2021

Med Admin Policies

The rules, regulations and policies under which we operate.

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SAFE MEDICATION ASSISTANCE AND ADMINISTRATION & HEALTHCARE RELATED POLICY AND PROCEDURES

POLICY

It is the policy of ORH/WSS to provide safe medication setup, assistance and administration:

1. when assigned responsibility to do so in the person's coordinated service and support plan (CSSP) or the CSSP addendum;
2. using procedures established in consultation with a registered nurse (RN), nurse practitioner (NP), physician's assistant (PA) or medical professional (MP); and
3. by staff who have successfully completed medication administration training before actually providing medication setup, assistance and administration.

For the purposes of this policy, medication assistance and administration include but is not limited to:

1. providing medication-related services for a person;
2. medication setup;
3. medication administration;
4. medication storage and security;
5. medication documentation and charting;
6. verification of monitoring of effectiveness of systems to ensure safe medication handling and administration;
7. coordination of medication refills;
8. handling changes to prescriptions and implementation of those changes;
9. communicating with the pharmacy; or
10. coordination and communication with the prescriber

Under no circumstances will the staff change any part of the Safe Medication Assistance and Administration policy. Any needed change to meet the need of a particular facility will be discussed with and changed by the ORH/WSS nurse only.

DEFINITIONS & ABBREVIATIONS

Medication Administration Record (MAR) means the record commonly referred to as a drug chart, is the report that serves as a legal record of the drugs administered to a person. The MAR is a part of a patient's permanent record.

Medication means a prescription drug or over-the-counter drug and includes dietary supplements.

Medication administration means following the procedures in the Medication Administration Procedure (located in this policy) to ensure that a person takes their medications and treatments as prescribed.

Medication assistance means to enable the person to self-administer medication or treatment when the person is capable of directing the person's own care, or when the person's legal representative is present and able to direct care for the person.

Medication setup means arranging medications, according to the instructions provided by the pharmacy, prescriber or licensed nurse, for later administration (such as a home visit).

Over-the-counter drug means a drug that is not required by federal law to bear the statement "Caution: Federal law prohibits dispensing without prescription".

Prescriber means a Certified Nurse-midwife, Certified Registered Nurse Anesthetists, Certified Clinical Nurse Specialists in Psychiatric and Mental Health Nursing, Other Certified Nurse Specialists, Licensed Medical Doctor, Licensed Doctor of Osteopathy, Licensed Doctor of Dentistry, Licensed Doctor of Optometry, Licensed Podiatrist, etc.

Prescription means the signed written order, or an oral order reduced to writing, given by a practitioner licensed to prescribe drugs for patients in the course of the practitioner's practice, issued for an individual patient and containing the following: the date of issue, name and address of the patient, name and quantity of the drug prescribed, directions for use, and the name and address of the prescriber.

Psychotropic medication means any medication prescribed to treat the symptoms of mental illness that affect thought processes, mood, sleep, or behavior. The major classes of psychotropic medication are antipsychotic (neuroleptic), antidepressant, antianxiety, mood stabilizers, anticonvulsants, and stimulants and nonstimulants for the treatment of attention deficit/hyperactivity disorder. Other miscellaneous medications are considered to be a psychotropic medication when they are specifically prescribed to treat a mental illness or to control or alter behavior.

Self-Administration of Medications: means that the person will administer their own medications, with little/no prompting or assistance from staff. Before this can happen, the RN will need to perform an evaluation, and written approval will be gained from the person's PCP and guardian if applicable.

ABBREVIATIONS

CR	contained release
DC	discontinue
HS	hour of sleep
LA	long acting
LPN	Licensed Practical Nurse
MAR	Medication Administration Record
MP	Medical Professional
PC	Program Coordinator
QDDP	Qualified Developmental Disability Professional
PRN	as needed
RN	Registered Nurse
SOM	standing order medication
SR	sustained release
XL	extra long

ADMISSION/RE-ADMISSION

ADMISSION

1. When a referral is made for a client, the RN reviews the pertinent medical information and may do an assessment of the person.
2. The RN and the Administrator/Program Director discuss if our openings are appropriate for the person's care needs.
3. If it is determined that the person will be moving in to one of the homes, a signed copy of the medication orders and a signed copy of the standing orders needs to be obtained.
4. If possible, the RN will attend the admission meeting to get the medications set up/checked in and do a skin assessment if applicable. If the RN is not able to attend, the PC needs to get the medications set up, compare what is brought to the house with what the orders say, and make sure the MAR is accurate. Medications can only be given if we have an order for them.
5. RN or PC also needs to make sure that any controlled medications are counted, documented, and double locked.

RE-ADMISSION

1. If a client is admitted to the hospital or a similar facility, the RN needs to be contacted.
2. The RN needs to be kept up to date with any information from the hospital about changes in condition.
3. When the person is getting close to discharge, the RN needs to be notified.
4. The RN will do an assessment to determine if the person's level of care has changed as such that we would no longer be able to meet their needs.
5. The RN will review their findings with the Program Team, and a decision will be made about whether or not the person can return to the group home. If the person does return, an updated copy of signed physician's orders is required.

STAFF TRAINING

1. Unlicensed staff may administer medications only after successful completion of a medication administration training course using a training curriculum developed by a RN, clinical nurse specialist in psychiatric and mental health nursing, certified nurse practitioner, physician's assistant, or medical professional. The training curriculum must incorporate an observed skill assessment conducted by the trainer to ensure staff demonstrate the ability to safely and correctly follow medication procedures.
2. Staff must review and receive instruction on individual medication administration procedures established for each person when assigned responsibility for medication administration.
3. Staff may administer subcutaneous injectable medications only when the necessary training has been provided by a registered nurse.
4. Medication administration must be taught by a registered nurse, clinical nurse specialist, certified nurse practitioner, physician's assistant, or medical professional if, at the time of service initiation or any time thereafter, the person has or develops a health care condition that affects the service options available to the person because the condition requires:
    a. specialized or intensive medical or nursing supervision; and
    b. Nonmedical service providers to adapt their services to accommodate the health and safety needs of the person.
5. The RN remains legally responsible for the direct care staff to which these tasks are delegated.

RESPONSIBILITIES OF STAFF ASSIGNED TO MEDICATION ADMINISTRTION

Should there be more than one staff member on the shift, one person will be assigned to be in charge of the medications. That person will:

1. assume the lead role in the event of a medication error,
2. be responsible for all calls regarding medication needs or errors to the PC, and
3. administer all scheduled and PRN (as needed) medications to all persons.

TYPES OF MEDICATION

Medications can be routine, PRN, Standing Order, Controlled/Narcotic, and/or Psychotropic. See the following paragraphs for explanations about the different types.

- **Routine Medications**: maintenance doses administered according to a standard repeated cycle of frequency.
- **PRN Medications**: medications prescribed and given "as needed" for a specific purpose. The medication can only be given for the purpose for which it is prescribed. When PRN's are used, they must be added to the PRN section of the MAR if they are not already there, and a reason for use must be listed along with whether or not the medication resolved the symptoms for which it was given.
- **Standing Order Medications**: "over-the-counter" comfort medications. If these medications are used, the entire order needs to be copied from the SOM list and written on the MAR.
- **Controlled Drugs/Narcotics**: There are additional responsibilities for the security of controlled medications when these medications are prescribed in the ORH/WSS settings. Any and all new Controlled Medication (schedule II-IV) must be reported to the RN either by email or phone. This needs to be reported **within 24hrs** of receiving the prescription.
  1. Controlled drugs must be kept in a separate locked box in the medication area (double locked).
  2. Each time staff opens the box containing the controlled drugs they must fill out the controlled medication cabinet count sheet. (see example on the following pages- there are two methods used in the houses: padlocks and red tags).
  3. When administering controlled meds staff needs to count the medications and fill out the controlled medication count sheet. There must be a count sheet for each controlled medication.
  4. At shift change, there will be two staff counting the controlled medications together. At the evening/overnight shift exchange, the two staff members will fill out the Daily Money and Controlled Medication Count form and fax it to the office by 8:00 am every morning for review. If there are any discrepancies they need to be reported to the On-call immediately.
  5. Controlled medications delivered by the pharmacy will be counted and logged in on the controlled medication count sheet by whichever staff is working at the time of delivery.
  6. When sending controlled medications home with a person for a home visit, the medications are to be labeled with the person's name, the medication, dose, and the time and date the medications are to be given. Document the number of medications sent on the medication set-up form and the controlled medication count sheet. Once they have been packaged to send with the person's leave staff needs only to count the controlled meds that remain in the house. If there are any controlled meds that return to the house they are added back to the house count.
  7. When a controlled medication is discontinued the ORH/WSS RN must be notified. The RN will then make arrangements to come to the house and destroy the medication with the PC. The medication

must continue to be locked up and counted until the RN is able to come to the house.

8. **Missing or not counting controlled medications also constitutes a serious medication error and should be reported immediately to the On-Call who will notify the ORH/WSS RN.**

Taking Controlled Medications prescribed for someone else is a Felony!

- **Psychotropic Medications**:

1. When ORH/WSS is responsible for administration of a psychotropic medication, ORH/WSS must develop, implement, and maintain the following documentation in the person's CSSP addendum according to the requirements in sections 245D.051:
   a. A description of the target symptoms the prescribed psychotropic medication is to alleviate.
      (1) The program must consult with the expanded support team to identify target symptoms;
      (2) "Target symptom" refers to any perceptible diagnostic criteria for a person's diagnosed mental disorder, as defined by the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR), or successive editions, that has been identified for alleviation; and
   b. The documentation methods the program will use to monitor and measure changes in target symptoms that are to be alleviated by the psychotropic medications if required by the prescriber.
2. The program must collect and report on medication and symptom-related data as instructed by the prescriber.
3. The program must provide the monitoring data to the expanded support team for review every three months, or as otherwise requested by the person or the person's legal representative.

<u>Classes of Psychotropic Medications</u>

Psychotropic medications are those that alter mood or behavior.

1. Antidepressants
2. Antianxiety / Sedative / Hypnotic
3. Antipsychotics
4. Stimulants
5. Mood Stabilizers

<u>Side Effects</u>

All psychotropic drugs have side effects and require careful monitoring. Some common side effects are:

- drowsiness
- dry mouth
- blurred vision
- headache
- indigestion
- nausea
- vomiting
- shaking

- confusion
- dizziness or lightheadedness
- tardive dyskinesia (a syndrome that often includes rhythmic involuntary movements of the tongue, face, mouth or jaw; i.e., frequent poking out of the tongue, chewing, puckering, or blowing out of the cheeks - sometimes is accompanied by involuntary twitching or tremors in the hands or feet)

Elderly people taking psychotropic medications are prone to falls so may require assistance. Side effects may occur early in drug therapy, or may not occur until after months of treatment.

Although the person's medical professional is responsible for prescribing an antipsychotic drug and determining the correct dosage, anyone who cares for someone (i.e., ORH/WSS staff) receiving one of these medicines is responsible for monitoring the results, effectiveness, side effects, and interactions.

Report side effects and any other problems with a medication to the person's medical professional as soon as possible. When a person's health status changes, the medical professional should examine the person's medication regimen again, looking for drugs or dosages that might cause difficulties. Monitor anyone on these medications closely, watching for adverse effect and drug interactions.

Use and Monitoring

a. **Written Authorization**

Written authorization is required for medication administration or medication assistance, including psychotropic medications or injectable psychotropic medications.

(1) The program must obtain written authorization from the person and/or their legal representative before providing assistance with or administration of medications or treatments, including psychotropic medications and injectable medications.
(2) The program must obtain reauthorization annually.
(3) If the person and/or their legal representative refuse to authorize the program to administer medication, the staff must not administer the medication.
(4) The program must report the refusal to authorize medication administration to the prescriber as expediently as possible.

b. **Refusal to Authorize Psychotropic Medication**

(1) If the person receiving services or their legal representative refuses to authorize the administration of a psychotropic medication, the program must not administer the medication and report the refusal to authorize to the prescriber within 24 hours.
(2) After reporting the refusal to authorize to the prescriber within 24 hours, the program must follow and document all directives or orders given by the prescriber.
(3) A court order must be obtained to override a refusal for psychotropic medication administration.
(4) A refusal to authorize administration of a specific psychotropic medication is not grounds for service termination and does not constitute an emergency. A decision to terminate services must comply with the program's service suspension and termination policies.

Example

OAKRIDGE HOMES AND WOODVIEW RESIDENTIAL SERVICE

CONTROLLED MEDICATION COUNT

CONSUMER NAME: Olivia Zeeks MONTH/YEAR May 2021

MEDICATION: Valium RX NUMBER 7439217

	DATE	TIME	STARTING AMOUNT	AMOUNT GIVEN	RECEIVED FROM PHARMACY	ENDING AMOUNT	STAFF INITIALS	STAFF INITIALS
(1)	5/1/21	12⁰⁰/pm	50	1	0	49	PB	
			Example of giving medications					
(2)	5/3/21	1⁰⁰/pm	50	0	50	100	A.C	
			Entering medications when received from the Pharmacy					
(3)	5/3/21	3⁰⁰/pm	50	0	0	50	A.C	M.P
			Shift Change Count					

Initials	Signature and title	Initials	Signature and title
A.C	Abby Carter DSP		
M.P	Maggie Phillips DSP		

OAKRIDGE HOMES AND WOODVIEW RESIDENTIAL SERVICES

CONTROLLED MEDICATION COUNT USING RED TAGS

CONSUMER NAME: Jane Doe MONTH/YEAR: July 2021

MEDICATION: Lorazepam 2mg tablet RX NUMBER: 678341

DATE	TIME	STARTING AMOUNT	AMOUNT GIVEN	RECEIVED FROM PHARMACY	ENDING AMOUNT	STARTING RED TAG #	ENDING RED TAG #	STAFF INITIALS	STAFF INITIALS
Example of giving the medication:									
7·2·21	8:00 pm	15	1	0	14	90423	90424	AZ, RN	
						tag is cut so a new one is used after.			
Example of Shift Change:									
7·2·21	10:00 pm	14	0	0	14	90424	90424	AZ, RN	m.m.
7·3·21	8:00 AM	14	0	0	14	90424	90424	m.m.	L.R.
						Verify the tag # without opening it.			

Initials	Signature and title	Initials	Signature and title
AZ, RN	Ashley Zalorowski, RN		
m.m.	Molly Mouse, DSP		
L.R.	Lucy Rainbows, PC		

OAKRIDGE HOMES AND WOODVIEW RESIDENTIAL SERVICES

CONTROLLED MEDICATION COUNT USING RED TAGS

CONSUMER NAME: MONTH/YEAR:

MEDICATION: RX NUMBER:

DATE	TIME	STARTING AMOUNT	AMOUNT GIVEN	RECEIVED FROM PHARMACY	ENDING AMOUNT	STARTING RED TAG #	ENDING RED TAG #	STAFF INITIALS	STAFF INITIALS

Initials	Signature and title	Initials	Signature and title

OAKRIDGE HOMES AND WOODVIEW RESIDENTIAL SERVICE

CONTROLLED MEDICATION COUNT

CONSUMER NAME: MONTH/YEAR:

MEDICATION: PRESCRIPTION NUMBER:

DATE	TIME	STARTING AMOUNT	AMOUNT GIVEN	RECEIVED FROM PHARMACY	ENDING AMOUNT	STAFF INITIALS	STAFF INITIALS

Initials	Signature and title	Initials	Signature and title

Daily Money and Controlled Medication Count

This chart is to be filled out and scanned to your designated person at the Brainerd or Clarissa office each night.

Procedure:

1. Staff working the afternoon/evening shift must sit down ***with*** the staff working the overnight shift.
2. Afternoon/evening shift and overnight shift count the money ***together*** (client petty cash and house petty cash)
3. Afternoon/evening shift and overnight shift count controlled medications ***together***.
4. One staff records the accurate money and controlled medication counts on this Chart.
5. Both the afternoon/evening and overnight shift staff will compare the current day's counts to the previous day's counts. If the count is off, the PC or Program Team will be called (wait to make this call in the morning if after 10pm)
6. ***Both*** the afternoon/evening and overnight shift staff sign the bottom of this Chart and date.
7. Overnight Shift scans this Chart to the appropriate office. (This task has been added to the Overnight DSP Job Description)

Money Count		Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday
	Date							
Petty Cash: *Please **initial** that this was checked and the **count is correct.***	**House:**							

Controlled Medication Count:		Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday
Consumer								
Medication								
RX Number								
Consumer								
Medication								
RX Number								
Consumer								
Medication								
RX Number								
Consumer								
Medication								
RX Number								
Consumer								
Medication								
RX Number								
Consumer								
Medication								
RX Number								

By signing below, I am attesting to the fact that I have *visually* counted the above items at the date and time recorded below. I am also attesting to the fact that all of the above statement *matches* the current counts on the Petty Cash ledgers (for money) and the Controlled Medication count (for controlled substances):

Afternoon/Evening Shift Staff Signature							
Overnight Shift Staff Signature							
Date							
Time							
Initials of scanner:							

ROUTES OF MEDICATION

There are various routes by which a trained staff is authorized to administer medications. The proper route for administration should be specified in the physician order. The authorized routes of administration are as follow:

- Oral - swallowed by mouth
- Sublingual - dissolved under the tongue
- Topical - applied to the skin
- Eye - drops or ointments applied to the eye
- Ear - drops placed in the ear
- Rectal - inserted in the rectum
- Vaginal - inserted in the vagina
- Injection - dose of medicine given by way of syringe and a needle, forces a small amount of drug under the skin
- Inhalant - taken in through the mouth or nose by breathing or inhaling
- Transdermal - absorbed through the skin through application of a patch

UNIVERSAL PRECAUTIONS, INFECTION CONTROL, BLOODBORNE PATHOGENS

Universal precautions, sanitary practices, and prevention

Universal precautions apply to the following infectious materials: blood; bodily fluids visibly contaminated by blood; semen; and vaginal secretions. All staff are required to follow universal precautions and sanitary practices, including:

1. Use of proper hand washing procedure
2. Use of gloves in contact with infectious materials
3. Use of a gown or apron when clothing may become soiled with infectious materials
4. Use of a mask and eye protection, if splashing is possible
5. Use of gloves and disinfecting solution when cleaning a contaminated surface
6. Proper disposal of sharps in a sharps container or appropriate substitute
7. Use of gloves and proper bagging procedures when handling and washing contaminated laundry

Control of communicable diseases

(Reportable Infectious Diseases: Reportable Diseases A-Z - Minnesota Dept. of Health) (http://www.health.state.mn.us)

1. Staff will report any signs of possible infections or symptoms of communicable diseases that a person receiving services is experiencing to the Designated Coordinator or ORH/WSS RN
2. When a person receiving services has been exposed to a diagnosed communicable disease, staff will promptly report to other licensed providers and residential settings.
3. Staff diagnosed with a communicable disease, may return to work upon direction of a health care professional.

Gloves are worn for:

1. changing any types of dressings (touching blood, body fluids, mucous membranes, or non-intact skin of all persons)
2. clean up of any surfaces soiled with blood or body fluids (any fluids that might have blood in them (drainage from a wound, vomit etc.)
3. instillation of eye drops, for any infection that the person may have, or any skin break a staff member may have

4. clean up of any bowel accident, with or without obvious blood, vaginal secretions or semen
5. giving injections or checking blood sugars

Protective eye wear is worn for:

1. any oral care that could generate droplets of blood or body fluids that could provide a hazard to the staff.

Bloodborne Pathogens (BBP): are microorganisms present in human blood or other potentially infectious materials and can infect and cause disease in humans. These pathogens include, but are not limited to, hepatitis types A, B, and C, HIV, MRSA, Staph, VRE, and C-Diff.

A. Bodily fluids that can harbor BBP:

- Blood
- feces
- semen and vaginal secretions
- saliva/sputum
- synovial fluid
- cerebrospinal fluid
- all body fluids containing blood

B. Bloodborne Pathogens can be transmitted via the following routes:

1. Airborne
2. Droplet
3. Contact
4. Bloodborne

C. How do you get exposed?

Bloodborne Pathogens can be transmitted via the following

1. needlesticks or cuts from used needles or sharps
2. contact of eyes, nose, mouth or broken skin with blood

3. assaults - bites, cuts, knife wounds
4. punctures
5. splashes

D. What should you do if you get exposed?

1. needlesticks and cuts:
   a. clean the site of injury with soap and flush with water for **at least 15 minutes**
2. flush mucous membranes with water or saline for **at least 15 minutes**
3. splashes: flush nose, mouth, or skin with water
4. splashes in the eye - irrigate with water, saline, or sterile wash
5. **seek medical attention as soon as possible**
6. **notify supervisor and complete FIRST REPORT OF INJURY**

E. Preventative Measures:

1. Engineering controls
   a. Follow procedures regarding the use of sharps containers, needleless devices, etc.
2. Personal Protective Equipment (PPE)
   a. Follow procedures regarding the use of protective equipment (i.e., gloves, masks, eyewear etc.)
   b. Follow procedure regarding the proper removal of gloves

3. Administrative Controls
   a. Follow procedures that were taught in Med Class and other training sessions
      (1) Never recap needles.
      (2) Treat all human blood and body fluids as if known to be infectious for HIV, HBV, or other potentially infectious material.
      (3) Note locations of all necessary equipment, containers, disinfectants, and soaps.
      (4) Decontaminate work surfaces:
         (a) at the start and end of procedures
         (b) immediately after a spill

(c) before removal of equipment
(d) between clients if using for more than one person
(e) use disposable equipment only once

(5) Dispose of waste properly
(6) Label containers - hazard communication
(7) Wash hands frequently using proper hand washing procedure (see Hand Washing below):
(a) always between persons
(b) always before leaving the work area
(8) Blood Spill Clean Up
(a) Know WHERE the Bloodborne Spill Kit is located at the house you work at
(i) follow the directions for its use (instructions are on the inside)
(ii) notify your PC if you should have a need to use it
(b) dispose of all materials used to clean up the spill (e.g., towels, gloves, etc.) in a biohazard bag

Hand Washing

Hand washing is performed by all employees to remove any obvious soil; to be able to provide food handled in the cleanest manner; and to reduce the risk of transmission of infections between persons, staff and visitors. **It is the most important means of reducing transfer of infection.**

Procedure:

1. Removal of large jewelry is desirable.
2. Wet hands and wrists with running water.
3. Apply soap.
4. Using friction wash hands and wrist area for 20 seconds, or as long as it takes to sing the Happy Birthday song, paying particular attention to the areas between the fingers, palms, under the nails, back of hands and wrist area.
5. Rinse under running water, keep hands pointed downward, and take care not to touch the inside of the sink.
6. Dry hands using paper towels.
7. Turn off the water using a dry paper towel.

A Few Examples of When Staff Should Wash Their Hands:

1. When they are soiled.
2. After using the toilet.
3. Before and after coming in contact with a person.
4. Before you handle a resident's food or food tray.
5. Before and after eating.
6. After combing hair.
7. After using handkerchief or tissue.
8. After handling any of your persons belongings, supplies or equipment used for care.
9. Before and after setting up medications.
10. Between medications for different persons.
11. Before giving eye drops or ointment.
12. After smoking.

WHICH MEDICATIONS MAY STAFF ADMINISTER?

****ALL medications and treatments (even over the counter medications) MUST have a physician's order before staff may administer****

- **Prescribed Medications**: these have been prescribed by a Medical Professional, Dentist, Psychiatrist, Ophthalmologist, Optometrist, Certified or Registered Nurse Practitioner, etc.
- **PRN Medications**: these medications are ordered by the prescriber on as "as needed" basis. When it is administered it will be documented in the appropriate space for the date on the MAR and recorded on the PRN documentation sheet. A note will also be written in the Individual Progress Notes in red identifying the reason the medication was given and the results of the use of the PRN. Be specific as to the target behaviors present if it is a psychotropic medication and the non-medication approaches used prior to the medication.
- **Standing Order Medications**: these medications will be added to the MAR only when the medication is used for the first time in a particular month and then recorded on the correct date. The order must be copied exactly as written on the Standing Order Medication List. A note must also be made in the progress record each time the standing order medication is used indicating the reason and results of the use of the medication. The medication must also be recorded on the PRN documentation page. A Standing Order Medications List is obtained with the following procedure:
  1. Present the person's medical professional with a copy of the ORH/WSS standing orders at the time of the admission physical or at the earliest convenience after the person's admission.
  2. Place the original standing order form in the permanent record under medical.
  3. Place a copy in the person's daily log book, in the MAR for easy reference.
  4. Send a copy to the ORH/WSS Registered Nurse (RN) each year
  5. Do not use any other over the counter medications without the provider's written approval.
  6. Have these orders reviewed annually at the time of the person's annual physical.

INJECTABLE MEDICATIONS

The program may administer injectable medications according to a prescriber's order and written instructions when one of the following conditions has been met:

1. The program's RN or LPN will administer the intramuscular or subcutaneous injections:
2. The program's supervising RN, with the medical professional's orders, may delegate the administration of subcutaneous injections to staff who have received the necessary training (i.e., Insulin Pen, Epi Pen); or
3. There is an agreement signed by the program, the prescriber and the person and/or their legal representative identifying which subcutaneous injectable medication may be given, when, and how and that the prescriber must retain responsibility for the program administering the injection. A copy of the agreement must be maintained in the person's record.

Only licensed health professionals are allowed to administer psychotropic medications by injection.

ORDERING & RECEIVING MEDICATIONS AND RELATED TASKS

OBTAINING MEDICATION ORDERS

Medication/treatment orders need to be **written** by a prescriber. **Only the RN can take a verbal order** over the phone, followed by a written order. The only exception to this is in the case of a medication error where contacting a physician is necessary- in this scenario staff may take verbal directions from the provider followed by written instructions/orders.

Orders are obtained:

- A copy of all current medication orders is received before/at admission along with a signed copy of the standing medication order sheet.
- At every appointment, staff will bring an Oakridge appointment form that is appropriate for the type of appointment (EX: use a dental form for dental appointments, annual physical form for annuals etc.) The staff attending the appointment will verify that all information that was discussed is either written on the appointment form OR is clearly written in the after-visit summary and the AVS includes a physician's signature. The orders will be sent to Safedose per the appointment form instructions.
- If a person needs a new order or needs a change, we can also contact the physician and request the change (EX: a person purchases OTC vitamin C and wishes to take it- staff may lock the medication in the med cupboard and contact the prescriber to ask for an order. The person may begin taking the vitamin when the written order is received back. Example 2 would be if we need a change such as if someone takes a laxative daily but is frequently having loose stools- it would be appropriate to share this with the prescriber and request the order be changed to every other day).

STANDING ORDER MEDICATIONS FOR OAKRIDGE HOMES

Client's Name: _____ Birth date: _____

Primary Care Provider: Please check yes or no and sign on the last page. Re-signed annually.

Yes	No	Medication Order
		Tylenol 325 mg, (or generic) 2 tabs by mouth every 4 hours OR Extra strength Tylenol 500mg 1-2 tabs every 4 hours, PRN for pain or temperature above 100 degrees **Do Not Exceed 4000mg total from all sources in 24 hours.**
		Ibuprofen 200mg, 2 tabs by mouth every 6 hours PRN for pain, **Do Not Exceed 6 tablets in 24hrs.**
		Tums or Rolaids- regular strength, chew 2-4 tabs PRN for heart burn symptoms, repeat hourly if symptoms re-occur. **Do not exceed 7500mg in 24 hours**. If "heart burn" symptoms include heaviness over the chest, or pain in the arm, neck or shoulders, nausea or vomiting, contact the physician immediately.
		Pepto Bismol Original Strength- take 30mL (if liquid) OR take two tablets by mouth PRN for nausea, diarrhea, indigestion. **Do Not Exceed 8 doses in a 24 hour period.**
		Maalox or generic Regular Strength take 4 teaspoons (tsp.) by mouth 4 times a day PRN for indigestion. **Do Not Exceed 16 tsp. total in a 24 hour period.**
		Milk of Magnesia- take 30mL by mouth PRN for constipation. Give on 2nd day with no bowel movement.
		Fleet enema (or generic). Follow instructions on box. Give on 3rd day with no bowel movement.
		Robitussin DM syrup, (or generic), 2 tsp by mouth every four hours PRN for **cough.** Use sugar-free for diabetics.
		Sudafed PE decongestant (or generic) 10mg- 1 tab by mouth every 4 hours PRN for nasal/sinus congestion. **Do Not Exceed 6 tabs total in a 24 hour period.**
		Benadryl (or generic) 25mg by mouth every 4-6 hours PRN for temporary relief of itching and/or allergy symptoms. **Do Not Exceed 150mg total in a 24 hour period.**
		Claritin (or generic) 10mg - 1 tab by mouth in 24 hours PRN for hay fever/allergy symptoms, runny nose, sneezing
		Saline nasal spray for dry nasal passages, congestion and flushing. Follow bottle directions PRN.
		Mucinex 200mg tabs, take 1-2 tabs by mouth every 4 hrs PRN for chest congestion or thick mucus, **Do Not Exceed 6 tabs in a 24 hour period. OR Mucinex ER 600mg,** take 1-2 tabs every 12 hrs PRN for chest congestion or thick mucus, **Do Not Exceed 4 ER tabs in a 24 hour period**. Do not cut or crush.
		Chloraseptic Throat Spray (Regular Strength)- apply one spray to the back of the throat, wait 15 seconds, then spit out. Repeat every 2 hours PRN for sore throat. If sore throat is accompanied by a fever greater than 100.4 degrees or last more than three days, contact physician.
		Orajel- follow instructions on box for mouth pain related to cold sores, cheek bites, toothaches, dentures etc. If pain is caused by toothache or dentures, follow up with dentist.

Yes	No	Medication Order (page 2)
		Debrox (or generic) drops to soften ear wax- three drops each ear twice daily for 3 days per month.
		Triple Antibiotic Ointment (or generic) -apply topically to cleansed minor wounds, healing burns, or local Inflammation three times a day PRN. If signs of healing are not evident in three days contact physician.
		Hydrocortisone Cream (or generic)- apply topically to affected area PRN for itching, rash, insect bites, etc.
		Anti-fungal powder or cream such as Tinactin, Desenex (or generic) --spread topically to washed and dried feet for symptoms of athlete's foot, or to groin areas for jock itch, twice a day for two weeks. If no improvement at the end of one week contact physician.
		Caladryl lotion (or generic) 8% calamine/1% pramoxine. Apply topically PRN to affected area no more than 3-4 times a day. For rashes, bites, poison ivy, poison oak, bee stings etc.
		Selsun or Head & Shoulders- shampoo/conditioner PRN to treat dandruff like symptoms, if no response after 2 weeks call primary care provider.
		Sunscreen--(SPF 15 or above) apply topically ½ hour before sun exposure, and every 1 ½ to 2 hours PRN while in the sun. More often if in water.
		Aloe Vera (or generic)- Apply topically PRN to minor sunburnt skin. Repeat as needed.
		Insect repellant--apply topically to exposed skin before being in insect infested areas.
		Blistex or preferred chap stick to dry chapped lips PRN.
		May crush medications and give together as needed per ORH RN's discretion (**EXCEPT** medications that state "do not crush")
		May use thickened liquids or modified diets per ORH RN's discretion.

Primary Care Provider's Signature_____ Date_____

Please send all medication changes to:
Safedose Pharmacy
6970 Corporate Drive
Indianapolis IN 46279
P: 888-696-9595
F: 888-881-8585

OAKRIDGE HOMES ANNUAL PHYSICAL

Person:_____ Date of Birth:_____ House:_____
Appt Date/Time:_____ Location:_____
Target Weight: _____ Diet: _____

Current Medications and Reason for Taking: See attached MAR.
*If reason for taking isn't listed, please add.

Height:_____ Weight:_____ Temperature:_____ Pulse:_____ Blood Pressure:_____

- Is this person free from communicable diseases? Yes No
- Are alcoholic beverages contraindicated? Yes No
- Is this person current on recommended vaccines? Yes No

Please explain above answers if needed: _____
_____
_____

Summary of Examination/Overall Health: _____
_____
_____
_____
_____

Medication/Treatment Changes (new, discontinued, or dosage change): _____
_____
_____
_____

Suggested Re-examination Date:_____
Provider Signature:_____ Date:_____
Location:_____

Did anything at this visit change <u>anything</u> in this person's physical and/or mental health needs?
Yes_____ No_____If ***yes*** the notification occurred:
Guardian:_____Date:_____Time:_____
Case Manager:_____Date:_____Time:_____

Oakridge Staff sign to indicate that they have provided the Health Care Provider a ***complete*** list of the client's current medications and treatments (either on this form or by attaching copies of the current MARS) and that all information discussed during the appointment is documented here or on an attached after-visit summary. Signature: _____

Please send all medication changes to:
Safedose Pharmacy
6970 Corporate Drive
Indianapolis IN 46279
P: 888-696-9595
F: 888-881-8585

OAKRIDGE HOMES COUNSELOR NOTES

Person:_____ Date of Birth:_____ House:_____
Appt Date/Time:_____ Location:_____

Reason for Visit:

Diagnosis:

Comments:

Recommendations/Orders:

Suggested Re-examination Date:_____

Provider Signature:_____ Date:_____
Location:_____

Did anything at this visit change anything in this person's physical and/or mental health needs?
Yes_____ No_____
If ***yes*** above Notification occurred:
Guardian:_____Date:_____Time:_____
Case Manager:_____Date:_____Time:_____

Oakridge Staff sign to indicate that they have provided the Health Care Provider a ***complete*** list of the client's current medications and treatments (either on this form or by attaching copies of the current MARS) and that all information discussed during the appointment is documented here or on an attached after-visit summary. Signature: _____

Please send all medication changes to:
Safedose Pharmacy
6970 Corporate Drive
Indianapolis IN 46279
P: 888-696-9595
F: 888-881-8585

OAKRIDGE HOMES DENTAL EXAM

Person:_____ Date of Birth:_____ House:_____
Appt Date/Time:_____ Location:_____

Does this person have a condition where he/she needs to be administered an antibiotic prior to this appointment? YES _____NO _____ If Yes, time the antibiotic was administered: _____

Check all services provided at this visit:

___oral hygiene instruction	___oral cancer exam	___blood pressure	__cleaning
___TMJ evaluation	___bite wing x-ray	___scaling	__saliva culture
___fluoride treatment	__lingual vit C test	___ other:	

Describe restoration/extraction:_____
_____
_____

Describe gum condition:_____
_____
_____

Recommendations/Orders:

Suggested Re-examination Date: _____

Provider Signature: _____ Date: _____

Did anything at this visit change <u>anything</u> in this person's physical and/or dental health needs?
Yes_____ No_____If ***yes,*** the notification occurred:
Guardian:_____Date:_____Time:_____
Case Manager:_____Date:_____Time:_____

Oakridge Staff sign to indicate that they have provided the Health Care Provider a ***complete*** list of the client's current medications and treatments (either on this form or by attaching copies of the current MARS) and that all information discussed during the appointment is documented here or on an attached after-visit summary. Signature: _____

Please send all medication changes to:
Safedose Pharmacy
6970 Corporate Drive
Indianapolis IN 46279
P: 888-696-9595
F: 888-881-8585

OAKRIDGE HOMES DIETICIAN EVALUATION

Person:_____ Date of Birth:_____ House:_____
Appt Date/Time:_____ Location:_____

Reason for Exam: _____
_____
_____

Weight Last Exam: _____ Weight This Exam: _____
Target Weight: _____ Prescribed Diet: _____

Recommendations/Orders:

Suggested Re-examination Date: _____
Provider Signature: _____ Date: _____
Location:_____

Did anything at this visit change anything in this person's physical and/or mental health needs?
Yes_____ No_____If ***yes,*** the notification occurred:
Guardian:_____Date:_____Time:_____
Case Manager:_____Date:_____Time:_____

Oakridge Staff sign to indicate that they have provided the Health Care Provider a ***complete*** list of the client's current medications and treatments (either on this form or by attaching copies of the current MARS) and that all information discussed during the appointment is documented here or on an attached after-visit summary. Signature: _____

Please send all medication changes to:
Safedose Pharmacy
6970 Corporate Drive
Indianapolis IN 46279
P: 888-696-9595
F: 888-881-8585

OAKRIDGE HOMES MEDICAL EVALUATION

Person:_____ Date of Birth:_____ House:_____
Appt Date/Time:_____ Location:_____

Reason for Exam: _____
_____
_____

If for medication blood level draw, date/time of last dose taken: _____

Diagnosis:

Recommendations/Orders:

Suggested Re-examination Date: _____
Provider Signature: _____ Date: _____
Location:_____

Did anything at this visit change anything in this person's physical and/or mental health needs?
Yes_____ No_____If ***yes,*** the notification occurred:
Guardian:_____Date:_____Time:_____
Case Manager:_____Date:_____Time:_____

Oakridge Staff sign to indicate that they have provided the Health Care Provider a ***complete*** list of the client's current medications and treatments (either on this form or by attaching copies of the current MARS) and that all information discussed during the appointment is documented here or on an attached after-visit summary. Signature: _____

Please send all medication changes to:
Safedose Pharmacy
6970 Corporate Drive
Indianapolis IN 46279
P: 888-696-9595
F: 888-881-8585

OAKRIDGE HOMES PSYCHIATRIC EVALUATION

Person:_____ Date of Birth:_____ House:_____
Appt Date/Time:_____ Location:_____

Reason for Exam: _____

If for medication blood level draw, date/time of last dose taken: _____

Diagnosis:

Target Behaviors	Criterion Level	Current Data (past 3 months)		

Recommendations/Orders:

*Has a new Psychotropic Medication order or dose been prescribed that requires an updated informed consent to be signed? Yes_____ No_____
*Discus/Moses/AIMS Score: _____ (attach copy if applicable)

Suggested Re-examination Date: _____
Provider Signature: _____ Date: _____
Location:_____

Did anything at this visit change anything in this person's physical and/or mental health needs?
Yes_____ No_____If ***yes,*** the notification occurred:
Guardian:_____Date:_____Time:_____
Case Manager:_____Date:_____Time:_____

Oakridge Staff sign to indicate that they have provided the Health Care Provider a ***complete*** list of the client's current medications and treatments (either on this form or by attaching copies of the current MARS) and that all information discussed during the appointment is documented here or on an attached after-visit summary. Signature: _____

Please send all medication changes to:
Safedose Pharmacy
6970 Corporate Drive
Indianapolis IN 46279
P: 888-696-9595
F: 888-881-8585

OAKRIDGE HOMES THERAPEUTIC MASSAGE

Person:_____ Date of Birth:_____ House:_____
Appt Date/Time:_____ Location:_____

Reason for Massage: _____
_____
_____

Length of Massage: _____ Cost:_____

Details of Massage (location in home given, area of body focused on, problem areas, comments, concerns etc):

Suggested Re-examination Date: _____
Massage Therapist Signature: _____
Date: _____

Did anything at this visit change anything in this person's physical and/or mental health needs?
Yes_____ No_____If ***yes,*** the notification occurred:
Guardian:_____Date:_____Time:_____
Case Manager:_____Date:_____Time:_____

Oakridge Staff sign to indicate that they have provided the Massage Therapist with a ***complete*** list of the client's current medications and treatments that may interfere with the massage (either on this form or by attaching copies of the current MARS) and that all information discussed during the appointment is documented here or on an attached after-visit summary.
Staff Signature: _____

Please send all medication changes to:
Safedose Pharmacy
6970 Corporate Drive
Indianapolis IN 46279
P: 888-696-9595
F: 888-881-8585

OAKRIDGE HOMES VISION/EYE EVALUATION

Person:_____ Date of Birth:_____ House:_____
Appt Date/Time:_____ Location:_____

Reason for Exam: _____
_____
_____

Concerns/Visual Changes Since Last Exam: _____
_____
_____

Visual Acuity:

	Un-Corrected	Corrected
Right:	_____	_____
Left:	_____	_____

Recommendations/Comments/Orders:

Suggested Re-examination Date: _____
Provider Signature: _____ Date: _____
Location:_____

Did anything at this visit change <u>anything</u> in this person's physical and/or mental health needs?
Yes_____ No_____If ***yes,*** the notification occurred:
Guardian:_____Date:_____Time:_____
Case Manager:_____Date:_____Time:_____

Oakridge Staff sign to indicate that they have provided the Health Care Provider a ***complete*** list of the client's current medications and treatments (either on this form or by attaching copies of the current MARS) and that all information discussed during the appointment is documented here or on an attached after-visit summary. Signature: _____

MONTHLY MAR CHANGEOVER AND REVIEW OF MARS

1. Near the end of each month you will receive a new MAR and an updated physician orders list from the pharmacy for each individual for the next month.
2. It is the responsibility of the PC (Program Coordinator) to check the MAR for accuracy before it is used.
3. In the absence of the PC, the PC can assign a staff member to complete the task.
4. After the employee checks the MAR and it is accurate place your initials and date at the bottom of each page of the MAR to indicate it has been checked.
5. Checking consists of the following:
    - Comparing the current MAR with the new physician order sheets.
    - Comparing the current MAR with the new MAR.
    - Checking for any new orders for the current month that hasn't been included on the MAR. This would be looking at the green and pink short-term Medication Change form that is found in the MAR book.
6. Changes to the new MARs would consist of:
    - Discontinuation dates for medications or treatments that require them.
    - Remove any discontinued medication orders or treatments.
    - Add any new orders or treatments to the new MAR.
7. If a medication or treatment is to end on a certain day of the month you will use a blue highlighter on the MAR and highlight the area after the last medication dose or treatment is to be completed.
8. Do not use yellow at this time-this indicates the order has been discontinued.
9. Notify the pharmacy of any changes that need to be added to the MAR for the next month.
10. The PC will send the previous month's MARs to the designated person at the ORH/WSS office by the 5th of each month for review. The RN will do an on-site review at least every 90 days. This review will include inspection of medication supply.

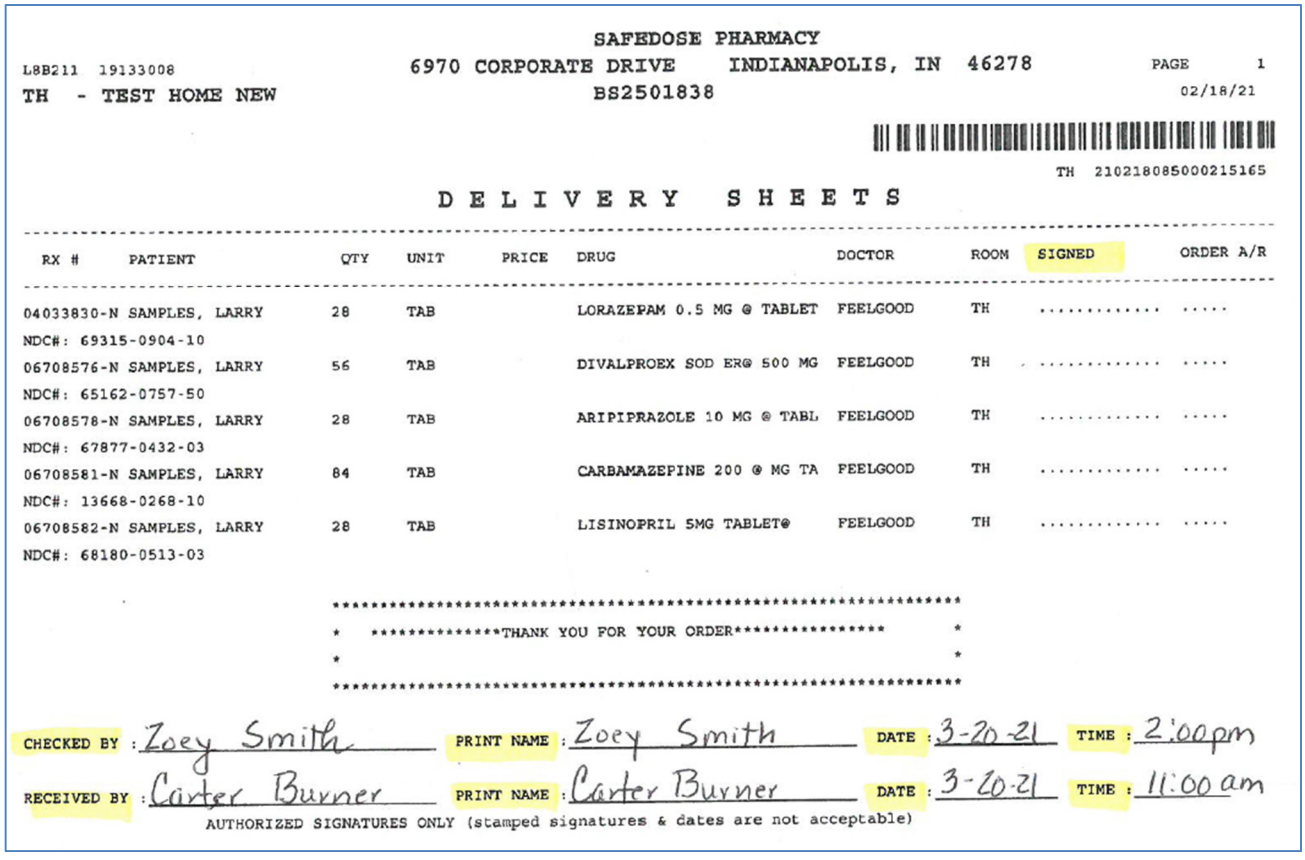
SAFEDOSE: MONTHLY REFILL PROCEDURE

1. Once a month SafeDose will send, via e-mail, a medication refill list for the next month to the PC and the staff in the house. The refill list includes scheduled/routine medications only.
2. It is the responsibility of the PC/designated staff to review it for accuracy. Compare the refill list to the MAR to make sure everything you need will be sent.
3. Next you will check your prn supply, and other medications such as ointments, drops, or inhalers where it is difficult to know when refills will be needed. If a refill is needed, add this into your reply to the refill email.
4. Reply to the refill email letting Safedose know either that the list is accurate and no changes are needed, or let them know what changes/additions are needed to the refill list.

Please Note: Safedose can be contacted at any time during the month if you notice that a medication is running low and you aren't expecting a shipment of meds soon. Please contact Safedose PRIOR to running out so that they have time to fill the medication and ship it- allow 3-5 days minimum whenever possible.

SAFEDOSE: CHECKING IN MEDICATIONS

1. SafeDose monthly medications will be shipped in a box to the house by UPS.
2. In the box you will find the medications and the delivery sheet. See below for an example of SafeDose Delivery sheet.
3. The staff member who is working at the time of the delivery is responsible for checking in the medications. Check that all the medications that are listed on the delivery sheet have been sent.
4. If everything matches, sign your name in the received by and checked by lines. If there are discrepancies, write them on the sheet and contact Safedose.
5. When completed scan it to SafeDose and place the delivery sheet in your SafeDose file for future reference.
6. If the box contains narcotics, you will need to add the new amount to the count sheets and place them in the lock box.
7. If you have a medication that needs to be refrigerated, you will place it in the separate locked medication fridge (if you have one) or it needs to be put in a lock box inside the main fridge (must be locked up even if it isn't a narcotic).
8. See Refrigerator Temperature policy for further instructions on medications that need to be kept cool.



SAFEDOSE PHARMACY
6970 CORPORATE DRIVE INDIANAPOLIS, IN 46278

L8B211 19133008 — PAGE 1
TH - TEST HOME NEW — BS2501838 — 02/18/21

TH 210218085000215165

DELIVERY SHEETS

RX #	PATIENT	QTY	UNIT	PRICE	DRUG	DOCTOR	ROOM	SIGNED	ORDER A/R
04033830-N	SAMPLES, LARRY	28	TAB		LORAZEPAM 0.5 MG @ TABLET	FEELGOOD	TH	.....	.....
NDC#: 69315-0904-10									
06708576-N	SAMPLES, LARRY	56	TAB		DIVALPROEX SOD ER@ 500 MG	FEELGOOD	TH	.....	.....
NDC#: 65162-0757-50									
06708578-N	SAMPLES, LARRY	28	TAB		ARIPIPRAZOLE 10 MG @ TABL	FEELGOOD	TH	.....	.....
NDC#: 67877-0432-03									
06708581-N	SAMPLES, LARRY	84	TAB		CARBAMAZEPINE 200 @ MG TA	FEELGOOD	TH	.....	.....
NDC#: 13668-0268-10									
06708582-N	SAMPLES, LARRY	28	TAB		LISINOPRIL 5MG TABLET@	FEELGOOD	TH	.....	.....
NDC#: 68180-0513-03									

**********THANK YOU FOR YOUR ORDER**********

CHECKED BY : Zoey Smith PRINT NAME : Zoey Smith DATE : 3-20-21 TIME : 2:00pm

RECEIVED BY : Carter Burner PRINT NAME : Carter Burner DATE : 3-20-21 TIME : 11:00 am

AUTHORIZED SIGNATURES ONLY (stamped signatures & dates are not acceptable)

REFRIGERATOR TEMPERATURE POLICY

1. This log will be maintained for refrigerators that have the individual's medication stored in it.
2. A refrigerator thermometer should be kept inside the refrigerator at all times.
3. Temperatures are to be taken daily and recorded on the temperature log sheet. Document the date, time, temperature and your initials on the log.
4. The refrigerator temperature is to be between 34°F and 46°F unless the medication states differently.
5. Set your temperature gauge in the refrigerator at the middle point between the minimum and maximum storage temperature to allow for proper storage temperature.
6. If the temperature is too warm or too cold adjust the temperature gauge in the refrigerator then recheck it again in a few hours.
7. If the temperature continues to be too cold or warm than notify your PC/ On-Call for direction.

Daily Refrigerator Temperature Log

Instructions: This log will be maintained for any refrigerator that has medications in it. Below you will document the temperature at least once daily. Refrigerators should be between 34 degrees Fahrenheit and 46 degrees Fahrenheit unless the medication states differently. If the temperature is out of range, adjust the refrigerator dials accordingly. If it remains out of range, contact the PC.

House: _____

Date	Time	Temp	Initials	Date	Time	Temp	Initials

Initials	Signature and Title	Initials	Signature and Title

ADJUSTING MEDICATIONS / TREATMENTS ON THE MAR

1. To adjust an order, you will need the signed order from the prescriber and this can be either a hand-written signature or signed electronically.
2. A prescriber can either be a doctor, nurse practitioner, physician assistant, physical, speech or occupational therapist, dentist, dietitian, etc.
3. The new orders can be found on the Oakridge corresponding forms, medical providers visit summary or on an e-mail that will be sent from SafeDose pharmacy.
4. See example A of a SafeDose e-mail.
5. The prescriber will send the change of orders to SafeDose.
6. The prescriber doesn't always notify SafeDose if the order has been discontinued.

- Scan over to SafeDose any orders, treatments, etc., that have been discontinued.
- Each house has a SafeDose informational sheet that will include phone numbers, e-mail addresses and other contact information.

7. You **can't** take a verbal order by the prescriber it must be written.
8. If the order is not clear then contact the PC and the PC will give you instructions as to what needs to be done.
9. You will need the current MAR or a blank MAR (medication administration record) to write the new order on. A blank MAR is to be used if the current MAR is full or there is not enough room to write the new order on it.
10. Do not put a routine order on a MAR sheet that is used for prn orders.
11. Any new prn orders will need to be written on the MAR on the sheet labeled PRN.
12. Use as much space as is needed on the MAR for the new order so that it is clear to read
13. See example B and C.
14. When there has been a change in a medication, treatment, etc. you will need to fill out a change of order form.

- The green form is used for changes that are permanent. See Example D.
- The pink form is used for changes that are for a certain time frame. See example E.

15. A blue or yellow highlighter will be needed when you are making medication adjustments on the MAR.
16. Any changes in the client's orders should be adjusted the day the order is received.
17. Call the PC if you have any questions related to any new orders or making the adjustments on the MAR for the new order.
18. As soon as the adjustment has been completed send the following to the nurse for review:

a. new order
b. revised MAR
c. either a Short-Term or Long-Term Medication Sheet

19. The medication is automatically sent from the provider's office to SafeDose to be filled.
20. If the medication needs to be given immediately then call SafeDose and have them send the prescription to the local pharmacy.
21. Staff is responsible to pick up the medication from the local pharmacy and start the medication as soon as they are able.
22. Depending on the new medication order you may need to remove medications from the SafeDose packets.

23. Occasionally you may receive a medication but don't have an order for it. Call the pharmacy that the medication came from and have them send the order to the house.
24. You can't give any medication without a written medical provider order.

Examples are included on the following pages…

Example A: Safedose emailed physician order

Example A

NewRx

Electronically Transmitted Prescription

Patient:
Phone: (320) 594-7150
0
Address: OAK RIDGE GROUP HOME
133 NORTH ST WEST
MN 56446
Sex: M
DOB: 03/19/1965
Patient ID:
Location:

Message Vendor: Surescripts
Clinic: CentraCare
Prescriber: Rene Jones
Supervisor:
Phone: (320) 732-2131
Fax: (320) 732-6913
0
Address: 50 CentraCare Drive
MN 563471404
DEA:
NCPDP ID:
NPI: 1457342032
MutuallyDefined:
Order Number: 337359381:0757509057
Agent:

Facility:
Address:
Phone: No Number Supplied
0
0
Facility ID:

Drug: alendronate 70 mg tablet (FOSAMAX)
Strength: 70
Drug Form: Tablet
Directions: Take 1 tablet (70 mg) by mouth once weekly.
Notes:

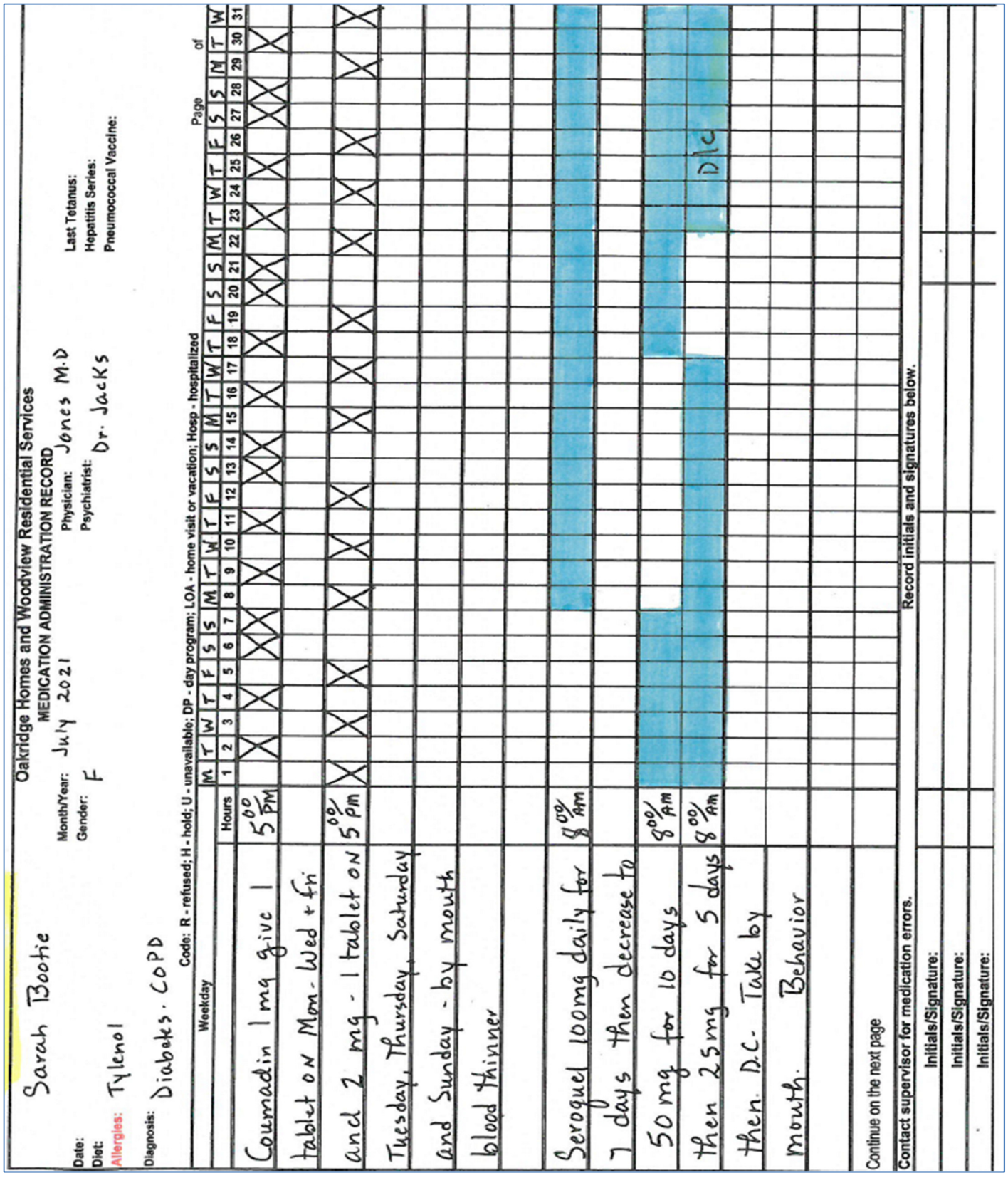
Rx Number: Not Supplied
Quantity: 12
Unit: Tablet
Days Supply: 38
Refills: R 3
DAW: No
Substitution Code: 0
Date Written: 04/15/2021
Effective Date:
Expiration Date:
Period End:
Diag. Qualifier:
Diag. Value:

Pharmacy: SAFEDOSE PHARMACY
6970 CORPORATE DRIVE

From: 6834865829001
Message ID: 2063785477
Relates To Message ID: 337359381:0757509057

Source: ~ 6834865829001
Original document #: 1490811 received on 4/15/2021 5:48 PM EDT

Example B:



Oakridge Homes and Woodview Residential Services
MEDICATION ADMINISTRATION RECORD

Sarah Bootie
Month/Year: July 2021
Gender: F
Physician: Jones M.D
Psychiatrist: Dr. Jacks
Last Tetanus:
Hepatitis Series:
Pneumococcal Vaccine:
Date:
Diet:
Allergies: Tylenol
Diagnosis: Diabetes. COPD

Code: R - refused; H - hold; U - unavailable; DP - day program; LOA - home visit or vacation; Hosp - hospitalized

Page of

Weekday		M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W
	Hours	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	31
Coumadin 1 mg give 1 tablet on Mon - Wed + Fri	5 00 PM	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
and 2 mg - 1 tablet on Tuesday, Thursday, Saturday and Sunday - by mouth	5 00 PM	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
blood thinner																																
Seroquel 100mg daily for 7 days then decrease to	8 00 AM																															
50 mg for 10 days then 25mg for 5 days	8 00 AM																															
	8 00 AM																									DC						
then D.C. Take by mouth. Behavior																																

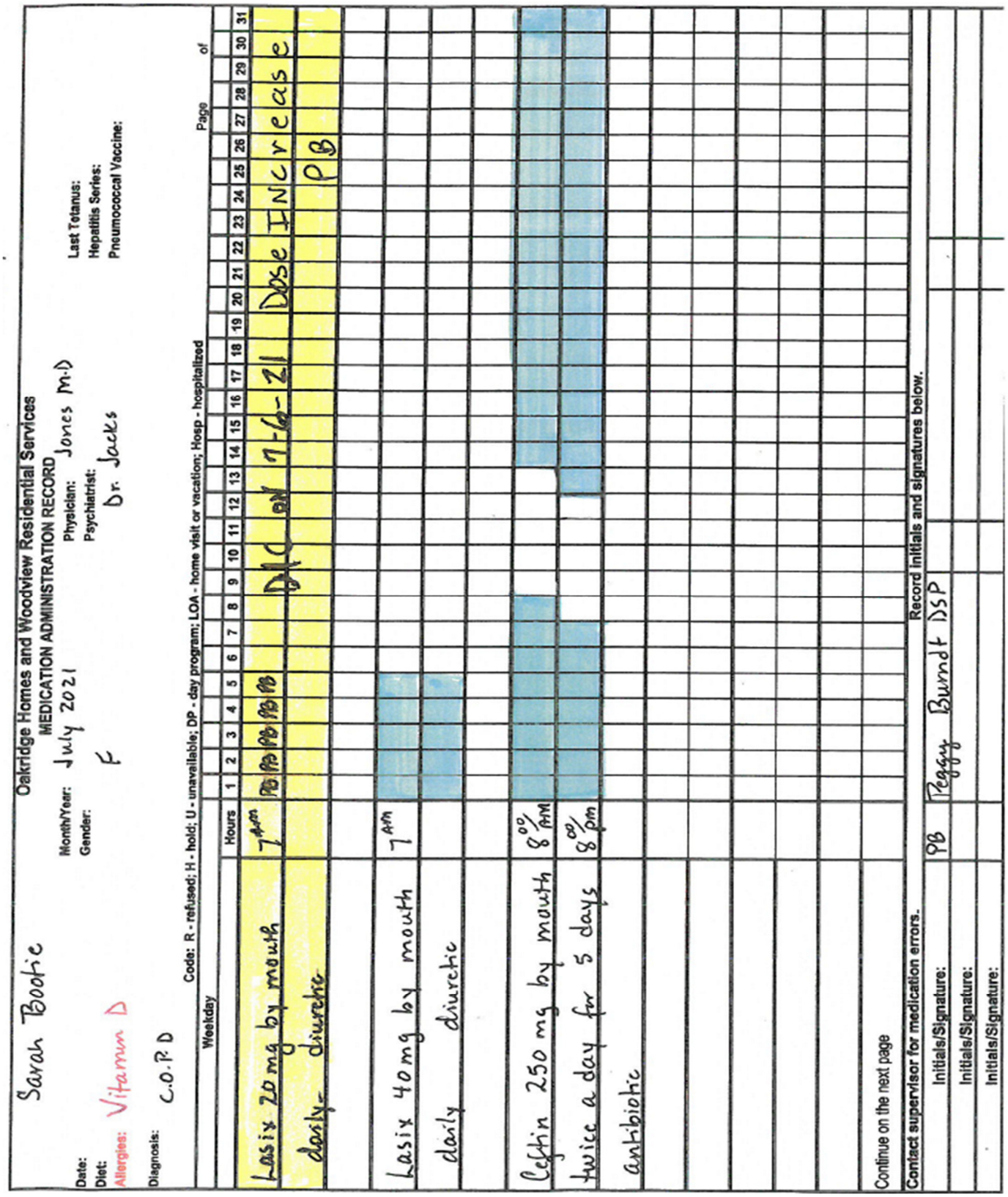
Continue on the next page

Record initials and signatures below.

Contact supervisor for medication errors.

Initials/Signature:																																
Initials/Signature:																																
Initials/Signature:																																

Example C:



Oakridge Homes and Woodview Residential Services
MEDICATION ADMINISTRATION RECORD

Sarah Bookie
Month/Year: July 2021
Gender: F
Physician: Jones M.D
Psychiatrist: Dr. Jacks
Last Tetanus:
Hepatitis Series:
Pneumococcal Vaccine:
Date:
Diet:
Allergies: Vitamin D
Diagnosis: C.O.P.D

Code: R - refused; H - hold; U - unavailable; DP - day program; LOA - home visit or vacation; Hosp - hospitalized

Page of

Weekday	Hours	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	31
Lasix 20 mg by mouth daily- diuretic	7 AM	PB	PB	PB	PB	PB				DC	on	11-19-21										Dose	Increase						PB			
Lasix 40 mg by mouth daily diuretic	7 AM																															
Keflin 250 mg by mouth twice a day for 5 days antibiotic	8:00 AM / 8:00 pm																															

Continue on the next page

Contact supervisor for medication errors.

Record initials and signatures below.

Initials/Signature:	PB	Peggy Burndt DSP																														
Initials/Signature:																																
Initials/Signature:																																

Example D: *(this form is always on GREEN paper)*

Medication Order Change

Client Information

Client: _____ Date: _____

Medication: _____

Medication Change Type: Discontinued _____ New Medication _____ Dose Change _____

Staff Completing Form: _____ Signature: _____

Provider Information

Prescribing Provider: _____ Clinic: _____

Staff Acknowledgement of Medication Change

****Please sign below to acknowledge medication change****

Staff:_____ Signature:_____ Date:_____

Staff:_____ Signature:_____ Date:_____

Staff:_____ Signature:_____ Date:_____

Staff:_____ Signature:_____ Date:_____

Staff:_____ Signature:_____ Date:_____

Staff:_____ Signature:_____ Date:_____

Staff:_____ Signature:_____ Date:_____

Staff:_____ Signature:_____ Date:_____

Staff:_____ Signature:_____ Date:_____

Staff:_____ Signature:_____ Date:_____

Example E: *(this form is always on PINK paper)*

Short Term Medication

Client Information

Client: _____ Date: _____

Medication: _____

Medication Type: _____

Staff Completing Form: _____ Signature: _____

Provider Information

Prescribing Provider: _____ Clinic: _____

Staff Acknowledgement of Short-Term Medication

****Please sign below to acknowledge medication change****

Staff:_____ Signature:_____ Date:_____

Staff:_____ Signature:_____ Date:_____

Staff:_____ Signature:_____ Date:_____

Staff:_____ Signature:_____ Date:_____

Staff:_____ Signature:_____ Date:_____

Staff:_____ Signature:_____ Date:_____

Staff:_____ Signature:_____ Date:_____

Staff:_____ Signature:_____ Date:_____

Staff:_____ Signature:_____ Date:_____

Staff:_____ Signature:_____ Date:_____

MEDICATION ADMINISTRATION: POLICY, PROCEDURES, & RELATED TASKS

WHEN SHOULD MEDICATIONS BE GIVEN?

Scheduled medications are given in accordance with the times prescribed by the medical professional. The typical times are shown below. If the PC determines that a time change is needed they need to contact the licensed nurse for approval.

Typical schedule for medications:

Daily – 8 am
Twice a day – 8am & 8pm
Three times a day – 8am, 4pm & HS (bedtime)
Four times a day – 8am, 12noon, 4pm, & HS *(bedtime)*
Bedtime (HS) – 8pm to 10pm

***Medications can be administered up to 1 hour before or 1 hour after the specified time.**

PRN means "as needed". These medications are given only when they are needed, as defined by the prescriber. Example: Tylenol 325mg, give 2 tabs by mouth as needed for pain. In this example, the only reason that Tylenol could be given is for pain, so you wouldn't be able to give it for any other reason (i.e., fever).

1. PRN medications are listed on the MAR if it is prescribed by the provider, or listed on the Standing Medication Order sheet.
2. When PRNs are used, the entire order must be written on the MAR (if it isn't already printed there).
3. Staff then need to follow the medication administration policy for giving the PRN medication to the person.
4. After following the 6 rights and 3 checks, the staff have the additional step of needing to include the specific reason why the medication was given. EX: PRN Tylenol 325mg was given off of the SMO for a headache (pain). "Headache" needs to be listed as the reason why the medication was given.
5. Staff then need to follow up at a later time (usually 30 minutes or more after the medication was given) to indicate whether or not the medication helped the situation. In the case of the headache example, you would need to document whether or not the Tylenol helped to relieve the headache.
6. If the medication did not help, then staff needs to document what they did next, including contacting the PC for further directions.

PAPER CLIP PROCEDURE FOR MEDICATIONS AND TREATMENTS

1. At the beginning of your shift you will need to check all of the individual's MARs for medications and treatments that are scheduled for your shift.
2. The person assigned to pass medications will be responsible for putting the colored paperclips on the MARs for their shift only.
3. The color of the paperclip to be used for the different medication times is selected by the house you work in.
4. A different colored paperclip is to be used for each time you will pass a medication.
5. If you have an individual that has 4 different times you pass medication during your shift you would be using four different colored paperclips.
6. There are two ways you can paperclip the medication on the MARs.
7. If you have an individual requiring medication at 8:00 am you would place one colored paperclip on the right side of the page for each 8:00 am medication that needs to be administered at that time.
8. The other way is to place one paperclip on the first 8:00 am medication to be given for that individual.
9. By placing the one paperclip at 8:00 am signifies there are additional 8:00 am medications that need to be given at that time.
10. Only place a paperclip on the left side of the page when you get to the end of the month so you will not be covering up the medication/treatment information.
11. When the paperclip is placed on the left side of the MAR make sure you have not covered up any directions for the prescribed medication.
12. The paperclip will be removed after you place your last initial on the MAR.
13. This procedure doesn't eliminate the buddy system check.

MEDICATION ADMINISTRATION PROCEDURE

1. At the beginning of your shift you would have followed the Paper Clip Procedure to paper clip the MARs for your shift.
2. Wash hands before beginning med pass and between each person.
3. Unlock medication storage area.
4. Open person's book to MAR (medication administration record).
5. **First Check**
   a. Take one person's medication from the storage area.
   b. Check the label(s), (Box/Container) against the MAR comparing the person's name, medication, dose, route and time/date of administration.
   c. Place a dot in the corner of the medication signature box on the MAR for each medication checked.
6. **Second Check**
   a. Check the medication package label/container label against the MAR
   b. Compare the person's name, medication, dose, route and time of date
   c. Check that the pill description on the package matches what's in the packet.
   d. Place 1st initial in the med box
   e. Place a mark on the package after check is complete for each med
   f. After all medications have been compared, put in med cup
7. **Third Check**
   a. Compare the empty med package a second time to MAR, checking the person's name, medication, dose, route, and date/time of administration.
   b. Place your 2nd mark on the med package for that drug.
   c. Count the number of pills in the med cup to ensure that it is equal to the number indicated in the med packet and the MARS.
8. Follow any special instructions, i.e.: crush, shake well, take pulse or blood pressure first.
9. Pour any liquids at eye level.
10. Ask the person to come to the staff to receive their medications. Speak to the person and use their name before administering their medications.
11. Lock the medication storage area and close the MAR if staff delivers the med to the person.
12. **Document your last initial** for all persons' medications given as soon **as the medications are taken**. You need to watch the person swallow the medication. If the medication is refused, put your last initial and then circle your initials.
13. Remove the colored paperclip after your last initial is placed on the MAR.
14. After all of the medications have been administered for that medication pass time, check that all medications have been administered and your initials are on the MAR (buddy check on yourself).
15. Wash hands before moving on to the next person.
16. Lock med storage area when finished with all meds.

Acceptable Codes on MAR: Your initials= med given, your initials circled= Refused, H=held, NA= not available, LOA= leave of absence (work, home visit, hospital). No box should be blank!

MEDICATION ADMINISTRATION OBSERVATION CHECKLIST

Upon passing the medication administration class, staff must then have a trained staff watch them pass medications on three separate occasions. One med pass = all of the medications for the whole house at 8am or 8pm. The third med pass must be observed by the PC, a QDDP/Admin, or the RN. Once all three med passes have been completed, the PC needs to scan and email this form to the RNs. The staff IS NOT allowed to pass medications without supervision until the RN has responded that this form was received and approved.

Date/Time:						
DID THE STAFF???	Y	N	Y	N	Y	N
1. Set up the MAR using the paperclip system?						
2. Wash hands before beginning med pass?						
3. Unlock medication storage area?						
4. Open the MAR to the person's section?						
5. Take one person's medication from the storage area and check the labels on the side of the Safedose box (or on the card/bottle) against the MAR comparing the consumer name, medication, dose, route, and time/date of administration? Place a dot in the corresponding box on the MAR. **First Check**						
6. Check the label on the Safedose packet (or on the card/bottle) against the MAR, comparing the consumer name, medication, dose, route and time/date of administration? Check the description of the pill's color/shape. Place a mark on the packet next to each med as you check it. Place your first initial in the corresponding box on the MAR. **Second Check**						
7. Remove the medications from their package and put in the medication cup?						
8. Recheck the label on the now empty packet (or card/bottle) against the MAR and compare the consumer name, medication, dose, route, and time/date of administration. Count the medications on to be given on the MAR, on the packet/card/bottles, and what's in your cup. **Third Check**						
9. Follow any special instructions, i.e.: crush, shake well, take pulse or blood pressure first, pour liquids at eye level. Etc.						
10. Put the medication boxes/bottles/cards etc. back into the medication closet?						
11. Ask the person to come to the staff to receive their medications? **Speak to the person and use their name before administering their medications.** If the staff delivered the meds to the person, did they lock the medication storage area first?						
12. Watch the consumer swallow the medications?						
13. **Document your last initial** for all medications given **as soon as the medications are taken**?						
14. Remove the colored paper clip after the medications were given?						
15. Use skin cleanser or wash hands before moving on to the next person?						
16. Repeat all of the above steps for the remaining people in the house?						

17. Complete the Buddy Check Procedure on self for all of the people in the house to make sure nothing was missed, including documentation?						
18. Ensure the medication storage area is locked up before leaving the area?						

PROCEDURE	**Demonstrated Correctly?**		**If med is not available did they explain the procedure correctly?**		**COMMENT**
	YES	**NO**	**YES**	**NO**	
Oral Medications, tablets, or capsules					
Liquid medication					
Insulin administration					
Eye drops					
Eye ointments					
Nasal spray					
Ear drops					
Rectal medication- Enema & Suppositories					
Applying a medical patch					
Removing a medical patch					
Inhalers					
Nebulizer treatments					
Glucometer testing					
Gastrostomy tube feedings					
Gastrostomy tube administration of medications					
EPI-PEN Administration Procedure					
Topical Medications					

Signature of Staff Being Trained: _____

Signature of Staff Observing Med Pass #1:_____

Signature of Staff Observing Med Pass #2: _____

Signature of Staff Observing Med Pass #3: _____

RN Approved: _____ **Date**:_____

BUDDY CHECK POLICY/PROCEDURE

The Buddy Check System refers to the process of double checking yourself and others that no medications or treatments were missed during that shift. If you are working alone, the Buddy Check should be done by yourself on yourself, immediately after you complete a med pass. If you are working with another staff, the second staff would complete the Buddy Check immediately after you complete the med pass. Buddy Check is then ALSO done at shift change between you (the leaving staff) and whoever the oncoming staff is. When you do the Buddy Check on yourself, you are not initialing on the Buddy Check Sheet. It is the second staff (right away or at shift change) who is documenting on the Buddy Check Sheet.

How to Do the Buddy Check:

1. Open the MAR to the first individual in the book.
2. Find the correct date on the MAR.
3. Run your finger down the column for the current date, checking EVERY medication listed as to whether there are initials in the box or not, and whether there should be. Examples: if it is currently 10am and I am doing the Buddy Check, and the first medication listed is an 8am medication, then I should see initials in the box. If the second medication listed is an 8pm medication, then I should see nothing in the box for today's date because it is not yet 8pm.
4. If everything matches what it should be, then you repeat steps 1-3 for the remaining individuals in the home and then sign the Buddy Check Sheet. If a discrepancy is found then proceed to step 5.
5. If a discrepancy is found, you need to attempt to figure out what the issue is by asking questions to the person who gave the medications and also verifying what is on hand (for instance if initials are missing in a box on the MAR for a medication that should have been given, then checking to see whether or not that packet is still in the Safedose box would be a good first step in determining if the medication was indeed given or not). If everything was given correctly but documentation was just missed AND you have caught the documentation error at the time of the Buddy Check BEFORE the staff has left the property, then it does not constitute a documentation error and the staff may initial as appropriate on the MAR. If the person leaves the premises then it becomes a documentation error AND the oncoming staff will receive a Buddy Check error for not completing these steps at shift change.
6. If the discrepancy found is more than just documentation and is an actual medication error, the office staff (during business hours) or On-Call person (after hours) need to be called immediately so they can contact the RN for further instructions. See the Medication Error section for further information on what constitutes a medication error and how to handle those situations.

BUDDY CHECKLIST

By initialing this form, I agree that I have verified that the medication passed by my co-worker was done accurately and in accordance with the Oakridge medication administration policy. If upon verification, the med pass is determined to be inaccurate or proper procedures were not followed, I agree to immediately report the issue to the Clarissa office or On call person and wait for further instructions for possible correction of the issue. If is determined that any staff initials this form without properly verifying the med pass or fails to report any issues, they will be subject to disciplinary action and may be terminated.

HOME: _____ MONTH: _____

	Client Initials	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	31
MORNING The person signing in this box is indicating that all morning medications were given accurately.																																
AFTERNOON The person signing in this box is indicating that all afternoon & evening medications were given accurately.																																
HS/PM The person signing in this box is indicating that all HS/PM medications were given accurately.																																

Record INITIALS and SIGNATURE on the lines below.

Initials/Signature:					
Initials/Signature:					
Initials/Signature:					

MEDICATION ERRORS

What is a Med Error?

Violation of one or more of the "Six Rights" constitutes a medication error:

1. Right Person
2. Right Time and Date
3. Right Medication
4. Right Dose
5. Right Route/Method of Administration
6. Right Documentation

Documentation errors may include

- not signing for a given medication
- not initialing for a medication
- not using the buddy check system
- not using the paper clip system
- other errors that may result from neglected or poor documentation

Errors with Rights 1-5 are considered Reportable Errors, whereas documentation errors are Non-Reportable. In both instances, a medication error report is filled out, but the word “reportable” is referring to whether or not there are people outside of Oakridge that need to be made aware of the error.

Steps to Follow when there is a Med Error

In the event an error occurs, the following procedure is implemented and the appropriate steps are followed.

1. Any medication error is to be reported immediately to the person who supervises that house (if after office hours, the person on-call) for directions on how to handle the medication error.
2. Medical professionals will be notified of ALL errors except documentation errors.
3. Medication Error Report:
   a. The staff finding the error will initiate the Medication Error Report and will:
      - Determine if the error is reportable or non-reportable and begin filling out the appropriate side of the medication error report form
      - answer all questions on the form completely,
      - scan/email a copy to the nurse, and on-call person after hours or designated QDDP, Program Director or administrator responsible for that house.
      - leave the form for the person making the error and the PC to complete
   b. The person making the error must:
      - complete the section referring to how the error could have been prevented,
      - sign and date the form
      - scan/email a copy to the nurse and the QDDP, Administrator or Program Director responsible for that house.
      - leave the form for the PC to complete
   c. The PC will:
      - review the information on the form

- sign and date the form
- send the form to the nurse

d. Record the error in the appropriate person's progress notes, describing the error, the directions from the medical professional, on-call person, or other medical resource and any effect experienced by the person, stating just the facts.
e. The nurse will complete the error report and file it appropriately.

Passing medications is a very serious responsibility; the persons supported rely on staff to give them correctly. Staff should strive to have no medication errors. Always follow the 3-check split initial system that is a part of this medication policy and has been taught in the medication administration class; do not take shortcuts.

Suggested Resources for Handling Medication Errors

a. Pharmacy Education Sheets that are issued for each medication when filled. Group homes should have these either in each person medical record or in a medication resource book.
b. www.nlm.nih.gov/medlineplus/druginformation .html
c. Pharmacist
d. Poison Control
e. Medical professional
f. Emergency Room and clinic triage nurses may be of value depending on the community where the homes are located.

Consequences of Med Errors

When medication errors occur, the RN will review the medication error report to determine if the error was an individual error or a system error. If the error is a system error, the system will be corrected and staff will be re-trained, but not disciplinary action will be taken. If the error is an individual error, the disciplinary process will be followed. Reportable and Non-Reportable errors are treated differently as listed below.

Reportable Errors

Reportable Errors means the team, case manager, legal representative, and medical provider will be notified of the medication, treatment, or therapy error. Reportable errors are assigned points depending on the type of error and whether or not there were any adverse reactions as a result of the error. The points stay on the staff member's record until one year from the date the error was made, and then the points for that error only will "drop off" the staff's record and no longer count against them.

- Reportable Errors Point Values:
    1. Wrong consumer = 6 points
    2. Wrong medications = 3 points
    3. Wrong time or date = 3 points
    4. Wrong dose = 3 points
    5. Wrong route/method of administration = 3 points
    6. Any error resulting in adverse reaction to the consumer = 6 points

Additional training may be required at any time per the discretion of the RN. Once a staff member has accumulated 18 points, they are no longer able to pass medication, and the following consequences will occur for a minimum of 90 days:

1. Staff may have a pay rate deduction of 50¢ per hour due to inability to perform an essential part of the job.
2. Possible scheduling changes and/or loss of hours due to necessity of providing persons with staff that are able to pass medication.
3. Possible termination of employment if there are no shifts or hours that can be provided that do not require medication passing ability.

During the 90 days, staff must take a condensed, intensive medication class with the RN and must have a minimum of 3 supervised med passes with no errors. If this is completed, the staff may be reinstated to their former rate of pay and medication passing duties. If a staff is reinstated, they must remain error free until their points are cleared according to the rolling calendar method described above. If they receive an error after reinstatement, the above guidelines will be used for a period of six months instead of 90 days. A third violation of this process may result in termination of employment.

<u>Reportable Errors for Person Refusals and/or Out of Home Errors</u>

A reportable medication, treatment, and therapy error report form needs to be filled out by staff if a person refuses medication and/or treatment and/or if medication or treatment is not taken appropriately while out of the home. The purpose of this error form is for tracking purposes; it is not a staff error.

<u>Non-reportable Errors</u>

- Non-reportable Errors consist of: Documentation (this is also listed on the other side of the report), Buddy System Check, or the Paperclip Procedure not being followed.
- Should a Non-reportable Error result, the team, case manager, and medical provider do not need to be notified. You will still need to send the completed Med Error Report(s) to the nurse.
- The Non-reportable Errors will also be tabulated twice a month and will be based on the number of episodes. For example: During that 2-week period, if any individual has 1 or more occurrences it will be considered one episode.
- Example of the disciplinary process is as follows:
    1. 1st Episode - Coaching
    2. 2nd Episode - Verbal
    3. 3rd Episode - Written
    4. 4th Episode - Suspension
    5. 5th Episode – Termination

For any type of error, the goal is to make you successful in the medication task by providing you the education and tools you need to safely administer medication to the individuals that we serve. Education and re-training will be the primary focus when errors occur, with the disciplinary process in place to emphasize the severity and importance of following the medication related policies and procedures.

REPORTABLE MEDICATION, TREATMENT, and THERAPY ERROR REPORT

Name of Person Discovering Error: _____Date & Time of Error: _____
Employee(s) Involved:_____
Client Name: _____Birth date: _____House Name/Number: _____
Type of Error: ☐Wrong Drug ☐Wrong Dose ☐Wrong Route ☐Wrong Time ☐Wrong Consumer
☐ Missed Dose/Treatment or Therapy ☐Refusal of Medication/Treatment or Therapy ☐Other
Description of Error (Include Name of Medication and Dose): _____
_____
_____
_____
Who was contacted for direction regarding error (medical provider, QDDP, Nurse, Poison Control, etc.)? Name of person contacted: _____
Date & Time of Contact: _____ Name of Staff Making Contact: _____
Recommendations from person contacted: _____
_____
_____
Possible Adverse Reactions: _____
_____
Adverse Reactions: ☐Yes ☐No
Description of Adverse Reactions, if any: _____
_____
_____
Explain How this Error Could Have Been Prevented:_____
_____
_____
_____
ORHWV Nurse Comments: _____
_____
_____

Signature of Person Making Error: _____ Date: _____
Signature of PC: _____ Date: _____
Signature of ORHWV Nurse _____ Date: _____

(Circle One)

Date Notification was sent to Case Manager: _____ by Fax / Hand Deliver / Call / Email
**All errors except wrong documentation, buddy system, or paper clip procedure must be sent to the case manager.*

Date Notification was sent to Guardian/Legal Rep: _____ by Fax / Hand Deliver / Call / Email
**All errors except wrong documentation, buddy system, or paper clip procedure must be sent to the guardian/legal representative.*

Date Notification was sent to Prescribing Provider: _____ by Fax / Hand Deliver / Call / Email / MyHealth Chart
**provider should be notified for wrong medication, wrong route, wrong dose, continued refusal of medications, or any error that results in an adverse reaction.*

NON-REPORTABLE MEDICATION, TREATMENT, and THERAPY ERROR REPORT

Name of Person Discovering Error: _____ House:_____
Employee Involved: _____Date & Time of Error: _____
Client Name: _____ Birth date: _____
Type of Error: ☐Wrong/Missing Documentation ☐Paperclip System ☐Buddy Check System
☐Other:_____
Contacted Regarding Error (RN, QDDP, PC etc.): _____

Employee Who Made the Error, Fill Out the Following Areas:
Description of Error: _____
_____
_____
_____
_____

Explain Why the Procedure Was Not Followed: _____
_____
_____
_____
_____

How Can You Prevent This Error from Occurring Again? _____
_____
_____
_____

ORHWV Nurse Comments:_____
_____
_____
_____
_____

Signature of Person Making Error:_____

Signature of PC:_____

Signature of ORHWV Nurse:_____

Example

Oakridge Homes/Woodview Support Services (ORH/WSS)
Medication Administration Policies

REPORTABLE MEDICATION, TREATMENT, and THERAPY ERROR REPORT

Name of Person Discovering Error: Susie Staff, DSP Date & Time of Error: 7·1·21 8:00 AM
Employee(s) Involved: Mark Madeup, DSP
Client Name: Joe Jolly Birth date: 4·2·75 House Name/Number: 1037
Type of Error: ☐ Wrong Drug ☐ Wrong Dose ☐ Wrong Route ☐ Wrong Time ☐ Wrong Consumer
☒ Missed Dose/Treatment or Therapy ☐ Refusal of Medication/Treatment or Therapy ☐ Other
Description of Error (Include Name of Medication and Dose): Joe did not receive his Scheduled 8AM dose of lisinopril 10mg for high blood pressure.

Who was contacted for direction regarding error (physician, QDDP, Nurse, Poison Control, etc.)? nurse Patty

Date & Time of Contact: 7·1·21 10:15 AM Name of Staff Making Contact: Susie Staff
Recommendations from person contacted: Patty said to take Joe's blood pressure and give the lisinopril 10mg as ordered.

Possible Adverse Reactions: high blood pressure, headache

Adverse Reactions: ☐ Yes ☒ No
Description of Adverse Reactions, if any: none noted

Explain How this Error Could Have Been Prevented: following the med administration procedure, noting on the MAR that the lisinopril was in a separate bottle, doing the buddy check procedure on myself and at shift change.
ORHWV Nurse Comments:

Signature of person making the error: Mark Madeup, DSP Date: 7·1·21
Signature of PC: Date:
Signature of ORHWV Nurse Date:

(Circle One)
Date Notification was sent to Case Manager: 7·1·21 by Fax / Hand Deliver / Call / Email – 10:32 am
All errors except wrong documentation, buddy system, or paper clip procedure must be sent to the case manager.

Date Notification was sent to Guardian/Legal Rep: 7·1·21 by Fax / Hand Deliver / Call / Email – 10:33am
All errors except wrong documentation, buddy system, or paper clip procedure must be sent to the guardian/legal representative.

ate Notification was sent to Prescribing Physician: NA by Fax / Hand Deliver / Call / Email / MyHealth Chart
physician should be notified for wrong medication, wrong route, wrong dose, continued refusal of medications, or any error that results in an adverse reaction.

Example

Oakridge Homes/Woodview Support Services (ORH/WSS)
Medication Administration Policies

NON-REPORTABLE MEDICATION, TREATMENT, and THERAPY ERROR REPORT

Name of Person Discovering Error: Susie Staff, DSP House: 1037
Employee Involved: Susie Staff Date & Time of Error: 7·1·21 8AM
Client Name: Joe Jolly Birth date: 4·2·1975
Type of Error: ☐ Wrong/Missing Documentation ☐ Paperclip System ☒ Buddy Check System
☐ Other:
Contacted Regarding Error (RN, QDDP, PC etc.): Nurse Patty

Employee Who Made the Error, Fill Out the Following Areas:
Description of Error: I did not perform the buddy check at the start of my shift at 9Am which resulted in a missed medication not being caught.

Explain Why the Procedure Was Not Followed: Mark was excited to show me photos of his new dog and we got distracted with that until he suddenly had to leave to pick up his children.

How Can You Prevent This Error from Occurring Again?: Complete all of the required shift change duties right away without distractions.

ORHWV Nurse Comments:

Signature of Person Making Error: Susie Staff

Signature of PC:

Signature of ORHWV Nurse:

MEDICATION SETUP FOR ABSENCES FROM THE HOME

If a person is going to be gone from the home over a medication time, the staff may setup the medication to be given at a later time.

1. Staff will fill out a Medication Setup Record form indicating which medications they have setup.
2. If the medications needed are in a Safedose packet, then you would just tear off the packets that correspond to the correct date/time of the leave of absence from the roll and send those with the person.
3. If the medications are located in a bottle or bubble pack card, you would punch out the pills needed, and put them in a small clear plastic bag, and write all of the information of the medication on the outside of the packet. Do this for each med pass time. When done, your packets should resemble the Safedose packets. (Date, time, medication, dose, number of pills, pill description).
4. If the person is going to a day program, you do not need to do anything further. If the person is leaving with non-Oakridge staff for any other reason, staff also need to fill out the Temporary Release from Facility form.

Medication Setup Record

Document the information below each time a trained staff completes medication setup when the person will be away from home. Trained staff must document the medication setup in the consumer's medication administration record.

Person's Name: _____ Date of medication setup: _____
Staff Completing Medication Setup: _____
Staff Releasing Medications to Responsible Party: _____
Person Receiving the Medications: _____ Date & Time: _____
Responsible Party Signature: _____
Staff Signature: _____
For each medication setup document the following information:

Name of Medication	
Dose	
Quantity:	
Times to be administered	
Dates to be administered	
Name of Medication	
Dose	
Quantity:	
Times to be administered	
Dates to be administered	
Name of Medication	
Dose	
Quantity:	
Times to be administered	
Dates to be administered	

Name of Medication	
Dose	
Quantity:	
Times to be administered	
Dates to be administered	
Name of Medication	
Dose	
Quantity:	
Times to be administered	
Dates to be administered	
Name of Medication	
Dose	
Quantity:	
Times to be administered	
Dates to be administered	
Name of Medication	
Dose	
Quantity:	
Times to be administered	
Dates to be administered	

TEMPORARY RELEASE FROM FACILITY
Medication Release and Physical Inspection

BEFORE PERSON LEAVES:

I have inspected _____ for signs of injury or disease prior to this person's temporary release to _____. I have found _____
_____
_____

I have included a Medication Setup Record form and the necessary medications for the duration of this temporary release (if applicable).
I have explained to the party signing the responsibility portion of the form the use of any medications to be administered, or other treatments necessary for the person's well-being while away from the facility. I have provided a set of Medication Administration Records (MAR) which includes a complete list of all medications and treatments prescribed.

Staff Signature: _____

****

RESPONSIBLE PERSON and/or FACILITY REPRESENTATIVE (i.e. HOSPITAL STAFF, POLICE, ETC.)
I accept full responsibility for the proper disposition of these medications and the care of this person while away from Oakridge Homes. I acknowledge that I have received a set of Medication Administration Records (MAR), which includes a complete list of all medications and treatments prescribed, the corresponding medications, and I agree with the notes regarding the person's physical condition upon leaving the facility.

Responsible Person/Facility Rep Signature: _____
Date of Release:_____ Time of Release:_____ am/pm

****

AFTER PERSON RETURNS:
I have observed and/or asked _____ for signs of injury or disease upon this person's return to Oakridge Homes. I have found _____
_____

Medications returned: _____
_____
_____

If medications were not given/missed/refused etc. during the visit, please fill out a med error form.

Date of Return:_____ Time of Return:_____ am/pm

Staff Signature_____Date_____

DESTRUCTION OF MEDICATIONS

1. Find a Medication Destruction Form.
2. Fill in the person's name and location.
3. Enter the date, medication prescription number, and amount to destroy or sending back to SafeDose.
4. If you return the medication(s) to SafeDose:
    a. Prepare the medications to send back to SafeDose.
    b. Document on the form that it is being sent to SafeDose.
    c. PC and DSP initial form. Make two copies, send one with the medications being sent and keep one for our records.
    d. **If you are sending back controlled medications the entire process needs to be done together, PC & DSP!**

5. **Controlled medications must be destroyed with the ORH RN. Stop here and contact the ORH RN before destroying the medication!**
6. Remove the medication from its original container(s) and mix it with an undesirable substance, such as used coffee grounds or use an empty soda/water bottle with a mixture of dish soap and water. (Take off the circular label to keep someone from thinking it is indeed soda.)
7. If you used coffee grounds place in a container such as a margarine, sour cream or cool whip type container to prevent the drug from leaking or breaking out of a garbage bag. You will then wrap the container in duct tape to prevent leaking in the garbage.
8. Put the container in a garbage bag and take this garbage bag directly to the trash can outdoors to be removed the next pick-up day.
3. Finish by initialing on the form as PC and staff.

Medication Destruction Form

Person's Name _____ **House Name/Number** _____

DATE	MEDICATION AND STRENGTH	PRESCRIPTION NUMBER	AMOUNT	RETURN TO PHARMACY	NARCOTIC	PC SIGN	STAFF SIGN	ORH RN SIGN

Non-controlled medications can be destroyed with the PC and one other staff. Controlled medications must have the RN be one of the two staff.

Staff Initials	Staff Signature and Title	Staff Initials	Staff Signature and Title

Updated 7/9/21

OBSERVATION

Observation is the act of noticing or seeing something. It means being attentive to the people you see and to the things going on around you. There are two categories of observations.

Objective Observation:

These are things you see, feel, hear, smell, or measure. They are also called signs. There are many things to observe such as behavior, physical condition, reactions, activities, movement, eating, mental condition, changes in condition and signs of illness. These are objective observations you should make:

1. Measurements:
    a. vital signs
        (1) temperature
        (2) pulse
        (3) respirations
        (4) blood pressure
        (5) weight
    b. urine output
    c. intake of liquids and solids
2. Physical condition:
    a. swelling
    b. color of skin and nails (pale, flushed, yellow, gray, bluish)
    c. odors
    d. skin redness, irritation, bruises, breaks, tears, burns
    e. difficulty breathing
    f. coughing
    g. wound drainage
    h. firmness in the stomach area
    i. gas, incontinence
    j. skin condition and turgor (Is the skin dry? Does it return quickly to normal shape when pinched?)
3. Activities, assisted or unassisted:
    a. bathing
    b. sleeping
    c. walking
    d. use of assistive devices
    e. movement
4. Mental condition
    a. awareness
    b. orientation (Do they know what time and day it is? Do they know where they are?)
    c. consciousness
    d. confusion
    e. mood
5. Situations
    a. falls
    b. rapid changes in condition

c. accidents, burns, injuries

Subjective Observation

These are things you are told, or things you have a feeling about. They are also called **symptoms**. Pain is a subjective observation; only the person knows how much pain he or she is feeling and no one else can judge his or her level of discomfort. We can objectively observe that the person is restless, or is making facial grimaces, or is moaning as if in pain, but the pain itself is a **subjective** experience. If a person tells you he or she is not feeling well, that is a subjective observation.

1. Person statement about:
   a. pain or discomfort
   b. appetite
   c. feelings
   d. other concerns

What should you observe?

Many things do not have to be measured on a regular basis unless it is part of the person's plan of care. Anytime anything seems unusual you should observe it more closely. Anytime the person expresses concern about something you should pay close attention. It is very important to observe and report **changes** in the person's normal condition or behavior. **A change in behavior is often the first sign of illness.**

When should you observe?

Observe **ALL THE TIME**.

a. When you are helping with a person's personal care, observe skin, hair, color, strength, flexibility, stamina, speech, behavior, color of urine, and other aspects of their physical and mental condition.
b. When you are helping with a meal, watch what is consumed (food and drink, type and amount).
c. When you are helping with ANY activity or aspect of care, even just talking to a person, stay alert and watch carefully for **anything different or new** and anything you should report or record.

How should you observe?

Use all your senses. Practice noticing details.

Reporting: If you notice anything out of the ordinary for the person, you **should take care of the person first** (call 911 if appropriate, provide first aid, etc.). After you have called 911 or determined that the situation is stable, then you contact your PC and/or the QDDP/On-Call who will notify the RN. Report as many details as you can, and fill out the corresponding form for the situation (incident/behavior report, skin observation, medication error report etc.).

Report even if you don't think it is important. Whenever you see, hear, smell, touch, or feel something that raises a question in your mind, ask about it. When in doubt, report!

DOCUMENTATION

Documentation is one of the most important duties workers perform. Effective documentation is:

- timely
- systematic
- accurate
- descriptive
- clearly written

It must comply with standards established by accrediting and licensing organizations, state and federal agencies, insurance companies, and ORH/WSS. The person's record is:

a. confidential
b. essential for well-coordinated care
   (1) Be factual.
   (2) Use only abbreviations contained in this ORH/WSS policy.
   (3) Be exact about the time things occur.
   (4) Be brief; stick to the main point; be specific.
c. a legal document
   (1) Write legibly in appropriate color ink.
   (2) Draw lines through mistakes and initial them. Do NOT white-out or erase.
   (3) Draw lines through unused spaces so no one can write in them later.
d. a story about the person; it is not the place to write about problems with coworkers, supervisors, short staffing, etc.

Progress notes should contain documentation of the events of the person's day and read as a story. Anything that pertains to the person's psychological, physical, or social well-being must be recorded. Don't forget to include the positive and fun parts of their lives!

1. **Program Issues in Progress Notes – Black Ink:** Behavior changes; (always be on the lookout for a medical reason). Sometimes this is the only way these folks have of telling us they have a medical problem.
   a. Daily participation in home/community events
   b. Leave for vacation/home visit, and the return. Where they went and with whom
   c. Any unusual event. Anything interesting – Good or Bad

2. **Health Issues in Progress Notes – Red Ink:**
   a. Acute illness, with or without elevated temperature, i.e., vomiting, diarrhea, upper respiratory infection. Document on all shifts until condition subsides.
   b. Injuries and what was done.
   c. Medication changes - Monitor whether the medication is *effective,* or, if they have any side-effects. Chart any person reactions until well-adjusted to the medication.
   d. Treatments, whether they are a nursing or MP's order, it is important to document the effectiveness of the treatment.
   e. Seizures must be documented on the seizure documentation page and as a narrative in the progress report.
   f. Medical professional visits: the reason, who they saw (dentist, physical therapist,

etc.), where, and any recommendations made by the medical professional.

3. **Psychotropic Issues in Progress Notes – Blue Ink:**
    a. The goal designed to assist the person to work with their psychotropic medication.
    b. Their participation and outcomes of the goal
    c. Behaviors and management of the same.

PROCEDURES FOR ADMINISTRATION OF MEDICATIONS BY ROUTE & RELATED TASKS

ASSESSING FOR NON-VERBAL SIGNS OF PAIN

Some people are not able to verbally tell you they are having pain. Below are some of the most common non-verbal expressions of pain in adults.

- Look of pain on the person's face, facial grimacing or a frown, holding eyes tightly shut or pursed lips.
- Clenched or clutching blankets or seat cushions.
- Hand movements that show distress.
- Guarding a particular body part or reluctance to move.
- Moaning with movement or groaning or whimpering.
- Small range of movement or slow movement.
- Increased heart rate or blood pressure or sweating.
- Restlessness, constant shifting in bed.
- Crying or distress.
- Making more or fewer sounds.
- Withdrawing, appearing uneasy and tense, perhaps drawing legs up or kicking.
- Slowness to fall asleep or increased sleep.
- Low appetite (and consequently low nutritional intake).
- Increased confusion.
- Anger, aggression, irritability or agitation.

Some people show little or no signs that they are in pain, and some of the above signs may not be due to pain but to something else.
If the individual is showing signs of pain notify your PC or the Designated Coordinator. Update nurse as needed.

ASTHMA: GENERAL INFORMATION

Definition: Asthma is a condition in which your airways narrow and swell and may produce extra mucus. This can make breathing difficult and trigger coughing, a whistling sound (wheezing) when you breath out (exhale) and shortness of breath.

Signs and Symptoms:

- Shortness of breath
- Chest tightness or pain
- Trouble sleeping caused by shortness of breath, coughing, or wheezing
- Coughing or wheezing attacks that are worsened by a respiratory virus, such as a cold or the flu

Asthma Triggers:

- Airborne allergens, such as pollen, dust mites, mold spores, pet dander or particles of cockroach waste
- Respiratory infections, such as the common cold
- Physical activity
- Cold air
- Air pollutants and irritants, such as smoke
- Certain medications, including beta blockers, aspirin, non-steroidal anti-inflammatory drugs, such as Ibuprofen (Advil, Motrin IB) and naproxen sodium (Aleve)
- Strong emotions and stress
- Sulfites and preservatives added to some types of foods and beverages, including shrimp, dried fruit, processed potatoes, beer and wine.
- Gastroesophageal reflux disease (GERD), a condition in which stomach acids back up in throat.

8/31/20

Signs and symptoms the person's asthma is probably worsening:

- Asthma signs and symptoms that are more frequent and bothersome
- Increasing difficulty breathing
- The need to use a quick-relief or fast-acting inhaler more often

If you notice any of the above symptoms with the individual update the PC or the on-call right away.

The individual should seek immediate medical care if:

- Rapid worsening of shortness of breath or wheezing
- No improvement even after using a quick-relief or fast-acting inhaler
- Shortness of breath when you are doing minimal physical activity

Call 911 immediately if they are having difficulty in breathing.
The PC will be contacted after the individual has been taken care of.
You DON'T need permission from your supervisor to call 911.

Always follow the individual's protocol given by medical provider.

BLOOD SUGAR: HOW TO OBTAIN A BLOOD SUGAR WITH A GLUCOMETER

1. Wash hands.
2. Gather supplies: Gloves, alcohol wipe, cotton ball (or similar), glucometer, lancet, and test strip.
3. Advise the individual as to what you are doing.
4. Ask them which finger they would like to use to get a sample of blood.
5. Clean their finger with alcohol pad. Ensure that area is completely AIR dry before the finger stick.
6. Do not blow on finger or "fan" to help aid in the drying process, this will introduce germs.
7. Take the lancet and pierce the skin of the individual's finger to get a droplet of blood. (it is ok to squeeze their finger to get a bigger droplet of blood)
8. Take the test strip and insert it into the glucometer. This will automatically turn the machine on.
9. Place the tip of the test strip onto the droplet of blood on the individual's finger. You will want a big enough droplet of blood to fill the tip of the strip. Typically, the glucometer will "beep" when enough blood has been obtained.
10. When ready, the machine will display the blood glucose reading.
11. Take a cotton ball (or similar) and wipe the individual's finger and ensure that bleeding has stopped.
12. Clean and put away all supplies.
13. Record blood sugar in MAR or on blood sugar sheet
14. Wash hands.

CPAP/BiPAP USAGE AND CLEANING

USAGE

1. Check the MAR for an order indicating that the individual has been prescribed to use a CPAP or BiPAP machine. The MAR should also indicate the cleaning/replacement schedule of the different parts, so make sure to check whether or not it is time to change one of the pieces.
2. CPAPs and BiPAPs are used while people are sleeping. If the individual needs assistance with putting on the face mask, wash your hands and assist them. Ensure that the nose piece has made a seal with their skin- if you hear air "hissing", there is not a good seal.
3. Some CPAPs and BiPAPs have a water chamber to help moisten the air the individual is breathing in. If this applies, make sure there is water in the water chamber, or fill to the fill line with distilled water.
4. When they wake up, you can assist with removal if needed (wash your hands first). Make sure to shut off the machine.

CLEANING

Daily (tubing, nasal mask, headgear):

1. Place the tubing, nasal mask/pillows, and headgear into a sink with warm water and a mild soap.
2. Move the supplies around in the water, rubbing together etc. for about 5 minutes.
3. Rinse well with clean, warm water.
4. Place the mask and headgear on a towel to air dry.
5. Hang the tubing (ex: over the towel bar or the shower curtain rod) to air dry.

Weekly (filter and water tank):

1. Remove the filter from the back of the machine.
2. Rinse under running tap water.
3. Squeeze the filter to make sure all of the dust is eliminated.
4. Blot the filter with a clean towel to remove most of the moisture.
5. Put the filter back into the machine.
6. Remove the water tank.
7. Wash with warm, soapy water.
8. Rinse thoroughly with clean tap water.
9. Dry with a clean towel.
10. Refill with distilled water to the fill line.
11. Place back into machine.

REPLACEMENT

1. Follow the manufacturers guidelines for the specific machine that is being used and the individual's insurance allowances.
2. Typically, a replacement schedule would be something like:
    - Full face mask- every 3 months
    - Headgear-every 6 months
    - Nasal cushions/pillows- every month
    - Tubing- every 3 months

- Non-disposable filters- every 6 months
- Water tank/humidifier chamber- every 6 months
- Machine itself- serviced once per year, replaced every 5 years

3. The schedule that is being followed should be indicated on the MAR so that staff knows when each piece is due to be replaced.
4. If a piece if broken or not working properly prior to the time when it is scheduled to be changed, notify your PC and/or the RN.

DIABETES: HYPERGLYCEMIA (HIGH BLOOD SUGAR)

SIGNS AND SYMPTOMS

- Increased thirst
- Frequent urination
- Fatigue
- Nausea and vomiting
- Shortness of breath
- Stomach pain
- Fruity breath odor
- A very dry mouth
- A rapid heartbeat

If your muscle cells become starved for energy, your body may respond by breaking down fat stores. This process forms toxic acids known as ketones. If you have ketones (measured in blood/urine) and high blood sugar, the condition is called diabetic ketoacidosis. Left untreated, it can lead to a diabetic coma.

Severely high blood sugar (above 600) turns your blood thick and syrupy. The excess sugar passes from your blood into your urine, which triggers a filtering process that draws tremendous amounts of fluid from your body. This is called diabetic hyperosmolar syndrome. Left untreated, this can lead to life threatening dehydration and a diabetic coma.

TREATMENT

- There is no “set standard” for treating hyperglycemia.
- Each individual has a protocol to follow from their medical provider.
- Be sure to follow each individual’s protocol when a high blood sugar reading is confirmed.
- If no glucometer available and symptoms persist, seek medical attention.
- **If the individual is slow to respond or unresponsive call 911 immediately.**

Notify PC or on-call with a higher than normal blood sugar reading for further instruction.

DIABETES: HYPOGLYCEMIA (LOW BLOOD SUGAR)

Signs and Symptoms:

- Feeling shaky
- Being nervous or anxious
- Sweating, chills, and clamminess
- Irritability or impatience
- Confusion
- Fast heartbeat
- Feeling lightheaded or dizzy
- Hunger
- Nausea
- Pallor (color draining from the skin
- Feeling sleepy
- Feeling weak or having no energy
- Blurred/impaired vision
- Tingling or numbness in the lips, tongue, or cheeks
- Headaches
- Coordination problems, clumsiness
- Nightmares or crying out during sleep
- Seizures

A low blood sugar level triggers the release of epinephrine (adrenaline), the "fight-or-flight" hormone. Epinephrine is what can cause the symptoms of hypoglycemia such as thumping heart, sweating, tingling, and anxiety.

If the blood sugar level continues to drop, the brain does not get enough glucose and stops functioning as it should. This can lead to blurred vision, difficulty concentrating, confused thinking, slurred speech, numbness, and drowsiness. If blood sugar stays low for too long, starving the brain of glucose, it may lead to seizures, coma, and possible death.

TREATMENT

A good rule to follow is the 15-15 rule:

- Give 15 grams of carbohydrates
  - Peanut Butter with a piece of bread or crackers
  - All natural fruit juice (grape juice has the highest amount of carbohydrates)
  - Honey
- Check blood sugar after 15 minutes.
- Repeat steps until blood sugar is at acceptable level.
- Glucose tabs if ordered from medical provider.
- Follow specific protocol for the individual if available.

When symptoms are present, be sure to check the blood sugar immediately with a glucometer (if the individual has one) to confirm they have a low blood sugar reading.
Notify PC or on-call with a lower than normal blood sugar reading for further instruction.
If the individual does not have a glucometer and the symptoms continue, seek medical attention.
Update medical provider as needed for low blood sugars.

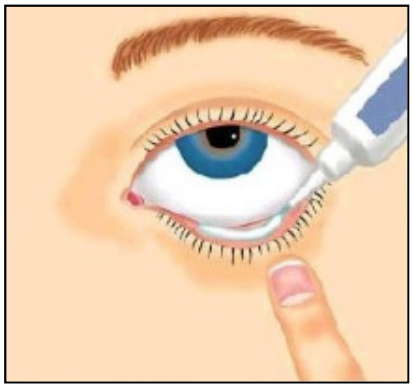
If the individual is sluggish or unresponsive call 911 immediately.

EYE DROPS

1. Gather necessary equipment and supplies (medication, gloves and a Kleenex).
2. Wash your hands.
3. Put on your gloves.
4. Have the person in a sitting position with their head tilted back or they may lie flat on their back.
5. Instruct the individual as to what you are doing.
6. Use one hand to gently pull their lower eyelid down away from the eye.
7. Hold the dropper tip directly over the eyelid pocket.
8. The dropper tip should be as close to the eye as possible without touching the eye.
9. Do not drop the drop unto the pupil or touch the eye with the container.
10. Squeeze the bottle gently and let the eye drop fall into the pocket.
11. Once the drop is in the eye, instruct the individual NOT to blink their eye or move it around to spread the drop. Instead, gently close their eyes just once.
12. If you have to give a second drop of the same medication you will need to wait 5 minutes before putting in the second drop.
13. If you are putting in two different types of drops wait five minutes between drops. This will keep the first eye medication from being washed out by the second eye drop medication.
14. If needed, you may use a Kleenex to gently wipe off any moisture under the eye by using a different part of the Kleenex or separate Kleenex to prevent cross contamination.
15. After completion, wash your hands and complete the documentation in the MAR.

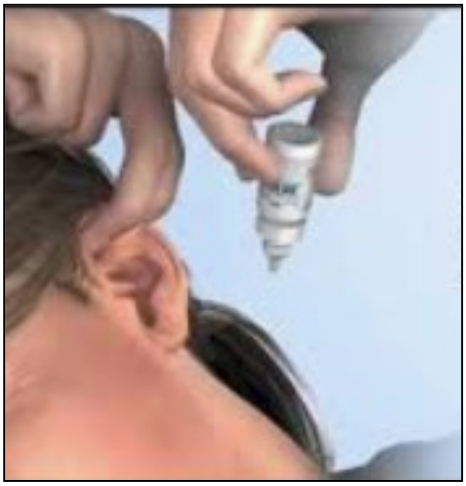
EYE OINTMENTS

1. Gather necessary equipment and supplies (medication, gloves and a Kleenex).
2. Do not let the top of the tube touch the individual's eye, caregiver's fingers or any other surface. This is to keep it free from germs such as bacteria.
3. Wash your hands.
4. Put on your gloves.
5. If the individual is wearing contacts they need to be removed them before applying the ointment.
6. Have the person either in a sitting position with their head tilted back or they may lie flat on their back.
7. Instruct the individual as to what you are doing.
8. Ask the individual to look upward.
9. Use one hand to gently pull down the lower eyelid of the eye to be medicated.
10. Hold the tube upside down near to the eye.
11. Place a small ribbon of the ointment starting from the outside of the eye towards the nose.
12. Apply enough pressure to the tube to release a thin line of ointment and wipe away excess.
13. Vision may be a little blurred after you use the eye ointment.
14. Have the individual close their eye for a moment or two blink a few times to spread the ointment around the inside of their eye and the vision should clear.
15. Instruct them not to rub their eyes.
16. Repeat the process in your other eye if both eyes are affected.
17. When you have finished, remember to replace the cap on the tube in order to prevent the ointment from becoming contaminated. Try not to touch the top of the tube.
18. Wash your hands at end of procedure and complete the documentation in the MAR.



EAR DROPS

1. Wash your hands.
2. Gather your supplies (medication, cloth or Kleenex).
3. Instruct the individual as to what you are doing.
4. Ear drops should be room temperature.
5. Position the individual's head so that the ear faces upward.
6. If the bottle has a dropper, draw some liquid into the dropper.
7. Gently pull the ear out and upward.
8. Instill the prescribed drops.
9. Have the individual keep their head tilted for a couple of minutes to prevent the drops from leaking out.
10. Wipe away any extra liquid with a Kleenex or cloth.
11. Wash your hands, put supplies away then complete the documentation in the MAR.



EAR LAVAGE

1. Wash your hands.
2. Gather your supplies which are the ear lavage syringe, medication, container for drainage and towel.
3. Instruct the individual as to what you are doing.
4. Provide the procedure in a private place if the individual will let you.
5. Draw up the room temperature solution into the syringe. Solution is determined by medical provider.
6. Have the individual sit upright with a towel on the shoulder to capture the solution that drains from the ear.
7. You can place a basin or another type of container underneath the ear to catch the solution.
8. Gently pull the ear upward and backward to allow the solution to enter the ear more easily.
9. Place the syringe in the ear, inserting it up and toward the back of the ear. This position will help the earwax separate from the ear and drain out of it.
10. Gently and slowly press on the syringe to allow the solution to enter the ear.
11. If the individual feels pain or pressure then stop the irrigation.
12. Repeat the above step until ear is clear of wax or the determined amount of solution has been used.
13. If the wax will not come out after repeated attempts then stop and update the medical provider or follow the medical provider's instructions for this.
14. Dry the ear using a towel.
15. Wash your hands, clean the equipment and put it away.
16. Complete the documentation in the MAR and document in the progress notes the result of the ear(s) lavage.
17. Update the medical provider as needed.

EPI-PEN

1. If the individual is unable to give their own EpiPen injection then the staff will administer it.
2. Gather necessary supplies which are gloves and the EpiPen.
3. The individual can be standing, sitting or lying down to administer the medication.
4. There are directions on the EpiPen for administration.
5. Pull off the colored safety cap (usually blue in color) by pulling straight up do not bend or twist.
6. Place the color tip that has the needle in against the middle of the outer thigh.
7. The injection can be given through clothes if needed.
8. The needle should be administered at a right angle (perpendicular) to the thigh.
9. Swing and push the auto - injector firmly into the thigh until it clicks.
10. The click indicates the needle went into the skin.
11. Keep the EpiPen in place for 3 seconds before you remove it.
12. Remove the pen after 3 seconds and massage the site for 10 seconds.
13. If the EpiPen is not effective call 911 immediately.
14. Let 911 or the ambulance attendants know you have 2nd EpiPen and follow their instructions.
15. After giving the EpiPen seek medical attention the effects could wear off in 10 or 20 minutes.
16. Wash hands and complete the documentation in the MAR.

Remove the EpiPen® / EpiPen® Jr. Auto-Injector from the carrier tube:

FLEET ENEMA OR LIQUID RECTAL MEDICATION

1. Check MAR for correct medication, dose, route, time, and person.
2. Provide privacy and explain what is going to happen.
3. Wash hands and apply gloves.
4. Assist the individual onto their left side with their right knee over their left leg.

5. If the individual can't lay on their left side then it is okay for them to lay on their right side.
6. Make sure you pad the bed in case of leakage.
7. If needed lubricate the tip of the nozzle with a water-based lubricant.
8. Depending on the medication it will be stored in the medication cabinet or in the refrigerator.
9. Insert the nozzle tip **slowly** between the colon and the feces and if you meet a resistance then **stop otherwise you may put a hole into the individual's rectum which will require medical intervention**.
10. You will insert the entire lubricated nozzle tip into the rectum.
11. Insert the nozzle into the rectum gently, if you meet resistance pull out and reinsert again slowly.
12. Slowly squeeze the bottle until the solution is emptied into the bowel.
13. Quickly cover their rectum for a few minutes with your glove hand.
14. This will help the individual to retain the fluid. Initially the rectum area may spasm.
15. If you have difficulty inserting the nozzle tip of the bottle into the rectum, there is pain or any bleeding noted notify your PC or the on-call right away for direction.
16. Dispose of the bottle.
17. Remove gloves and wash hands
18. Document in the MAR and progress notes if needed.

GARGLING- INCLUDING SALT WATER RINSE

1. Wash your hands.
2. Gather your supplies (gloves, glass/cup and the solution for gargling).
3. Instruct the individual as to what you are doing.
4. Fill the gargling cup/glass with the gurgling solution starting out with less of the solution in the cup/glass.
5. Put a small amount of gargling liquid in their mouth and swish it around for a few seconds.
6. For salt water rinse; use ½ teaspoon of salt in a full glass/cup of warm water.
7. The goal is to try and get the front and sides of the mouth, areas that gargling wouldn't get, during this first sweep.
8. Have them move their cheeks in and out, and their tongue back and forth in the mouth.
9. Tell them:
   a. "Tilt your head back and without swallowing the liquid, try to open your mouth and make the "ahhh" sound".
   b. Keep the back of the throat closed (epiglottis), so none of the liquid gets swallowed accidentally.
   c. Gargle the mixture around the back of the throat.
   d. Rinse it around the mouth, teeth and gums.
   e. Spit out the solution into the sink.
10. Repeat the above picture if needed.
11. Wash your hands; put supplies away if needed then complete the documentation in the MAR.

INHALERS

MIST INHALER

1. Wash your hands.
2. Gather supplies (inhaler and gloves).
3. Instruct the individual as to what you are doing.
4. Put the inhaler in the spacer if you have one.
5. Shake it for about 5 seconds.
6. Hold the inhaler up with your index finger on top and your thumb underneath to support it. Use the other hand to hold the spacer if needed.
7. Instruct them to breathe out.
8. Put the mouthpiece between the individual's teeth, and have them close their lips tightly around the spacer or the inhaler.
9. Make sure the tongue doesn't block the opening.
10. If not using a spacer direct the inhaler towards their throat.
11. Instruct the individual to breathe out.
12. Press the top down and have them breathe in until their lungs are filled completely about 3 to 5 seconds.
13. Instruct them to hold the medication in their lungs as long as they can (5 – 10 seconds is good), then have them breathe out.
14. If your medication has a steroid in it, have the individual rinse their mouth out with water and spit the water out to prevent thrush or a yeast infection in the mouth.
15. Wash your hands, put supplies away and document in the MAR.

DRY POWDER INHALER

1. Gather your supplies (medication and gloves).
2. Wash your hands.
3. Instruct the individual as to what you are doing.
4. Remove the inhaler cap if there is one.
5. Do NOT use a spacer.
6. Add or load a dose of medicine as directed by the health care provider.
7. Have the individual tilt their head back a little and breathe out slowly and completely.
8. Do NOT have the individual breathe out into the inhaler this will blow some of the powered medication out of the inhaler.
9. Place inhaler's mouthpiece between the individual's front teeth and instruct them to close their lips around it.
10. Press down on the inhaler and then have the individual inhale quickly and deeply through their mouth for 2 to 3 seconds. This pulls the powder into their lungs.
11. After the powder has been inhaled, take the inhaler out of the mouth.
12. Instruct the individual to hold their breath for 10 seconds or as long as they can. This lets the medicine settle into the lungs.
13. Instruct the individual to breathe out slowly through pursed lips.
14. Remind them not to breathe into the inhaler.
15. Repeat these steps if you have to take a second dose.
16. If the medication you are giving is a steroid then have them rinse their mouth out with water and spit the water out to prevent thrush or a yeast infection in the mouth.
17. Wash your hands, put supplies away, and then complete the documentation in the MAR.

INSULIN INJECTIONS

1. Gather necessary supplies; (insulin) pen, 2 insulin needles, alcohol pads, sharps container and gloves.
2. Insulin will be stored in the refrigerator or the medication cupboard depending on the manufacturer's guidelines.
3. Wash your hands.
4. Check the label against the MAR following the medication administration procedure.
5. Mix the insulin solution in the syringe by either rolling it between the palms of your hands or by tipping it up and down.
6. Do not shake the solution this will form air bubbles in the syringe.
7. Prime the pen which means removing air bubbles from the needle and ensures that the needle is open and working.
8. The pen must be primed before each injection.
9. Place a needle on the syringe.
10. To prime the insulin pen, turn the dosage knob to the 2 units indicator.
11. With the pen pointing upward, push the knob all the way and you should see drops of insulin being pushed out of the needle.
12. If you do not see the drops coming out of the needle then repeat steps 10 and 11.
13. If both attempts of priming the insulin pen are not successful then remove the current needle, place it in the sharps container and replace it with a new needle.
14. Repeat steps 10 and 11 again.
15. Turn the dial to the ordered amount of insulin.
16. If possible, the insulin dosage should be checked by another staff if available or, the individual receiving the insulin if they are able to verify the dose.
17. Gently clean the skin with an alcohol pad and if that isn't available then clean the injection site with soap and water.
18. Pinch the skin gently at the injection site.
19. Pierce the skin at a right angle (perpendicular).
20. The usual places to inject insulin are:
    a. the upper arm
    b. the front and sides of the thighs
    c. abdomen
    d. hips
21. Don't inject insulin closer than 2 inches from the belly button.
22. To keep the skin from thickening, try not to inject the insulin in the same place. Rotate injection places.
23. Push the plunger button on the pen all the way down until the plunger meets the pen.
24. Leave the insulin pen in place for 6 seconds after administering the insulin. If pulled out too soon the full dose of insulin is not administered.
25. Remove the needle, place it in the sharps container, and cleanse the site with an alcohol pad or soap and water.
26. Wash your hands, put equipment away and document in the MAR.

INSULIN: SLIDING SCALE

1. Insulin must be given according to a physician's order. Sometimes the insulin is ordered on a sliding scale, meaning the number of units of insulin that you will give the person is not always the same. The scale is individualized for the person, by the physician, and is listed on the MAR.
2. To determine the amount of insulin to give, you need to know the person's current blood sugar. To do this, you will either check their blood sugar with a glucometer following the glucometer policy, or check the reading on their sensor following the Libre or Dexcom policies.
3. Once you know the blood sugar value, you will compare this to the sliding scale on the MAR, and determine how much insulin to give.
   An example of a scale is shown below:

Blood Glucose	Units of Insulin to Give
0-150	0 Units
151-200	2 Units
201-300	4 Units
301 or more	10 units and contact physician

   In this example, if the blood sugar reading was 170, you would look on the chart and know to give 2 units of Insulin because 170 is between 151 and 200.
4. Sometimes the sliding scale amount is all of the Insulin that they get, and other times the order will say to give a set amount of Insulin, PLUS the sliding scale amount. Example: "Give 5 units of Insulin at noon along with units as determined by the sliding scale". For this example, you would be giving 5 units plus the 2 Units from the chart, for a total of 7 Units that would be administered as one total dose.
5. Once the correct dosage is determined, you then follow the Insulin Administration Policy to give the dose.
6. Document on the MAR the blood sugar reading and the number of units of Insulin that were given and the site it was given in.

LIBRE CONTINUOUS GLUCOSE MONITORING

APPLYING THE SENSOR

1. Wash your hands and gather your supplies.
2. Put on gloves.
3. Have the person served sit down and explain what you are going to do.
4. Choose your application site- The site MUST be on the back of one of the arms, not over top of any scars, moles, or open/irritated skin, and not in an area where the arm bends. Rotate arms/sites to avoid skin breakdown.
5. Wash the chosen site with soap and warm, dry, then cleanse with an alcohol wipe and allow to fully air dry.
6. Peel the lid back on the sensor pack to open it, but do not remove the sensor.
7. Take the cap off of the sensor applicator and set the lid aside.
8. Line up the dark mark on the sensor applicator with the dark mark on the sensor pack and press down firmly until it comes to a stop.
9. Lift up on the applicator, removing the sensor pack from the packaging. **Do not touch the end of sensor pack as this contains a needle**. It is now ready to be applied.
10. Place the sensor and applicator over the prepared site, and press down firmly to attach it to the site. This will activate the needle, so bruising and some bleeding is expected. **If bleeding doesn't stop, remove the sensor and contact the physician.**
11. Gently pull the activator away from the site, replace the cap, and discard in the sharps container.
12. Confirm that the sensor is securely in place by gently pressing down on the outsides of the adhesive and making sure it is firmly in place.

USING THE SENSOR

1. Touch the home button to turn on the reader (looks like a phone).
2. Touch "start new sensor".
3. Hold the reader within 1.5 inches of the sensor. If the sound is turned on, you will hear a beep. This activates the sensor. The sensor is then ready to start showing glucose readings 60 minutes after activation.
4. To get a reading, touch "check glucose" on the screen of the reader.
5. Hold the reader within 1.5 inches of the sensor. If the sound is on, you will hear a beep when the glucose reading is complete.
6. The glucose reading will show on the screen, along with an arrow that indicates if the glucose level is increasing or decreasing.

Note: If the person is showing symptoms of low or high blood sugar and the reading on the sensor doesn't seem to match the symptoms, double check the blood sugar with a traditional finger stick blood glucose reading.

REMOVING THE SENSOR

1. The sensor is intended to last 14 days and will automatically stop working after 14 days of use.
2. To remove, wash your hands and put on gloves.
3. Gently pull up on the adhesive that surrounds the sensor, and peel off the skin.

4. Hold the sensor in your palm while you remove your gloves, turning them inside out so the sensor is now wrapped in the glove.
5. Throw the sensor and gloves in the trash.
6. Wash your hands
7. Inspect the site where the sensor was to check for skin irritation, redness, bleeding, etc. – document if applicable.
8. Follow steps above for applying and starting the new sensor.

Please see THE User's Manual that came with the Libre, or the online version at https://www.freestyle.abbott/us-en/support/overview.html to view pictures and other helpful tips.

LIQUID MEDICATION

USING A MEDICATION CUP:

1. Wash your hands.
2. Gather your equipment (medication and a plastic measuring cup).
3. Shake the medication well.
4. Pour the medication away from the containers label to protect the label from drips.
5. Put the medication cup on a flat, level surface and measure at eye level.
6. You can also hold the medication cup at eye level and pour the prescribed amount in the medication cup.
7. Use the lines on the medication cup to fill it to appropriate line.
8. Always use the dosing device that comes with the medicine, such as syringe or dosing cup.
9. Never use household measuring devices to give liquid medication. They are inaccurate and may deliver more or less than prescribed.
10. Don't mix and match cups to different products you might end up giving the wrong amount.
11. If you over fill the cup do not pour it back into the container destroy the excess according to the destruction policy.
12. Return medication back to appropriate place.
13. After administration of the medication, wash your hands then complete the documentation in the MAR.

USING A SYRINGE:

1. Wash your hands.
2. Gather necessary equipment, (the appropriate size syringe and plastic medication cup).
3. Shake medication well.
4. Fill the syringe with the correct amount of medication by placing the syringe tip into the medication bottle and pulling back on the plunger to get the prescribed dosage of medication.
5. Tip the bottle enough so you will be able to draw back the medication.
6. Remove the syringe from the bottle and push the plunger gently to force the air out of the end.
7. Check that you have the correct amount of medication left in the syringe.
8. Put the medication into a plastic cup for the individual to drink.
9. Return the medication back to its appropriate place.
10. After administration of the medication, wash your hands then complete the documentation in the MAR.

MEDICATED PATCHES

1. Check the MAR to determine when the previous patch should be removed.
2. Check if the patch has been removed per providers directions, if not, remove it per policy and notify the PC for directions.
3. The medical provider will need to be notified for directions before the new patch can be applied.
4. Gather supplies which are the medicated patch, gloves, ink pen and a sharps container or its equivalent.
5. Choose a spot on your upper body, upper arms or per manufacturer's directions to apply the patch.
6. Do not apply the patch to your arms below the elbows, to your legs below the knees, or to skin folds.
7. Don't cut or shave any body hair when applying the patch.
8. Rotate the sites.
9. Prior to applying the patch write the date, time and your initials on the non-medicated side. This will indicate how long the patch has been on.
10. Put your gloves on and place the patch, sticky side down, onto the skin.
11. Apply the patch to clean, dry, hairless skin that is not irritated, scarred, burned, or calloused. If abnormalities are observed then update your supervisor.
12. Using the palm of your hand, press down on the patch to make sure the patch is firmly attached to the skin.
13. After applying the patch, wash your hands then complete the documentation in the MAR.

NASAL SPRAYS

PRESSURIZED CANISTER:

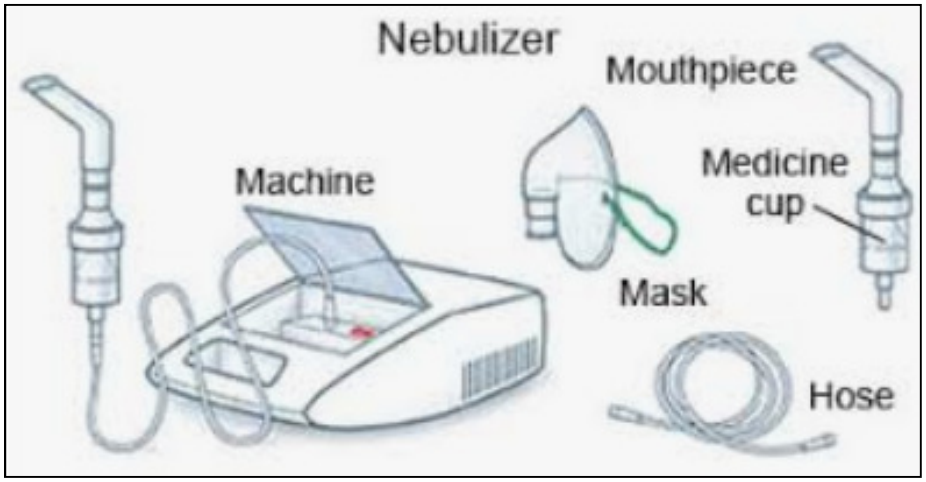
1. Wash your hands.
2. Gather your supplies (medication and gloves).
3. Instruct the individual as to what you are doing.
4. Make sure the canister fits snugly in its holder.
5. Shake the canister several times just before using it.
6. Instruct the individual to gently blow their nose to clear it of mucous before using the medicine.
7. Keep their head upright and ask them to breathe out slowly.
8. Hold the nasal spray container in one hand.
9. Insert canister tip into nostril aiming at the back of their head.
10. Use your finger or the individual can do this to close the nostril on the side not receiving the medicine.
11. Press down on the canister as you instruct them to breathe in slowly through their nose.
12. Repeat these steps for the other nostril.
13. If you are using more than one spray in each nostril follow all the steps again.
14. Instruct the individual not to sneeze or blow their nose just after the spray.
15. Wash the canister device at least weekly.
16. If this is used correctly the spray should not drop from the nose.
17. Wash your hands, put supplies away then complete the documentation in the MAR.

PUMP SPRAY:

1. Wash your hands.
2. Gather your supplies (medication and gloves).
3. Instruct the individual as to what you are doing.
4. Shake the medication several times before you use it.
5. Remove the cap.
6. Instruct the individual to gently blow their nose to clear it of mucous before using the medicine.
7. Keep their head upright and ask them to breathe out slowly.
8. Hold the pump bottle with your thumb at the bottom and your index and middle finger on top.
9. Gently insert the bottle tip into the nostril.
10. Squeeze the pump as you instruct the individual to breathe in slowly through their nose.
11. Repeat these steps for the other nostril.
12. Instruct the individual not to sneeze or blow their nose just after the spray.
13. If this is used correctly, the medication should not drip from the nose,
14. Wash your hands, put supplies away then complete the documentation in the MAR.

NEBULIZER TREATMENT

1. Wash your hands.
2. Gather your supplies (nebulizer machine, tubing and medication).
3. Instruct the individual as to what you are doing.
4. Connect the hose to the nebulizer machine.
5. Fill the medication cup with the medication.
6. Attach the hose and mouthpiece to the medicine cup.
7. Place the mouth piece in the individual's mouth and turn the machine on.
8. Instruct them to keep their lips firm around the mouthpiece so all the medicine goes into their lungs.
9. An oxygen mask can also be used if they are unable to close their lips around the mouthpiece.
10. Have them breathe through their mouth until all the medication is used. This takes 10 to 15 minutes.
11. Turn the machine off when done.
12. Wash the medication cup and mouthpiece with soap and water, rinse it and air dry it until the next treatment.
13. Do not clean the tubing, instead, hang it up to dry. Bacteria will form in the tube if you get it wet.
14. The nebulizer tubing is changed according to what is allowed by the insurance company.
15. Wash your hands; put supplies away if needed then complete the documentation in the MAR.



SILVER NITRATE STICKS

WHAT ARE SILVER NITRATE STICKS USED FOR?

A caustic pencil (or silver nitrate stick) is a device for applying topical medication containing silver nitrate and potassium nitrate, used to chemically cauterize skin, providing hemostasis or permanently destroying unwanted tissue such as a wart, skin tag, aphthous ulcers, or over-production of granulation tissue.

STORAGE

Store at room temperature in the closed package, in a dry place protected from light. Exposure to light will cause the silver nitrate tip to turn black, but will not affect the product's ... Store at room temperature in the closed package, in a dry place protected from light

WHAT THEY ARE & HOW THEY WORK

Silver Nitrate is commonly known as a caustic antiseptic and an astringent. Potassium Nitrate has been used as a topical antiseptic on mucous membranes.

The degree of action depends upon the concentration used, and the period of time during which the compound is allowed to act. The Silver Nitrate is precipitated by chloride, thus washing with a sodium chloride solution can quickly neutralize the actions of the silver ions.

The Silver Nitrate and Potassium Nitrates in a caustic stick is in a dried, solid form at the tip of a wooden or plastic stick. When the material is applied to a wound or lesion, the tissue moisture or blood dissolves the dried nitrate salts, which then chemically burn the tissue. This does require moisture for activation.

How to Apply Silver Nitrate Sticks to a wound

1. Silver Nitrate can cause significant levels of pain to the patient. May need to consider administering analgesia or local anesthetic agents prior to the application of Silver Nitrate.
2. Wash your hands.
3. Gather supplies: Gloves, wound protectant, distilled water, dressing, tape is optional and a silver nitrate stick.
4. Advise the individual as to what you are doing.
5. Provide privacy.
6. Put on disposable gloves.
7. Apply a skin protectant to the site prior to applying the silver nitrate.
8. Protects intact skin from chemical damage.
9. Ensure that the surrounding skin is not touched. The newly burnt skin tissue will appear a gray-ish color.
10. Moisten the tip of the silver nitrate stick with distilled water
11. **Do not use normal saline** to moist the tip as this will diminish the effectiveness of the silver nitrate.
12. When applying Silver Nitrate, the process is to rub and rotate the tip of the applicator along the tissue to be treated.
13. Apply an appropriate dressing.

14. The dressing should keep the area dry to discourage regrowth of hyper granulation.
15. Hyper granulation is excess flesh/tissue that grows around sites such as a feeding tube and goes beyond the height of the surface of the site.

Notes

- Silver salts stain tissue black due to deposition of reducing silver.
- The stain gradually disappears within a period of 2 weeks and can also be accidentally spread to undesirable locations where it can cause skin staining and tissue burns.
- **Accidental application to unintended tissue** is treated with copious water irrigation.
- If there is contact with the eyes, hold eyes open and immediately flush thoroughly with water for at least 15 minutes and consult a physician.
- When using this product, always wear protective gloves, and never use around eyes.
- Repeated applications of silver nitrate may cause a gray or blue-black discoloration of treated skin. This is caused by the silver component of this medicine and is generally not harmful. However, silver nitrate can cause skin burns.

SUBLINGUAL AND BUCCAL TABLETS

1. Wash your hands.
2. Gather your equipment which is your medication and gloves.
3. Instruct the individual not to chew or swallow the tablet.
4. Instruct the individual not to eat, drink, smoke or use chewing tobacco while a tablet is dissolving.
5. Using gloves, hand place the tablet under the tongue or between the cheek and gum, and let it dissolve and absorb into the blood through the tissue there.
6. Follow directions from the medical provider for additional doses.
7. Advice the individual to rest 15 to 20 minutes after taking the medication to prevent dizziness or fainting.
8. After administration of the medication, wash your hands then complete the documentation in the MAR.

SUPPOSITORIES

RECTAL SUPPOSITORY

1. Wash hands
2. Gather supplies: Gloves, suppository, lubricant, wash cloth/paper towel/toilet paper.
3. Advise the individual as to what you are doing.
4. Put a protective under pad on the bed in case there is leakage or they have a bowel movement.
5. Have the individual get into a comfortable position on their bed and provide privacy.
6. Have the individual lay on their left side with their lower leg straighten out and their upper leg bent forward towards their stomach.

7. If the individual can't lay on their left side then it is okay for them to lay on their right side.
8. Put on disposable gloves.
9. Open the suppository and put lubricant on the tapered end of the suppository.
10. Lubricate the suppository tip with a water – soluble lubricant such as K-Y Jelly, not petroleum jelly (Vaseline).
11. If you don't have the above lubricant then moisten their rectal area with cool tap water.
12. With gloved hands, gently spread cheeks apart and insert suppository (tapered end first) about 1 inch with your index finger.
13. Insert the suppository alongside the feces and the colon wall.
14. Insert the suppository very **slowly** between the colon and the feces and if you meet a resistance then **stop otherwise you may put a hole into the individual's rectum which will require medical intervention**.
15. If the suppository is not inserted pass the sphincter the suppository may pop out.
16. After insertion of the suppository then remove your finger quickly and cover their rectum for a few minutes with your glove hand. This will help prevent the individual to push the suppository out. Initially the rectum area may spasm.
17. Have the individual remain laying down for about 5 minutes to avoid having the suppository come out.
18. If you have difficulty inserting the suppository, unable to get the suppository into the rectum, there is pain or any bleeding noted notify your PC or the on call right away for direction.
19. Discard used materials and wash your hands thoroughly.
20. Assist the individual to wipe away/clean area if needed.
21. Document results on the toileting chart if they have one.

VAGINAL SUPPOSITORY

1. Wash hands.
2. Gather supplies: Gloves, suppository with applicator.
3. Advise the individual as to what you are doing.
4. Put the suppository in the applicator.
5. Have the individual lie on their back with knees bent on their bed.
6. Gently insert the applicator into vagina as far as it will comfortably go.
7. Press the plunger to release the suppository and remove applicator.
8. Have the individual lie down for several minutes to let the medication absorb.
9. Remove gloves and wash hands.
10. Document in appropriate place.

TABLET AND CAPSULE MEDICATIONS

1. Gather your supplies (medication, medication cup, glass of water and pill crusher if needed).
2. Follow the medication and paper clip procedure.
3. Sit up medication for one person at a time.
4. Wash your hands.
5. When pouring tablets/capsules out of a bottle, use the lid of the bottle to pour the medication into then drop the medication into medication cup.
6. Don't handle medication with your fingers.
7. Open any pre – packaged medications and place it in a med cup.
8. Sit up your medications over a table, counter top, etc.
9. If you drop a medication on the table, counter top, etc., put a glove on and put it into the medication cup.
10. If the medication falls on the floor don't use it, set up another pill and follow the med destruction policy.
11. If you are removing medication from a medication card (bubble pack) hold the card over your medication cup and punch the card to let the pill drop into the medication cup.
12. Place your initial, time and date beside the area the pill was removed from on the medication card.
13. Crush medications with the pill crusher if the individual is unable to swallow the tablet or capsule.
14. Carefully spoon 2- 3 tablespoons of soft food into the medication cup containing the crushed medications.
15. Some medication should not be crushed because this will alter the absorption or stability of the medicine.
16. If you see on the prescription label CR, XL, LA, SR, ER, CD, etc., this means do not crush the medication unless there is a medical provider order to crush the medication.
17. Enteric medications should not be crushed, broken or chewed.
18. Give medication to the individual according to the individual's preference and ability.
19. Ask the individual to take a small sip of cold liquid, water is preferred to ensure they are able to swallow without difficulty.
20. Give them water to help swallow the medication instead of juice because the juice can affect the absorption of the medication.
21. Don't give medications with hot fluids it can alter the ability of the medicine.
22. Remain with the individual to be certain all medications have been taken.
23. Wash your hands, put supplies away and document in the MAR.

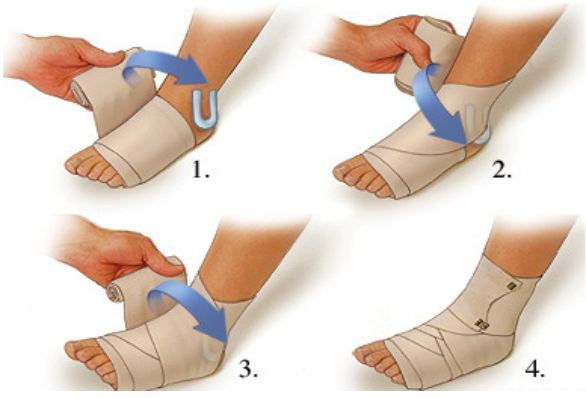
TOPICAL MEDICATIONS

1. Gather necessary equipment and supplies (gloves, tongue blades, plastic cups, etc.).
2. Wash your hands.
3. Provide privacy.
4. Inform the individual what you are doing and bring them to a private area to provide the treatment.
5. Expose the area of skin that requires the treatment.
6. Use the medication sparingly unless directed differently from the medical provider.
7. Put your gloves on and squeeze the appropriate amount of ointment out of the tube onto your glove hand.
8. Or, if the medication is in a container use a tongue blade to scoop it out and placed it on your glove hand.
9. After completion of the treatment wash your hands.
10. Return medication back to appropriate place and complete the documentation in the MAR.

PROCEDURES FOR ADMINISTRATION OF TREATMENTS/CARES/ADLS

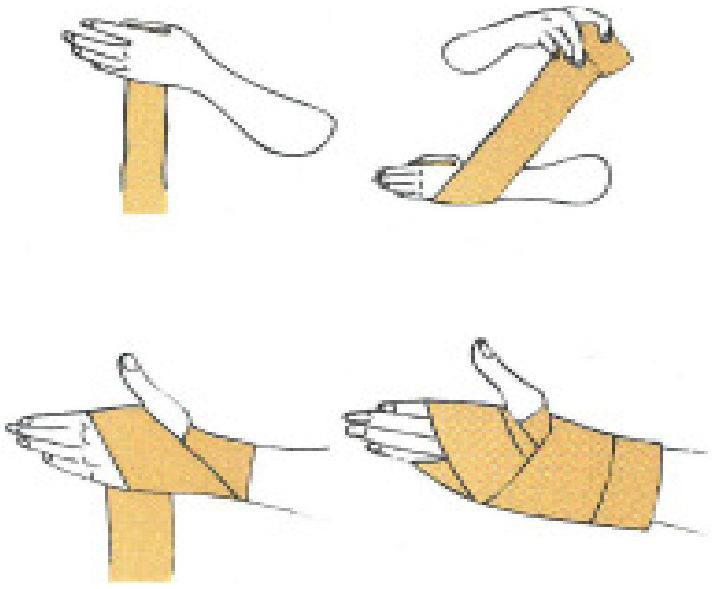
ACE WRAP: ANKLE

1. Wash hands.
2. Gather supplies: Ace bandage.
3. Follow Medical Provider orders for the individual.
4. Advise the individual as to what you are doing.
5. Roll up the elastic bandage if it isn't already rolled up.
6. Hold the ankle at about a 90-degree angle.
7. Start where toes meet the body of the foot. Hold the loose end of the bandage at the side of foot.
8. Wrap the bandage around the ball of the foot once, keeping it somewhat tight with a light pull.
9. After this, slowly start circling your way around the arch of the foot.
10. Pull the bandage diagonally from the bottom of the toes across the top of the foot and circle it around the ankle.
11. Now bring the bandage diagonally across the top of the foot and under the arch in a figure-eight pattern.
12. When you get to the ankle bone, wrap the bandage around the felt piece so it stays in place under the ankle bone.
13. Continue around the ankle and foot in a figure eight, moving toward the heel on the bottom and toward the calf at the top of the eight.
14. The wrap should cover the entire foot and end about 1 ½ inches above the ankle.
15. Most compression wraps are self-fastening or come with clip fasteners. If not, use tape to secure the end. Do not use a safety pin.
16. The wrap should be snug but should not cut off circulation to the foot.
17. The individual's circulation should be checked throughout the day and if the below symptoms are present notify your PC for directions.
    - Check skin temperature, it should be warm to the touch and not cool.
    - Skin color, it should not be red, bluish or have a white tinge to it.
    - Swollen
    - Complaints of pain, numbness or tingling in the area.
18. Record on MAR that treatment was completed and wash hands.



ACE WRAP: WRIST

1. Wash hands.
2. Gather supplies: Ace bandage.
3. Follow Medical Provider orders for the individual.
4. Advise the individual as to what you are doing.
5. Wrap the bandage around wrist once, staring at the pinky side of the hand with the hand facing down.
6. Pull the bandage to the thumb side around the palm once.
7. Cross the bandage back down to the wrist and wrap again around the wrist.
8. Reverse the wrap to the pinky side of the hand and around the palm wrapping around the wrist again.
9. Use the rest of the wrap to stabilize the wrist making sure to not wrap wrist too tightly.
10. The individual's circulation should be checked throughout the day and if the below symptoms are present notify your PC for directions.
    - Check skin temperature, it should be warm to the touch and not cool.
    - Skin color, it should not be red, bluish or have a white tinge to it.
    - Swollen
    - Complaints of pain, numbness or tingling in the area.
11. Chart the MAR that treatment was completed.
12. Wash hands.



BATHING: BATH TUB OR SHOWER

1. Wash hands.
2. Gather supplies: Body soap, shampoo, wash cloth, towel, shaving supplies if needed, clean cloths, and gloves.
3. Advise the individual as to what you are doing and put on gloves.
4. Assist the individual to remove cloths if needed.
5. If the individual is choosing a tub bath:
    a. Fill tub with the appropriate amount of warm water ensuring that temperature is at no more than 112° Fahrenheit.
    b. Assist the individual into the tub. Be sure to ask the individual if they need assistance with bathing before leaving. If assistance is needed, try and have the individual assist as much as possible.
6. If the individual is choosing a shower:
    a. Turn on the shower for the individual ensuring that the water temperature is at no more than 112° Fahrenheit.
    b. Assist the individual into the shower. Be sure to ask them if they need assistance with shower before leaving. If assistance is needed, try and have the individual assist as much as possible.
7. Assist the individual to wash/rinse hair using shampoo.
8. Assist the individual to wash/rinse entire body using soap and washcloth.
9. If the individual is female, ask if she would like to shave while in the tub/bath.
10. When tub bath/shower is completed, assist the individual out of the tub/bath and assist them to get dressed if needed.
11. If the individual is male, ask if they would like to shave.
12. Once the individual is out of the bathroom, clean tub/shower. Put any dirty/used linen in appropriate area, and wash hands. Don't throw any dirty linen or clothing on the floor. Place in a plastic bag or laundry basket.
13. Be sure to note any areas of concern in regards to the individual's skin and notify the PC.
14. Nurse to be updated as needed.

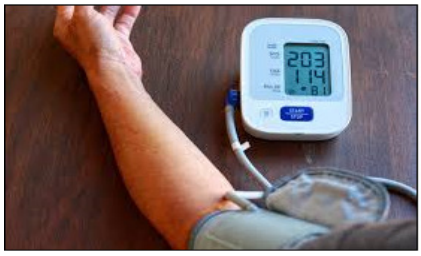
BATHING: BED BATH

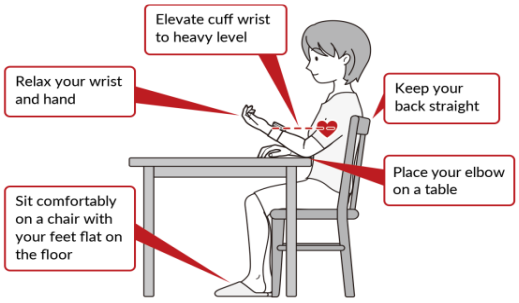
1. Wash hands.
2. Gather supplies needed
    a. Gloves
    b. Several washcloths
    c. Several towels
    d. Basin of clean water
    e. Basin of soapy water
    f. Baby soap of other gentle, non-irritating cleanser
    g. Lotion, other personal care products
    h. Table to hold everything on.
    i. Blanket
3. Fill a basin or washtub with warm water**.**
4. The water temperature should be 115 degrees F (46 degrees C) or less. You want it to be comfortable to the touch, but not too hot.
5. You may add soap to the basin to create a bowl of warm, soapy water for washing, or keep the soap separate and apply it directly to the individual's skin.
6. If you plan to shampoo the individual's hair, you'll need shampoo that's easy to rinse out (such as baby shampoo) and a special basin designed for washing hair in bed.
7. If you don't have a special basin, you can make do by placing an extra towel or two under their head to protect the bed from getting too wet.
8. You will need two towels and two washcloths.
9. Be sure to adjust the temperature in the room if necessary, to prevent them from getting a chill.
10. Remove their clothes and cover them with either a large towel or sheet.
11. This will ensure they will stay warm during the bath as well as providing some privacy.
12. The sheet or towel will stay on their body the whole time.
13. Keep in mind that this process can be embarrassing for some people, so try to work quickly.
14. First apply soap or soapy water to the wash cloth.
15. Start with the individual's face. Gently wash the individual's face, ears and neck with soapy water.
16. Rinse away the soap with a separate washcloth. Dry the cleansed area with a towel.
17. Wash the individual's hair. Gently lift their head into the shampooing basin.
18. Wet the hair by pouring water over the individual's head, taking care not to get it in their eyes.
19. Apply shampoo, then rinse it away. Pat the hair dry with a towel.
20. Wash the individual's left arm and shoulder. Fold over the sheet/towel on the left side of the body down to the hip.
21. Wash and rinse the individual's shoulder, underarm, arm and hand.
22. Dry the washed areas thoroughly, especially the underarm, to prevent chafing and bacteria growth.
23. Recover with the sheet/towel to keep them warm.
24. Repeat this process for the other side of the body.
25. Wash the individual's torso. Fold the sheet/towel down to the waist and gently wash and rinse the chest, stomach and sides.

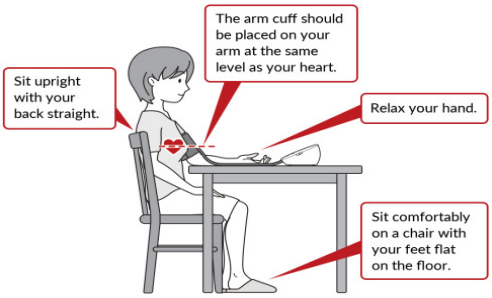
26. Be sure to wash carefully among any folds in the individual's skin, since bacteria tends to get trapped there.
27. Dry the torso carefully, especially among the folds.
28. Recover the individual with the sheet/towel to keep them warm.
29. Wash the individual's legs. Uncover their right leg up to the waist, and wash, rinse and dry the leg and foot.
30. Recover the right leg and uncover the left, then wash, rinse and dry the leg and foot.
31. Recover the lower half of the body.
32. Bathing the Back and Private Area. Empty the water basin and refill with clean water.
33. Since approximately half the individual's body is now clean, it's a good time to refill the water.
34. Ask the individual to roll on their side if they are able**.** You may have to assist them.
35. Make sure they are not too close to the edge of the bed.
36. Wash the individual's back and buttocks. Fold the sheet/towel over to expose the entire back side of the patient.
37. Wash, rinse and dry the back of their neck, back, buttocks and parts of the legs you may have missed.
38. Wash the genital area and anus. Put on gloves if desired.
39. Lift the individual's leg and wash from front to back. Use a clean washcloth to rinse the area. Be sure to clean thoroughly between folds, and dry the area thoroughly as well.
40. Males should be washed behind the testicles.
41. If they have foreskin on their penis pull the skin back towards the individual's abdomen, cleanse the area and pull the skin back down. If the skin is not pulled back down the area will swell and cut off circulation.
42. Wash female's labia, but there's no need to clean the vagina.
43. This part of the body should be washed every day, even when you're not giving a full-body bed bath.
44. Redress the individual either in their pajamas or clothes**.**
45. Apply lotion to their arms, legs and back before putting their clothes/pajamas back on.
46. If the individual is on bedrest they should be given a back rub.
47. Comb their hair and apply cosmetics and other body products according to the individual's preferences.
48. Put supplies away and clean up the area.

BLOOD PRESSURE

1. Wash hands.
2. Gather supplies; automatic blood pressure cuff/monitor, (could be either for wrist of for upper arm) writing utensil, and paper.
3. Let the individual know what you will be doing.
4. Have the individual be in sitting position with legs uncrossed.
5. OK to take blood pressure if the individual is lying down if that is the usual way blood pressure is taken for that individual.
6. Place the blood pressure cuff on the individual (either wrist or upper arm).
7. Securing placement by wrapping around the individuals' wrist/arm using Velcro adhesive.
8. Turn blood pressure monitor on and press start button to start inflating blood pressure cuff. (cuff will inflate/deflate on own)
9. After cuff deflates, a reading will appear on blood pressure monitor screen.
10. Record the blood pressure reading on MAR/Vitals sheet. Systolic/Diastolic ex: Normal BP is 120/80.
11. Alert PC/On-call if you obtain an abnormal reading. Some blood pressure monitors will also take pulse as well.
12. If blood pressure needs to be taken a second time due to error, wait 2-3 minutes until taking again.
13. Wash hands and put supplies away. If blood pressure cuff/monitor is shared by more than one individual, be sure to clean/sanitize after use.







BRACES AND SPLINTS

There are several types of casts, braces, and splints available. Which type that is used is dependent on the part of body that is affected and the injury being treated.

- Plaster cast is made from gauze and plaster strips soaked in water, which is then wrapped around the injured part to harden in 24-48 hours.
- A synthetic cast is made from fiberglass or plastic strips, making it lighter than a plaster cast.
- A splint, also called a half cast, is made from slabs of plaster or fiberglass held in place with a bandage wrap/ace bandage.
- Splints are often used temporarily when swelling is present. After swelling goes down, a more permanent cast is put on.
- A brace is made of hard plastic and Velcro and can be removed.

Physicians use casting, bracing, and splinting to treat a variety of conditions, including:

- Achilles Tendonitis
- Arthritis
- Bone Fracture
- Carpal Tunnel Syndrome
- Connective Tissue Disease
- Dislocation
- Heal Spur
- Joint, knee, and elbow pain
- Ligament injuries
- Repetitive use injuries
- Rotator cuff tears
- Sprains, strains, and tears
- Tendon injuries
- Tendonitis
- Tennis elbow

Persons should have an order from a medical provider as to whether they should be wearing a splint, brace, or cast.

Caregiver should follow medical provider orders and instructions on how to put on/take off if a removable brace, and how to care for splint/cast.

If unsure, contact the nurse or the designated coordinator.

9/4/20

CATHETER CARE: FOLEY/DAILY CARE

1. Wash Hands.
2. Gather supplies: Soap, water, wash cloth, towel, gloves.
3. Advise the individual as to what you are doing.
4. Wet wash cloth and apply a small amount of soap. Have client clean genital area. (Assist client/customer if needed)

a. Women: Separate the Labia and clean from front to back
b. Men: Pull back foreskin, if needed, and clean the area including the penis.

5. Clean urethra (urinary opening) where the catheter enters body. (assist the individual if needed)
6. The catheter/tubing should be cleaned from where it enters the body moving in a downwards direction.
7. Ensure that catheter is being held in place as to not put tension on the tubing.
8. Rinse area with water and gently dry.
9. Ensure that bag is lower than bladder.
10. Place dirty linen in correct area. (not to be placed on the floor)
11. Remove gloves and wash hands.

CATHETER CARE: BAG CHANGE

1. Wash hands.
2. Gather supplies: Clean wash cloth or a 4x4 piece of gauze, night/day drainage bag (whichever you are changing to), gloves.
3. Advise the individual as to what you are doing.
4. Put on gloves.
5. Empty urine from the drainage bag into toilet or measuring container if needing to record output.
6. Make sure that spout of the drainage bag never touches the side of the toilet or any emptying container.
7. Place the clean wash cloth or gauze under the connector to catch any leakage.
8. Pinch off the catheter with your fingers and disconnect the used bag.
9. Wipe the end of the catheter with an alcohol pad.
10. Wipe the connector on the new bag with the second alcohol pad.
11. Connect the clean bag to the catheter and release finger pinch.
12. Check all connections and straighten any kinks in tubing.
13. Ensure bag is lower than bladder.
14. Clean/put away any supplies used.
15. Clean/store day/night bag following correct policy/procedure (whichever bag not using)
16. Take off gloves and wash hands.

CATHETER CARE: CLEANING DAY/NIGHT BAG

1. Wash hands.
2. Gather supplies: White vinegar, water, gloves.
3. Rinse bag (whichever the individual is not using) with cool water.
4. **Do not use hot water** because it can damage the plastic equipment.
5. To decrease odor, fill the bag halfway with a mixture of 1-part white vinegar and 3 parts water.
6. Shake the bag and let it sit for 15 minutes.
7. Rinse bag with cool water and hang up to dry.
8. The bag should not be hung in a shared bathroom.
9. Find a designated area in the individual's room to hang.
10. Once bag is dry, put in a plastic container with a lid.
11. Remove your gloves and wash your hands.

CATHETER CARE: EMPTYING/MEASURING URINE OUTPUT

1. Wash hands.
2. Gather supplies needed: Gloves, measuring device, alcohol wipes, paper towel in case of spillage, eye protection.
3. Advise the individual as to what you are doing.
4. Ask the individual to go into the bathroom.
5. Put on gloves and eye protection.
6. Remove the drainage tube from the bag.
7. The drainage tube is located at the end of the catheter.
8. This is usually a colored tab that is tucked into bag.
9. It will have a clip that is squeezed together with a clamp that holds the urine in the bag.
10. Hold the drainage tube over the toilet or a measuring device and squeeze the tab together which will release the urine that is collecting in the bag.
11. Do not touch the toilet or measuring device with the end of catheter.
12. Once the bag is drained of urine, squeeze the end together to close the tube.
13. Using an alcohol wipe, clean end of tube/catheter before putting back into holder on bag.
14. If you need to track output, use measuring device and document the amount shown on measuring device in MAR or Intake/Output sheet.
15. Use CC or mL when recording the amount.
16. Clean/put away any supplies used.
17. If changing bags, follow policy/procedure to clean/store day/night bag.
18. Remove gloves and wash hands.

CATHETER CARE: SUPRAPUBIC

1. Wash hands.
2. Gather supplies: Soap and water, wash cloth/gauze, gloves.
3. Advise the individual as to what you are doing.
4. Have the individual wet the wash cloth with water and apply soap.
5. Assist the individual if needed. Gently wipe the area around the catheter.
6. Note any areas of concern and report to PC or Q on-call.
7. Clean drainage bag per policy/procedure.
8. Ensure the catheter is draining in either a new bag or into a container while cleaning bag to prevent leaking.
9. If changing the catheter bag, follow correct policy/procedure.
10. Be sure to have the **catheter bag lower than the bladder**.
11. Clean/put away supplies
12. Take off gloves and wash hands.
13. If catheter falls out at any time, take to clinic or ER for reinsertion. Depending on the house, 911 may need to be called.

COLD PACKS

1. If cold pack usage has been ordered by the physician, follow the instructions of the physician (ex: 15 mins per time, 3 times per day). If it's ordered, then it needs to be on the MAR as the doctor ordered it.
2. If the person does not have an order for continuous icing but is wanting to use ice/cold pack for a one-time situation (ex: bumped shin on the bed frame and wants a cold pack), you may do this.
3. Remove the cold pack from the freezer and either wrap in a pillow case or a towel.
4. Apply to the affected area for 15-20 minutes, making sure the cold pack is not in direct contact with the skin.
5. Remove cold pack, put towel/pillow case in laundry, and return cold pack to the freezer.
6. Inspect the area where the cold pack was used, document any unusual findings.

Document the use of the cold pack. If the cold pack is ordered by the physician and on the MAR, then you document on the MAR. If it is a one-time usage, you would document in the progress notes. Either way, make sure to include whether or not it was effective.

COLOSTOMY CARE: BAG CHANGE

1. Wash hands
2. Gather supplies: Gloves, soap, water, wash cloth, towel, new colostomy bag with clip, skin prep/wipes, stoma paste or ring seal, scissors, measuring device, trash bag.
3. Advise the individual as to what you are doing.
4. Have the individual either stand up or lie down, whichever is more comfortable.
5. Empty the old pouch and remove. Place in garbage bag.
6. It is OK to put a paper towel over the stoma while cleaning area around it in case of leakage.
7. Wash area around stoma with warm water, soap, and wash cloth.
8. Be sure to dry area thoroughly before placing new bag.
9. Wipe area around the stoma with skin prep/wipes. This will help adhere the ring seal to the individual's skin.
10. If the individual uses stoma powder, it is OK to sprinkle on when skin around stoma is still wet and then apply the skin prep.
11. Let the area dry for 1-2 minutes.
12. Use the measuring device to measure the correct size opening for new bag.
13. **DO NOT** touch the measuring device to the individual's skin.
14. Once you have the correct size, use scissors and cut.
15. If you have a 2-piece bag system, attach the bag to the ring.
16. Peel the paper of the ring seal or apply stoma paste around stoma.
17. Place the seal evenly around the stoma and hold in place for a few seconds. The individual may want to place a warm wash cloth over the seal to help make the seal stick.
18. Be sure to attach clip on end of bag to hold contents in bag.
19. Clean and put away all supplies.
20. Wash hands.

COLOSTOMY CARE: EMPTY POUCH

1. Wash hands.
2. Gather supplies needed.
3. Gloves, toilet, chair (if client unable to sit far enough back on toilet), paper towel/toilet paper.
4. Advise the individual as to what you are doing.
5. Bag should be emptied when half full.
6. Have the individual sit as far back on toilet as possible. If they are unable, have the individual sit on a chair as close to toilet as possible.
7. Expose the colostomy bag and unclamp the end of the bag.
8. Hold the end of the bag over the toilet and unroll the end of the bag.
9. Empty contents of bag into toilet.
10. Once bag is emptied, clean the outside of the bag with paper towel/toilet paper.
11. Roll up/fold the end of the bag and replace clip.
12. Clean and put away all supplies.
13. Wash hands.

CONSTIPATION

SIGNS AND SYMPTOMS

- Passing fewer than three stools a week
- Having lumpy or hard stools
- Straining to have bowel movements
- Feeling as though there's a blockage in their rectum that prevents bowel movements
- Feeling as though they can't completely empty the stool from their rectum
- You may notice a change in the individual's behavior.
- Elevated temperature
- Distended abdomen
- Pain in the abdomen area
- Small bowel movements
- Diarrhea

Constipation may be considered chronic if you've experienced two or more of these symptoms for the last three months.

TREATMENT

- Follow the plan of care for the individual
- Use standing medication orders for constipation
- Encourage the individual to eat foods high in fiber (prunes, pears, spinach, oat bran etc.)
- Encourage the individual to drink plenty of water
- Encourage the individual to exercise

Update PC or on-call in regards to the situation
If the individual continues to be constipated, seek medical attention

DRESSING CHANGE: WET TO DRY DRESSING

A "wet to dry" dressing is used to remove dead tissue from a wound/open area. A piece of gauze is moistened with a cleansing solution. Then it's put on the wound and allowed to dry. After the dressing dries, the dead skin tissue sticks to the gauze and comes off the wound when the bandage is removed. When the wound has no more old, dead tissue, new tissue forms and healing begins.

BEFORE YOU CHANGE THE DRESSING

- Before you start, tell the person you are going to clean the wound.
- Let them know it may hurt and bleed a little bit when you take off the old dressing.
- If the dressing change will be uncomfortable give pain medicine a 1/2 hour before the dressing change is to be done.

HOW TO CHANGE THE DRESSING

1. Gather necessary supplies such as gauze squares (fine mesh, not cotton-filled), cleansing solution as ordered by the doctor, plastic bag, small glass/plastic container, adhesive tape, Q-tips, roller bandage (if needed) and scissors.
2. Wash your hands.
3. Unfold a gauze square until there is one layer. Place the square in a clean container such as a glass. Touch only the corner of the gauze to keep it clean.
4. When you use a glass/container wash it with soap and water before you place the gauze and solution in it.
5. The size of the gauze square will depend on the size of the wound.
6. Pour enough cleansing solution over the gauze to make it wet.
7. If normal saline solution is used recap the bottle. Always place an open date on the saline bottle.
8. Type of solution is usually ordered by the medical provider.
9. Remove the old dressing from the wound and place it in a plastic bag.
10. When removing the dressing it may stick to the wound which is normal. Pull it out slowly.
11. Clean the inside of the wound with a 2 x 2 or 4 x 4 gauze pad moistened with cleansing solution. The cleansing solution is ordered by the medical provider.
12. Throw away the soiled gauze pad in the plastic bag.
13. Look at the wound to see if it's healing. The wound should be pink and may have some bleeding.
14. Remove your gloves after the area is cleansed and put on a clean pair of gloves.
15. Place the moist gauze in the wound. You may need to use a clean Q-tip to gently push it into the opening.
16. The packing should fill up the space of the opening.
17. The gauze should not be dripping with the solution.
18. Cover it with a dry gauze square. Only touch the corners of the clean gauze to keep it clean.
19. Tape the edges of the dry gauze.
11. If the wound is large or difficult to tape securely, wrap a clean roller bandage over the gauze. Tape the end of the roller bandage.
12. Throw away the remaining cleansing solution that is in the glass or container.

13. Wash your hands again.
14. Document the treatment in the MARs
15. Document the appearance of the site at least daily in the individual's progress record.
    - Document the drainage on the old dressing.
    - Document what was on the dressing that was pulled out of the wound/open area.
    - The color and the amount of the drainage.
    - Was there an odor and describe what it smelled like?
    - The size of the open area.
    - What does the inside of the open area look like, was it pink in color, gray in color, etc.?
    - The skin surrounding the open area was it red or pink in color?
    - Was there any swelling around the site?
    - The surrounding skin firm to the touch or spongy?

<u>WHEN TO CALL THE DOCTOR</u>

- Call the doctor if you don't think the wound is healing.
- If the wound isn't healing properly, you'll see one or more of these signs:
    - Change in drainage from wound (color, odor, or amount).
    - Swelling or redness around wound.
    - Fever

HOT PACKS/ HEATING PADS

1. Before using heat therapy, you will need to have an order from the physician. We can only use electric heating pads, NOT the kind that you warm in the microwave. This is to be sure that the temperature is regulated and to help avoid burns.
2. If not already on the MAR, write the complete order on the MAR (Ex: apply heat pad to left shoulder on medium setting for 15 minutes, three times per day).
3. Following the instructions on the order, turn on the heating pad and apply to the affected area for the ordered amount of time.
4. If the person is not able to verbalize whether or not the heat is too hot for them, staff need to check the area every 5 minutes to make sure the person is not uncomfortable and that the skin is not getting too hot.
5. Remove the heat and inspect the area for anything unusual.
6. Document the using of the heating pad on the MAR.

LYMPHEMDEMA THERAPY

Lymphedema is a condition characterized by painful swelling in the extremities (arms and/or legs) which is caused by a system blockage.

- The swelling occurs when lymph nodes are no longer facilitating the proper drainage of lymph fluid from an area of the body.
- Primary lymphedema can be a congenital condition or caused by infection, trauma or most commonly, treatment of cancer.
- The lymphedema fluid can't be cured, but it can control the swelling and keep it from getting worse. It can last for years or a lifetime.

SYMPTOMS

There are a number of symptoms that affect individuals with lymphedema that typically worsen over time:

- Extremity swelling caused by lymphatic fluid
- Main symptom is swelling in an arm or leg that may be accompanied by pain or discomfort.
- Change in skin quality such as skin fibrosis (thickening and scarring of connective tissue)
- Extremity tenderness or pain
- Intermittent redness of the extremity, known as cellulitis (inflammation of the subcutaneous tissue)
- Excess fat in the extremity

TREATMET

- Procedure for lymphedema is individualize for each client.
- Treatment consists of devices and therapy for the fluid accumulation.
- Devices consist of elastic bandage, Compression stockings and a Lymphedema pump.
- Elastic bandage is a stretchy bandage used to wrap sprains and strains. Provides support and compression during recovery.
- Compression stockings are elastic hosiery that squeeze blood up the legs to prevent swelling and blood clots.
- A lymphatic compression pump – is a medical device that provides lymphatic compression therapy to reduce lymphatic swelling by using a gradient pump that pushes air into a multi chamber pneumatic sleeve device that is filled on the arm or the leg.
- Exercise, wrapping, massage, and compression can help reduce fluid.

PROCEDURE CONSISTS OF

1. Wrapping an arm or leg.
2. Pneumatic compression.
3. Compression garments.
4. Complete decongestive therapy (CDT) which is divided into two phases.
    - Phase 1 – removing the fluid
    - Phase 2 – maintenance therapy
5. Massage, if ordered

Symptoms you may see on an individual receiving Lymphedema therapy.

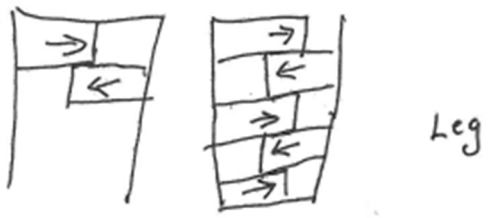
- If you notice any of these symptoms notify your PC.
- Update the medical provider as needed for any abnormalities.
- Sensational Heaviness of a Limb
- Fatigue in a Limb
- Puffiness of the Skin
- A Decreased Ability to See Veins
- Asymmetric Appearance of the Extremities
- Spongy Skin
- Dry, Scaly Skin
- Blisters
- Skin Infections

USE OF VELCRO WRAPS

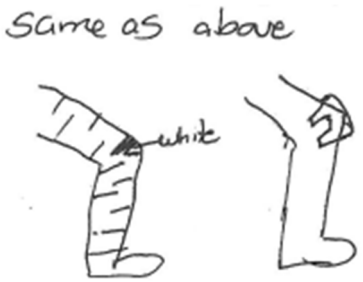
Most conventional lymphedema treatments require the individual to wear compression bandages or gloves and other kinds of compression garments. These devices help to force out excess fluids from limbs and prevent this swelling reoccurring. Although these bandages work well, some people find them difficult to apply. Velcro wraps are much easier to apply as an alternative to compression bandages and garments, and they work just as effectively. Medical care providers will explain and show the individual how they need to apply the Velcro wraps or compression bandages.

APPLYING LEG VELCRO GARMENTS

1. Wash your hands
2. Explain the procedure to the individual
3. Gather the equipment which will vary per person. Compression pump, hoses, ace wraps, stockinette and Velcro wraps.
4. The compression pump settings are preset so all that is needed to do is turn the machine on after the wraps are applied.
5. Place stockinette on legs.
6. Place calf wrap on; pull 2 straps in opposite directions for a snug fit, crossing in the front.



7. Place black protector on calf, then shoes on.
8. Place thigh wrap on next when standing, with the dip on the inner thigh as high as possible.



9. Again, pull the 2 straps at a time, crossing in front/side for a snug fit.
10. Place knee strap on over the knee snug where the knee bends and shows some stockinette.
11. Fully place the black protector on full leg, Velcro at the top of the wraps.
12. Fold over stockinette.
13. Document treatment in the MAR.
14. See diagram on how to apply the Velcro Garment.
15. Cleaning process – Handwash and dry lay on towels or a flat drying rack.

ORAL CARE: GENERAL INFORMATION

1. Wash hands.
2. Gather supplies: Toothbrush, toothpaste, cup of water, mouthwash and gloves
3. Advise the individual as to what you are doing.
4. Have the individual stand at the bathroom sink.
5. Wet the toothbrush and apply a small amount of toothpaste.
6. Assist the individual if needed to gently brush the inner, outer and bite surfaces of their teeth.
7. If the individual uses mouthwash, assist them to fill the desired amount in the cup.
8. Have them gargle, swish and then spit into the sink.
9. If needed assist the individual in wiping off any excess water, toothpaste, mouthwash from their facial area.
10. Clean and put away supplies.
11. Wash hands.

ORAL CARE: IN BED

1. Wash hands.
2. Gather supplies: Toothbrush, toothpaste, cup of water, a basin for the individual to spit in, towel/clothing protector and gloves.
3. Advise the individual as to what you are doing.
4. Ensure that the individual is sitting in an upright position.
5. Place towel/clothing protector around their neck to protect their clothing while they are in bed.
6. Wet the toothbrush and apply a small amount of toothpaste.
7. Have the individual open their mouth and use a gentle motion to brush their inner, outer, and biting surfaces of their teeth.
8. If they cannot tolerate the use of a toothbrush, foam sticks and mouthwash can be used instead.
9. Be sure to let them assist as much as possible.
10. Allow the individual to take mouthfuls of water, rinse the mouth and spit into the basin.
11. Wipe any excess water/toothpaste off of the individual's facial area.
12. Clean and put away supplies and empty basin.
13. Wash hands.

ORAL CARE: DENTURE CARE IN BED

1. Wash hands.
2. Gather supplies: Denture brush, denture cup, clothing protector, paper towel, cup of water, basin, and gloves.
3. Advise the individual as to what you are doing.
4. Have them sit in an upright position and place a towel/clothing protector around their neck.
5. Have the individual remove their dentures from their mouth and place them in the denture cup. Assist as needed.
6. Have the individual take a sip of water and swish/spit into basin.
7. Ask the individual if they would like to use an oral swab on the inside of their mouth. Assist as needed.
8. Assist the individual to wipe any excess water off of facial area and remove towel/clothing protector.
9. Take the denture cup to bathroom.
10. Place paper towel in bottom of sink and place dentures in sink.
11. Turn on water and wet denture brush. Gently brush all surfaces and rinse.
    a. At HS, place the dentures into a denture cup with water.
    b. If ordered, use denture cleaner tab.
    c. Place dentures/cup in safe place over night.
12. Clean and rinse supplies.
13. Wash hands.

OXYGEN CONCENTRATORS

1. Oxygen concentrators must be prescribed by a provider. They work by taking the room air, separating out the O2 from the room air, and delivering the concentrated O2 through a nasal cannula or face mask.
2. The unit makes a humming sound when running, and has an alarm that sounds if there are errors.
3. Make sure the unit is powered "off" before plugging in. Plug in to an outlet in a convenient area of the home.
4. If a humidifier is being used on the concentrator, fill with distilled water to the fill line, and secure the humidifier bottle back to the concentrator by screwing it tightly in place.
5. Attach the oxygen tubing to the other end of the humidifier, or to the concentrator if not using the humidifier bottle.
6. Turn on the unit. Some models have an alarm that sounds briefly when first turned on.
7. Confirm that the flow meter is set to the prescribed rate (Liters per minute). If not, adjust the knob accordingly until the unit matches the number of liters on the MAR.
8. Place the nasal cannula or face mask on the person so it fits comfortably.
9. Turn off the unit when not in use.
10. Document oxygen use in the MAR.

PORTABLE OXYGEN CONCENTRATORS

1. Before using a portable oxygen concentrator, verify on the MAR that it has been ordered by a physician for the individual in question.
2. Use the device in its carrying bag, placed in a cart, or positioned upright on a table or the floor.
3. Open the battery compartment and make sure there is at least one battery in there. It can hold two batteries.
4. Close the battery compartment.
5. When not in use, connect the AC/DC power supply to the concentrator, and plug into a power source. The unit should also come with a car charge adapter.
6. When in use, unplug the power supply.
7. Connect the nasal cannula to the concentrator.
8. Press the power button to turn on the concentrator.
9. Confirm that the flow rate is set to what the physician has order (liters per minute). If it is not set at the prescribed rate, adjust the rate so that it is at the correct number of liters per minute.
10. Put the nasal cannula on the individual.
11. Make sure to pay attention to the battery life of the specific model being used. Many models are only about 45 minutes per battery.
12. When finished using, turn off with the power button and plug the concentrator back in to the power supply.
13. Document usage in the MAR.

OXYGEN CYLINDERS (TANKS)

1. Oxygen cylinders are tanks of compressed gas. They are flammable, and can explode if knocked over- so they MUST be stored in a secure rack of some sort. Do not store within 10 ft of furnaces, hot water heater, fireplaces, and any other heat source.
2. Verify that oxygen is ordered for your individual by checking the MAR for details about when and how to use the oxygen, and at what rate (Liters per minute).
3. Find the two small and one large holes on the cylinder valve.
4. On the regulator, you will see two small pins and one large pin that match the holes on the cylinder valve.
5. Place the regulator on the cylinder valve, lining up the pins and holes.
6. Tighten the T-Handle on the regulator.
7. Use the cylinder wrench, and turn counterclockwise (to the left) to open the cylinder valve. If you hear oxygen escaping, turn the valve off, check the regulator placement, and retighten the T-Handle.
8. Check the valve of the regulator to verify how much oxygen is the cylinder.
9. Attach your oxygen tubing.
10. Verify that the oxygen flow rate is set to the correct Liters per minute (per the order on the MAR). Adjust the dial to the correct flow rate if it doesn't match the MAR.
11. To turn off you would turn the valve clock wise (to the right). Always turn off when not in use.
12. Document oxygen use in the MAR.

OXYGEN SAFETY RULES

Oxygen does not explode and cannot burn by itself. HOWEVER, fire will occur when oxygen exists in combination with a combustible or flammable material and a source of ignition

To prevent the chance of fire, follow these rules:

- **DO NOT** permit the use of open flames or burning tobacco in the room where oxygen is being used or stored. If an individual is a smoker, they should remove cannula and shut of oxygen.
- **DO NOT** use any household electric equipment in oxygen enriched areas. (e.g., electric razors, heaters, electric blankets)
- **DO NOT** use heavy coatings of oily lotions, face creams, or hair dressings while using oxygen.
- **DO NOT** use aerosol sprays in the vicinity of oxygen equipment.
- **DO NOT** use petroleum-based products (i.e., petroleum jelly) around oxygen.
- **DO NOT** oil or grease any oxygen equipment.
- **DO NOT** allow oxygen tubing to be covered by any objects.
- **DO NOT** leave oxygen equipment running when it is not being used.
- **DO NOT** abuse or handle oxygen containers roughly.
- **DO NOT** store oxygen in confined areas or in the trunk of a car.
- **DO NOT** allow untrained persons to adjust oxygen equipment.
- **DO NOT** store oxygen containers near radiators, heat ducts, steam pipes or other sources of heat.
- **ALWAYS** store oxygen cylinders secured with a chain or stand.
- **NEVER** change the prescribed flow rate for individual without an order from the medical provider.
- **Switch to cylinder rather that a concentrator during severe weather (power outage)**

OXYGEN SATURATION READINGS

1. Wash hands.
2. Gather supplies needed: Pulse Oximeter, pen and paper.
3. Instruct the individual as to what you are doing.
4. Place oximeter on the individual's finger.
5. It may take a few minutes to get an oxygen reading.
6. If it is taking a longer than normal amount of time to obtain a reading, try putting oximeter on a different finger.
7. If the individual has cold fingers or if nail polish is present, it can be difficult to get an accurate reading. (for cold fingers, you can attempt to warm the individual's fingers by placing your hands over fingers to warm them)
8. A normal oxygen rate is 90% or above unless the medical provider has stated differently for that individual.
9. Alert PC/On-call if oxygen rate drops below 90% and is not normal for the individual.
10. Follow proper protocol for each individual. The specifics will be located in the individual's chart.
11. After obtaining reading, record in MAR/vitals sheet.
12. Clean oximeter and wash hands.

OXYGEN: VENTILATOR MASK

(Astrial Ventilator)

- The ventilator is a small table top device used in people with lung and respiratory diseases such as Chronic Obstructive Respiratory Disease (COPD).
- The machine adapts to the person's sleeping pattern. It helps to regulate the person's breathing pattern while asleep or when their symptoms flare up.
- Therapy can take place when the individual is awake or sleep.
- Daytime can limit social interactions but is typically used at night to keep the person's airway open and help them to breathe easier.
- During the night a mask is used and during the day a mouth piece is used.
- Each machine has an instruction manual that is pertinent for that machine.
- Staff will need to review the manual prior to implementation of the breathing device for additional information.

How to turn the ventilator on:

1. Wash hands.
2. Gather supplies for tubing change when needed.
3. The connection tube, mouth piece and mask are changed according to manufactures recommendation.
4. Usually the machine is preset up when it arrives for the individual to use.
   If not contact the nurse or the on-call person for direction.
5. Plug the machine into the outlet.
6. It also has an internal Lithium- Ion battery with a run time of 8 hours under normal conditions.
7. Connect oxygen tubing to oxygen tubing coming from back of Astrial.
   Take off nasal cannula.
8. Put on mask and make sure its secure (when laying down you may need to adjust the straps).
9. Touch the screen on the Vent and to unlock screen push confirm button, then push start button.

How to turn ventilator off:

1. Touch the vent screen.
1. Touch the unlock button then press confirm button.
2. Press and hold the stop button until the blue bar goes across and release.
3. Touch confirm stop button.
4. Take off the mask.
5. Connect the oxygen back to your cannula.

Troubleshooting:

1. Have mask on and connected before turning vent on.
2. Turn vent off before taking the mask off.
3. If the mask is too loose the person may experience a mask air leak which can affect the breathing.

4. The ventilator should have a routine maintenance service every two years in accordance with the reference guide.
5. The battery should be checked at routine appointments or sooner if there are problems.
6. The internal battery is designed to deliver continuous power when the AC power is disrupted or when the person is mobile (example in a wheelchair).
7. Report any problems to your PC immediately.

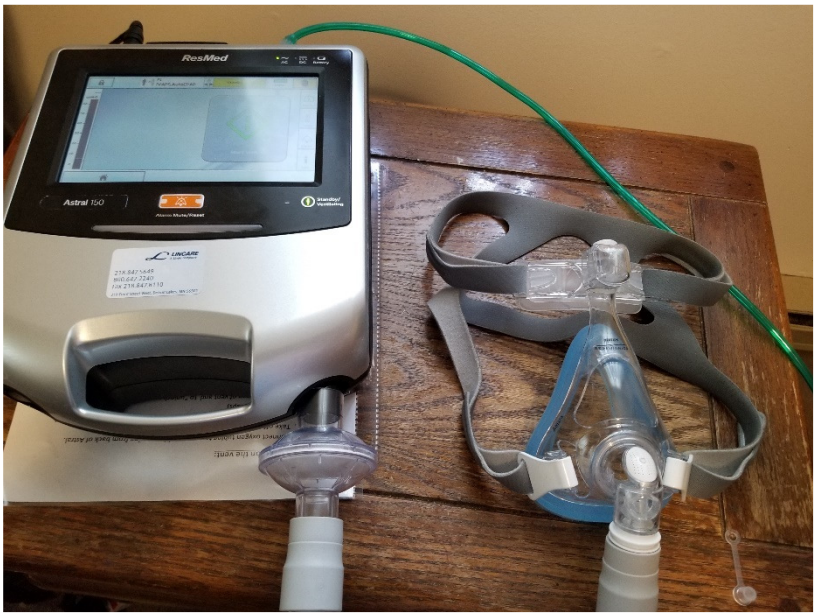
Things that will make the ventilator to start to alarm:

- Talking while using the vent.
- If it doesn't detect breathing.
- When a ventilator is being used with the internal battery as the sole battery source, the low battery alarm is design to activate when there are 20 minutes of ventilation time remaining.
- Critical low battery alarm is designed to activate when there are 10 minutes of ventilation time remaining.

Side effects:

The most common side effects of therapy include:

- Dry nose
- Nasal congestion
- Runny nose
- General discomfort
- Claustrophobia



PERINEAL CARE FOR MEN

1. Gather supplies which are 2 towels, wash cloth, soap, gloves, wash basin and the individual's clothes.
2. Be sure the water temperature is at a comfortable level and not too hot or cold-not above 112 degrees Fahrenheit
3. Instruct the individual as to what you are doing.
4. Wash your hands and put on the gloves.
5. With the individual on their back, instruct them to open their legs.
6. Use a towel to cover the individual for modesty before exposing the perineal area.
7. Cleanse the perineum, using front to back motions with soap, rinse and pat dry.
8. Never wash back to front; this causes contamination and can cause infections.
9. If you are caring for an individual who is not circumcised, be sure to gently pull the foreskin back away from the penis tip.
10. You will gently be pulling the skin up towards the individual's abdomen.
11. Clean underneath the foreskin with soap and warm water, rinse it and pat dry.
12. Go around the urinary opening in a circular fashion, down to the penis shaft.
13. Pull the foreskin back down over the penis.
14. If you are unable to pull the foreskin back notify your PC right away.
15. If the foreskin is not pulled back the penis could swell and the individual may need medical intervention.
16. After completion of the task assist the individual with dressing if needed.
17. Remove gloves, wash your hands, remove the equipment and wash your hands again.

PERINEAL CARE FOR WOMEN

1. Wash hands.
2. Gather supplies: Gloves, wash cloths, towels, soap, and basin of warm water with a temperature of no more than **112° Fahrenheit.**
3. Advise the individual as to what you are doing.
4. Place a clean towel under the individual hips.
5. Use a sheet or blanket to cover the individual for modesty before exposing perineal area.
6. Start with the individual inner thighs and gently cleanse the area.
7. Clean the outer labia and work inwards using a “front to back” technique to cleanse the outer genital area.
8. Cleanse the anal area.
9. Use a clean towel to gently pat dry the areas that were cleaned.
10. Remove the towel from underneath the individual.
11. Remove and dispose of supplies in proper area.
12. Take off gloves and wash hands.
13. Note any areas of concern and update PC for directions.

MANUAL PULSE

1. Wash hands.
2. Gather supplies: pen and paper.
3. Instruct the individual as to what you are doing.
4. Place your first and middle fingers between the bone and the tendon over the radial artery. (Radial artery is located on the thumb side of wrist).
5. Once you feel pulse, count beats for 60 seconds and that will be the beats per minute. (you can also count beats for 30 seconds and multiply by two to get the same number)
6. Normal pulse/heart rate ranges in between 60-100 beats per minute.
   Alert PC/On-call if you obtain and abnormal reading.
7. Wash hands and record on MAR/vitals sheet.

RANGE OF MOTION (ROM)

DEFINITION

Activity aimed to improve movement of specific joint.

- **Passive range of motion (PROM)** – movement applied to a joint solely by another person or a passive motion machine. When passive range of motion is applied, the joint of the individual receiving the exercise is completely relaxed while the outside force moves the body part, such as a leg or an arm.

- **Active range of motion (AROM)** – movement of a joint provided entirely by the individual performing their own exercise. There is no outside force aiding in the movement.

- **Active assist range of motion (AAROM)** – movement of a joint with partial assistance of an outside force. This range of motion may result from the majority of motion applied by the individual or by the person assisting the individual. It may also be a half/half effort on the joint from each source.

WHAT YOU SHOULD KNOW ABOUT RANGE OF MOTION EXERCISES

- Assist the individual with the specific exercises that are provided by the medical provider. Never do an exercise that was not given to the individual by his/her medical provider.

- Do exercises in the same order each day. Start at the top/head and end at the bottom/feet.

- Move slowly, gently, and smoothly. Avoid fast or jerky motions.

- Stop immediately if the individual (complains of) pain. It is normal for the individual to feel some discomfort at first. Regular exercise will help decrease the discomfort over time.

To provide any type of ROM you will need an order from a medical provider.

RESPIRATIONS: HOW TO COUNT

1. Wash hands.
2. Gather supplies: Pen and paper.
3. The best way to obtain/count respirations from the individual is to do this task while taking the individuals' pulse/heart rate.
4. If you tell the individual that you are counting their respirations, you will not get an accurate count.
5. After you are finished getting the individual pulse/heart rate, continue holding the individual's wrist so they think you are still checking their pulse.
6. Rather than counting beats for a pulse/heart rate, count how many times the individual inhales/exhales in 60 seconds.
7. A full respiration is when the individual inhales and exhales.
8. You can also count how many times they inhale/exhale in 30 seconds and then multiply by two to get the same number.
9. If you obtain the individuals' pulse/heart rate from an automatic blood pressure cuff, you will have to get respiration rate when they are not paying attention to what you are doing. This way you will be able to get an accurate count for respirations.
10. Follow procedure in number 3 to obtain/count respirations.
11. Normal respirations rates for an adult range in between 12-16.
12. Alert PC/On-call if you obtain an abnormal respiration rate.
13. Wash hands and record on MAR/vitals sheet.

SEIZURE INFORMATION AND PROCEDURES

Seizures occur when the electrical system in the brain malfunctions and instead of controlled discharging of electrical energy, the brain cells continue to fire resulting in seizure activity. Many people that have seizures may experience an aura prior to the seizure. An Aura can be an unusual taste, a visual disturbance, nausea, a dreamy feeling, or a cry or yell.

A. **Causes of Seizures:**
The causes of seizures are epilepsy, Alzheimer's disease, high fevers (especially in small children), head injuries, tumors, abscesses, intracranial surgery, circulatory disorders (i.e., stroke), drug or alcohol toxicity, and Central Nervous System infection (i.e., meningitis).

B. **Types of Seizures:**

1. **Grand Mall (Tonic-Clonic) Seizure:** These are the most common type of generalized seizure. They alternate between rigidity (tonic) and then jerking movements of body and face (clonic). These seizures can be very disturbing to witness, the person may be cyanotic (blue lips, nail beds, and face) due to a disturbed breathing pattern during the seizure. The person's breathing could decrease or even cease during the tonic phase, it typically returns in the clonic phase but can be irregular. Persons can foam at the mouth and breathing can be noisy and labored. The person may bite their tongue or inside of the mouth during the seizure so there may be blood in the sputum. The person also could be incontinent of bowel or bladder. Following the seizure, the person could be confused and lethargic. They may have head or body aches and want to sleep; full recovery can take a few minutes up to several hours depending on the person.
   a. First Aid for Tonic-Clonic Seizures (also called a grand mal or a convulsion)
      (1) Stay calm. Do not leave the person unless it is to call 911.
      (2) Loosen clothing around the neck, place something soft (not a pillow) under the head, remove glasses, and remove sharp or hard objects that may be in the area.
      (3) Do not force objects into the person's mouth.
      (4) Do not restrain movement or attempt to lift the person.
      (5) Turn the person on his or her side to pen the airway and allow secretions to drain.
      (6) Stay with the person until the seizure ends and they are their usual self.
      (7) Let the person rest until he or she is fully awake.
      (8) Be reassuring and supportive when consciousness returns.

      *A convulsive seizure is usually not a medical emergency unless it lasts longer than five minutes, or a second seizure occurs without a return to consciousness.

      Two or more Grand Mal seizures without a return to consciousness can be fatal. This condition is called Status Epilepticus and is a MEDICAL EMERGENCY.

2. **Status Epilepticus Seizure:** This is two or more Grand Mall seizures without a return to consciousness. This can be fatal. This condition is a **MEDICAL EMERGENCY**.
3. **Partial Complex Seizure:** A person having a partial complex seizure is unable to interact normally other people and they are unaware of their movements, speech, and actions. They

will not remember what happened after the seizure is over and they have recovered full. They are in a trancelike state and appear to be awake but their level of consciousness is altered. The person may wander around and even speak during the seizure but their words will not make sense. They may be incontinent.

Because the person is unaware of what they are doing it is important to keep them safe. Remove any hazardous objects in their way. Gently direct them away from hazards. A person could possibly walk out into the street without looking or attempt to go up or down stairs unaware of the hazard. During a partial complex seizure and recovery time the person may become violent if confronted, remember to keep a safe distance and gently try to guide them away from dangerous situations.

a. First aid for Partial Complex Seizures:
   (1) Do not restrain.
   (2) Remove hazardous objects from their path.
   (3) Gently direct the person to sit down and gently guide away from dangerous situations. Use force only to protect them from immediate harm (i.e., walking in front to an oncoming car).
   (4) Observe but do not approach the person if they appear to be angry or combative.
   (5) Remain with the person until they are fully aware of their surroundings.

4. **Petit Mal (Absence) Seizure:** This seizure has a very short duration, only a few seconds and can be indicated by a blank stare, blinking or rolling back of the eyes, slight mouth movements, and possible incontinence. They usually retain their posture and resume activity quickly. These may be over before they are even noticed. There is no immediate first aid necessary.
5. **Aura:** An aura is a feeling, experience, or movement that just seems different. It can also be a warning that a seizure is going to happen.
6. **When to call 911:**
   - Seizure lasts more than 5 minutes.
   - More than one grand mal seizure without return to consciousness.
   - Problem with breathing once the seizure has ended.
   - Injury with seizure.
   - Second seizure within 24 hours if person does not have in Individualized Seizure Protocol.
   - High fever.
   - If person is pregnant.
   - If person is diabetic.
7. **Prevention of Seizures:** Some ways to help prevent seizures include the following:
   - Well-balanced diet.
   - Moderate physical and mental activity.
   - Adequate rest. (Lack of sleep can increase seizure activity.)
   - Avoid stimulating stressors.
   - Maintain a regular medication schedule.
   - Regular follow-up with the doctor.

   Seizure activity can increase during times of illness; pay close attention to symptoms of illness.

8. **Treatment of Seizures (Epilepsy):**
   There are several treatment options for people that have epilepsy. Some people can have excellent control of seizures and may have them very rarely; others have a difficult time with seizure control and will continue to have seizures regularly. The treatment options include; drug therapy, bio-feedback, magnet placement, and surgical intervention. Follow ORH/WSS policies and procedures concerning what to do for seizures unless the person has an Individualized Seizure Plan.

9. **What to Do for A First Time Seizure:**
   - Call 911 if the seizure meets the criteria listed above in *WHEN TO CALL 911*.
   - Otherwise, arrange for a medical evaluation.
10. **Individualized Seizure Protocol Form:** Persons who have had seizures in the past may have an Individualized Seizure Protocol that you should follow.

C. **Documentation of Seizures:** Write in the progress notes in RED. The narrative should include:
   1. The activity of the person before the seizure occurred.
   2. Length of time the seizure lasted.
   3. How the seizure activity looked to you.
   4. What the person looked like (i.e., color, frothy mouth, eyes rolled, any sounds made, etc.)
   5. What care you provided.
   6. Time the person returned to normal function.
   7. Whether or not they were incontinent.
   8. If there was any injury evident.

**For individuals with known or frequent seizures, you may use the "Seizure Documentation Checklist" instead of the narrative charting. If you do this, you should still make a note in the progress notes that the person had a seizure and that the description of the event is on the seizure checklist.*

SEIZURE DOCUMENTATION CHECKLIST

Client Name:_____ Date:_____
Time seizure started:_____ Time Ended:_____ Total Time:_____
Where seizure occurred:_____
Check all that apply:

Began Acting Strangely		Stated a Seizure Is Coming		Yelled/Called Out	
Body Rigid/Stiff		Became Unconscious		Fell	
Frothed at Mouth		Incontinent of Urine		Incontinent of Bowel	
Face Turned Pale		Face Cyanotic (blue)		Eyes Rolled Up	
Body Jerked or Convulsed (one side or both?)		Repeated Word or Phrase		Stared Blankly	
Bit Tongue		Injury:		Headache/Complaints After:	
Lost Awareness of Surroundings but Remained Conscious		Did Not Recall Events Afterwards		Other:	

Behavior/Condition before seizure: _____
_____
_____

Behavior/Condition after seizure: _____
_____
_____
_____

Was First Aid/Medical Attention Provided? _____
_____
_____
_____

Did the person sleep after the Seizure? How long? _____
_____
_____
_____

SKIN BREAKDOWN/ SKIN CHECKS

People who are dependent on you for repositioning and/or who spend most of their time in a wheelchair/recliner/bed are prone to skin breakdown. These individuals should have a head to toe skin check completed on every shift to look for signs of skin breakdown following the procedure listed below. These individuals should also be repositioned a minimum of once every two hours, unless otherwise specified by their physician.

Skin Check Procedure:

1. Wash hands
2. Advise person as to what you are doing.
3. Have person lie in a comfortable position.
4. Put on gloves.
5. Below is a list of concerns that should be brought to the nurse's attention:
    a. Changes in color of skin. (i.e., red, pink, white, or blue areas)
    b. Changes in the temperature of skin. Is it colder or warmer to the touch than what is normal for person?
    c. Swelling in the extremities or any other area.
    d. Scabs. This can indicate the starting of a pressure ulcer.
    e. Bruising. If the person is on blood thinner, bruising can indicate that their blood is too thin and the medical provider may need to be updated. Bruising could present as one large bruise, or several smaller ones.
    f. Blisters
    g. Lumps
    h. Complaints of discomfort or pain in a certain area.
    i. Spongy areas. These areas would include ears, shoulders, hips, spine, elbows, buttock area, knees, ankles, heels and toes. Spongy areas are the first sign of skin breakdown.
6. Anything that is unusual for the person needs to reported to the nurse.
7. Starting at the head, palpate/touch persons scalp, looking and feeling for any bumps or bruises. Be sure to look behind ears. Observe face, including eyes.
8. Moving down the neck (front and back), palpate/touch each shoulder and arm looking for bruising, spongy areas, and skin discoloration. Be sure to pay close attention to bony areas including the wrist.
9. Look/observe both front/back of torso, again looking for any bruising or discoloration. Palpate/touch shoulder blades.
10. Thoroughly check buttock and hip area. Be sure to palpate/touch hip area. If person is not ambulatory, these areas can break down quickly.
11. Palpate/touch both legs including ankles, feet, and toes. Paying special attention to the knees.
12. If any skin issues are noted, use Skin Breakdown form to mark the areas of concern.

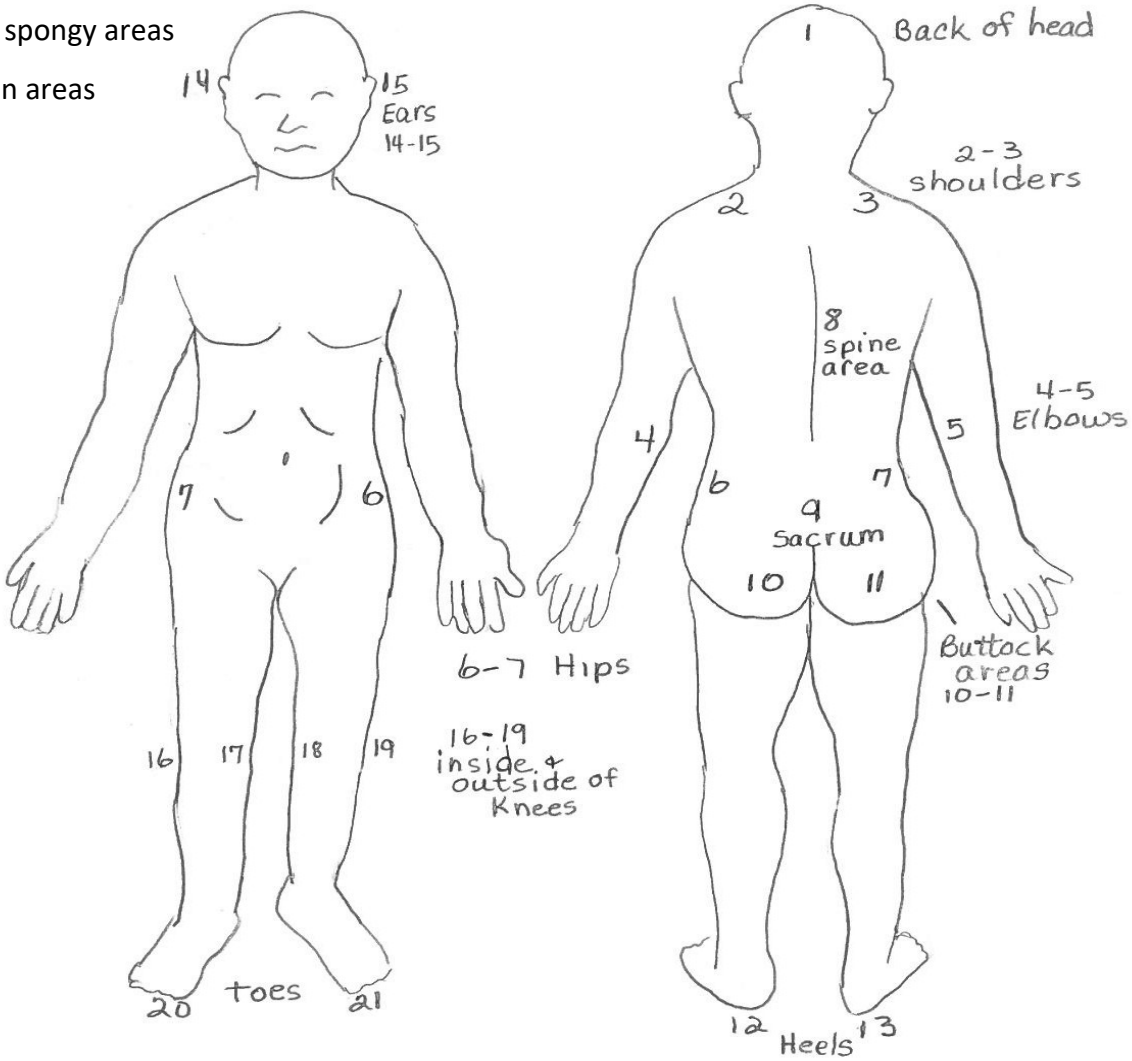
SKIN BREAKDOWN FORM

Person: _____Date:_____ Location:_____

Staff completing form: _____

CIRCLE the area where there are indications of skin breakdown such as:

1. A red, pink or whitish area
2. Any spongy areas
3. Open areas



Document your findings in detail, including measurements if possible: _____

_____

_____

_____

_____

Please fax/email to Oakridge RN immediately when something is noted.

TEDS: THROMBO-EMBOLUS DETERRENT STOCKINGS (COMPRESSION SOCKS)

- TEDS are specially designed stockings/socks that help reduce the risk of developing a deep vein thrombosis (DVT) or blood clot in lower leg.

- Wearing TEDS can prevent a pulmonary embolism (blood clot in the lungs).

- The stockings/socks are made of firm elastic and provide compression over the ankle, mid-calf, and thigh.

- The compression has the effect of speeding up the circulation in veins, which makes clotting less likely.

TEDS should not be worn by an individual unless specifically ordered by a medical provider.

TEMPERATURE: NON-CONTACT FOREHEAD THERMOMETER

1. Wash hands.
2. Gather any needed supplies: thermometer, pen and paper.
3. Instruct the individual as to what you are doing.
4. You will be obtaining the individual's temperature on their forehead. Each thermometer could be different.
    a. One example of obtaining temperature is turning mechanism on, then touching the individual's forehead (middle), then dragging along to either side of forehead (temple) while holding button in. Once you release button, the thermometer will display a reading. This is the most frequently used thermometer.
    b. Another example is a thermometer that does not require you to touch the individual's forehead. Simply turn the mechanism on, aim the thermometer towards the individual's forehead and push button.
5. Record temperature reading in MAR/vitals sheet.
6. Clean thermometer and wash hands.

TEMPERATURE: TYMPANIC (INSIDE THE EAR)

1. Wash hands.
2. Gather supplies needed: Thermometer, pen, and paper.
3. Alert the individual as to what you are doing.
4. Put a new cover on each time you use thermometer.
5. Put the covered tip into the ear opening. DO NOT use force or push hard. The thermometer tip should not touch the ear drum. For an adult, gently pull the ear up and back.
6. Press the button to turn on the thermometer.
7. Hold the button until the thermometer beats, or follow the instructions for your thermometer.
8. Remove thermometer for the ear opening.
9. The temperature reading will show on the screen.
10. Record the temperature on the MAR/vitals sheet.
11. Remove and discard the throw away cover.
12. Clean thermometer and wash hands.

TRANSFER ASSISTANCE USING A TRANSFER BELT

1. Transfer belts can be used with or without a physician's order. If there is an order to use a transfer belt while the individual is walking/transferring then a transfer belt MUST be used.
2. Before use, inspect the belt to make sure it is not torn, ripped, frayed, or otherwise compromised. If it is, do not use it and contact your PC.
3. Place the belt around the individual's waist and tighten so there is only enough room for two fingers underneath the belt.
4. For some people, when they stand up from a sitting position, the belt may become looser than it was when they were sitting down. If this is the case, tighten the belt again before proceeding.
5. Whether you are using a transfer belt to assist someone in standing up from a seated position, or using it to walk along with them, the staff person should be to the side and slightly behind the individual, with their hand gripping the transfer belt from underneath with your palm facing up.
6. If you are assisting the individual to standing, make sure that you are using proper body mechanics (bending at the knees, lifting with your knees- not your back).
7. When the task is completed- REMOVE the belt! Transfer belts should never be left on an individual when not in use.

TRANSFER DEVICE: EZ STAND

1. Wash hands.
2. Gather supplies: Individual, lift pad and the EZ Stand.
3. Alert the individual as to what you are doing.
4. Have the individual in a sitting position either on the edge of bed, chair, or toilet/commode.
5. Position the harness around the upper body of the individual so the sides of the harness are between the torso and arms, resting 2-3 inches below the underarm.
6. For the safety of the individual, securely fasten the safety strap around the individuals' torso.
7. Secure the buckle and pull the strap to tighten.
8. Position shin pad and foot plate.
9. The foot plate has several adjustments to raise or lower the plate.
10. The normal setting is in the lowest position.
11. The shin pad has several vertical adjustments for various patient heights and conditions and normally is left in the middle position.
12. The skin pad can be adjusted horizontally toward the individual as well, and is normally used in the position closest to the mast of the EZ stand.
13. Position the stand in front of the individual.
14. Be sure that the base is open and in locked position.
15. With the lift arm in lowest position, attach the harness to the hooks at the end of the EZ stand arm using the loops at the end of the harness.
16. Use the shortest loops when possible.
17. To ensure the individual's safety and comfort, make sure to use the same color loop on each side.
18. Position the individual's arms on the outside of the harness and have them place their hands on the padded handles.
19. Once the individual is ready to stand, push the **UP** button to raise client into the standing position.
20. Once standing, close the base of the stand and push stand to the next location.
21. Once in position, stand next to client and push the **DOWN** button to lower the individual into bed, chair, or toilet/commode.
22. Unlock the individual from the stand and make the individual is comfortable.
23. Put EZ stand away and wash hands.
24. If the equipment is battery operated, make sure you keep it plugged in when not in use or an extra charged battery on hand.

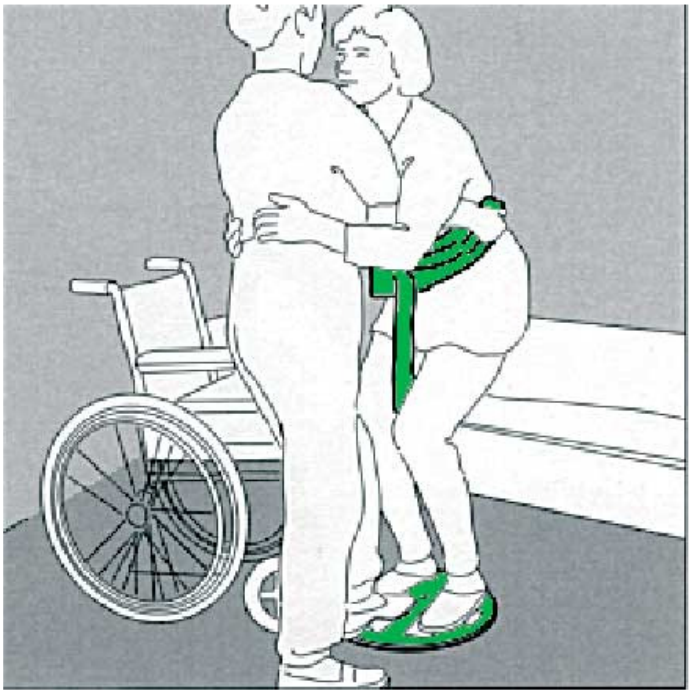
TRANSFER DEVICE: HOYER LIFT

1. Before using a Hoyer lift, the individual needs to have an assessment done by their provider to determine that this is the safest method of transferring. The provider will write an order for the Hoyer lift. A sling will have to be ordered that matches the specific Hoyer lift that is purchased, and sized according to the individual that the Hoyer lift is for.
2. Before staff can use a Hoyer lift with an individual, they need to be observed and signed off on competency by the RN. Lifts can be manual, or powered, and sling styles vary, so the RN needs to ensure competency with the materials that will be used.
3. Hoyer lifts require 1-2 staff depending on the model, the size/care level of the individual and other factors. The RN will determine if 1 or 2 staff are required for safe transfers, and then this must be followed accordingly. 2 staff will always be safest, so even if the RN determines that it is okay to use only 1 staff, 2 staff should be used whenever possible. If the RN has determined that 2 staff are needed, 1 staff is never okay.
4. Before and after each use, inspect the sling to check for any rips, tears, frays, etc. that would indicate it is compromised. If you find anything like that, do not use the sling.
5. If the person is starting out in a sitting position (wheelchair, couch, etc.) and the sling is NOT already underneath them, do step 6, then skip to step 10. If the person is lying down and the sling is NOT already underneath them, skip to step 7. If the person is sitting or lying down but the sling IS already underneath them, skip to step 10.
6. To get the sling underneath a person who is sitting upright, you would have the person lean forward as far as they safely can, and slide the sling behind their back and under the butt as much as you can. Then have the person sit back, and lift one leg at a time while you pull the sling under their butt/thigh until it is in position. Go to step 10.
7. To get the sling under a person who is in bed or lying down on a flat surface, you would assist/roll them to their side, tucking the half of the sling that is closest to their body, underneath their side as best as you, for the entire length of their body. Smooth out the half that is further from their body so it is flat and ready for them to lay on.
8. Assist/roll the individual to their other side, so they are now laying on the half that you smoothed out, and the half that you tucked can be pulled flat and also smoothed.
9. Assist/roll the person flat on their back. Now the whole sling should be flat and underneath the person.
10. Adjust the leg straps according to the specific sling being used (most slings have straps that crisscross between their legs).
11. Move the Hoyer into position, so the boom is over top of the person, and the legs of the Hoyer are spread as wide as the space allows.
12. Lock the wheels, and lower the boom close to the person so hooking up the sling is easier.
13. Connect the sling handles on the correct loop to the Hoyer (many slings have color coded handles- it should be indicated in the individual's plan which loop is being used).
14. Raise the boom by either pressing the up button or pumping the hydraulic handle (depends on your type of lift).
15. As the person is raised, make sure that they remain facing the operator, and that you do not allow them to swing around freely.
16. Unlock the wheels, close the legs on the base of the lift, and move the lift to wherever you are bringing the person (their wheelchair, the couch, etc.).

17. Once to the new location, open the base of the legs again, and lock the wheels on the lift. If you are bringing the person to/from their wheelchair or something else that is also moveable, make sure that those wheels are locked as well.
18. To lower the person, you will need to either press the down button, or turn the hydraulic pressure release knob counter clockwise (again depends on the type of lift you are using).
19. Once the individual is securely in the new location, unhook the sling from the boom of the lift.
20. Unlock the lift wheels, and move the lift away from the person.
21. Depending on the person, and the type of sling, some slings are okay to leave underneath the person and others need to be removed when not being used. This should be in the individual's plans as well.
22. To remove the sling from a seated person, you would have them lift one leg at a time while you pull the sling out from underneath them. Then have the person lean forward while you pull it out from behind their back.
23. To remove the sling from a lying down person, you would roll them on to their side, tuck one half of the sling under the side they are laying on, roll the person to their other side, and pull the sling out from under them.
24. If the Hoyer lift is battery operated, make sure to plug in while not in use so the battery stays charged.
25. Clean the pad according to the manufacture's recommendation.

TRANSFER ASSISTANCE USING A PIVOT DISC

1. Wash hands
2. Gather supplies: Transfer/gait belt and pivot disc
3. Advise the individual as to what you are doing.
4. Place the pivot disc on the floor in front of the individual.
5. Place the transfer/gait belt on the individual.
6. Before transferring the individual, tell them what you will be doing.
7. Grab the transfer/gait belt on either side of the individual and assist them to stand up.
8. Turn the individual using the pivot disc to the desired location. (chair, bed, commode/toilet)
9. Gently ease them onto the desired location. (chair, bed, commode/toilet)
10. Remove the transfer/gait belt.
11. Wash hands.



TUBE FEEDING: GENERAL INFORMATION

TYPES OF FEEDING TUBES

- **Nasogastric Tube (NG Tube):** Passed into either nostril, down the esophagus and into the stomach. This is used for short term feedings.
- **Gastrostomy Tube (G Tube or PEG):** Surgically placed through the abdominal wall into the stomach. The tube will be located below the rib cage and to the left.
- **Jejunostomy Tube (J Tube or PEJ):** Surgically implanted in the upper portion of the jejunum (part of the small intestine). The tube will be located lower in the abdomen and more toward the center than the G Tube. Feedings through a J Tube **MUST** always be by a pump.

FEEDING TECHNIQUES

- **Bolus:** A set amount of formula is given over a short period of time via syringe.
- **Gravity Drip:** A set amount of formula is placed in a tube feeding bag and delivered via gravity. The rate may be controlled via a clamp in the tubing.
- **Pump:** Formula is placed in a tube feeding bag, and the line going from the feeding bag to the tube is connected to a feeding pump. The pump is set to deliver a specified amount of formula over a specific time frame.

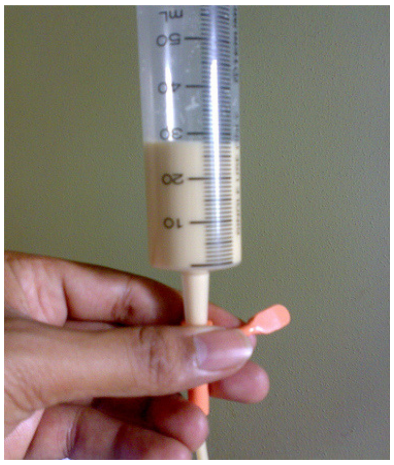
OTHER INFORMAITON

- Medical Provider (MP) order should state the type of tube feeding the individual has. (G-tube, J-tube for example)
- MP or dietitian should state the feeding technique. (Gravity, Bolus, or Pump)
- MP or dietitian should state the type of nutritional supplement to be given, the amount and frequency.
- MP or dietitian should state the rate/hour for nutritional supplement. (if using a pump)
- MP or dietitian should state the frequency and amount of water flushes.
- MP order should state guidelines for daily care. (cleaning solutions, ointments, etc.)
- If the MP doesn't give direction for daily care of the site the nurse will give directions.
- MP order should state whether the individual is able to have anything by mouth (NPO). This order should include the quantity, consistency, and special feeding instructions.

- **Before you can place anything in the feeding tube you need to FOLLOW THE PROCEDURE FOR Checking Tube Placement**.

INFORMATION TO BE DOCUMENTED BY CAREGIVER

- Daily administration of feeding
- Daily maintenance and monitoring
- Intake and Output (I & O)
  - Intake and output should be followed for anyone on tube feedings to monitor their fluid status and prevent complications such as dehydration or constipation. This will be at the discretion of the nurse if it needs to be done.
  - Intake should include the amount of any tube feedings, flushes, and liquid medications.
  - Output should include urine, stool, and emesis. (estimates may have to be made). A bowel chart should also be used to track the frequency and character of stools.

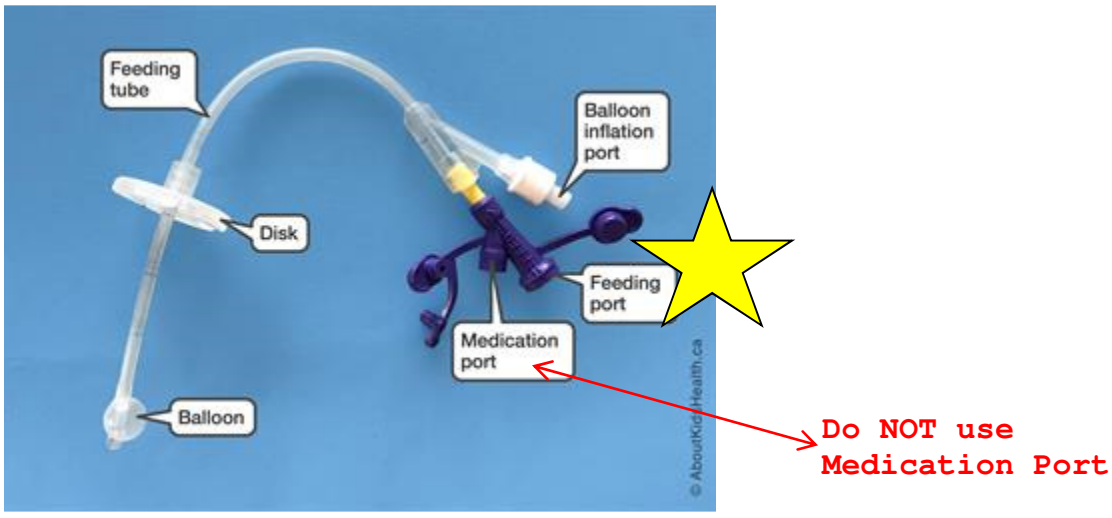


- Weight (follow medical providers orders)
- Bowel charts
- Stoma care
- Mouth care (should be provided each shift. Follow medical providers orders).
- Any other information requested by the medical provider.

You must check tube placement before giving any medications, nutritional supplements, or water flushes. This is done using the FEEDING PORT which is typically the largest of the openings on the tube (see ★ below)

- Take a 60 mL syringe with a plunger in place, insert into the feeding tube and pull back for stomach contents. It will pull back hard. (Old procedures instructed you to push air into the stomach…however, new procedures instruct…DO NOT push air into the stomach).

- The stomach contents will be white, yellow, or green in color. When you see this, it indicates the tube is in the stomach. Put the stomach contents back into the stomach.



TUBE FEEDING PROCEDURE

PREPARATION FOR ADMINISTRATION OF TUBE FEEDING

- Wash hands
- Gather supplies needed: Gloves, 60 cc syringe with plunger, nutritional supplement, feeding bag (if needed), water (room temp).
- Advise the individual as to what you are doing.
- If the person is in bed, make sure the head of the bed is elevated to at least **45°**, unless otherwise specified by the medical provider.
- If on a feeding pump, this elevation must be continuous 24/7.
- If on a bolus or gravity feedings, the individual needs to be elevated for at least 30-60 minutes after feeding, or longer as directed by the medical provider.
- Observe for complaints or signs of nausea or cramps.
- Observe for vomiting and/or diarrhea.
- Observe for abdominal distention.
- Observe for tube placement. (follow policy/procedure)
- Observe that the tube is anchored per protocol or with tape if needed.
- Observe the dressing/4x4 for blood, drainage, or leakage.
- Observe for bleeding or irritation at the insertion site.

FLUSHING THE TUBE

- The feeding tube should be flushed per medical providers/dietitian directions as to the frequency, type, and amount of each water flush. (if no direction for water flushes, give 30-60 cc's)
- Unless otherwise specified by the medical provider/dietitian, the feeding tube should be flushed:
    - Before and after bolus or gravity administration of nutritional supplement
    - Before and after medication administration

ADMINISTER TUBE FEEDING

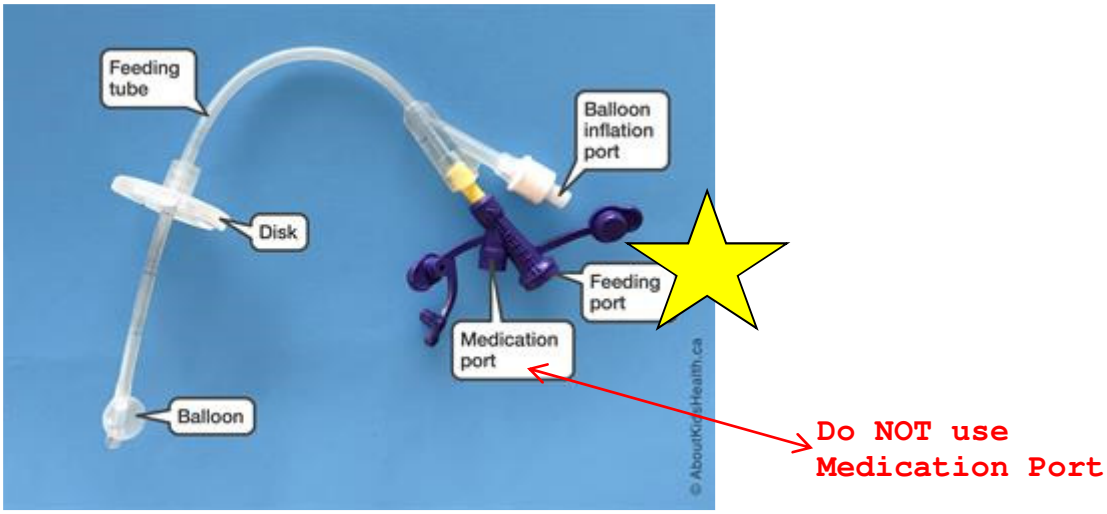
- Administer feeding per medical provider/dietitians' direction
    - Gravity (follow policy/procedure)
    - Bolus (follow policy/procedure)
    - Pump (follow policy/procedure)
- Administer amount and type of flush per medication provider /dietitian's direction.
- Be sure to monitor the individual for any complications during feeding.
- If any nutritional supplement is left over, put initials, date/time on container and cover tightly and refrigerate.
- Nutritional supplement should be at room temperature when administered.

FEEDING TUBE FALLS OUT

- **If the feeding tube falls out at any time notify the PC immediately for directions.**
- The tube must be reinserted right away because it will close up in a short period of time.

- Depending on house arrangements you will take them to either the clinic or the ER and have it reinserted immediately.
- In some cases, the house has made arrangements to contact the paramedics for reinsertion of the feeding tube in the house.

Feedings, medications, and flushes should be given through the correct opening on the tube. This is done using the FEEDING PORT which is typically the largest of the openings on the tube (see below)



TUBE FEEDING: BOLUS

1. Wash hands
2. Gather supplies needed: Gloves, empty container, container of water (room temperature), nutritional supplement, 60 cc syringe with plunger, wash cloth or paper towel.
3. Advise the individual as to what you are doing.
4. Check for tube placement.
5. Open the end of the tube ensuring that the tube is clamped off/pinched to prevent leaking.

6. Draw up the desired amount of water into the syringe, (30-60cc or amount ordered by the medical provider) and place tip of syringe into feeding tube.
7. Unclamp the tube feeding and flush the amount of water in syringe using the plunger. Remember to "push" fluids slowly.

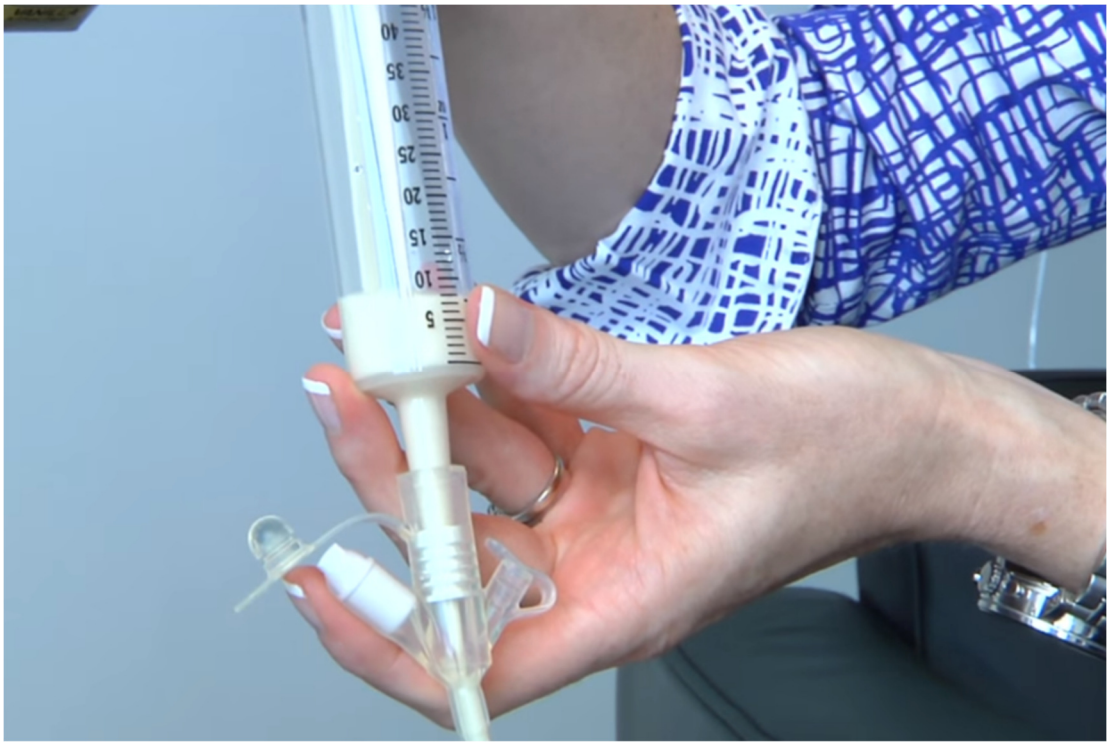
8. Re clamp the feeding tube and remove the syringe
9. Pour the desired amount of room temperature nutritional supplement into the empty container.
10. Draw up the desired amount of nutritional supplement into the syringe.

11. Place the tip of the syringe into the feeding tube and unclamp.
12. SLOWLY push the nutritional supplement into the feeding tube.
13. Be sure to clamp the feeding tube in between each syringe of formula to prevent leaking.
14. Refill the syringe with formula. Repeat the procedure until you have injected the prescribed amount of formula.
15. Remember to clamp feeding tube when completed.
16. Draw up the desired amount of water into the syringe, (30-60cc or amount provided by the medical provider).

17. Unclamp the tube feeding and flush amount of water in syringe using the plunger. Remember to "push" fluids slowly.
18. Clamp off the feeding tube.
19. Clean/put away all supplies.
20. Record intake in MAR or intake/output sheets.
21. Wash hands.

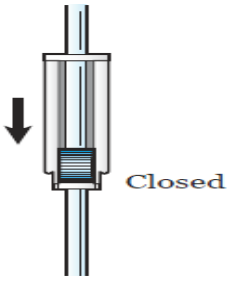
Helpful Tips

- Monitor the individual during feedings
- Always re clamp your feeding tube before removing syringe to avoid spilling
- Move clamp on feeding tube to different positions to avoid permanent kinking of tubing.
- To avoid clogging, always flush with the appropriate amount of water.
    - Before/after Feedings
    - Before/after **EACH** medication administration
    - Before/after any additional fluids
- If not using tube feeding daily, be sure to flush with 30-60cc of water at least once a day or amount provided by medical professional.
- Administer nutritional supplement at room temperature
- Initial and date/time any unused portion of nutritional supplement and store tightly covered in fridge.
- Feeding bags and syringes to be changed weekly unless directed differently by medical provider.



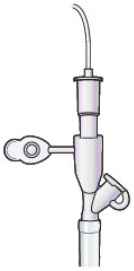
TUBE FEEDING: GRAVITY WITH A FEEDING BAG

1. Wash hands.
2. Gather supplies: Gloves, nutritional supplement, gravity feeding bag, gravity pole or hook to hang bag, clean cloth or paper towel, container of water at room temperature, empty container.
3. Advise the individual as to what you are doing.
4. Check for tube placement.
5. Be sure to clamp off the roller clamp on the gravity feeding bag.



6. Pour the desired amount of nutritional supplement into the gravity drainage bag.
7. Hang the gravity drainage bag 2-3 feet above the individual.
8. Hold the end of the feeding bag tube over the empty cup and SLOWLY open the roller clamp allowing nutritional supplement to flow through tubing and then close clamp again. This will allow for any air in tubing to be released.
9. Open the end of the feeding tube (be sure that feeding tube is clamped shut to avoid leaking)

10. Insert the 60cc syringe into the end of the feeding tube.
11. Pour the desired amount of water into syringe, (30-60cc or amount ordered by the medical provider) unclamp and flush. (follow policy/procedure).
12. Re clamp the feeding tube and disconnect the syringe
13. Connect the end of the gravity feeding tube bag to feeding tube.



14. Unclamp feeding tube and slowly open the gravity feeding bag to allow for nutritional supplement to flow into feeding tube.

15. The feeding should take 30-45 minutes.
16. If feeding is flowing to fast, slowly close the clamp on the gravity feeding bag to slow that flow down.
17. When the feeding bag is empty, close the roller clamp on the gravity feeding bag tubing and close the clamp on feeding tube.
18. Disconnect the gravity feeding bag and set aside.
19. Insert the syringe into feeding tube and unclamp.
20. Pour desired amount of water into syringe, (30-60cc or amount ordered by the medical provider) unclamp and flush. (follow policy/procedure)
21. Clamp off feeding tube and remove syringe.
22. Clean and put away all supplies (rinse syringe and gravity feeding bag with warm water and let air dry)
23. Record input amount in MAR or Intake/output sheets,
24. Remove gloves and wash hands.

Helpful Tips

- Monitor the individual during feedings
- Always re clamp your feeding tube before removing syringe to avoid spilling
- Move clamp on feeding tube to different positions to avoid permanent kinking of tubing.
- To avoid clogging, always flush with the appropriate amount of water.
    - Before/after Feedings
    - Before/after **EACH** medication administration
    - Before/after any additional fluids
- If not using tube feeding daily, be sure to flush with 30-60cc of water at least once a day.
- Administer nutritional supplement at room temperature
- Initial and date/time any unused portion of nutritional supplement and store tightly covered in fridge.
- Feeding bags and syringes to be changed weekly unless directed differently by medical provider.

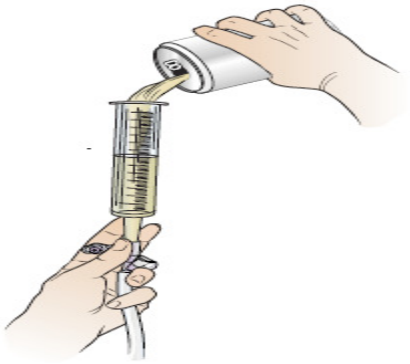
Revised: 01/19/21

TUBE FEEDING: GRAVITY WITH SYRINGE

1. Wash hands.
2. Gather supplies needed: Gloves, 60cc syringe, container of water, nutritional supplement, clean cloth or paper towel.
3. Advise the individual as to what you are doing.
4. Have them sitting/lying in a comfortable position. If lying down, client should be sitting at a 45-degree angle.
5. Check for tube placement.
6. Open the end of the tube ensuring that the tube is clamped off/pinched to prevent leaking.

7. Place the tip of the syringe into the end of the tube. (plunger should be out of the syringe)
8. Pour the appropriate amount of water into syringe, (30-60cc or amount ordered by the medical provider) unclamp and flush. (follow policy/procedure)

9. **SLOWLY** pour the desired amount of nutritional supplement into the syringe. Pouring too fast can cause stomach discomfort for the person.
10. Continue this process until desired amount of nutritional supplement is administered.



11. Keeping the syringe in place, pour the appropriate amount of water into syringe, (30-60cc or amount ordered by the medical provider) unclamp and flush. (follow policy/procedure)
12. Clamp off the tube.

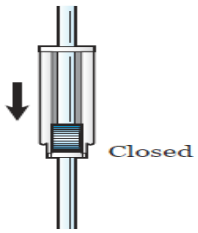
13. Clean and put away all supplies used. (rinse syringe after each use)
14. Record input amount in MAR.
15. Remove gloves and wash hands.

Helpful Tips

- Monitor the individual during feedings
- Always re clamp your feeding tube before removing syringe to avoid spilling
- Move clamp on feeding tube to different positions to avoid permanent kinking of tubing.
- To avoid clogging, always flush with the appropriate amount of water.
    - Before/after Feedings
    - Before/after EACH medication administration
    - Before/after any additional fluids
- If not using tube feeding daily, be sure to flush with 30-60cc of water at least once a day or as directed by medical provider.
- Administer nutritional supplement at room temperature
- Initial and date/time any unused portion of nutritional supplement and store tightly covered in fridge.
- Syringes should be changed weekly unless directed otherwise from medical provider.

TUBE FEEDING: PUMP

1. Wash hands
2. Gather supplies: Gloves, nutritional supplement, pump attached to IV pole or something similar, pump feeding bag, container of water, empty container, cloth or paper towel in case of spillage, 60cc syringe.
3. Advise the individual as to what you are doing.
4. Check for tube placement.
5. Have the individual sit in a comfortable position in a chair or bed. If in bed, they **must be at a 45-degree** angle.
6. Close roller clamp on pump feeding bag.



7. Pour desired amount of nutritional supplement into pump feeding bag. (The bag will only hold 1,000mL/4 cans at a time)

8. Hold the end of the feeding bag tube over empty container.
9. Remove the cap at the end of the tube.
10. Slowly open the roller clamp on the feeding bag tube allowing nutritional supplement to run through tubing, then re clamp. This allows the air in tubing to be removed.
11. See the reference guide/manual that came with the specific pump you are using for troubleshooting and pump set up instructions.

TURN AND REPOSITION

1. Wash hands.
2. Gather supplies: pillows or a rolled blanket.
3. Advise the person as to what you are doing.
4. If able to, raise bed to a comfortable position. If unable, ensure that you are using proper body mechanics to prevent injury.
5. Cross the person's arms over their chest.
6. Grasp the persons shoulder and hip on the opposite side of where you are standing.
7. Gently pull the person towards you and place a pillow/rolled blanket behind person at the mid/lower back. This will ensure person will not roll onto back after being repositioned.
8. Ensure that the knees and ankles are not resting on each other. To do this, slightly bend the top leg and place a pillow between the legs/ankle.
9. Check that the person is not lying on arm. You can place a pillow under the top arm for comfort if person chooses.
10. Check with the person for comfort and adjust as needed.
11. Person should be turned/repositioned every 2 hours or as directed by health care provider.
12. Rotate between side lying (left/right side) and on their back.
13. Chart in MAR or designated area.

UROSTOMY CARE: CHANGING THE BAG

1. Wash hands.
2. Gather supplies: Gloves, new bag with wafer/ring, soap, water, wash cloth, towel, skin prep, stoma powder (if the individual uses it), barrier ring (if the individual uses it), measuring device, scissors and gauze/paper towel/clean wash cloth.
3. Advise the individual as to what you are doing.
4. Remove the clip (save it) and throw the old urostomy bag away. (it's easier to empty the urostomy bag before removing).
5. Cover the stoma with gauze/paper towels/ wash cloth to keep urine from leaking out.
6. Replace if the gauze/paper towels/wash cloth become urine soaked.
7. Clean the area around the stoma with warm water, soap, and wash cloth.
8. The area should not be sticky.
9. Pat area dry and leave open to air for 1-2 minutes.
10. Take the measuring device and measure stoma.
11. **DO NOT** touch the measuring device to the person's skin.
12. Once you have the correct measurement, cut wafer to that size using a scissor.
13. Make sure the area has remained clean while measuring new bag/wafer.
14. Clean any urine off skin.
15. Peel the backing off of wafer and place wafer around stoma.
16. If the individual uses a thin barrier ring, place this first. Have the individual hold it in place with their hands, the warmth will help the wafer seal.
17. Be sure to close the new pouch with the clip to prevent leakage.
18. Clean and put away any supplies.
19. Report output in MAR or intake/output sheets if needed.
20. Report any unusual finding to PC or on-call.
21. Wash hands.

UROSTOMY CARE: EMPTYING THE BAG

1. Wash hands.
2. Gather supplies: Gloves, toilet or specified container to hold urine, paper towel/toilet paper, eye protection.
3. Advise the individual as to what you are doing.
4. Have the individual stand next to toilet or specified container to hold urine.
5. Put on gloves and eye protection.
6. Assist them to remove (or just move away) clothing.
7. Open the clip at the end of the bag and drain all urine from bag. Always be sure to monitor urine for color and odor.
8. Use a paper towel/toilet paper to wipe the end of the drain and close the clip.
9. Record amount if needed in MAR or intake/output sheets.
10. Report any abnormal finding to PC or on-call.
11. Clean and put away any supplies used.
12. Wash hands.

VITAL SIGNS RECORD

Obtain a **complete set** of vitals at least once per month. Some vitals (such as blood pressure) may be ordered more frequently by the prescriber. Check vitals any time the person seems "off" or says they are not feeling well.

Name _____ Target Weight: _____

DATE	Time	Temperature	Blood Pressure Arm used: Right Left	Pulse	Respirations	Weight

WEIGHT: STANDING SCALE

1. Wash hands.
2. Alert the individual as to what you are doing.
3. Gather supplies: Scale, pen, and paper.
4. Take the individual to a private place in home. Make sure to “zero out” scale before using. Have them stand on scale to obtain reading.
5. If the individual is unsteady on feet, assist them when he/she is stepping on scale.
6. Ensure the individual is safely standing on scale before letting go, if you are assisting on scale.
7. Do not weigh on carpet, you will get an inaccurate reading.
8. Have the individual step off the scale.
9. If the weight is greater or less than 5 pounds, reweigh them and if no change then notify your PC.
10. If you see a continuous weight gain or loss notify PC.
11. PC to contact the nurse if the individual is continuing to gain or lose weight for directions.
12. Record reading in MAR/vitals sheet and wash hands.

WEIGHT: WHEELCHAIR SCALE

1. Wash hands.
2. Gather supplies needed: Wheelchair scale, pen, and paper.
3. Alert the individual as to what you are doing.
4. Push the individual who's sitting in wheelchair onto the scale.
5. Turn scale on.
6. Weight/number should show on screen.
7. Remember to subtract the weight of the wheelchair from the reading to get the correct weight of the person being weighed.
8. Remove the individual from scale and record weight in MAR/vitals sheet.
9. Do not weigh on carpet, you will get an inaccurate weight.
10. If the weight is greater or less than 5 pounds, reweigh the individual and if no change then notify the PC.
11. If you see a continuous weight gain or loss, notify your PC.
12. PC to contact the nurse if the individual is continuing to gain or lose weight for direction.