approval.
9. Incorrect documentation – discrepancy in count or inventory, not documenting administration of a medication and documenting a medication was given when it was not.

Contact physician, pharmacist or Staff Nurse immediately concerning:

a. Any medical action to be taken.
b. Possible effects and significant symptoms that may occur.
c. Recommendations for adjusting the next scheduled medication dosage.

Contact emergency medical assistance immediately if error poses a dangerous situation (e.g., difficulty breathing or unconsciousness).

Contact the Staff Nurse or designated staff immediately. If you make or discover a medication error, you must write a General Event Report.

Medication Error Corrective Procedure

The following medication error corrective procedure is to be followed when medication errors are made by medication aides. These guidelines set a minimum standard. Further action will depend on the specific error, intent, and the impact on the participant served. If a person uses deliberate deception and tries to hide or cover up an error, it may result in termination.

a. Error made is a missed dose, wrong time, documentation, or inventory error:

1. After one error of this nature, the Staff Nurse or designated staff will counsel the medication aide.
2. After repeated errors of this nature, the medication aide will need to meet with ABLED, Inc.'s Staff Nurse for further evaluation of competency. Until this is completed, the staff person will not be allowed to administer medications. This may affect their current work schedule.

b. Error made is wrong person, wrong medication, wrong dose, or wrong route:

1. After one error of this nature, the Staff Nurse or designated staff will counsel the medication aide.
2. After a second error of this, the medication aide will need to meet with ABLED, Inc.'s Staff Nurse for further evaluation of competency. Until this is completed, the staff person will not be allowed to administer medications. This may affect their current work schedule.

The intent of this procedure is to ensure safe, accurate medication administration to participants served. We expect persons will learn from their errors, not continue to make them again and again. Often times a person who repeatedly makes medication errors is also making errors in other aspects of their job.

It will be at the discretion of the Staff Nurse if the medication aide may retake the Medication Administration Training more than two times for corrective action.

Direction and Monitoring

As a medication aide you are permitted to participate in the observation and reporting of desired effects, side effects

and interactions of medications with direction and monitoring provided by a licensed health care professional.

If you observe a physical symptom (e.g., rash, headache, nausea, etc.) or a behavior that is out of the usual context for the participant (e.g., aggressive behavior, confusion, extreme fatigue, etc.):

1. Contact 911 immediately if reaction causes a dangerous situation (e.g., difficulty breathing or unconsciousness).
2. Check medication information sheet to see if reaction may be related to the medication.
3. Notify the ABLED Executive Team the day of the observation – if reaction is severe, contact these persons after contacting 911.
4. The ABLED Executive Team may contact or ask you to notify the physician.
5. Follow physician's recommendations.
6. Complete a General Event Report on Therap Services.

Adverse Reaction

a. Side Effects

Generally speaking, medications have two effects: therapeutic effects and side effects. If you take an aspirin for a headache, the therapeutic or intended effect is relief from the pain of the headache. The side effect or unintended effect might be an upset stomach from the aspirin.

Along with its intended results, a drug may cause a number of unwanted side effects. These effects can happen when you start a new medication, decrease, or increase the dose of a medication, or when you stop using a medication.

Side effects can be unpleasant or potentially harmful. Since most medications are taken orally, gastrointestinal symptoms – loss of appetite, nausea, bloating, constipation, and diarrhea – account for a high percentage of reactions.

Gastrointestinal disturbances, headache, fatigue, vague muscle aches, malaise (general feeling of illness or discomfort) and a change in sleep patterns are usually considered mild reactions. However, these symptoms may not seem mild to the participant experiencing them.

Moderate reactions include the above symptoms when they become increasingly distressful or intolerable. Added to this list are reactions such as skin rash, visual disturbances, muscle tremors, difficulty in urinating (especially in elderly men) and changes in mood or mental functioning.

Mild and moderate reactions do not necessarily mean a medication will be discontinued. Sometimes the physician may adjust the dosage, frequency of administration, timing of doses, or order the use of other agents to relieve distress. An example would be recommending a stool softener if the medication causes constipation. Although relatively rare, some medications cause severe reactions that may be life-threatening. Examples include reactions that could cause a bleeding disorder or damage to the liver or kidneys. Because of your close interactions with participants supported, you may be the first one to recognize changes in a participant's condition. Be especially alert whenever a participant starts a new medication. This is particularly critical when a participant has difficulty communicating. Signs that a participant may be having problems with medication include:

- Sleepiness or drowsiness at unusual times.
- Change in appetite, thirst, or sleep patterns.
- Increase or unexpected decrease in usual challenging behaviors. These may include aggression, self-injury, yelling, crying or repetitive behaviors.

- Unusual behaviors for the participant. A change in his or her mood.
- Rashes, hives, signs of a "cold", discomfort or illness.

It is important to have a general idea of drug actions and possible side effects. The medication information sheets received from the pharmacy are your best resource for this information. You may contact the pharmacy for medication information sheets. Therap offers a drug look up link on the MAR as well. Another source to access medication information sheets is the web site Medline Plus (www.nlm.nih.gov/medlineplus/druginformation.html).

Each month you must document whether you noticed potential side effects or not on the MAR. "SIDE EFFECTS" will be listed on the MAR. It is not a medication, but an avenue to document whether potential side effects were noticed or not. Documenting as "administered" on the MAR under "SIDE EFFECTS" allows for comments which are reported to the Staff Nurse for monitoring.

b. Allergic Reactions

Some participants develop allergic reactions to a specific drug. An allergic reaction is actually a response of the immune system to a foreign chemical in the body, in this case the medication. A participant can develop an allergy to a medication at any time. This means even if a participant has taken a medicine before, he/she can still develop an allergic reaction to it. Mild to moderate allergic reactions may include skin rashes or eruptions, itching, fever, wheezing and swelling of the eyes, hands, and feet.

A life-threatening allergic reaction called anaphylaxis or anaphylactic shock causes difficulty in breathing, low blood pressure, and cyanosis (blue cast to the skin caused by lack of oxygen). Other symptoms may include: severe hives (raised itchy rash), swelling of the tongue and throat, abdominal pain, and diarrhea. This is a medical emergency and 911 must be called. A participant may have an EpiPen that is ordered to be administered immediately upon experiencing symptoms. This will help the participant keep an open airway until emergency personnel arrive. Administration of an EpiPen is an additional activity, and you will receive training by your ABLED, Inc. Staff Nurse if you work with this participant.

Participants with known severe allergic reactions should wear a Medic Alert bracelet.

c. Tardive Dyskinesia

Tardive dyskinesia is a drug-induced disorder of the nervous system with involuntary bizarre movements of the eyelids, jaw, lips, tongue, neck, and fingers. This syndrome of side effects is usually associated with long-term use (usually 1-2 years or more) of antipsychotic medication. The drugs most associated with tardive dyskinesia include Mellaril, Thorazine, Navane, Haldol, and Prolixin. These are old generation medications, and many have been replaced with medications causing less severe side effects. Reglan (metoclopramide) which is used to treat heartburn related to gastric reflux may also have this serious side effect, usually from long term usage.

Once it starts, the pattern of uncontrollable chewing, lip puckering and repetitive tongue protruding (fly- catching movement) may be irreversible. Again because of your close interaction with the participant, you may be the first person to note unusual changes in a participant's condition and your quick reaction is of utmost importance.

d. Staff Responsibilities Related to Adverse Reactions

1. All staff who administer medications must be familiar with the potential adverse reactions of the medications they are administering and know where this information can be found.
2. If potential adverse reactions are observed:
    1. Contact 911 immediately if reaction causes a dangerous situation (e.g., difficulty breathing or loss of consciousness).

2. Notify the ABLED Executive Team or ABLED, Inc.'s Staff Nurse the day of the observation – if reaction is severe, contact these persons after contacting 911.
3. The ABLED Executive Team may contact or ask you to notify the physician.
4. Follow physician's recommendations.
5. Complete a General Event Report on Therap Services.

3. Once the physician discontinues the medication, these uncomfortable symptoms usually start to subside. Over-the-counter medications may be offered if approved by the physician. Obtain appropriate authorization to administer. Comfort measures that may be helpful include:
   - Rash – Applying cool, wet towels to rash areas helps to reduce itching and warmth. An OTC antihistamine may reduce itching.
   - Nausea – Offer small sips of clear liquids. Allow rest and keep away from food odors. An OTC antacid may help to relieve the nausea.
   - Diarrhea – Offer clear liquids for 12-24 hours to slow movement of the bowel. Once diarrhea starts to subside, offer the BRATT diet (B = bananas, R = rice, A = applesauce, T= toast and T = tea). This diet helps to replace lost nutrients, give the stool form, and relieves cramping. An OTC anti-diarrhea med may slow the bowel and reduce cramping.
   - Constipation – Increase fluids and offer fruit juices. Offer high fiber foods – dried fruits, whole grain cereals and bread, fresh fruits, and vegetables. An OTC laxative may relieve constipation.
   - Headache, fatigue, malaise – Allow to rest. Offer OTC analgesic (Tylenol, Advil, aspirin).

Key Points to Remember

The following is a summary of key points you must remember in order to provide medications safely and accurately.

- You must have a physician/physician's assistant/nurse practitioner's order to give any medication including PRNs.
- If you do not understand an order or have questions, check it out.
- Wash hands prior to medication administration and between participants as needed.
- Do not give medications if the label is illegible.
- Do not touch medications with bare hands.
- Pour liquids at eye level. Also place the hand over the label while pouring to protect the label.
- Be respectful of the participant's right to be free of physical and verbal abuse.
- If you do not know the participant check their picture on Therap.
- Do not leave medications with a participant supported to take at a later time.
- Do not give a medication if the participant says it does not look like one that they usually take; check it out.
- Do not give medications past their expiration date.
- Watch for changes in medications such as color or consistency.
- Always lock the medication cabinet when leaving the area.
- Do not crush or chew sustained release, enteric coated, buccal, or sublingual medications.

- Document after administration of medication: documentation means you have already done it.
- Check when a PRN medication was last given before administering.
- Report and record refused and missed medications according to ABLED, Inc. policy.
- Report errors and complete General Event Reports according to ABLED, Inc. policy.
- If you administer the wrong medication to the wrong participant, contact physician or pharmacist first for medical guidance.
- Report and record possible reactions to medications.
- Report missing controlled substances to ABLED or the Staff Nurse immediately.
- Always practice the Five Rights of Medication Administration.

Medical Forms and Retention

All ABLED, Inc. medical forms included herein below. Upon completion these forms will be retained electronically for no less than six years in the main office.

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ABLED

PHILIPPIANS 4:13

BLOOD GLUCOSE MONITORING COMPETENCY

Name:	**Date:**
Indicate: ☐ **Baseline** ☐ **Re-Assessment**	**Evaluated by:**
Method of Assessment: *Indicate all that apply*	☐ Observation ☐ Demonstration ☐ Interview with staff ☐ Interview with family

	Yes	No	N/A
Demonstrates washing hands according to CDC guidelines			
Demonstrates/Verbalizes supplies needed (GC machine, lancets, needles, test strips, alcohol wipes, 2x2 gauze)			
Demonstrates/Verbalizes checking the expiration dates on test strips			
Demonstrates/Verbalizes understanding of operating glucose testing machine according to owner's manual (will vary depending on type of Glucose monitor)			
Demonstrates/Verbalizes proper cleaning of area prior to testing (alcohol swab and allows to air dry)			
Demonstrates/Verbalizes puncturing skin with lancet			
Demonstrates/Verbalizes wiping first drop of blood following puncture with 2x2 gauze			
Demonstrates/Verbalizes applying pressure to finger and allowing blood to collect at puncture site			
Demonstrates/Verbalizes proper blood collection to test strip according to owner manual			
Demonstrates/Verbalizes understanding of disposing needles in an approved sharps container			
Verbalizes understanding when to notify a LHCP if blood sugar at > 500 or < 60			
Verbalizes understanding S/S of Hypoglycemia (Confusion, dizziness, nausea, feeling shaky, irritable, sweating, pale, clammy, rapid HR, seizures, LOC)			
Verbalizes understanding immediate step to take if individual is showing S/S of a low blood sugar or blood glucose is less than 60 (Give 15g of carbohydrates then monitor and take BS again; if continues to stay low give another 15g of carbohydrates and test again in 15 min; if continues notify the physician)			
Verbalizes understanding foods that would equal 15g of carbohydrates (glucose tablet, sweet juice, candy or sugar lump)			
Verbalizes understanding S/S of Hyperglycemia (Increase thirst, increase urination, headaches, blurred vision, increase fatigue)			
Verbalizes understanding that will decrease high BS (exercise, drink water, decrease stress)			
Verbalizes understanding when to call 911 (if individual loses consciousness or BS >600)			
Demonstrates/Verbalizes understanding of proper documentation			

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INSULIN PEN ADMINISTRATION COMPETENCY

Name:	**Date:**
Indicate: ☐ **Baseline** ☐ **Re-Assessment**	**Evaluated by:**
Method of Assessment: *Indicate all that apply*	☐ Observation ☐ Interview with family ☐ Interview with staff ☐ Demonstration

	Yes	No	N/A
Verbalizes basic understanding of the medication administration			
Verbalizes understanding of S/S of hypoglycemia (Confusion, blurred vision, change in heart rate, fatigue, pale skin, anxiety, sweating and irritability)			
Verbalizes understanding when individual shows S/S of hypoglycemia or BS is below 70mg/dl (eat or drink 15g of carbohydrates such as orange juice or candy; recheck BS in 15 min if still below repeat 15g of carbohydrate and recheck BS in 15 min)			
Demonstrates/Verbalizes needed supplies (Alcohol wipes, medication, gloves & sharps container)			
Demonstrates/Verbalizes preparing a clean surface for equipment and medication			
Demonstrates/Verbalizes checking medication with the MAR (6 Rights)			
Demonstrates/Verbalizes checking the expiration date			
Demonstrates proper hand hygiene			
Demonstrates/Verbalizes proper PPE (gloves)			
Demonstrates removing insulin pen's cap			
Demonstrates wiping the pen tip with an alcohol wipe			
Demonstrates removing the protective seal from a new needle, screwing the needle in place			
Demonstrates dialing a dose of 2 units to prime the pen			
Demonstrates holding the pen with the needle pointing straight up and tap lightly so the bubble will rise to the top			
Demonstrates pressing the injection button all the way in and checking to see that the insulin comes out of the needle (if no insulin comes out repeat the priming steps)			
Recheck the order with the MAR			
Demonstrates checking the pen shows "0" then turns the dial until the number shows in the window that matches the MAR			
Rechecks the MAR to confirm the correct dose			
Demonstrates/verbalizes putting on gloves			
Demonstrates/Verbalizes cleaning injection site with an alcohol wipe and allowing it to dry			
Demonstrates/Verbalizes keeping the pen straight and inserting the needle into the skin. Using your thumb, press the injection button all the way down, when the number in the window returns to "0", slowly count to 10 before removing the needle			
Demonstrates/Verbalizes releasing the button and removing the needle from the skin			
Demonstrates/Verbalizes discarding needle away in a sharp's container			
Demonstrates/Verbalizes recording the insulin administration on the MAR			
Verbalizes understanding what symptoms to watch for and which require emergency care (911)			

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EMERGENCY ANAPHYLAXIS/EPIPEN INJECTION COMPETENCY

Name:	**Date:**
Indicate: ☐ **Baseline** ☐ **Re-Assessment**	**Evaluated By:**
Method of Assessment*: Indicate all that apply*	☐ Observation ☐ Demonstration ☐ Interview with staff ☐ Interview with family

	Yes	No	N/A
Understands what anaphylaxis is (Acute, potential life-threatening reaction to a substance in the body)			
Describes symptoms of anaphylaxis (light headedness, breathing difficulties (slow, fast or shallow) wheezing, clammy skin, confusion, loss of consciousness, blue lips)			
Verbalizes understanding the need for medical intervention (EpiPen, calling 911)			
Verbalizes understanding the importance of assessment and action during an anaphylaxis reaction			
Verbalizes where the EpiPen is stored at			
Verbalizes understanding to remove the individual away and/or out of suspected allergen (grass, bee, dust, spiders, medications, food, etc.)			
Verbalizes understanding to call for help (call 911)			
Verbalizes understanding and demonstrates how to use an EpiPen			
Verbalizes/demonstrates the steps to administering an EpiPen 1. Remove the EpiPen from the container tube 2. Hold the auto-injector in your fist with the orange tip pointing downward 3. With your other hand remove the safety release by pulling straight up without bending or twisting it 4. Using the upper leg (thigh) swing and push the auto-injector firmly until it “clicks” 5. Hold firmly in place for 3 seconds (count slowly) 6. Remove the auto-injector from the leg 7. Massage the injection area for 10 seconds 8. Call 911 for further evaluation			
Verbalizes understanding of the importance of knowing how to prepare EpiPen prior to administration in an emergency situation			
Verbalizes understanding the need to document the occurrence and who to notify			

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VNS TRAINING AND COMPETENCY

Name:	**Date:**
Indicate: ☐ **Baseline** ☐ **Re-Assessment**	**Evaluated by:**
Method of Assessment: *Indicate all that apply*	☐ Observation ☐ Demonstration ☐ Interview with staff ☐ Interview with family

	Yes	No	N/A
State the potential signs of a seizure: (Staring, jerking movement or uncontrolled muscle spasms, stiffening, LOC, breathing problems, loss of bowel or bladder control, falling suddenly, temporary confusion)			
Verbalizes understanding the first steps to do if an individual is having a seizure: (Give them room, place on the floor, clear area of hard or sharp objects, provide cushion for their head and NEVER HOLD THEM DOWN or RESTRAIN them.)			
Verbalizes understanding the why you need to be aware of how long the seizure is lasting: (When to use the VNS and when to call 911)			
Verbalizes understanding what a VNS is: Vagus Nerve Stimulation			
Verbalizes understanding when it's appropriate to use the VNS: (During a seizure)			
State where the magnet is currently located: (usually left side of chest)			
Verbalizes the location of implanted simulator			
Demonstrates or verbalizes understanding how to swipe the magnet across the implanted stimulator slowly (saying slowly one-one thousand, two) then remove the magnet from the chest			
Verbalizes understanding that you do not hold the magnet over the chest			
Verbalizes understand that you can use the VNS if the seizures return, up to 5 minutes			
Verbalizes understanding when to call 911 (if the seizure last longer than 5 minutes) or the individual is injured			
Verbalizes understanding once seizure has stopped place on side to help with breathing and potential aspiration			
Verbalizes the understanding where to find the indiviual safty plan and the importance to review it often			
Verbalizes understanding how to document seizure and action took and whom to notify			

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RECTAL SUPPOSITORY/RECTAL GEL COMPETENCY

Name:	**Date:**
Indicate: ☐ **Baseline** ☐ **Re-Assessment**	**Evaluated By:**
Method of Assessment*: Indicate all that apply*	☐ Observation ☐ Demonstration ☐ Interview with staff ☐ Interview with family

	Yes	No	N/A
Rectal Suppository			
Verbalizes basic understanding of the medication administrating			
Checks order per policy (6 Rights and Safety checks)			
Checks medicating for expiration date			
Demonstrates proper hand hygiene			
Verbalizes understands and/or uses proper PPE (gloves)			
Demonstrates proper explanation to the patient what they are going to do			
Verbalizes understands/Demonstrates proper patient position (On left side)			
Verbalizes understands in importance of patient privacy			
Verbalizes understand/Demonstrates proper insertion of suppository (Lubricating suppository, insert rounded end first, using index finger, insert 3-4)			
Demostrates/Verbalizes understands to wipe excess lubracate or stool off patient			
Verbolizes understand/Demostrates proper PPE disposal			
Verbolizes/Demostrates documentating administration on MAR			
Verbolizes understanding to document the patients response to the medication on the MAR			
Rectal Gel/Diazepam			
Diazepam (Makes the nerves in the brain less sensitive to stimulas causing a calming effect) Most common side effect are drowsiness, others are light-headedness and confusion			
Verbalizes basic understanding of the medication and why/when it should be administered			
Verbalizes understands proper storage /According to packaging			
Verbalized importance of checking dose with the MAR (At the time received from pharmacy and at the time of administration)			
Verbalizes understanding/Demostates proper prosition (on left side)			
Verbalizes understanding of rechecking dose on the administration tube			
Verbalizes understanding that the “Pin” is to be removed with the cap			
Verbalizes understanding/Demorstates how to lubricate the rectol tip			
Verbalizes understanding/Demostates to gently insert the syringe (tip should be firmly againt buttock)			
Verbalizes understanding/Demostrates slowly count to 3 while injecting gel			
Verbalizes understanding/Demostrates count slowly to 3, once gel is injected into the rectum (Before removing the applicator/tube)			
Verbalizes understanding/Demostrates removing applicator/tube			
Verbalizes understanding/Demostrates to hold buttock together for one more slow count to 3			
Verbalizes understanding/Demostrates Call 911 if indicates (Seizure does not stop or anything that appear life theating issues)			
Verbalizes understanding/Demostrates to remain with the patient			
Verbalizes understanding/Demostrates NOT to restrain while having a seizure			
Verbalizes understanding/Demostrates placing the patient on their side if possible (Keeps tongue from blocking airway, choking or aspriation)			

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SUBCUTANEOUS INJECTION COMPETENCY

Name:	**Date:**
Indicate: ☐ **Baseline** ☐ **Re-Assessment**	**Evaluated by:**
Method of Assessment: *Indicate all that apply*	☐ Observation ☐ Demonstration ☐ Interview with staff ☐ Interview with family

	Yes	No	N/A
Verbalizes basic understanding of the medication administrating			
Demonstrates/Verbalizes needed supplies (alcohol wipes, medication, gloves & sharps container)			
Demonstrates/Verbalizes preparing a clean surface for equipment and medication			
Demonstrates/Verbalizes checking medication with the MAR (6 Rights)			
Demonstrates/Verbalizes checking the expiration date			
Demonstrates proper hand hygiene			
Demonstrates/Verbalizes proper PPE (gloves)			
Demonstrates removing pen cap			
Demonstrates wiping the pen tip with an alcohol wipe			
Demonstrates removing the protective seal from a new needle, screw the needle in place			
Demonstrates dialing prep dose to prime the pen			
Demonstrates pressing the injection button all the way in and checking to see that the medication comes out of the needle			
Recheck the order with the MAR			
Demonstrates checking the pen shows “0” then turns the dial until the number shows in the window that matches the MAR			
Rechecks the MAR to confirm the correct dose			
Demonstrates/Verbalizes cleaning the injection site with an alcohol wipe and allowing it to dry			
Demonstrates/Verbalizes keeping the pen straight and inserting the needle into the skin. Using your thumb, press the injection button all the way down. When the number in the window returns to “0”, slowly count to “10” before removing the needle			
Demonstrates/Verbalizes release the button and remove the needle from the skin			
Demonstrates/Verbalizes discarding needle away in a sharp’s container			
Demonstrates/Verbalizes recording the medication administration on the MAR			
Verbalizes understanding what symptoms to watch for and which require emergency care (911)			

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INTERMUSCULAR MEDICATION COMPETENCY

Name:	Date:
Indicate: ☐ **Baseline** ☐ **Re-Assessment**	**Evaluated by**:
Method of Assessment*: Indicate all that appl*	☐ Observation ☐ Demonstration ☐ Interview with staff ☐ Interview with family

	Yes	No	N/A
Staff will demonstrate or verbalize the following steps for administering medication through an Intermuscular Injection (IM)			
Verify the Medication with the MAR (Name, dose, medication, route and time)			
Has a basic understanding of medication adverse reactions			
Check participant for any allergies to the medication you want to administer			
Gather supplies (Medication, needle, syringe, gloves and alcohol wipes)			
Wash hands using proper hand washing technique			
Draw the correct dose of medication according to the MAR			
Make sure the air bubbles are removed by lightly tapping on the syringe once the air bubbles are at the top of the syringe, slowly press up the plunger until a small drop of the medication appears			
Put on Gloves			
Recheck the dose to the MAR			
Select an administration site (upper arm/deltoid or outer one third of thigh)			
Assess the site for tenderness, wounds or any other abnormalities (do not inject into any abnormalities in the skin)			
Clean the skin with an alcohol wipe and allow the skin to dry			
Remove the needle cap			
Pull the skin Taut with the forefinger and the thumb on the nondominated hand			
Use a dart like movement, administer the injection at a 90-degree angle			
With your non dominate hand stabilize the syringe with our thumb and forefinger			
With you dominate hand to press the plunger and slowly inject the medication			
Withdraw the needle at the same angle it was inserted			
Apply light pressure, if needed and apply a bandage over the injection site			
Discard the needle and syringe in an approved receptacle			
CDC guideline video watched on the Intermuscular Injection			

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GASTRIC FEEDING TUBE COMPETENCY

Name:	**Date:**
Indicate: ☐ **Baseline** ☐ **Re-Assessment**	**Evaluated by**:
Method of Assessment*: Indicate all that apply*	☐ Observation ☐ Demonstration ☐ Interview with staff ☐ Interview with family

	Yes	No	N/A
Medication administration and general care of G-tube			
Verbalized understanding of what a G-Tube purpose. The anatomy/placement of G-Tube			
Verbalizes/Demonstrates proper handwashing			
Verbalizes understanding complications (dislodgment, infection, becomes non-patent, bleeding and leaking around site.)			
Verbalizes/Demonstrates supplies that are needed (medication, pill crusher, medication cup, water, 60cc syringe, and button extension set if needed)			
Demonstrates/Verbalizes understands: Observe stoma and skin around device for bleeding, skin breakdown, or leakage – notify a LHCP if any of the above stated signs are present			
Demonstrates/Verbalizes understands: Check for residual, by attaching syringe to tube/extension tube and lowering below stomach or pull back gently on the syringe. If stomach content to present; the tube is in its proper place and can be uses. If no content is present notify a LHCP Immediately			
Understed/Demonstrates that the individual should be placed in an upright position			
Verbalizes/Demonstrates using the 5 rights of the medication administration to the MAR when preparing the medications			
Verbalizes/Demonstrates preparing the medication 1) Crushing the medication into fine powder (If first time administering medication check with pharmacy to make sure it is ok to crush the medication) 2) Poor the crushed medication into a small about of water and let it dissolve 3) Medication should be mix into separate cup or syringes If liquid medication, draw up medication in its own syringe as prescribed			
Verbalizes/demonstrates proper medication administration 1) Clamp tube 2) If a g-tube is a button attach the external tube by inserting the locking end into the button and turn to the right until you feel it locking into place 3) Attach flushing syringe to the end of the feeding tube 4) Unclamp the tube 5) Flush the tube with water to check for patency (if water does not flow freely notified a LHCP and do not administer the medication) Give the dissolved medication (clamping the tube each time the syringe is removed)			
Verbalizes/demonstrates that each medication should be given by themselves and flushed with 10-20cc of water after each medication			
Verbalizes/demonstrates if a button tube was used, remove external tube by turning the tube to the left to unlock and removed.			
Verbalizes/Demonstrates proper medication administration documentation on the MAR			

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GASTRIC FEEDING TUBE COMPETENCY

Gastric Feeding Tube/Continues or Bolus Feedings	Yes	No	N/A
Equipment & Safety: Demonstrates/Verbalizes understanding of the following: • Checking the feeding orders and correctly performing the 5 rights for medication • Gather equipment: formula (room temp), syringe or gravity bag, pump feeding set, extension tubing and water (if ordered). • Maintains universal precautions throughout procedure: wash hands and apply gloves			
Check for Residuals: report any concerns.			
Feeding Preparation: Demonstrates/Verbalizes understanding of the following: • Clean top of formula container prior to opening • Attach extension tubing to feeding set/syringe • Close clamp on tubing. • Pour formula into feeding set/syringe • Open clamp and prime tubing. • Re-clamp			
G-button • Open button plug • Insert primed extension tubing with connected syringe/feeding set • Turn to lock into place **For Bolus/Gravity** • Pour formula into syringe until about ½ full • Unclamp tubing and allow to flow • Refer to Physician's Orders for length of feeding • Adjust flow by changing height of syringe • Continue to pour formula into bag/syringe until feeding is complete. **For Continuous/Pump** • Prime tubing as above • Place tubing in pump • Refer to feeding orders for length of feeding • Set rate/flow as ordered • Elevate the feeding above the level of the stomach. • Continue to pour formula into bag/syringe until feeding is complete.			
Verbalizes understanding: **Never** force solution through the tube. If tube is obstructed, DO NOT FEED and notify a LHCP			
Demonstrates/Verbalizes understanding: Vent g-button, if ordered, for abdominal distention/discomfort			
Demonstrates/Verbalizes understanding: The importance of flushing the G-tube with 15-30cc after every use to clear the G-tub from any debris.			
Demonstrates/Verbalizes understanding: Rinse equipment with warm water and allow to dry after each feeding. After last feeding of the day, discard feeding set and clean extension tube and syringe with warm water and dish soap. Rinse with water until clean. Air dry with ports open. Store appropriately.			
Demonstrates/Verbalizes understanding: Document feeding in Therap under Heath Tracking tab then Intake/Elimination tab			
Demonstrates/Verbalizes understanding: Encourage the individual to remain upright for 30 minutes after feeding			

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OSTOMY CARE COMPETENCY

Name:	**Date:**
Indicate: ☐ **Baseline** ☐ **Re-Assessment**	**Evaluated by**:
Method of Assessment*: Indicate all that apply*	☐ Observation ☐ Demonstration ☐ Interview with staff ☐ Interview with family

	Yes	No	N/A
Gather supplies: washcloth and warm water, stoma products/appliances per order/patient preference (wafer, bag, clip), gauze, pads, sizing measures, scissors, pen, nonsterile gloves, skin prep or other skin products per patient preference, and wastebasket.			
Demonstrate/Verbalize understanding the following steps:			
Wash their hand using proper technique			
Apply nonsterile gloves			
If mobile recommend to sit in the bathroom for easier access to supplies			
If in bed, expose the abdomen, consider individual privacy			
Apply drape/Chux under the individual or ostomy pouch			
Remove the pouch and empty it into the toilet			
Document output on Intake/Elimination under the Health Tracker tab			
Set the pouch aside in the basin or receptacle if at bedside			
Assess ostomy bag contents and remove current ostomy appliance			
Remove adhesive residue from the skin with adhesive remover wipes			
Clean the stoma and surrounding skin with clean wash cloth or gauze and room temperature tap water and pat dry			
Assess the condition of the stoma (stoma should be pink with no skin breakdown)			
Assess skin integrity around stoma (redness, sores, irritation, or signs of infection). Documenting skin integrity in the comment box in Intake/Elimination section under the Heath Tracking Tab			
Size the new appliance and cut according to appropriate size (make sure the hole in the new wafer is no than 1/8 inch of skin around the stoma should be exposed)			
Apply skin prep			
Remove the paper backing from the wafer and place it on the skin with the stoma centered in the cut out opening and press gently to the wafer to remove air/seal to the skin			
Apply pouch to wafer with clamp on pouch and opening is downward position			
Attach and close the pouch clamp			
Dispose of used supplies and wrapping			
Remove gloves and perform hand hygiene			
Document in the comment section Health Tracking under the Intake/Eliminating section the ostomy bag was changed and the condition/assessment of stoma and skin integrity around stoma site			

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OMNIPOD CONTINUOUS INSULIN DELIVERY COMPETENCY

Name:	**Date:**
Indicate: ☐ **Baseline** ☐ **Re-Assessment**	**Evaluated by:**
Method of Assessment*: Indicate all that apply*	☐ Observation ☐ Demonstration ☐ Interview with staff ☐ Interview with family

	Yes	No	N/A
Demonstrates/Verbalizes wash hand with soap and water before removing new pod and gather needed supplies			
Demonstrates/Verbalizes in activating the pod App			
Demonstrates/Verbalizes filling the Pod (removing the fill syringe and needle. Keeping the pod in its try during set up)			
Demonstrates/Verbalizes using alcohol prep swab to clean the top of the insulin vial			
Demonstrates/Verbalizes securely twist the fill needle onto the fill syringe			
Demonstrates/Verbalizes removing the protective cap from the needle			
Demonstrates/Verbalizes: • Fill syringe to desired amount of insulin by drawing air into the fill syringe equal to the amount of insulin you want. • Insert a needle into the vial of insulin and inject air, while the syringe is still in the vial, turn the vial and syringe upside down. Pull down on the plunger to withdraw insulin from the via land fill the syringe with the amount of insulin ordered. • With the needle still in the vial, tab or flick the syringe to dislodge any air bubbles to the top of the syringe. Then push in the plunger to expel any air bubbles out of the syringe and into the vial. Remove the needle from the vial.			
Demonstrates/Verbalizes • Leaving pod in its plastic tray. • Insert the needle straight down into the fill port. • Completely empty the syringe into the pod (the pod will beep twice, indicating the pod is ready to proceed.)			
Demonstrates/Verbalizes placing the controller next to the pod so they are touching and tap next			
Demonstrates/Verbalizes listening for the tone from the pod indicating the pod is activated and ready to be applied			
Demonstrates/Verbalizes: Change the Pod			
• Change pod when insulin is low or empty • Tap info on pod app • Tap view pod details • Tap change pot • Tap deactivate pod (pod will take a moment to deactivate			

	Yes	No	N/A
Demonstrates/Verbalizes: Connecting pod to Dexcom G6 • From the Omnipod app, select your sensor • Tap and confirm • Tap entry field within first box to begin entering transmitter SN • Tap Done and Save • Tap Confirm			
Verbalizes understanding of S/S of hyperglycemia or hypoglycemia and when intervention is required			
Verbalizes understanding this if the G6 does not appear to be working to do a manual glucose check			
Verbalizes understand of the safety plan			
Verbalizes understanding to use website (omnipod-5-patient-resource-guide.pdf) or the diabetes educator to help with trouble or guidline.			

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DEXCOM CONTINUOUS GLUCOSE MONITORING COMPETENCY

Name:	**Date:**
Indicate: ☐ **Baseline** ☐ **Re-Assessment**	**Evaluated by:**
Method of Assessment: *Indicate all that apply*	☐ Observation ☐ Demonstration ☐ Interview with staff ☐ Interview with family

	Yes	No	N/A
Verbalizes general understanding of the Dexcom G6 (Use and purpose)			
Demonstrates/Verbalized where to find help and ways to trouble shoot issues (Dexcom.com)			
Demonstrates/Verbalizes how to downloading app to smart phone or receiver and how to use app: • Receiver: Press and hold the button for 2 sec • Follow onscreen instructions to enter • Low high alerts • Sensor Code • Transmitter Serial number (SN)			
Demonstrates/Verbalizes to gather materials (Applicator, transmitter and alcohol wipes)			
Demonstrates/Verbalized how to pick sensor site (avoiding bones, muscle, irritated skin, tattoos, bumps) •Remediations stomach and back of upper arms			
Demonstrates/Verbalizes How to clean sensor site with alcohol			
Demonstrates/Verbalizes how to peel applicators adhesive backings (both of them)			
Demonstrates/Verbalizes placing the applicator adhesive on the skin			
Demonstrates/Verbalizes folding and breaking off safety guard on applicator			
Demonstrates/ Verbalizes pressing button on applicator to insert sensor			
Demonstrates/Verbalizes removing applicator and discarding			
Demonstrates/Verbalizes cleaning transmitter with an alcohol wipe			
Demonstrates/Verbalizes inserting transmitter (tab first) into the holder, click transmitter into place (flush with the holder)			
Demonstrates/ Verbalizes rubbing around patch 3 time			
Demonstrates/Verbalizes how to pain a new sensor			

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SELF-ADMINISTRATION OF MEDICATION COMPETENCY

Name:	**Date:**
Indicate: ☐ **Baseline** ☐ **Re-Assessment**	**Evaluated by:**
Method of Assessment: *Indicate all that apply:*	☐ Observation ☐ Interview with participant ☐ Interview with staff ☐ Interview with family

				Yes	No	N/A
Knows names of all the medications s/he takes? *If "no" check one of the following:*	☐Knows name of some of the medications taken ☐Knows none of the names of medications taken					
Reads medication label?						
Identifies medication? *Check all that apply for "yes" answered:*	☐Color	☐Sight	☐Quantity needed *(can count to at least 6)*			
Knows the reason each medication is taken? *If "no" check one of the following:*	☐Knows the reason for some of the medications taken ☐Does not know the reason for any medications taken					
Knows major side effects which may occur for all medication taken? *If "no" check one of the following:*	☐Knows some of the potential side effects ☐Does not know any of the potential side effects					
Knows who to notify when s/he notices/suspects a medication side effect? *If "yes" indicate who, when, how:*	Who: When: How:					
Knows how to notify appropriate person of new medications and/or changes? *If "yes" indicate how:*	How:					
Knows how to notify staff if medication is omitted? *If "yes" indicate how:*	How:					
Can tell time and takes medication by clock time?	☐Digital clock	☐Standard clock				
Takes medications at times associated with an activity *(e.g., meals, waking hour, bedtime, etc.)*?						
Takes medication with the aid of a device? *If "yes" indicate type of device used:*	☐Pill pod/cassette ☐Calendar	☐Alarm ☐Phone				
Independently fills reminder device?						
Needs assistance to fill medication aids? *If "yes" indicate type of assistance (e.g., verbal prompt) and who provides (e.g., physician assistant, staff support, nursing staff):*	Type:	Who:				

Takes medication only when prompted by supporting staff? *If "yes" indicate who provides support:*	Who:			
Independently manages own prescription refills?				

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	Yes	No	N/A
Manages own prescription refills with staff assistance only?			
Displays independence in appropriately taking over the counter (OTC) preparations?			
Needs assistance to take OTC preparation correctly?			
Independently understands "special instructions" when taking medication? *(e.g., take with food, take for 10 days, etc.)*			
Is physically able to swallow pill(s) and/or liquid(s) without difficulties?			
Is physically able to remove pill(s) from bottle or bubble pack without dropping?			
Is free from physical disabilities which may compromise or prevent self-administration?			
Is able to measure and pour liquid medication without spillage?			
Is able to self-administer eye medication?			
Is able to self-administer ear medication?			
Is able to self-administer nasal medication?			
Is able to self-administer topical medication?			
Is able to self-administer medication via patch?			
Is able to self-administer inhalant medication?			
Is able to self-administer rectal medication?			
Is able to self-administer vaginal medication?			
Is able to self-administer medication via injection?			
Displays knowledge of need for safe storage of medication away from access by others?			
Has a history of drug and/or alcohol abuse?			

Specific concern related to the participant's ability:

Recommendations: _____

_____

Evaluated by: _____.

Guardian: _____.

Shared Living Provider: _____.

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MEDICAL CONTACT FORM

Name: _____ Date of Birth: _____

Allergies: _____

Medications: _____

Pharmacy: _____ Phone: _____ Fax: _____

Medicaid #: _____ Medicare #: _____

Other #: _____

Reason for contact: _____

Diagnosis/Treatment/Recommendation/Contradictions/Medications Prescribed:

Unless otherwise indicated, I authorize 12 months of refill (or 6 months of refill on controlled medications).

If follow -up is necessary, indicate date needed: _____ _____

(Provider's Signature)

_____

(Date Signed)

Psychotropic medication change: Yes ___ No ___

ABLED, Inc. Comments:

_____ _____

Signature/Title Date

Copies: Original to ABLED, Inc. file.

Other: _____ Read by Med Aide (Initial and date) _____

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CARETAKER ACKNOWLEDGEMENT

I,_____, assume responsibility for the direction and monitoring of medications and additional activities for _____ (name of participant) while being supported by ABLED, Inc. employees or subcontractors. I also authorize ABLED, Inc. to administer medications by Certified Medication Aides in their employment or contract. I acknowledge and accept that these Medication Aides have been deemed competent to perform this task by a Licensed Health Care Professional and that the competency assessment has been completed on my behalf.

_____ _____

Signature Date

_____

Printed Name

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MEDICAL ADMINISTRATION RECORD EXAMPLE

ABLED, Inc.

Individual Name: [redacted]
Medicaid Number: [redacted]
Date of Birth: [redacted]

Medication Administration Record - June, 2016

Individual Name: [redacted]
Created By: Linda Tagart, Executive Vice President on 05/31/2016 04:06 PM
Approved By: Linda Tagart, Executive Vice President on 05/31/2016 04:06 PM
Form ID: MAR-ABLEDNE-E7Z3W765UFZ83 **Time Zone :** US/Central

Legends: M/R Missed/ Refused | LOA LOA | OH On hold | Deleted | *** User with no Initial

Scheduled Medication(s)

AMLODIPINE BESYLATE - Tablet, Oral (mouth), Scheduled (Medication)

Indication/Purpose Benign essential HTN.

Instruction/Comments Take 1 tablet daily.

Give Amount / Quantity: [Dose: 10]mg **Frequency:** 1 X DAILY
Begin Date & Time: 03/07/2016
Schedule Time Slot(s): N/A

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU
	STW	STW	STW	STW	STW	STW	STW	STW	STW	STW																				

ATROPINE SULFATE 1 % OPTHALMIC SOLUTION - Scheduled (Medication)

Indication/Purpose For drooling.

Frequency: TWICE DAILY
Begin Date & Time: 03/07/2016
Schedule Time Slot(s): 8:00 am, 9:00 pm

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU
8:00 am	STW	STW	STW	STW	STW	STW	STW	STW	STW	STW																				
9:00 pm	STW	STW	STW	STW	STW	STW	STW	STW	STW	STW																				