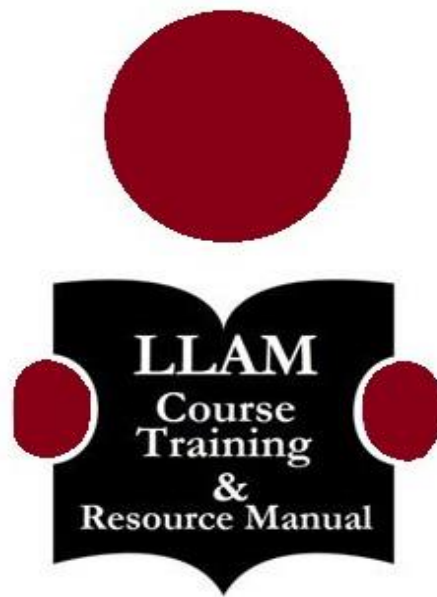




**Delaware Health & Social Services (DHSS)
Division of Developmental Disabilities Services (DDDS)**



**Limited Lay Administration of Medications (LLAM)
Recertification Training Manual**

LESSON 1 - MEDICATION ADMINISTRATION & THE INDIVIDUAL

OBSERVE, REPORT, COMMUNICATE

∞ Signs and Symptoms (A)

MEDICATION ADMINISTRATION (YOU AND THE INDIVIDUAL)

Observe, Report, Communicate



The learner will:

- ✓ Discuss signs and symptoms indicating a change in the individual.
- ✓ Identify emergency situations.
- ✓ Differentiate between objective vs subjective documentation.
- ✓ Discuss signs and symptoms of the “fatal four”.
- ✓ Describe the effects of medication on the body.
- ✓ Observe report and communicate processes appropriately.

While providing support and administering medication to individuals, you will observe for changes that may indicate a health problem, report changes that you have observed, communicate effectively with other staff and sometimes provide an emergency action.

It will be important for you to report and communicate changes you observe in the individual, so that help, if needed, can be provided in a timely manner to maintain or improve his/her health status.

Some individuals will be able to tell you when something is wrong, and others will not be able to verbally communicate, but will instead demonstrate behaviors indicating that something is wrong. When you get to know the individuals you are supporting, you will be able to identify changes in them that may indicate illness, pain or injury or medication effects or reactions.

important

The LLAM trained UAP does not interpret or explain changes in an individual's condition, or make clinical assessments, decisions or judgements, related to medications.

The LLAM trained UAP observes for changes in the individual. You will observe for any changes by what you see, hear, smell, or touch.

Example: You may **see** a physical change, such as a puffy face, redness or swelling of the skin, or cloudy urine. You may **hear** labored or noisy breathing. You may **feel** hot, moist, or cool skin. You may **smell** an unusual or unpleasant odor coming from a person's mouth, body or body fluids.

When an individual is unable to use words to tell you what is wrong, you must be able to observe through your senses to determine what the individual is telling you.

You will need to **OBSERVE, REPORT** and **COMMUNICATE** changes in the individual. This takes practice, but is critical so that you may pick up potentially significant or even life threatening problems related to health or medication.

For you to be able to safely administer medication, you will need to know **who** you are administering it to. You need to know the medication and **why** you are administering it. You will need to observe for any changes in behavior, or possible side effects or adverse reactions to the medication (**what**). If there are any physical, emotional or behavioral changes, you will report and communicate them (**when and where**).

- ⌘ **Who** (The individual, his/her diagnosis's, medications, routine, habits, preferences, behaviors)
- ⌘ **Why** (The medications; their side effects)
- ⌘ **What** (What is different than before)
- ⌘ **When** (Do I report now? Do I communicate? How?)
- ⌘ **Where** (Documentation)

OBSERVE



Observe the Individual (who)

- For any change in physical appearance
- For any change in behaviors, habits, routines, moods
- For any change in elimination patterns
- For any change in eating or drinking
- For any change in sleep habits



You need to know the individual's normal habits to be able to identify changes. Every interaction with the individual should include observing for possible changes. Changes may be subtle (drowsiness) or dramatic (sudden collapse).

⌘ *Signs and Symptoms*

A **SIGN**: You can see hear, feel or smell.

A **SYMPTOM**: You cannot see hear, feel or smell. The individual tells you.

Signals that something has changed are presented through **SIGNS** and **SYMPTOMS**.

SIGNS		SYMPTOMS	
ARE CHANGES THAT YOU SEE		ARE CHANGES THE INDIVIDUAL FEELS	
Temperature	Rash	Chills	Hunger
Rapid Pulse	Discharge	Nausea	Thirst
Open Wound	Sneezing	Dizziness	Sadness
Bruising	Coughing	Head Ache	Numbness
Swelling	Wheezing	Stomach Ache	Visual
Bleeding	Difficulty Swallowing		Hearing
Bloody Nose	Hygiene	Pain	
Swollen Glands	Behaviors	Tired	
Postural	Limping		
Guarding	Elimination Patterns		

The above list of **SIGNS** and **SYMPTOMS** identifies some s/s of change.

How many others can you name?

SIGNS and **SYMPTOMS** are SIGNALS that something in the body has changed.

Individuals may be aware of what they feel, but may not always communicate it, or communicate through behaviors:

Example:

Walter bangs his head on the table when his head hurts.

Samantha scratches herself when she feels sick.



- ◆ **SIGNS** and **SYMPTOMS** help a healthcare provider diagnose problems.
- ◆ Your job is to **IDENTIFY** changes and **REPORT** them.
- ◆ You will use your **5 SENSES** to detect change.
- ◆ You will **HEAR** when the individual cannot speak.
- ◆ Always **ASK** questions and **LISTEN** carefully to what the individual is saying.

LESSON 1 - MEDICATION ADMINISTRATION & THE INDIVIDUAL

OBSERVE, REPORT, COMMUNICATE

∞ The Fatal Four ^(F)

THE “FATAL FOUR”

There are four major health issues that occur more frequently and with more intensity in individuals with developmental disabilities.

They are referred to as the “*Fatal Four*” because if unrecognized can become life threatening. We will discuss them here because they are relevant to the continued observations we make regarding the health and well- being of those we support. Remember, signs and symptoms indicating a change in the health status of the individual require constant vigilance, and reporting and communicating these changes promptly make a difference in health outcomes of the individuals we serve.

The “Fatal Four” are:

- ✓ *Aspiration* ✓ *Constipation* ✓ *Dehydration* ✓ *Seizure*

Aspiration

Aspiration is a common problem among people who have difficulty swallowing (Dysphagia).

Aspiration means that food or fluids that should go into the stomach go into the lungs instead. When food or liquid goes into the lungs it can cause aspiration pneumonia. Aspiration Pneumonia can worsen quickly if not properly identified and treated. Aspiration pneumonia can result in death. The LLAM trained UAP must become familiar with the signs and symptoms of aspiration pneumonia.

Common signs of Dysphagia and/or Aspiration are:

- ✓ Coughing before or after swallowing
- ✓ Unexplained weight loss
- ✓ Excessive drooling, especially during meals
- ✓ Unexplained fevers that come and go
- ✓ Pocketing food inside the cheek
- ✓ Repeated episodes of choking
- ✓ Choking on certain foods, for example bread
- ✓ Coughing when lying flat
- ✓ Nose running or sneezing while eating
- ✓ Coughing from getting up quickly
- ✓ Complaining of something caught in throat
- ✓ Trouble chewing
- ✓ Getting tired while eating
- ✓ Taking a very long time to finish a meal
- ✓ A gurgling voice during or after eating or drinking
- ✓ Refusal to eat certain foods or finish a meal
- ✓ Trouble swallowing certain types of food or liquids

Common signs of Aspiration Pneumonia are:

- ✓ Frequent cough-foul smelling mucus or phlegm - may contain pus or streaks of blood.
- ✓ Sputum greenish in color and the person may cough up frothy fluid
- ✓ Shortness of breath/noisy breathing
- ✓ Heartbeat or breathing may seem faster than normal.
- ✓ Fever or chills accompanied by sweating
- ✓ Pain in the chest while coughing or when taking a deep breath
- ✓ Trouble swallowing
- ✓ Feeling as if something is stuck in their throat.
- ✓ Confusion, dizziness, faintness, unusually upset or anxious



It is worthy to note here that a common digestive disorder called *Gastroesophageal Reflux Disease (GERD)*, can contribute to aspiration or aspiration pneumonia. When the lower esophageal sphincter is weak it can allow food and stomach acids to reflux or return back up into the esophagus, and can then be aspirated into the lungs.

Symptoms of Gastroesophageal Reflux Disease (GERD) include:



- | | |
|---------------------------|------------------------|
| ✓ Dyspepsia (Indigestion) | ✓ Sore Throat |
| ✓ Hoarse Voice | ✓ Regurgitation |
| ✓ Bad Breath | ✓ Excessive Salivation |
| ✓ Breathing Problems | ✓ Chest Pain |
| ✓ Chronic Cough | ✓ Failure to Thrive |

Observe for any signs/symptoms of aspiration or aspiration pneumonia and educate other staff about what to watch for and what to do if they see the signs. Listen carefully to complaints from individuals.

***** Individuals with who are at risk for aspiration are placed on “Aspiration Precautions”. *****

This means that you are extra careful at meal times to ensure the individual has plenty of time to eat slowly, and the individual remains sitting up for at least 30 minutes after meals. There may be special orders from the HCP about how food should be prepared (i.e. cut up in small bites, thickened or thinned foods or liquids). Read orders carefully and always observe for signs or symptoms of aspiration.



***** Review the Medical Alert Form and Nursing Assessment for Aspiration Precautions *****

Constipation

The normal length of time between bowel movements varies widely from person to person. Some individuals have bowel movement three times a day; other, only one or two times a week. However, going longer than three days without a bowel movement is too long. After three days, the stool or feces becomes hard and more difficult to pass.

Common Causes of Constipation:

- ✓ Inadequate Fluid Intake
- ✓ Inadequate Fiber in the Diet
- ✓ Inactivity or Immobility
- ✓ Hypothyroidism
- ✓ Eating large amounts of Dairy Products
- ✓ Antacid Medicines Containing Calcium or Aluminum
- ✓ Medicines (especially Narcotics, Antidepressants, or Iron Pills)
- ✓ Overuse of Laxatives which can weaken Bowel Muscles
- ✓ Stress
- ✓ Colon Cancer
- ✓ Irritable Bowel Syndrome
- ✓ Pregnancy
- ✓ Depression
- ✓ Eating Disorders
- ✓ A Disruption of Regular Diet or Routine (*For Example: While Traveling*)
- ✓ Neurological Conditions Such As Parkinson's Disease Or Multiple Sclerosis
- ✓ Resisting Having Bowel Movements (*sometimes results from pain due to hemorrhoids*)



Symptoms of constipation that last longer than 2 weeks, symptoms of constipation that are severe (*regardless of duration*), changes in normal bowel habits and complications of constipation should be evaluated by a healthcare provider. Bowel Obstructions are ALWAYS fatal if not recognized and treated within 36 to 48 hours. In addition, other fatal complications can develop from bowel obstruction such as sepsis, which is an infection throughout the body. It is possible to have diarrhea (*loose stools*) and still have constipation or a bowel obstruction. Closely monitor an individual's bowel function if he/she has had recent abdominal surgery, injuries, medication changes, diet changes or changes in activity.

important

Review your agency's "**Bowel Protocol**", as all individuals who have a constipation diagnosis or is currently on a cathartic medication will have one on their Medication Administration Record (MAR). The bowel protocol will give you directions on how to prevent constipation and also to document when the individual has a bowel movement.

Dehydration

People with disabilities, in particular older adults, have an increased chance of becoming dehydrated because they:

- Don't drink enough because they do not feel as thirsty as other people.
- Have kidneys that don't work well.
- Choose not to drink because of an inability to control the bladder (*incontinence*).
- Have stomach and bowel disorders that cause fluid to move through the body too quickly.
- Have a physical condition which makes it:
 - ✓ Hard to hold a glass
 - ✓ Difficult or painful to get up from a chair
 - ✓ Painful or exhausting to go to the bathroom
 - ✓ Hard to talk or communicate to someone about symptoms
 - ✓ Necessary to take medication that increases urine output



Watch closely and report any signs or symptoms of dehydration to your supervisor especially if there is any fever, vomiting, or diarrhea.

Symptoms of Mild to Moderate Dehydration include:

- ✓ Dry sticky mouth
- ✓ Thirst
- ✓ Few or no tears when crying
- ✓ Dry skin
- ✓ Headache
- ✓ Constipation
- ✓ Sleepiness or tiredness
- ✓ Dizziness or lightheadedness
- ✓ Decreased urine output (*eight hours without urination*)

Symptoms of Severe Dehydration (a medical emergency)

- ✓ Extreme thirst
- ✓ Low blood pressure
- ✓ Fever
- ✓ Irritability or confusion
- ✓ Rapid breathing
- ✓ Sunken eyes
- ✓ Rapid heartbeat
- ✓ No tears when crying
- ✓ Little or no urination
- ✓ Very dry mouth, skin and mucous membranes
- ✓ Lack of sweating
- ✓ In serious cases, delirium or unconsciousness
- ✓ Dry skin that lacks elasticity and doesn't "*bounce back*" when pinched into a fold

! important

There should be a plan for how the individual is remaining hydrated, and you should continuously remain diligent in offering fluids. Eight (*8 ounces*) glasses of water are recommended per day unless the individual is on fluid restrictions or there is some other contraindication as in the HCP order. Observe for any signs of dehydration and encourage fluids, as some individuals will not ask.

Seizure Disorder (Epilepsy)



Seizures of all types are caused by disorganized and sudden electrical activity in the brain. About 2 in 100 people in the United States will experience an unprovoked seizure once in life. A solitary seizure doesn't mean someone has a seizure disorder (epilepsy). At least two unprovoked seizures are generally required for diagnosis of a seizure disorder.

Causes of Seizures can include:

- ✓ Low Blood Sugar
- ✓ Head Injury
- ✓ Brain Tumor
- ✓ Toxemia of Pregnancy
- ✓ Very high blood pressure
- ✓ Uremia related to kidney failure
- ✓ Abnormal levels of sodium or glucose in the blood
- ✓ Withdrawal from alcohol after drinking a lot
- ✓ Heat illness (heat intolerance/ heat exhaustion/heat stroke)
- ✓ Withdrawal from benzodiazepines (such as valium)
- ✓ Withdrawal from certain drugs, including some painkillers and sleeping pills
- ✓ Heart Disease
- ✓ Brain injury
- ✓ Poisoning
- ✓ Kidney or liver failure
- ✓ Venomous bites and stings
- ✓ Brain infection, including meningitis
- ✓ Drug abuse
- ✓ Stroke
- ✓ Choking
- ✓ Fever

It may be difficult to tell if someone is having a seizure, especially if you are not yet familiar with the person and his or her typical way of being. Some seizures may only cause a person to have staring spells and may go unnoticed. Specific symptoms depend on what part of the brain is involved and they can occur suddenly. Be aware of the individual's diagnosis's as seizure disorder may be one of them.

Symptoms of Seizure may include:

- ✓ Eye Movements
- ✓ Sudden Falling
- ✓ Grunting or Snorting
- ✓ Teeth Clenching
- ✓ Shaking of the entire body
- ✓ Brief blackout followed by period of confusion (*can't remember a period of time*)
- ✓ Mood changes such as sudden anger, unexplainable fear, panic, joy, or laughter
- ✓ Loss of bladder or bowel control
- ✓ Drooling or frothing at the mouth
- ✓ Temporary halt in breathing
- ✓ Changes in typical behavior such as picking at one's clothing
- ✓ Uncontrollable muscle spasms with twitching and jerking limbs

Symptoms may stop after a few seconds or minutes, or continue for 15 minutes. They rarely continue longer.

A person may have warning symptoms, sometimes called an “AURA” before seizures such as:

- ✓ Fear or anxiety
- ✓ Nausea
- ✓ Vertigo
- ✓ Visual symptoms (*such as flashing bright lights, spots, or wavy lines before the eyes*)

 ***important***

Call 911 if:

- ◆ This is the first time the person has had a seizure
- ◆ A seizure lasts more than 5 minutes or as otherwise directed by HCP
- ◆ The person does not awaken or return to typical behavior after a seizure
- ◆ Another seizure starts soon after a seizure ends
- ◆ The person had a seizure in water
- ◆ The person is pregnant, injured, or has Diabetes
- ◆ There is anything different about a seizure compared to the person’s usual seizures
- ◆ As outlined in the person’s Diastat protocol (*as applicable*)



All staff who work with an individual who has a seizure disorder are required to receive specific training related to the person’s seizures and the proper care and reporting of events.

Report and Communicate

When you have observed changes in the individual, you will report and communicate them. How you do this will depend on what it is that you have observed (*the change*). How will you know whether to communicate an observation to the next staff member, call the HCP or Call 911?

important

The LLAM Trained UAP:

Does not interpret or explain changes, make clinical assessments or decisions.

- #1** You notice that Jaime has sneezed twice this morning. This is a change that you would continue to watch for a few hours to see if it may mean that he/she is developing a cold, allergies etc. You would pass this information on in report so that other staff would be alerted to possible developing changes that may indicate a call to the HCP or nurse. You would continue to observe and communicate.
- example:**
- #2** Ellen is guarding her left side this morning and grimacing. You would call the HCP immediately, as Ellen is showing signs of pain and holding her side indicates something is going on. You would communicate your findings to your supervisor as well and other staff so that all are aware and know that appropriate action has been taken (a HCP visit). Document in the electronic record exactly what your findings are and actions taken.
- example:**
- #3** Jack has fallen and hit his head. You observe that he is disoriented and confused. Call 911. Prepare to provide CPR. Call your Supervisor. Communicate to others about the occurrence once emergency medical services have responded and document carefully.
- example:**

All changes in the individual, physically or behaviorally are important as even minor conditions can rapidly develop into urgent or emergency health crisis. All changes need to be communicated verbally and documented, even seemingly minor changes so that all staff are alerted to continue observing to see if the change becomes significant or not.

When an individual cannot communicate, or can communicate only in a limited way, we must watch even more closely for signs of behavioral, emotional or physical changes. *For example*, an individual who refuses to eat may be feeling sick to his stomach; an individual who pokes at an ear, may have an earache; and an individual who bangs his head may have a headache. Pain or discomfort is often a reason for grouchy, oversensitive, non-cooperative, or agitated behavior.

The way an individual sits, stands, or walks should be observed too. If an individual lies with her knees held up to her stomach, it may mean she is having stomach pain. You can observe an individual's strength by the way he moves or turns in bed, or his ability to walk, stand or hold up his head.



If there is any question in your mind about the significance of a change in the individual do not hesitate to call the HCP. Call your Supervisor or Nurse if you have any doubts. It is always better to be safe, so when it doubt, call.

 **important**

Once the individual is stable, call your supervisor. Remember to document all observations promptly and completely. If you need to call 911, tell them who you are, where you are, what has happened and when it happened. If you have administered the Epi-pen, save it and give it to emergency staff. Give as much information as you can to emergency staff to include list of medication.



- ✦ Always notify the HCP, supervisor or administrator and the consultative nurse in the event of emergency as well as the emergency contact/family member.
- ✦ Always notify the HCP as indicated by the HCP order, or when you feel it appropriate to do so. Call the HCP if in doubt. Call the consulting nurse or agency nurse with any questions or for guidance.
- ✦ Notify your supervisor (*before or after as indicated*) after any calls to nurse or HCP.
- ✦ All emergencies are documented in the electronic record.
 - ◆ After the individual is stable or received to emergency medical services
 - ◆ Include specifics (*what happened and what you did, any medications that were given, dates and times*).
- ✦ All calls to the HCP are documented on the electronic record as indicated by the agency policy. All orders received should be written only and placed on electronic record and MAR.
- ✦ All routine treatments must be as ordered, recorded in the electronic record.
- ✦ All documentation should be detailed and specific. It should read like a book (*chronological order*) to serve as communication for everyone who needs to know. It is a legal record.
- ✦ Give a complete report to oncoming staff and double check all of the electronic records for documentation completion before you leave your shift.



Ask yourself; what was different about this day, the individual? What do I need to remember to report and communicate so that I know the individual is safe and his or her care and support is uninterrupted?

REVIEW

- ✓ The LLAM trained individual observes for changes in the individual.
- ✓ Those changes are then reported and communicated to the HCP, supervisor, consultative or agency nurse.
- ✓ Documentation of changes are recorded in the electronic record.
- ✓ When in doubt about whether you should call the HCP, it is better to call.
- ✓ Call 911 if there is any illness or injury that may pose an immediate risk to a person's life or long-term health.

LESSON 1 - MEDICATION ADMINISTRATION & THE INDIVIDUAL

OBSERVE, REPORT, COMMUNICATE

∞ Subjective and Objective Observations (E)

MEDICATION ADMINISTRATION & THE INDIVIDUAL

Observe, Report, Communicate



Subjective vs Objective Documentation

You will be documenting on the MAR each and every time you administer medication. You will also be documenting in the electronic medical record individual responses to medications and observations or changes either physically or behaviorally. You will also document what you have reported and who you have reported to. Administering medication involves a cyclic process of observing, reporting, administering, observing, reporting, and documenting.

Your documentation as we have discussed previously should be clear, and in chronological order (*as events happen*). What you document in the electronic record should reflect the facts about what you are observing, not your opinion.

Subjective vs Objective Documentation

- **Subjective Documentation**
 - ⊕ Provides a statement of opinion based on a witnessed event or conversation
 - ⊕ Reflects the perspective of how the speaker views reality
 - ⊕ Opinion, belief, judgment, interpretation biased
 - ⊕ Not suitable for documenting
- **Objective Documentation**
 - ⊕ Provides an unbiased opinion of an event using a description of events observed.
 - ⊕ Uses direct quotations from an individual or a conversation with another person.
Not touched by the speaker's view of reality.

LESSON 2 - MEDICATION ADMINISTRATION FUNDAMENTALS

MEDICATION FUNDAMENTALS

☞ Terminology and Abbreviations (F)

Medical Terminology Abbreviations

Medical Terminology is a standardized means of communication within the healthcare industry. It is often composed of abbreviations to make documentation faster and easier. As you read documentation in the medical record, you will become familiar with how healthcare providers use medical terminology and abbreviations to communicate. It will be helpful for you to utilize resources that will help guide you to understand what is written or said. After a while, with practice, this will become common knowledge to you, and you will communicate the same way quite easily.

ABBREVIATIONS



Abbreviations are commonly used by prescribers to communicate in a way that is universally understood by others in the medical profession. Many medical conditions and drugs have long complicated names that would take time to completely write on an individual's chart or prescription.

Here is a list of common abbreviations found in medical records. Please note that in medical terminology, the capitalization of letters bears significance as to the meaning of certain terms, and is often used to distinguish terms with similar acronyms.

Common Medical Abbreviations					
@	at	CA	cancer	OOB	out of bed
ADL	activities of daily living	Cath	catheter	OS	left eye
Ad lib	as desired	CBC	complete blood count	OU	both eyes
AMA	against medical advice	Cl liq	clear liquids	\bar{p}	after
AP	apical or apical pulse	c/o	complaint of	po	by mouth
ASA	Aspirin	C+S	culture and sensitivity	prn	as needed
ASAP	as soon as possible	DC or dc	discharge or discontinue	qh	every hour
As tol	as tolerated	DNR	do not resuscitate	qhs	at hour of sleep
Bid	twice a day	gtt(s)	drop or drops	qid	4 times a day
BKA	below the knee amputation	HOB	head of bed	qs	quantity sufficient
BM	bowel movement	hs	hour of sleep	\bar{s}	without
B/P	blood pressure	IM	intramuscular	s/s	signs and symptoms
bpm	beats per minute	I+O	intake and output	sl	sublingual
BR	bedrest	NKA	no known allergies	sq	subcutaneous
BRP	bathroom privileges	NPO	nothing by mouth	SOB	shortness of Breath
\bar{c}	with	OD	right eye	UTI	urinary tract infection

Abbreviations are used to save time and space.



For a more complete list of medical terminology Abbreviations go to:

<http://www.delmarlearnine.com/companions/content/1401852467/studentresources/termabbrev.pdf> (this list is also included in the appendix in the back of the workbook)

There are also medical abbreviations that cannot be used on the MAR.

Joint Commission provides a list of abbreviations that cannot be used which is below and found at:

<http://iointcommission.org/assets/I/18/DO NOT USE List.pdf>.

These abbreviations cannot be used because of the high risk of misunderstanding or incorrectly writing or transcribing .

Official "Do Not Use" List		
Do Not Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc,,"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit",
Q.D., QD, q.d., qd (daily) Q.O,D , QOD, q.o.d, qod (every other day)	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day,"
Trailing zero (X.0 mg). Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO ₄ and MgSO ₄	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write "morphine sulfate" Write "magnesium sulfate,"

Most commonly used prefixes include:		
hypo	low	<i>example:</i> hypoglycemia (low blood sugar)
hyper	high	<i>example:</i> hyperglycemia (high blood sugar)
brady	slow	<i>example:</i> bradycardia (slow heart rate)
tachy	fast	<i>example:</i> tachycardia (fast heart rate)

REVIEW

ABBREVIATIONS

Exercise:

In the examples below, write the order in unabbreviated format:

1. Tegretol 100 mg po q 8 hours _____
2. Benadryl 50 mg tab 1 q 4 hrs prn _____
3. Tylenol EC 325 mg po bid _____

LESSON 1 - MEDICATION ADMINISTRATION & THE INDIVIDUAL

INDIVIDUALS VISIT TO THE HEALTHCARE PROVIDER (HCP)

What to Take (A)



The learner will:

- ✓ Define your role as advocate for the visit
- ✓ Identify the information/forms needed for the visit
- ✓ Identify what information you will need from the healthcare provider
- ✓ Discuss what you need to do after the visit to make sure treatment occurs

You will be taking the individual you support to his/her healthcare provider for annual and sick visits. This might be for a regular medical check-up or for a particular problem or concern that you, other staff, and/or the individual might want to discuss with the healthcare provider. Your role during the visit is very important. You might need to be an advocate for the individual, to make sure his/her medical needs are met.

You have the responsibility to ask questions of the medical personnel, to speak up for the needs of the individual you are accompanying, or to help ensure that the individual you are with is treated with respect and dignity, and that the medical treatment he or she gets is the same as it would be for anyone with the same condition.



As you prepare for the visit, ask yourself:

- 1) What information do I need to **take with** us to the health care provider?
- 2) What information do I want to **get from** the health care provider?
- 3) What do I need to do **after the visit** to make sure that the treatment occurs?

Information to take to the healthcare provider:

- ✓ The **Reason for the Visit**. Put this in writing on the **Medical Appointment Information Form (MAIR)**, and add **any other questions** you want to ask.
- ✓ A written summary of the individual's **medical history**. **This if found in the COR**. You are responsible for bringing the **COR** with you to the appointment.
- ✓ A **list of Current Medical or Dental Problems**.
- ✓ A **list of Medications** that the individual is now taking. Include all medications (**Prescriptions and OTC's**).
- ✓ A **list of any Allergies or Allergic Reactions** the individuals might have.
- ✓ In writing, note any **Physical, Emotional, or Behavioral Changes** that you or your staff has seen.
- ✓ The individual's **Health Insurance** information and **ID Card**.
- ✓ MAIR

New Castle Regional Office
2540 Wrangle Hill Road, 2nd
floor
Bear, DE 19701
PH: (302) 836-2100

Kent Regional: Office,
Thomas Collins Bldg.
540 S. DuPont Hwy., Suite 8
Dover, DE 19901
PH: (302) 744- 1110

Sussex Regional Office
Stockley Center:
26351 Patriots Way
Georgetown, DE 19947
PH: (302) 933-3100



Delaware Health & Social Services
Division of Developmental Disabilities Services

Medical Appointment Information Record [MAIR]

Name: _____ MCI#: _____ Date: _____

Ht: _____ Wt: _____ BP: _____ P: _____ Temp: _____

Doctor seen: _____ Specialty: _____

Known Drug Allergies: _____

Symptoms Present: _____

Physical findings: _____

Tests Done: _____

Diagnosis and Prognosis: _____

Restrictions: _____

Prescriptions & Treatment: _____

Return Appointment Date: _____

Signature of Doctor: _____

Address: _____

Phone: _____

The MAIR that you have brought to the visit will contain the information you need for an order here.

(The HCP writes on this side of the form)

Remember the components of an order?

MAIR Page 2

Name of Individual: _____

MEDICAL APPOINTMENT CHECKLIST

This form must be completed and taken on every doctor's appointment:

The following items must accompany you on this appointment

<input type="checkbox"/>	Medical Appointment Information Record	<input type="checkbox"/>	COR (Client Oriented Record)
<input type="checkbox"/>	Current MAR	<input type="checkbox"/>	Physical Exam form and Standing Medical Orders (for annual physical only)

The following questions must be answered prior to the doctor's appointment:

What is the nature (purpose) of this appointment?

Do this before the appointment.

- An annual physical
- An illness
- A follow up appointment

What symptoms are being experienced? How long have the symptoms been present? (Include when the illness started, how often does it occur and how long does it last?) _____

Has this occurred before? YES NO If yes when and what was done for it?

What has been done for the individual **Do this before the appointment** to help with this condition?

Signature/Title: _____ Date: _____

At the end of the appointment, these questions should be asked of the doctor:

What care is being ordered? _____

Do this at the end of appointment.

If medication is prescribed, what is the medication supposed to do? (What is the desired effect?) _____

Are there any side effects that we should be concerned about? _____

Signature/Title: _____ Date: _____

**PARC Approved: 11/15/04
Revised: 07/21/08, 06/02/09
Form #: 12/Admin**

LESSON 4 - MEDICATION ADMINISTRATION DOCUMENTATION

THE ORDER

∞ The Routine Order (A)



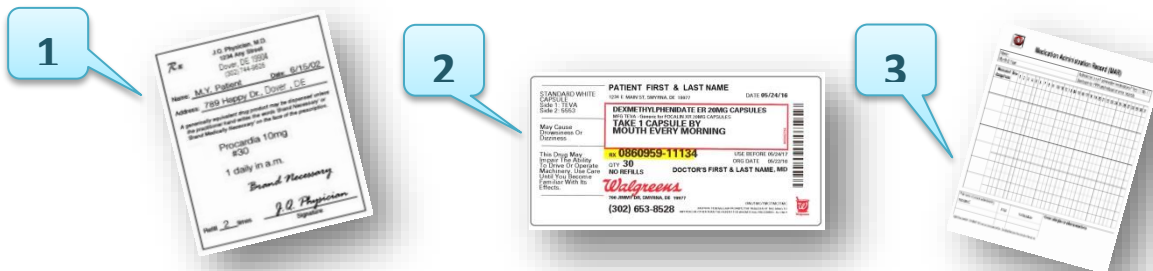
The learner will:

- ✓ Understand basic principles of documentation.
- ✓ Identify the necessary documents for transcribing medications.
- ✓ Identify components of the order, label and MAR.
- ✓ Demonstrate how to accurately transcribe medication to the MAR.

All medications given are documented. The information on **the order, the label and the MAR must match before you administer medication**. Accurate documentation is the 6th “right” in the process of medication administration. It is no less important than the other 5 “rights”, when it comes to the safety of the individuals we serve. In this section, you will learn principles of documentation critical to the process of administering medication.

Everything documented on the **Medication Administration Record (MAR)** is the result of information received from the HCP order. For every medication, *a HCP order is received to the pharmacy, and a label is generated*. Then the label is compared to the order for accuracy. The label information is then *transcribed to the MAR*. Once the MAR has been reviewed for accuracy, you are ready to begin the process of medication administration.

The three major forms used in documentation of medication administration are:



- 1) The Order:** Must always be written by a health care provider who is registered with the state of Delaware to prescribe medication. Medication can never be given without an order.
- 2) The Label:** When the pharmacy receives the individuals order, the medication is then prepared and dispensed into a medication container that is labeled. Medication can never be given without a label.
- 3) The Medication Administration Record (MAR):** Where all medications that are administered are recorded. Transcribing to the MAR requires ensuring that the order and the label match exactly.

! important

Do not give medication if the order, the label and the MAR do not match exactly. Stop and notify your supervisor, or consultative nurse. The discrepancy must be corrected prior to continuing with medication administration.

The Order:

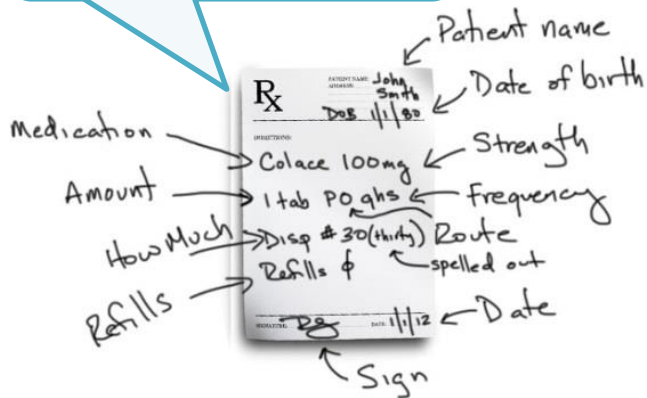
- ✿ May be written on the MAIR/PAIR by the HCP
- ✿ May be sent electronically to the pharmacy or called in by HCP
- ✿ Is different than the prescription
- ✿ Is compared to the pharmacy label to ensure label accuracy
- ✿ Becomes part of the electronic record

Components of a complete order:

- ✓ Medication Name (**Right Medication**)
- ✓ Strength of medication and the amount (**Right Dose**)
- ✓ Route of administration (**Right Route**)
- ✓ Frequency of administration (**Right Time**)
- ✓ Any special instructions

The MAIR is a HCP order
Don't forget the HCP signature.
Check for components of a complete order.

Written HCP order, also known as a prescription.



Types of orders:

- ✿ The Routine Order
- ✿ The PRN Order (*As Needed*)
- ✿ The OTC order (*Over-the counter Order*)

The Routine Order is written with instruction to give medication at established times.

This helps to ensure desired levels of medication will be maintained and doses will not be given dangerously close to each other. The order may not offer specific times but use terms like AM for morning and PM for night. Employers will assign specific times for the AM and PM medications to be given.

Example: Accupril 5 mg by mouth 2 times per day

Example: Lasix 20 mg/2 tablets by mouth once a day

! important

As a general rule, when the directions for medication do not include the specific dosage times, keep doses at least four (4) hours apart.

Routine medications that are given dependent on the outcome of an assessment such as blood pressure, pulse, etc., will be referred to a home health agency for nursing support for medication administration.

Sample of Standard Medication Times

Daily Medications	8 am OR 8 pm					
Twice Daily	8 am AND 8 pm					
Three x day	8 am		12 noon		8 pm	
Four x day	8 am			4 pm		8 pm
Bedtime						8 pm
Every 6 hours	6 am		12 noon		6 pm	
Before meals	7 am		12 noon	5 pm		
After meals	9 am		1 pm	6 pm		

****** Variations may occur from agency to agency. ******

Medications may be given 60 minutes before or after the indicated time. The exception is for medications to be given with or without food. Follow the directions on the label.

Medications that should be taken on an empty stomach should be given one hour before eating or two hours after eating.

Medications not given in the assigned time window are considered either too early or too late and are to be reported to the supervisor or administrator or consulting nurse. This shall be considered a med error and a med error report must be completed.

- a)** When a medication has been missed and the incident discovered over the 60 minute window, the HCP may be contacted for guidance.
- b)** A consultative nurse may receive orders for assisting staff regarding early or late or totally missed medications.

The assigned numerical times will appear on the MAR. AM and PM are not considered assigned times.

Unusual times outside of the established routine times may occur when a medication is ordered every six, eight or twelve hours, before meals or after meals.

Unusual times outside of the established routine times may occur when a medication is ordered every six, eight or twelve hours, before meals or after meals.

- a)** Special times will be assigned but at least one of the special times will fall on a routine assigned time.
- b)** Example-Give medication every 12 hours. The AM time will be the same as the AM routine medication time to help staff remember medication needs to be administered.
- c)** Staff will pass verbal and or written reminders to the next shift when medications are due at other than routine times.

Individual preferences will be taken into consideration as outlined in plan of care.

LESSON 4 - MEDICATION ADMINISTRATION DOCUMENTATION

THE ORDER

∞ The PRN (*as needed*) Order (B)

The PRN Order

A PRN Order is an “*as needed*” medication order given by the HCP for a specific individual when the individual requests the medication for the appropriate reason.



Note of exception: In the DDDS population we serve, the nonverbal individual must exhibit signs/symptoms for receiving medications that are clearly specified in the prescribers order. The individual may not be able to verbally request medication due to the level of comprehension/understanding, thus may exhibit signs through behaviors.

Example: May give Motrin 400 mg by mouth every 6 hours prn for earache, (*as indicated by pulling on ear, grimacing*). PRN Orders must clearly include a description of the *specific target signs or symptoms* for which the medication is to be received.

PRN Medications:

- ✿ Require a HCP order for all as needed medications both over the counter and by prescription.
- ✿ The prescription will outline the exact amount to be administered. ***Range orders such as 1-2 tablets q 4-6 hours are not acceptable.*** The order must be exact.
- ✿ For Over the Counter Medications:
 - Be sure to review the maximum dosage per day on the package.
 - Do not give more medication than is recommended in 24 hours.
 - Do not give medication closer than recommended on the package or the MAR.
- ✿ Contact the consultative nurse by the next business day whenever a prn medication is given. Contact with the consultative nurse should be documented in the electronic record.
- ✿ Will be labeled prescription containers or over the counter medications in their original package.
- ✿ If the PRN medication is an asthma inhaler or medication for a nebulizer unit and is not bringing relief within 5 minutes as ordered, call 911.
- ✿ Frequent use of an emergency medication such as an asthma inhaler must be reported to the prescribing practitioner.
- ✿ PRN documentation on the MAR should be kept separate from the routine sheets.

- When administering PRN medication you must sign the MAR, write a T-log and document effectiveness.
- The nurse consultant will review the MAR for any PRN medications that have been administered during the monthly health and medication audits. At this time the nurse will ensure prescriber's orders were followed and all required documentation completed.
- Individual's response must be documented within 2 hours of receiving the PRN medication.
- If the individual is not relieved by the medication and *is in not in crisis*, contact the nurse consultant or prescribing practitioner.
- If the individual is not relieved by the medication and *appears or states he/she is in crisis, call 911*.

Written HCP PRN order, also known as a PRN prescription.

R_x

PATIENT NAME: Jane Smith
 ADDRESS:
 DOB: 2/2/12

DIRECTIONS:

Medication → Zofran 4mg IV ← Route
 Frequency → q4h PRN ← Strength
 nausea ← "why"

SIGNATURE: [Signature] DATE: 2/1/12

Example of a HCP Script (Prescription)

Primary Care Associates
123 Wellness Road, Anytown, Canada, (123) 456-7890

Name: Priscilla Reed Date: July 2, 2008
Address: 265 Logan Avenue Age/Wt:

Rx: Tylenol #3
Sig: Take 2 tablets po q 6h prn pain
M: 1 month
R: 2

P. Smith
P. Smith CPSO # 98765

As needed (PRN)

DISCUSS THE COMPONENTS OF THE ORDERS ABOVE

Remember, information to get from the Healthcare Provider Includes:

- A written script for each new medication (May be in the form of E-Script, may be called into pharmacy or you may be given the script for the medication to take to the pharmacy)
- A written order for each new medication or treatment. This order must be signed by the HCP and or recorded on the MAIR.

An order may be on a prescription OR written on the MAIR. The original order is to be placed in the COR AND a copy of the order is to be placed in the front of the clients MAR.

Make sure that all of your questions are answered during the visit and that you get all of the necessary information like the prescription and the signed order sheet. Write down the answers for the question for both you and the other staff. You will not remember this information once you leave the visit so write it down immediately as the HCP shares it with you.

LESSON 4 - MEDICATION ADMINISTRATION DOCUMENTATION

THE ORDER

☞ Over The Counter Medication Orders (OTC) ^(C)

Over The Counter Medication Orders

Each individual receiving residential services must have in their medical record an **Over The Counter Medication Order (OTC) form**.

- ✓ This form is updated once per year by the individual's healthcare provider (*every 365 days*).
- ✓ The form indicates what medication and treatments the HCP *prescribes for the treatment of relatively minor health issues such as headache, slight fever, or minor abrasions*.
- ✓ The form provides instruction for how to monitor the use of these medication/treatments and when to seek assistance from a medical professional.
- ✓ OTC orders are transcribed to the MAR, and documentation occurs each time medication is administered.
- ✓ Always check the OTC order with the MAR before administering medication.
- ✓ A copy of the OTC form is kept in the COR (client Orientation Record) or MAR.
- ✓ When using OTC medication you must document usage and effectiveness in the electronic record.



Note the similarities between the PRN and the OTC order, and how they are different from Routine orders.

important

Also, important to know about HCP orders:

The LLAM trained UAP should follow the policy of the facility when a new order is prescribed or current medication administration instructions are changed. The new medication or changed medication instruction are promptly added to the MAR.

- ❖ The LLAM trained UAP only deals with the written order. The LLAM trained UAP may not receive a verbal or telephone order. Orders may be faxed to the residence.
- ❖ There must be copies of all orders in the electronic record.
- ❖ A HCP order must match the label and the MAR.
- ❖ If orders are ambiguous, illegible, or confusing, the prescribing practitioner should be promptly contacted to clarify the order before any medication administration occurs. Poor penmanship, misunderstanding of penmanship and errors in transcription often contribute to errors.

LESSON 1 - MEDICATION ADMINISTRATION & THE INDIVIDUAL

EFFECTS OF MEDICATION

∞ Desired Effects and Undesired Effects of Medication (C)



DESIRED AND UNDESIRE EFFECTS

Desired Effects: The medication is **bringing** about the desired results.

Example: *Cough suppressant eliminates cough.*

No Response: Medication does not appear to be working

Example: *Cough suppressant does not eliminate cough.*

Side Effects: The medication is bringing about effects that may or may not be desirable. Not part of the main effect.

Example: *Cough suppressant eliminates cough and may cause drowsiness.*

Precautions: Caution labeling on the medication container. These labels warn of interactions with the environment and or foods.

Example: *Do not take this cough suppressant while driving.*

Allergic Reaction: Medication that causes rashes (sometimes with itching), hives, or fatal shock. An allergy can occur several days after an individual has been on a medication, or from a medication the individual had many times before. This reaction may be life threatening and/or result in anaphylaxis.

Example: *After taking cough suppressant, the individual is itching.*



If the individual is having trouble breathing, call 911 and notify appropriate supervisor/personnel per facility policy.

Adverse Reaction: This is different from a side effect. Adverse reactions are negative responses to medications. An adverse reaction is an injury caused by the drug and any harm associated with the use of the drug (at a normal dosage and/or due to overdose). The reaction is not necessarily life threatening and use of the medication MAY NOT be discontinued.

Example: *The individual develops a yeast infection after starting on an antibiotic.*



LLAM trained UAP's are not expected to identify adverse drug reactions but instead must immediately report any changes in status or physical behavior.



Drug Interactions: Two or more medications that react with each other. Can make one drug less effective. Or more effective, and sometimes harmful.

Example: *Taking cough syrup containing a decongestant, while taking a cold tablet containing the same decongestant.*

Food Interaction: Drugs reacting with food or beverages.

Example: *Mixing alcohol with sleep aides or sedatives*

Drug- Condition Interaction: May occur when an existing condition makes certain drugs ineffective or potentially harmful.

Example: *Grapefruit juice interacts with cholesterol and blood pressure medications.*

It is important to watch for medication side effects and interactions. Medications mixed together may cause problems for the individual that will show up as signs and/or symptoms that you will be able to identify. Even food or alcohol, caffeine and nicotine can mix with medications to cause interactions.

! important

Important to remember:

- ✓ Alcohol is a drug, not a medication, and can cause problems if an individual is taking medication. Sometimes alcohol makes the medication stronger, sometimes it cause the medication not to work well.
- ✓ The more medications taken by an individual, the greater the possibility that he or she might have a medication interaction.
- ✓ The health care provider and you need to know all the medication the individual is taking, including over-the-counter medication and herbal medications, and non-medical substance such as coffee, tea, tobacco and alcohol.
- ✓ Many medications taken for mood and behavior take time to work.
- ✓ Give medications only as prescribed in the Doctor's order.
- ✓ Observe for any changes (signs and symptoms) in the individual, either physically or behaviorally. (what you see, hear, smell, and feel)
- ✓ Report changes to the Supervisor, Consultative Nurse, Healthcare Provider.
- ✓ Document changes in the medical record communicate with staff.

LESSON 1 - MEDICATION ADMINISTRATION & THE INDIVIDUAL EFFECTS OF MEDICATION

☞ Drug Information and Resources (D)

It is the responsibility of LLAM trained UAP to review possible side effects of the medications(s) being given. Information on medication side effects should be available in each entity using LLAM.

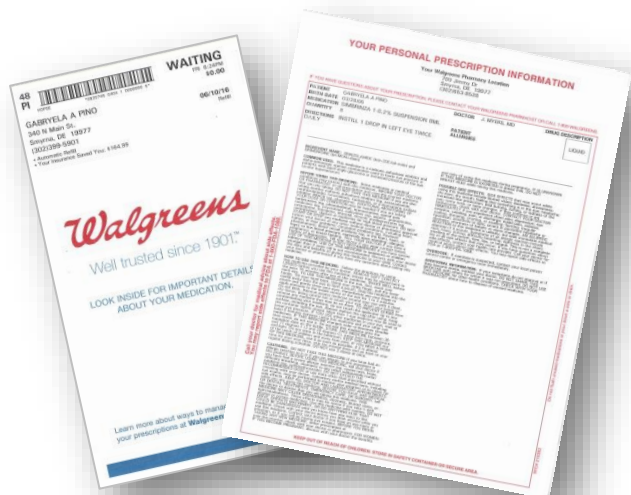
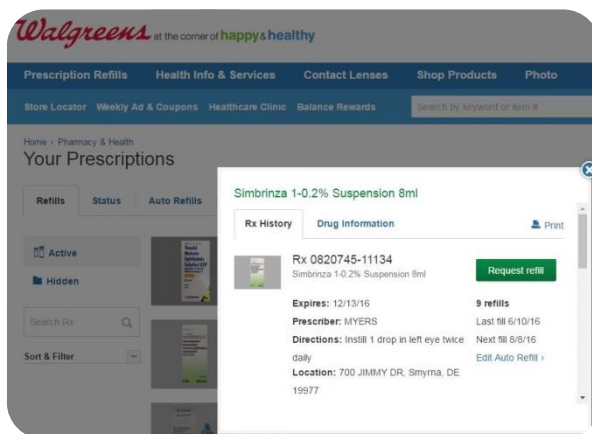
The LLAM trained UAP is not responsible for assessing side effects but should observe individual's for mental, physical and behavioral changes. Report all observations of mental, physical, and behavioral changes per facility policy.

For over the counter (OTC) medication, the information concerning how to use the medication and how to properly store it is printed on the package or bottle. Also, any pharmacist can provide answers to questions on use and storage.

For prescription medication, the following resources are available concerning how to use the medication and how to properly store it:

- ◆ The container itself will give directions for use including whether it should be taken with or without food. Also if a drug must be refrigerated or has to have special handling, the pharmacist will put it on the container or labeling.
- ◆ The pharmacy listed on the container can be called to ask for information concerning use and storage.
- ◆ The individual's practitioner listed on the container can be contacted for information in accordance with facility policy.
- ◆ **The Drug Reference Manual** and/or online resources may be used for medication look up.

The nurse, pharmacist, prescriber and supervisor/designated person per facility policy can be used as a resource for questions related to the medication and/or its administration.



LESSON 4 - MEDICATION ADMINISTRATION DOCUMENTATION

MEDICATION LABEL

🔗 The Medication Label (A)



The learner will:

- ✓ Read and understand medication labels and instructions.
- ✓ Understand and follow medication-warning labels.

The Medication Label

You have now assisted your individual to the HCP's visit, received medication orders and picked up the medication from the pharmacy (*or sometimes the medication is sent to the residence from the pharmacy*).

What next? You will compare your visit notes with the pharmacy label.

Check that medication the HCP ordered is the same medication you received.

If not, ask questions!

The pharmacist is an excellent resource for additional questions as well.

The **Medication Label** contains all of the necessary information needed to administer medication to the individual you are caring for. By Federal and State laws, all medications must be in federally approved packaging with labels containing all of the necessary information.

LLAM trained UAP's may only administer medication that is prescribed and dispensed by person(s) licensed to dispense medication in Delaware. All medication must be in the original container.

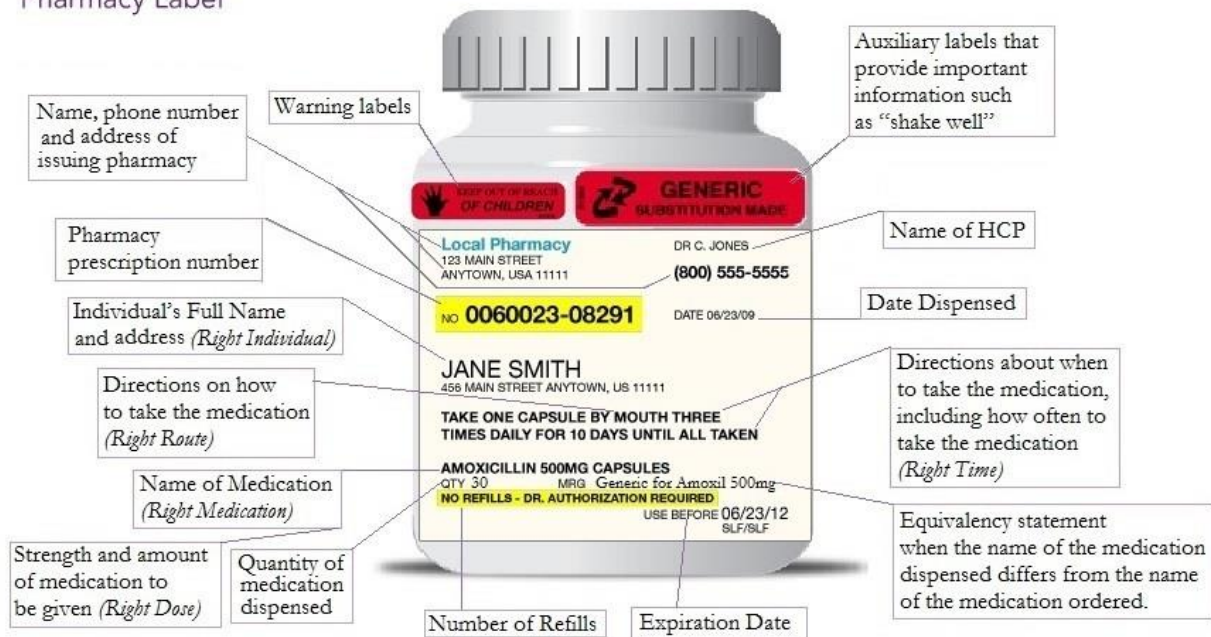
Important points to remember about the medication label:



- If dispensed by the pharmacy the container must have a label.
- If an over-the-counter medication, the medication must be in the original manufacturer's packaging with the manufacturer's label attached, or in a pharmacy container with appropriate labeling.
- If medication label is not legible or appears to have been altered by someone (writing on the label) do not give the medication to the individual until legible instructions are obtained. If the label is not legible or not valid:
 - ◆ Contact the Prescribing practitioner or pharmacy for a new prescription or to have the container relabeled.
- Medication labels should never contain more than one kind of medication. Notify the supervisor immediately if this ever happens. Do not use.
- Never remove medication from an original pharmacy container and place in another container. This is considered dispensing and requires appropriate licensure.
- Pour liquids out of the bottle on the side away from the label.
- Consultative nurse may make changes to the pharmacy label according to HCP orders.
 - ◆ Changes in order are reflected in MAR and on electronic record.
 - ◆ Nurse documents date, time and initials on label.

MEDICATION LABEL:

Prescription Drug
Pharmacy Label



Medication Labels must have the following information on the label:

- ✓ Individual's full name (*Right Individual*)
- ✓ Name of Medication (*Right Medication*)
- ✓ Strength and amount of medication to be given (*Right Dose*)
- ✓ Directions on how to take the medication (*Right Route*)
- ✓ Directions about when to take the medication, including how often to take the medication (*Right Time*)
- ✓ Name of HCP
- ✓ Date Dispersed
- ✓ Expiration Date
- ✓ Pharmacy prescription number
- ✓ Name address and phone number of issuing pharmacy
- ✓ Equivalency statement when the name of the medication dispensed differs from the name of the medication ordered.
- ✓ Number of Refills
- ✓ Warning labels
- ✓ Quantity of medication dispensed
- ✓ Auxiliary labels that provide important information such as "*shake well*".

LESSON 3 - HANDLING MEDICATION

HANDLING MEDICATION

∞ The Medication Count (D)

- ◆ Controlled Substances (D-1)
- ◆ Non-Controlled Loose Medication (D-2)

CONTROLLED SUBSTANCE COUNT (D-1)

The individual's MAR indicates when a medication is a **Controlled Substance** and must be counted. The individual's medication administration record (MAR) is to be completed and signed each time the medication is administered. In addition, the count sheet must be used as well, to indicate the amount of medication both before and after administration.

- Use one sheet per medication
- Controlled substances require a second documentation to be completed at every change of shift.
- Off going staff must count controlled medication in the presence of the oncoming staff at each shift change. If there is not an "oncoming" staff member a count must be completed at a minimum of every 24 hours by off going and oncoming staff.
- The amount of medication (*if any*) administered during the shift can be found on the Individuals MAR and count sheet.
- Errors should be reported to the supervisor or administrator and off going shift personnel are to remain until the error is resolved or staff is excused by the supervisor.

A **"count discrepancy" occurs** when a count is off and there is suspicion of tampering, theft or unauthorized use of drugs. Contact your supervisor immediately or your on/call administrator.

A **count discrepancy has not occurred** if the matter can be easily resolved. For example, if you can find an incorrect addition or subtraction in the count book, or if staff can document a medication that rolled under a refrigerator, or if a medication was properly disposed of.

Diversion (theft) of medication, including diversion of controlled substances, will be promptly reported to the Office of Narcotics and Dangerous Drugs at (302) 744 4547. In addition, theft or diversion of controlled substances or other medications will be handled according to agency policy.



The controlled substance count sheet should be kept in the archive of records, stored for 1 year along with MAR's. The State of Delaware has identified drugs and substances that are to be controlled. Count pages must be updated as medication is being administered.

COUNTING NON-CONTROLLED LOOSE MEDICATIONS (C-2)

All loose routine medications (*i.e. not in a blister pack*) should be counted and documented. Loose medications do not require a daily count, but shall be documented on a count sheet each time the medication is administered. Counting loose medication does not require two people to count, but any discrepancy is reported and an incident report generated.

- All medications must be in a labeled container
- There is no mixing of different medications in the same container
- Medications are never to be transferred to another container

Individual's Name: _____

Medication/Strength: _____

Prescription Number: _____



Quantity: _____

DATE	TIME	AMOUNT ON HAND	AMOUNT USED	AMOUNT LEFT	SIGNATURE

LESSON 3 - HANDLING MEDICATIONS

HANDLING MEDICATION

☞ Disposal of Unused Medication (E)

Disposal of Unused medications

Follow agency policy and procedure for disposal of medications that are no longer ordered to be administered to the individual. Disposal of medication needs to be documented on the electronic record with 72 Hours.

Medications that are being discontinued may be returned with appropriate documentation to the pharmacy for disposal whenever possible.

Alternatively, with two people present, medications may be discarded on site. Both observers should sign a medication record which includes documenting the date, time, medication quantity, prescription number, individual name and the method of disposal.



ALL controlled medications, including suppositories, should be destroyed on site by two personnel following employer policy and procedure.

If not possible to return medications, dispose of unused medications by having the process:

- ◆ Supervised and documented by two people within the facility.
 - ◆ Liquids, creams, suppositories, ointments and crushed pills/tablets may be disposed of in kitty litter or may be discarded directly into a bio-hazardous container. All disposed products should not be accessible to participants.
 - ◆ Wrap in newspaper and discard creams, suppositories and ointments in the original containers directly into a trash receptacle that is not accessible to clients.
- ◆ Document the date, time, medication amount, and disposal method on the MAR and have both supervising people sign the sheet.
- ◆ Discarded medication containers should have the labels scratched out with black (*indelible ink*) marker.

Some controlled substances listed on the FDA list can be disposed by flushing. The FDA continually evaluates medicines for safety risks and will update the safe disposal of each, as needed. Please visit “[Disposal of Unused Medicines: What You Should Know](http://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187.htm)” page at: <http://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187.htm> for the most current information.



LESSON 4 - MEDICATION ADMINISTRATION DOCUMENTATION

THE MEDICATION ADMINISTRATION RECORD (MAR)

🔗 Principles of Documentation (A)



The learner will:

- ✓ Understand basic principles of documentation.
- ✓ Identify the necessary documents for transcribing medications.
- ✓ Identify components of the order, label and MAR.
- ✓ Demonstrate how to accurately transcribe medication to the MAR.

The Medication Administration Record (MAR)

Medication cannot be administered until the MAR has been completed. Documentation is an important part of administering medication. Remember the **Right Documentation is the 6th Right of safe medication administration**. The MAR may be pre-printed by the pharmacy or generated by the agency.

The practice of administering medication involves providing the individual with a substance prescribed and intended for the diagnosis, treatment, or prevention of a medical illness or condition. Documentation of medication administration is an important responsibility. The medication administration record tells the story of what substances the individual has received and when. Like other health care records, it is also a legal document.



Note: If it is not documented, it was not done!

Agencies may have differing *Medication Administration Records*. These records must contain:

- ☑ The individual's name
- ☑ Allergy Status: Write "No Known Allergies" (*Abbreviated as "NKA"*) if the individual has no allergies. Do not leave this blank.
- ☑ Month/Year
- ☑ Names of all current medications
- ☑ Dosage, route(s) and time(s) of administration for all medications.
- ☑ Special instructions
- ☑ Date of Birth

ALL TRAINED UAP's are responsible for ensuring that orders have been properly transferred before giving medication.

Each medication transcribed onto the MAR must include:

- Name of the medication
- Strength of the medication
- Dose and amount of the medication to be given
- Frequency and specific times when the medication is to be given
- Date when the medication was (*or is to be*) first given (*Start Date*)
- Date when the medication is stopped, if one is given (*Stop Date*)
- Transcribed date and your initials/signature
- All medications in a container need a start date (*or open date*) written on the bottle.
Example: eye drops, ear drops, nose sprays, topicals and OTC medications

What you Document:

- Document the administration after you give the ordered medication.
- Document if the individual refuses taking the medication.
- Document any change that is different from the individual's normal condition including behavior changes.
- Medication errors including omissions (*medications that are missed /not given for some reason*). Omissions of medications are considered errors and need to be documented.
- Location and severity of pain when administering a pain medication.
- Be sure to sign and initial the back of the MAR

How to Document:

🔗 Principles of Documentation

Proper documentation is needed to support the safety of the individual
The Medication Administration Record (MAR) is a legal document and can be used to support you in a court of law.

- ◆ Write neatly and accurately.
- ◆ Use black ink only. No pencil.
- ◆ Check name on the MAR.
- ◆ No white out or scribbling, or attempt to erase an error.
- ◆ Document *after* giving medications, not before.
- ◆ If it wasn't documented, it wasn't done!
- ◆ Only document medications that *you* administer.
- ◆ Is complete with no blanks to be filled in later.



If you make an error in documenting:

Draw a single line through the error, and initial.

Explain on the back of the MAR.

LESSON 4 - MEDICATION ADMINISTRATION DOCUMENTATION

THE MEDICATION ADMINISTRATION RECORD (MAR)

⌘ Medication Documentation Key ^(B)

MAR Documentation Key

KEY

MEANING

Your Initials



Are written in the indicated box/square under the correct day and time you administered the medication. Your signature should also be written where indicated on the MAR so others will know who you are.

Medication Refusal



Medication refusals are documented by circling you initials. Medication refusals require documentation of explanation on back of MAR. If an individual refuses a medication and does not give a reason why, try again in 15 minutes. If the individual refuses again, try one more time, in another 15 minutes, before considering this a final refusal.

V = Vacation



This code is to be used anytime that an individual is scheduled to be away from their primary residence for any extended visit. This may include for a vacation, respite or weekend visit with friends or relatives.

H = Hospital



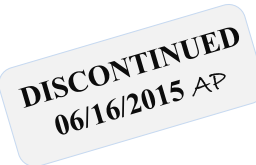
Code is to be used anytime that an individual is hospitalized and does not receive their medication due to the hospitalization.

X = Medication Is Not Given



This code is used to indicate days and or times in the future that the medication is not to be given. *It is not used for refusals.*

Discontinued Medications



When a medication is discontinued, you will write across the indicated order that the medication is **DISCONTINUED** with the date, time and your initials. It is important that no other person can give a discontinued medication. Some agencies use yellow highlighter as well, so that it is very noticeable to staff. Remember also, that when a medication is changed in any way the old order needs to be discontinued before transcribing the new order to the MAR.

Special Instructions / Precautions:

This is where we get specific instructions and/or warnings related to how we administer the Individual's medication. Such instructions could include, **“Finish taking all this medication unless otherwise ordered by HCP”** or **“May be given in applesauce”**. Special Instructions/precautions come from the HCP's and/or the healthcare providers order. These should be written on the MAR next to the medication that it applies to or in its own box if it does not pertain to a specific medication.

Same medication with two different doses :

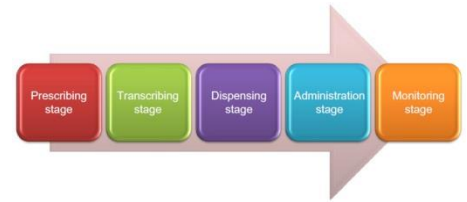
⌘ *Example:* **Tegretol 200 mg po two times a day and 100 mg po every day at 4 pm**
(This order will require two separate MAR entries)

LESSON 5 - SAFE MEDICATION ADMINISTRATION

PREPARING TO ADMINISTER MEDICATION

∞ The Medication Process (B)

THE MEDICATION PROCESS



The LLAM trained UAP:

1. Reviews the MAR for medications due (name, dosage, purpose and possible side effects).
2. Reviews the MAR for allergy status.
3. Works with one individual at a time to prevent other individuals from interfering with the medication process.
4. Completes hand hygiene immediately before administering medications, and follows other universal precautions as needed, such as wearing gloves.
5. Identifies the right individual, and will never administer medication unless the individual can be identified per DDDS policy (picture ID on MAR).
6. Uses individual name during the administration process.
7. Prompts the individual to wash hands if indicated.
8. Explains to individual what you are about to do before giving medication to include time schedule of medications, purpose, possible side effects. Answer questions individual may have.
9. Prefills water cups to avoid distraction, and/or prompts for food and drink of preference when indicated; never turn away from individual during medication process.
10. Provides for Privacy.
11. At the right time, unlocks storage area, obtaining right medication, and compares the prescription label to the MAR, making sure all information matches (**First Check**). If in doubt, the LLAM trained UAP will not administer medication until it has been confirmed that medication is correct. Only medications in the original, pharmacy containers, with legible labels will be used.

- 12.** Before pouring or removing medication from the package, checks the prescription label against the medication order to make sure they match (*Second Check*).
- 13.** After the medication is poured/removed from packaging, but before it is administered, checks the prescription label against the MAR again to make sure they match (*Third Check*).
- 14.** If Prescription Label and MAR do not agree, STOPS and notifies Supervisor. Does not give medication until problem is resolved.
- 15.** Crushes oral medications *only with direction received in prescribing practitioners order*. Notifies prescribing practitioner if individual cannot swallow medication as ordered.
- 16.** Measures liquids with appropriately marked measuring device (*never household spoon*). Stop if unsure about the measurement and notifies supervisor, administrator, pharmacist or healthcare provider.
- 17.** Administers the medication using the 6 rights (*right individual, right medication, right dose, right route at the right time, right documentation*) and that individual is in right position and receives medication according to right method. Also, assists with medication administration, rather than “administers” in appropriately identified individuals.
- 18.** Observes individual taking medication. Never leaves individual during administration. Medication is never left unattended.
- 19.** Returns medication to correct storage area and locks the storage area.
- 20.** Documents medication on MAR, comparing the pharmacy label to the MAR. Uses the 6 rights. Document medication refusal, report to house manager or consultative nurse.
- 21.** If an individual refuses a medication and does not give a reason why, try again in 15 minutes. If the individual refuses again, try one more time, in another 15 minutes, before considering this a final refusal.
- 22.** Prompts the individual to wash hands if indicated.
- 23.** Completes hand hygiene.
- 24.** Report a medication error as per facility policy.

LESSON 5 - SAFE MEDICATION ADMINISTRATION

MEDICATION ERRORS

∞ Causes of Medication Errors (A)

∞ Reporting Medication Errors (B)

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The learner will:

- ✓ Identify common causes of medication errors.
- ✓ State what steps should be taken when a medication error occurs.
- ✓ Identify necessary information about the individual and the medication administration to report.

Medication Errors

CAUSES OF MEDICATION ERRORS

A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, client or LLAM trained UAP.

A medication error occurs specifically when there is failure for the ***right individual*** to receive the ***right dose*** of the ***right medication*** at the ***right time*** or the ***right route***, ***omission***, ***inaccurate transcription***, or by an incident of diversion of medication (*theft*).



Errors do occur despite training and precautions. For individual safety, errors should be reported immediately upon discovery.

! *important*

Depending on the medication error, 911 or Poison Control (800-222-1212) may need to be called. Errors must be documented according to DDDS policy.

Examples of Medication Errors Include:

- ◆ Failure to exactly follow prescriber's orders on medication label.
- ◆ Failure to administer only upon current orders.
- ◆ Failure to follow hands-on procedures taught in class.
- ◆ Failure to follow the 6 rights
- ◆ Failure to accurately label a medication.
- ◆ Failure to accurately transcribe a medication to the MAR.
- ◆ Improper medication storage.
- ◆ Running out of medications.
- ◆ Failure to follow manufacturer's specifications/directions for use.
- ◆ Failure to follow accepted standards and employer policy/procedures for medication administration.
- ◆ Failure to listen to a client's or other responsible party's concern.
- ◆ Failure of staff communication of a new medication or a change in medication.

Considerations in determining if a medication error occurred:

- ◆ Medication error resulting in medical treatment.
- ◆ Medication error resulting in harm or potential to cause harm.

Reporting Medication Errors:

 ***important***

OVERDOSE: Call the Poison Control Center. If the individual is having difficulty breathing or loses consciousness, call 911 and send individual to emergency room.

If there is an error

- ◆ In the right medication, or
- ◆ To the right individual, or
- ◆ In the right route, or
- ◆ In the right time such as a missed dose, call the individuals HCP/Pharmacist/Nurse per the agency's policy and document the error accordingly.



It is the legal responsibility and ethical responsibility of the LLAM trained UAP to report/document all errors. Avoiding or choosing not to report/document errors could lead to serious injury or even death of an individual.

Handling of Medication Errors:

- ◆ The first person finding the medication error is responsible to report the error and document in the Electronic Record.
- ◆ Medication deviations will be reported to administration, documented and the documentation retained by the agency.
- ◆ Errors made by the LLAM trained UAPs will be tracked and appropriate corrective action taken, including counseling, to prevent future errors.
- ◆ Counseling can include discussion with an action plan for improvement, retake of course/testing, or retesting.
- ◆ LLAM trained UAPs who have two errors within a six month timeframe will not be authorized to give medications until the entire medication course is completed.
- ◆ Medication errors that are a result of a pharmacy error should be reported to the pharmacist for immediate correction.

DDDS may request reports that include reportable data.

LESSON 1 - MEDICATION ADMINISTRATION & THE INDIVIDUAL

INDIVIDUALS VISIT TO THE HEALTHCARE PROVIDER (HCP)

∞ Vital Signs

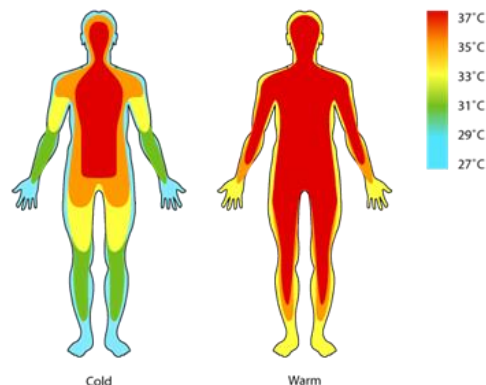
What are vital signs?

Vital signs reflect the function of 3 body processes that are essential for life. Their values give us information regarding: regulation of body temperature, breathing and heart function. The four vital signs are **Temperature, Pulse, Respirations, and Blood Pressure**. In the body, vital signs vary within certain limits and can be affected by fear, anxiety, eating, noise, pain, sleep, weather, illness, and anger to name a few. Since Vital signs give us critical information in relation to how the human body is functioning, accuracy is essential when you measure, record, and report. Vital signs should be taken when the person is at rest and either lying down or sitting.



What is Body Temperature?

Body temperature is the amount of heat in the body. It is a balance between the amount of heat produced and the amount lost by the body. Heat is produced as cells use food for energy. It is lost through the skin, breathing, urine and feces. The normal core body temperature of a healthy adult is said to be 98.6 F. Temperature rates can vary due to factors such as age, metabolism rate, illness, medications, alcohol consumption, menstrual cycle, sleep disturbance and change in climate to name a few. Body temperature is lower in the morning and higher in the afternoon and evening. Temperature sites are the mouth, rectum, under the arm, ear and forehead. A thermometer is used to obtain temperature.



✓ **Points to remember:**

Oral temperature should not be taken if the person:

- ⊕ Is paralyzed on one side of the body.
- ⊕ Has a convulsive (seizure) disorder
- ⊕ Breathes through the mouth
- ⊕ Is unconscious
- ⊕ Has had surgery or an injury to the face, neck, mouth, or nose
- ⊕ Has a sore mouth
- ⊕ Is receiving Oxygen

Temperature via the ear should not be taken if the person:

- ⊕ Has ear drainage
- ⊕ Has an ear disorder

Rectal temperature should not be taken if the person:

- ⊕ Has Diarrhea
- ⊕ Has a rectal disorder or injury
- ⊕ Is confused or agitated
- ⊕ Had rectal surgery
- ⊕ Has heart disease

What is a pulse?

Arteries carry blood from the heart to all parts of the body. The pulse is the beat of the heart that is felt at an artery as a wave of blood passes through the artery. The arteries are close to the body surface and lie over a bone. Therefore most pulses are easy to feel. The pulse rate is the number of heartbeats or pulses felt in one minute. Your pulse is lower when you are at rest and increases when you exercise. Pulse rates vary from person to person. For an adult 18 years and over, a normal heart rate is 60-100 beats per minute (BPM). Some medical conditions such as heart disease, high blood pressure or diabetes can affect your heart rate. Heart disease can cause what is called a pulse deficit. This occurs when there is a difference between your heart beats and pulsations in your extremities. A rate less than 60 or more than 100 is considered abnormal. Blood pressure equipment can also count pulses. It is important to report any change in the participants pulse as this may indicate an underlying condition.

✓ **Points to Remember:**

- ⊕ Recording and reporting the wrong pulse rate can harm the individual
- ⊕ incorrect blood pressure cuff size can affect pulse value

What is respiration?

Respiration means breathing air into and out of the lungs. Oxygen enters the lungs when you breathe in (inhalation) and carbon dioxide leaves the lungs when you breathe out (exhalation). The chest rises during inhalation and falls during exhalation. Respirations are normally quiet, effortless and regular. Both sides of the chest rise and fall equally. Respirations should be counted when the person is at rest. A healthy adult has 12 to 20 respirations per minute. Heart and respiratory disease often increase the respiratory rate.

✓ **Points to remember:**

- ⊕ Seek immediate medical care for noisy respirations or if the person is having pain or difficulty breathing

What is a blood Pressure?

Blood pressure (BP) is the measure of the force of blood pushing against the blood vessel walls. Stress, smoking, lack of physical activity, sleep apnea, Diabetes, chronic kidney disease, or too much salt in the diet are all factors that can affect one's blood pressure. Blood Pressure is measured using two numbers. The top number is the Systolic number. This number represents pressure on the blood vessels when your heart beats and squeezes blood through your arteries to the rest of your body. A normal Systolic pressure is below 120. The bottom number is the Diastolic number. This number represents the pressure in the arteries when the heart rest between beats. A normal Diastolic pressure is less than 80. Blood pressure increases with age. Women usually have lower blood pressures than men do but blood pressures rise in women after menopause.

✓ **Points to remember:**

- ⊕ Ensure Blood pressure cuff size is appropriate for the individual
- ⊕ Do not take pressure in an arm that has a cast or a dialysis access site
- ⊕ Do not take blood pressure on the side of breast surgery
- ⊕ Do not take pressure on an injured arm
- ⊕ Ensure that the cuff is snug. A loose fitting cuff will cause an inaccurate reading
- ⊕ Apply the cuff to a bare arm or wrist, clothing can affect the measurement

LESSON 5 - SAFE MEDICATION ADMINISTRATION

PREPARING TO ADMINISTER MEDICATION

Hand Hygiene (C)



The learner will:

- ✓ Identify when hand hygiene procedures are used to reduce risk of transmitting germs that can cause infection
- ✓ Describe and demonstrate procedures for hand hygiene using both soap and water and alcohol based hand sanitizers.

HAND HYGIENE

Hand hygiene is the most important factor in preventing the transmission of germs that cause infection.



A. Hand hygiene refers to using soap and water to clean hands, or to use an alcohol based hand sanitizer (waterless antiseptic product). Hand hygiene should be performed:

- When coming on duty.
- Before and after direct contact with individuals (*bathing, toileting, oral care*).
- Before and after assisting individuals with meals.
- Before and after administering or assisting with administration of medication.
- After contact with body fluids or excretions, mucous membranes, non-intact skin, catheters, bedpans, specimens, and wound dressings, even if hands are not visibly soiled.
- If moving from a contaminated to a clean body site during an individual's care.
- After contact with inanimate objects in the immediate vicinity of the individual.
- Before and after removing gloves.
- Before and after administering eye drops.
- Before and after changing bed linens and after handling dirty laundry.
- Before and after collecting urine specimens.
- Before and after changing a dressing.
- After completing duty.

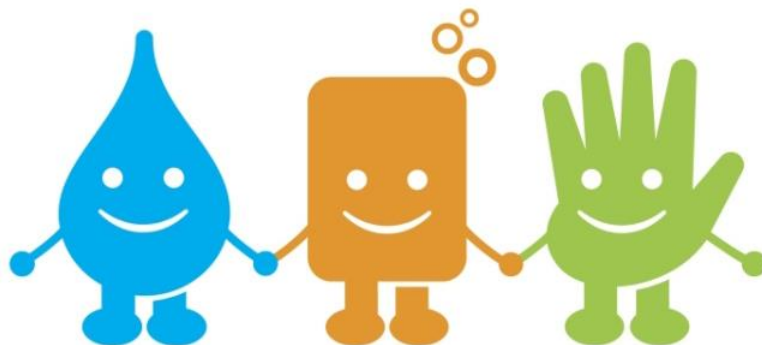
B. Staff must wash hands with soap and water:

- When hands are visibly dirty or contaminated with organic material.
- When hands are visibly soiled with blood or other body fluids.
- Before eating.
- After using the restroom.
- Before and after contact with a resident and/or articles in isolation; before entering and upon leaving the isolation room.

C. Staff must wash or assist individuals with hand washing with soap and water:

- When individuals hands are visibly dirty or contaminated with organic material.
- When individuals hands are visibly soiled with blood or other body fluids.
- When individual demonstrates “hand to mouth” behavior.
- Before the individual eats. If the individual can reach the sink, hand washing with soap and water is the preferred method. For those who cannot reach the sink, and who do not feed themselves, hand washing may be accomplished using an alcohol based disposable hand wipe.
- After the individual uses the bathroom.
- Before leaving an isolation room.

Special Consideration: When an individual demonstrates “hand to mouth” behavior, alcohol based hand sanitizers or wipes shall not be used. Hand hygiene using soap and water must be completed.



Other aspects of hand care and protection:

Glove Use:

- ◆ Gloves should be worn whenever there is potential for contact with blood or body fluids.
- ◆ Gloves will be used as an adjunct to, not a substitute for hand washing.
- ◆ Hand hygiene is always performed after removing
- ◆ Gloves should be changed when moving from one procedure to another on the same individual (Example: oral care after completing bath).
- ◆ Gloves are never reused
- ◆ For staff with sensitivity to Latex or other glove materials, alternative products will be provided.

Lotion:

- ◆ A lotion may be used to prevent skin dryness associated with hand washing
- ◆ If used, lotion will be supplied in small individual use or pump dispenser containers that are not refilled.
- ◆ Compatibility between lotion and antiseptic products and the effect of
- ◆ Petroleum or other oil emollients on the integrity of the gloves will be considered at the time of product selection.

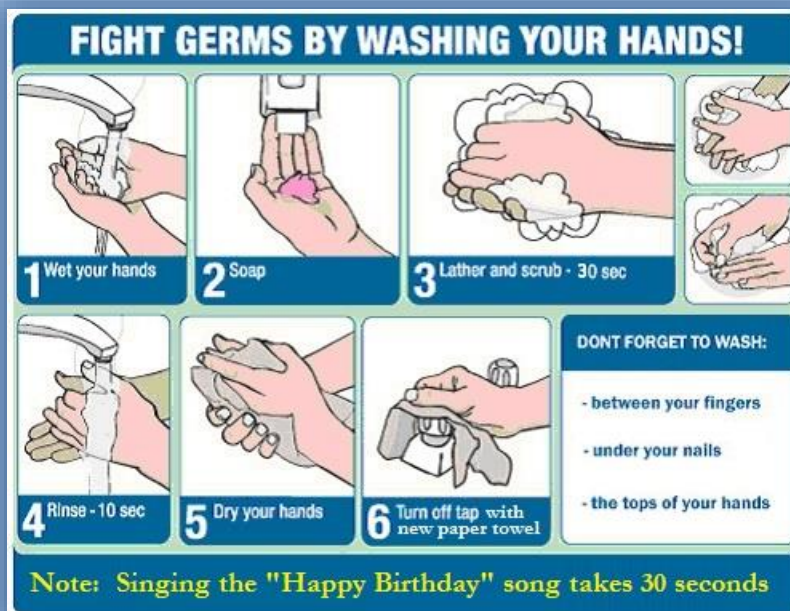
Fingernails:

- ◆ The UAP, regardless of where care and/or services are delivered shall have nail tip length no more than ¼ inch long when observed from the palm surface of the hand.



Refer to skill # 1

Hand Hygiene Medication Administration Competency Skills Checklist



LESSON 5 - SAFE MEDICATION ADMINISTRATION

PREPARING TO ADMINISTER MEDICATION

∞ Routes of Medication ^(F)

ROUTES OF MEDICATION

We will now take a close look at each of the “routes” of medication administration authorized by LLAM. *(Step by step review of competency and then demonstration of each will follow this section)*

The Oral Route



Most Medication is taken by mouth (*orally*) and swallowed. The types of medication taken by mouth are pills, caplets, tablets, capsules and liquids.

Solid Form: pills, capsules, caplets, tablets, enteric coated

❖ Points to Remember:

- ⊕ Place medication in a medication cup.
- ⊕ Ensure individual is properly positioned.
- ⊕ If you are giving several pills to the same individual at the same time, you can put them all in the same medication cup. *(Determine ability to take multiple pills, always be cautious of choking hazards)*
- ⊕ If you are giving a pill and a liquid at the same time, give the pill first, and then give the liquid.
- ⊕ If you have written instructions by the health care provider to mix medication with food give in only one ounce or less, unless the pharmacy or healthcare provider tells you to do it differently.
- ⊕ Always observe the resident taking the medication to assure the medication is swallowed, before documenting on MAR.
- ⊕ Always ensure that the dose that is taken is the exact amount ordered for the individual.
- ⊕ Follow special instructions from pharmacy or HCP regarding food restrictions, and precautions.

Offer sufficient fluids when administering medication. Offer enough fluids to moisten mouth prior to swallowing pills and provide for hydration *(unless contraindicated in order)* Read label and MAR carefully for instructions.

❖ More Points to Remember:

- ⊕ Never change the form of a medication without a healthcare provider's written order.
This means:
 - ▶▶ Do not touch medications with your hands.
 - ▶▶ Do not crush or dissolve a capsule, tablet or caplet.
 - ▶▶ Do not take the medication out of a capsule.
 - ▶▶ Do not mix the medication in food or liquid (*without order*).
 - ▶▶ Remember, the only exception to the rule is if you have a written order from a healthcare provider (*and it is clearly transcribed from label onto MAR*).

Liquid Form: solutions, suspensions, elixirs, syrups

❖ Points to Remember:

- ⊕ Shake the bottle well before giving medication (*unless otherwise instructed*).
- ⊕ When removing cap, place upside down on clean surface.
- ⊕ Hold your hand over the label while pouring the liquid medication to prevent soiling the label.
- ⊕ Use only a marked medication cups placed at eye level for pouring (*for accuracy*)
- ⊕ If giving two liquids and one is cough syrup, give cough syrup last, for it will coat the throat.
- ⊕ Lock medications that need to be refrigerated in refrigerator.
- ⊕ If you pour out too much, throw the unused part away. Do not return it to bottle.
- ⊕ Do not mix two liquids together.
- ⊕ Use clean paper towel to wipe mouth of bottle before replacing lid.



Refer to skill # 2

Medication Administration Competency Skills Checklist



Note: Most prescription antibiotics have a short shelf life and frequently have to be either refrigerated or kept away from heat and out of direct sunlight. All doses of the antibiotics should be administered to the individual per the prescription. The pharmacy label lists the date when the medication will expire. The label expiration date should be checked every time it is administered. Do not use medication beyond the expiration date.

The sublingual Route



Sublingual medications are placed under the tongue to dissolve. The healthcare provider will instruct you if a medication is to be given under the tongue and not swallowed (the pharmacist will place a special label on the medication container naming it as sublingual and/or to be dissolved under the tongue. Sublingual medications are sometimes ordered for heart problems or seizure disorders.

❖ Point to remember:

- ⊕ When administering sublingual medication, make sure you explain the importance of allowing it to dissolve under the tongue and not to chew or swallow. Do not offer liquids for 10 minutes after medication is dissolved.

The Inhalant Route



Inhalant medications are medications inhaled through the nose (nasal inhalants) or inhaled through the mouth (*oral inhalants*), and are commonly used for asthma and allergies. Nebulizer units are machines that produce a strong flow of inhaled medication.

Many inhalant medications are given to stop or prevent an asthma attack.

❖ Points to Remember:

- ⊕ Be sure to wash your hands before and after handling medications and gloving.
- ⊕ Be aware of discard dates on these medications as they must be discarded and replaced promptly.
- ⊕ Follow directions on package inserts
- ⊕ Always allow access of an individual to emergency inhaler or nebulizer.
- ⊕ Never leave an individual in crises! If unsure about the procedure or if the client refuses, immediately contact supervisor, or HCP, or call 911.
- ⊕ If medication is an emergency ASTHMA medication and is not bringing relief within 5 minutes as ordered, **Call 911 immediately.**

Remember, pulmonary inhalant medications must be stored and charted like other internal medication. Always get specific instructions from the nurse, pharmacist or healthcare provider before giving medication by this route if unsure about how to give.

In addition, oxygen is an inhalant medication. All rules and regulations that are followed for medications are also followed for all oxygen. Oxygen requires a written order from the health care provider and must be included on the MAR for staff to sign. Staff must also verify ordered flow rate twice per shift and document on MAR. The healthcare provider's orders must be specific, clear and concise.

******* Additional training may be required for use of inhaler, special equipment and administration of oxygen *******



Refer to skill # 3

Inhalant Medication Administration Competency Skills Checklist

The Topical Route



Topical medications are ordered for a variety of reasons to include treatment of infection, rashes, dry skin and itching and so forth. Topical medications include creams, ointment, lotions, tinctures, solutions, suspensions, soaps, shampoos, and eye, ear, nose preparations. Topical medications are administered by applying the medication to part of the body: the skin, hair, eyes, ears, or nose. Topical medications may be for treatment of a specific body part (*local*) or a whole body system (*systemic*). Medications for external use, are stored and locked just like any other medication, but must be kept separate from internal use medications (*such as a different box container/on another shelf in cabinet*). Topical medications must always be specific about where to apply. Always wash hands and wear gloves when administering topical medications.

Example: Apply to “rash on left forearm” 2 times daily

NOT

Apply to “affected area” 2 times daily

❖ Points to Remember:

- ⊕ Wash hands or use alcohol hand sanitizer and wear gloves when administering topical medication
- ⊕ Read and follow package instructions
- ⊕ Apply medication to clean, dry skin
- ⊕ Pour, or with a clean spoon, dip out just enough of the medication for one application into a clean container and use. Never put unused medication back into its original container.
- ⊕ Tubed ointments can be squeezed onto a gauze pad or a bandage.
- ⊕ Do not shake powders, to avoid inhaling
- ⊕ Do not rub or massage the area of application unless directed to do so.
- ⊕ Do not bandage the area unless instructed per order
- ⊕ Never touch the skin with a tube of medication to prevent contamination of tube. This can spread infection.
- ⊕ Do not share tubes of ointment or liquid medications between individuals to avoid spreading infection.



Refer to skill # 4

Topical Medication Administration Competency Skills Checklist



Note: Skin should be inspected frequently for any signs or bruising, swelling, rash, abrasions or blistering, or any worsening conditions of the skin. Report any change in condition of skin to supervisor.

The Transdermal Patch:



Transdermal medication can be used for such things as treating hormonal problems, heart problems, motion sickness and to help people stop smoking. Transdermal medication patches give an individual a constant, controlled amount of medication through the skin.

❖ Points to Remember:

- ⊕ Do not forget your gloves to avoid absorption of medication.
- ⊕ Remove the old medication patch and discard per package directions.
- ⊕ Rotate sites where patches are applied. Medication patches should not be applied to the same site as the old patch. Document site on the MAR.
- ⊕ Obtain written instructions from the healthcare provider for what to do if the patch comes off, at the time the order is received.
- ⊕ Unless otherwise ordered by health care provider, apply and remove the patch at the same time every day. *(This allows for the medication to be taken into the blood in the proper dosage at all times)*
- ⊕ Date, time and initial patch. Don't forget to document on MAR.
- ⊕ Inspect the individual carefully for skin rashes, blisters, or scratching. Listen for complaints of itching, burning or discomfort at site of patch placement.
- ⊕ The transdermal patch is an external medication and requires separate storage from internal medications.
- ⊕ Avoid applying patch to hairy areas.

■ **Shampoos:**



❖ **Points to Remember:**

Shampoos are usually prescribed for scalp and skin conditions. It is important to follow the specific orders of the healthcare provider or pharmacist.

- ✓ Be sure to protect the individual's eyes, nose and mouth when applying shampoo.
- ✓ Wear glove and apron to protect your skin and clothing.

■ **Eye Medications:**



Eye medication is usually administered for eye infection, glaucoma, or dryness, and comes in the form of eye drops or ointments. Make sure the word “ophthalmic” or “eye” is written on the label of the medication. The label should also indicate which eye or if both eyes are to be treated. Never share eye medications. Encourage the client to self-administer eye medication whenever possible.

❖ **Points to Remember:**

■ **Eye Drops:**



- ⊕ Always wash hands and wear gloves when administering eye medications.
- ⊕ Ask individual to sit down
- ⊕ Only treat eye(s) as directed by order.
- ⊕ Gently pull the lower lid down and place the prescribed amount of medication on the inner aspect of lower lid.
- ⊕ Encourage individual to remain seated for a few minutes after applications to ensure vision is not blurred.
- ⊕ Don't touch the applicator tip to eye or eyelid to prevent serious injury or contamination of the tube or vial.
- ⊕ Don't place drops directly on eyeball
- ⊕ Never put pressure on the eyeball
- ⊕ Never share medication between individuals

■ **Eye Ointments:**



- ⊕ Apply a thin line of ointment in the pocket of lower lid starting from the inner aspect of the eye, to the outer aspect. Gently wipe away excess ointment with tissue.
- ⊕ Encourage individual to remain seated for a few minutes to ensure vision is not blurred.
- ⊕ Don't touch applicator tip to eye or any surface.
- ⊕ Don't place ointment directly on eyeball.
- ⊕ Never share medication between individuals.



Refer to skill # 5

Eye Medication Administration Competency Skills Checklist

■ *Ear Medications:*



❖ Points to Remember:

- ⦿ If medication has been refrigerated, allow to stand for 10 minutes. Cold medication can cause pain.
- ⦿ Pharmacy label should indicate which ear or if both ears are to be treated.
- ⦿ Ask the individual to tip his/her head so that the treated ear is higher than the unaffected ear and instill the precise number of drops prescribed.
- ⦿ Ask the individual to maintain this position for 1 minute.
- ⦿ Do not touch applicator to ear. Do not put anything in the ear unless directed by prescriber's order.



Refer to skill # 6

Ear Medication Administration Competency Skills Checklist

Nasal Medications:



❖ Points to Remember:

- ⦿ Ensure the right position; head up in sniffing position for instilling spray, and head back for instilling drops.
- ⦿ Follow directions on package label.
- ⦿ Do not place the tip of the medication deep into the nose. Place tip just at opening of nose.
- ⦿ May gently occlude the nare of the side not being administered by placing gloved finger on outside of nose while individual inhales spray.
- ⦿ Do not allow dropper tip to touch nostrils. Do not allow bottle caps to touch surfaces (*keep on side or upside down*).

Rectal Medications:



Rectal medications may be given for seizures, fever, or constipation. Enemas are given for constipation. Both suppositories and enemas are administered in the rectum. Rectal medications should be given by same sex as the individual if possible.

❖ **Points to remember for SUPPOSITORY administration:**



- ◆ Most suppositories are kept refrigerated. Slight softening of the suppository may allow for easier passage. Remove suppository from the refrigerator and expose it to room temperature for 10 minutes before insertion. A small amount of water soluble lubricant may be used to lubricate the tip of the suppository if needed.
 - ⊕ Wear gloves
 - ⊕ It is recommended to have a witness when administering suppositories
 - ⊕ Read and follow directions on package label
 - ⊕ Provide privacy, comfort and explanation of procedure.
 - ⊕ Remove medication from refrigerator and warm in room air for ten minutes (*slight softening may allow for easier passage*).
 - ⊕ Collect supplies such as towel, tissues, water soluble gel as needed.
 - ⊕ If possible, have individual empty bowel or bladder prior to administering medication
 - ⊕ Remove any wrappings from suppository
 - ⊕ Ensure individual is in right position on left side with right knee drawn up.
 - ⊕ Use water soluble lubricant to lubricate suppository if needed
 - ⊕ Insert pointed or rounded end into the rectum, pushing gently passed the sphincter muscle (*about 1 inch*)
 - ⊕ If suppository pops out, do not reuse. Open a new suppository and re-administer.
 - ⊕ Encourage individual to remain lying down to retain the suppository for specified time frame.
 - ⊕ Ensure bathroom is appropriately prepared (*or bedside commode*) for assistance to bathroom.
 - ⊕ Dispose of wrappings, container properly.

❖ **Points to remember for ENEMA administration:**



- ⊕ Wear gloves
- ⊕ Provide privacy, comfort and explanation of procedure.
- ⊕ Remove enema from refrigerator (*if stored in refrigerator*) and run under warm water
- ⊕ Read and follow directions on package label
- ⊕ Collect supplies such as towel, tissues, water soluble gel as needed (*most enemas have been prepared with water soluble gel on application tip*).
- ⊕ If possible have individual empty bowel or bladder prior to administering medication.
- ⊕ Ensure individual is in right position on left side with right knee drawn up
- ⊕ Use water soluble lubricant if needed
- ⊕ Insert application tip into rectum, about 1 inch, and empty contents of the container into rectum
- ⊕ Encourage individual to remain lying down for specified time frame in order to retain medication.
- ⊕ Ensure bathroom is appropriately prepared (*or bedside commode*) for assistance to bathroom
- ⊕ Dispose of wrapping/container properly



Refer to skill # 7

Rectal Medication Administration Competency Skills Checklist

Vaginal Medications:



Vaginal medications are medications placed in the vagina, usually in the form of suppositories, creams or ointments. Vaginal medication is usually administered for infections, vaginal dryness, menopausal symptoms or birth control. Only female staff should administer or be present during administration of vaginal medication.

❖ Points to Remember:

- ✦ Wear gloves
- ✦ It is recommended to have a witness when administering suppositories
- ✦ Read and follow package label or prescribers order.
- ✦ Provide privacy, comfort and explanation of procedure.
- ✦ Usually given at nighttime after the individual bathes and just before bedtime to make sure the medication stays in the vagina for the right amount of time.
- ✦ Have individual eliminate (*bowel/bladder*) prior to procedure if possible.
- ✦ Position properly on back with knees bent and legs apart
- ✦ When inserting suppository, remove wrapper, and insert pointed or rounded end into the vagina using applicator or gloved finger, about two inches into vagina. Use a slightly downward movement toward tailbone.
- ✦ Only use applicator for that individual. Applicators are not shared.
- ✦ Check vaginal area for any signs of irritation and promptly report.
- ✦ Provide for comfort and hygiene (*peripad, underpants*) and clean applicator according to instructions on package insert.

Teach females to self-administer vaginal suppositories or creams and clean cream applicators wherever possible. Females receiving antibiotic therapy are prone to vaginal discharge. LLAM trained UAPs should be aware that not all vaginal discharges indicate some form of sexually transmitted diseases (STD's). The LLAM trained UAP should be sensitive when dealing with potential STD issues.



Refer to skill # 8

Vaginal Medication Administration Competency Skills Checklist

important

Never Administer Medications by any of the above routes if:

- The label on the Medication does not match the medication/treatment order.
- The medication does not seem to be the same as you usually give the individual.
- You think the medication may have been tampered with.
- It is documented that the person is allergic to the medication.

- ☑ You are not sure of the 6 Rights of medication administration.

LESSON 5 - SAFE MEDICATION ADMINISTRATION

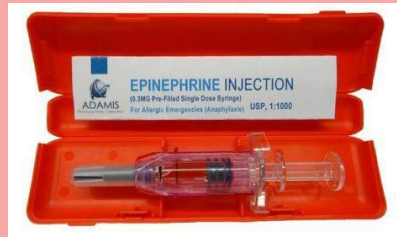
ADMINISTERING EMERGENCY MEDICATIONS

∞ The Epi-Pen (A)



The learner will:

- ✓ Recognize signs and symptoms of anaphylaxis.
- ✓ Demonstrate how to use the epi-pen for indications warranting use.
- ✓ Verbalize how to order, store and dispose of epi-pen.



- **Definition:** Epinephrine is prescribed as an emergency injection for an individual with life threatening allergic reactions.
- **Policy:** The LLAM trained UAP may administer epinephrine to an individual in an allergic crisis by administering an emergency epinephrine injection (auto-injector or epi-pen).
- **Procedure:**
 - ◆ **LLAM trained UAP** should periodically read the package insert regarding administration of the emergency epinephrine injection and practice with a trainer pen.
 - ◆ The emergency injection must be prescribed specifically for the individual to whom it is being administered.
 - ◆ The order must state what circumstances would warrant the use of the injection.
 - ◆ If the individual meets the criteria for administration as indicated by the healthcare provider, administer the emergency injection.
 - ◆ Identify the right individual, and proceed only if you know the individual Dial 911
 - ◆ Proceed with delivering resuscitation or CPR measures, if required.
 - ◆ Notify the facility or employer administration as soon as possible.
 - ◆ Document the medication in the MAR or per the employer's policy.

Serious Allergic Reactions (Anaphylaxis)

A life threatening allergic reaction **{Anaphylaxis}** is a severe reaction to a specific allergen or allergic trigger, such as food, biting insects, medications and latex.

Symptoms Include:



Head

- ⊕ Feeling very anxious
- ⊕ Confusion
- ⊕ Dizziness
- ⊕ Passing out



Mouth

- ⊕ Itching
- ⊕ Swelling of lips and/or tongue
- ⊕ Tingling of lips or tongue



Lungs

- ⊕ Shortness of breath
- ⊕ Coughing
- ⊕ Wheezing
- ⊕ Difficulty breathing



Skin

- ⊕ Rash
- ⊕ Itching
- ⊕ Hives
- ⊕ Redness
- ⊕ Swelling



Throat

- ⊕ Itching
- ⊕ Tightness/closure
- ⊕ Coughing
- ⊕ Hoarseness



Heart

- ⊕ Weak pulse
- ⊕ Fast heartbeat
- ⊕ Dizziness
- ⊕ Passing out



Stomach

- ⊕ Vomiting
- ⊕ Nausea
- ⊕ Diarrhea
- ⊕ Cramps



Severe reactions can happen anytime, anywhere.
Know your individual's "Allergy Status".
Severity of symptoms can change quickly and be life threatening.

WHAT'S THE PLAN?

- Avoid known allergens (the individual)
- Recognize signs and symptoms of anaphylaxis
- Know the healthcare provider's orders
- Review the MAR at the start of the shift
- Know Emergency Contact Information
- Know medications currently being taken
- The documentation and reporting process at your agency.





➤ ***Before Use:***

- ◆ Be Prepared. Know the order. Know the individual. Know the medication, its use, when to use it, how to use it, side effects as described in package insert/medication information sheets.
- ◆ Always check the expiration date of the Epinephrine auto-injector
- ◆ Do not use the auto-injector if you are unsure of how to use it, if the color of liquid is cloudy or has particulate, or if it looks as if auto-injector has been tampered with. Report promptly to your supervisor.

➤ ***After Use/disposal:***

- ◆ The remaining liquid that is left after this fixed dose cannot be further administered and should be discarded.
- ◆ Put the auto-injector, needle first into the carrier tube.
- ◆ Give used epinephrine auto-injector to a healthcare worker for disposal. Do not throw away in regular trash.

➤ ***Reorder:***

- ◆ Epinephrine Auto-Injector before the expiration date on the label.

HOW TO ADMINISTER



See other side for instructions

EPIPEN® 0.3 mg EPINEPHRINE AUTO-INJECTOR

1 Remove blue safety release by pulling straight up without bending or twisting it.

2 Swing and firmly push orange tip against outer thigh so it "clicks" AND HOLD on thigh approx. 10 seconds to deliver drug.

3 Seek emergency medical attention.

Rx only
After use, most of liquid stays in auto-injector and can't be reused. Delivers 0.3 mg intramuscular dose of epinephrine from epinephrine injection 1:1000 USP (0.3 mL). Each 0.3 mL also contains 1.8 mg sodium chloride and 0.5 mg sodium metabisulfite.

EPIPEN® 0.3 mg EPINEPHRINE AUTO-INJECTOR
for Allergic Emergencies (Anaphylaxis)

REPLACE IF SOLUTION IS DISCOLORED

STORE AT 68° TO 77° F (20° TO 25° C)
DO NOT REFRIGERATE
PROTECT FROM LIGHT
CONTAINS NO LATEX

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Mfd. for Mylan Specialty L.P., Basking Ridge, NJ 07920, USA
by Meridian Medical Technologies, Inc.
Columbia, MD 21046, USA, a Pfizer company
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Made in U.S.A.

NEEDLE ↓ END NEEDLE ↓ END

See other side for instructions

EPIPEN Jr® 0.15 mg EPINEPHRINE AUTO-INJECTOR

1 Remove blue safety release by pulling straight up without bending or twisting it.

2 Swing and firmly push orange tip against outer thigh so it "clicks" AND HOLD on thigh approx. 10 seconds to deliver drug.

3 Seek emergency medical attention.

Rx only
After use, most of liquid stays in auto-injector and can't be reused. Delivers 0.15 mg intramuscular dose of epinephrine from epinephrine injection 1:2000 USP (0.3 mL). Each 0.3 mL also contains 1.8 mg sodium chloride and 0.5 mg sodium metabisulfite.

EPIPEN Jr® 0.15 mg EPINEPHRINE AUTO-INJECTOR
for Allergic Emergencies (Anaphylaxis)

REPLACE IF SOLUTION IS DISCOLORED

STORE AT 68° TO 77° F (20° TO 25° C)
DO NOT REFRIGERATE
PROTECT FROM LIGHT
CONTAINS NO LATEX

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Columbia, MD 21046, USA, a Pfizer company
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Made in U.S.A.

NEEDLE ↓ END NEEDLE ↓ END



How to Administer an EpiPen®

- ✓ Identify someone to call 9-1-1.
- ✓ Flip open cap at top of carrier tube.



- ✓ Remove EpiPen® from carrier tube and remove the blue safety release.



- ✓ Form a fist around the unit with the orange tip pointing downward.
- ✓ Swing and firmly push orange tip against outer thigh until click is heard.
(Auto-injector may be given through clothing).



- ✓ Hold in place for 10 seconds. The injection is now complete.
- ✓ Remove pen from thigh and massage injection site for 10 seconds.
- ✓ Place used auto-injector into carrier tube and give to EMS when they arrive.
- ✓ Document administration of EpiPen® in Medication Administration Record (MAR).



Always refer to the package insert for additional information on administration.

LESSON 5 - SAFE MEDICATION ADMINISTRATION

ADMINISTERING EMERGENCY MEDICATIONS

Diastat Rectal Gel ^(B)



The learner will:

- ✓ Identify Diastat order from healthcare provider
- ✓ Identify responsibilities of staff
- ✓ Accurately demonstrate procedure for administration of Diastat
- ✓ Identify when 911 should be called
- ✓ Identify necessary forms, documentation and report procedures
- ✓ Verbalize procedure for disposal of Diastat medication

Diastat is a medication that comes in a pre-packaged rectal delivery system and is used to stop prolonged seizures and clusters of increased seizure activity. It works much more quickly than oral medications and is much easier to give than IV diazepam. It has been shown to begin having an effect in as little as 5-15 minutes. Diastat is intended and approved for use in emergency situations by the LLAM trained UAP.

Diastat (Diazepam) rectal gel belongs to a class of anticonvulsant medications called benzodiazepines, which produce a calming effect on the brain and nerves (central nervous system).

It is the responsibility of the nurse to make sure that the individual and his or her Guardian or advocate are given enough information to enable them to give informed consent for the use of Diastat.

➤ *Responsibilities of Caregivers when Diastat is ordered.*

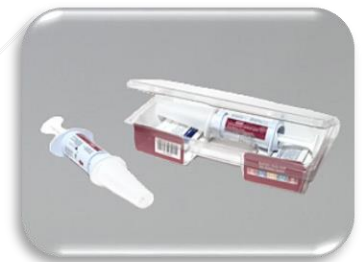
- ◆ Staff members who accompany the person to medical appointments must take with them a copy of the Diastat Order Form.
- ◆ Ask the healthcare provider to review the Diastat Order form with you.
- ◆ A copy of the Diastat Order Form is then faxed to the consultative nurse on the same day the order is received.

- ◆ On- site training is performed within 2 days of receiving the prescription by a Nurse. At the time of the training the nurse will review and verify the dosages of the AcuDial syringes. The nurse will develop the individual Diastat Protocol. He/she will also be available for questions or technical support if needed.
- ◆ Only staff trained in LLAM may administer Diastat rectal gel.

➤ *Responsibilities of the Agency when Diastat is ordered.*

- ◆ To ensure that program supervisors will verbally inform, in a timely manner, the prescriber, the consultative, and other provider agencies that a dose of Diastat has been given to an individual.
- ◆ To monitor adherence to the instructions on the Diastat Order Form and the Individual Diastat Form.
- ◆ For each use of Diastat usage, a thorough event note should be documented in the chart, which includes a description of the seizure, length of seizure, time and dose of Diastat given, and the response of the individual to the medication and side effects noted.
- ◆ The supervising house manager will check the AcuDial syringes when they come from the pharmacy:
 - ☑ Remove the syringes from the case.
 - ☑ Check expiration date to ensure medication not expired.
 - ☑ Confirm the dose is visible in the dose display window and is the dose that written by the prescriber on the Diastat Order Form. Do this for each of the syringes.
 - ☑ Confirm that the green **"READY"** band is visible. Do this for each of the syringes.
 - ☑ Return both syringes to the case.
 - ☑ The community nurse will review these items when she/he performs her on-site training session.

Preparing To Administer Diastat Rectal Gel by the LLAM Trained UAP:




➤ *Identify the right individual*

- ◆ Individual must have an order for Diastat on the medication administration record.
- ◆ Read the prescription label
- ◆ Explain the procedure to the individual

➤ *Identify the medication*

- ◆ Review Dr. order prior to each shift and compare with label and MAR
- ◆ Make sure medication has been stored appropriately
- ◆ Remove medication from package
- ◆ Check expiration date to ensure medication is not expired.
- ◆ Confirm that prescribed dose is visible and correct.
- ◆ Green "Ready" band is visible
- ◆ Confirm TIMING (when during procedure to give medication)

Administration of Diastat rectal gel by the LLAM trained UAP

- 1) Begin timing of seizure (prepare)
- 2) Wear Gloves if possible
- 3) Gently place individual on side where he/she can't fall, facing you
- 4) Bring pants down to below buttocks
- 5) Remove syringe from package and quickly check dose and green "Ready" band again
- 6) Push up with thumb and pull to remove cap from syringe. Be sure seal pin is removed from cap
- 7) Lubricate Diastat applicator tip with the lubricating packet
- 8) Bend upper leg forward
- 9) Separate buttocks to expose rectum
- 10) Gently insert syringe tip into rectum
 - ✿ Slowly count to three (3) while pushing the plunger in until it stops
 - ✿ Slowly count to three (3) before removing tip
 - ✿ Remove tip slowly count to three (3) while holding buttocks together
- 11) Keep individual on side facing you
- 12) Note time medication was given and continue to observe individual
- 13) Call 911 if
 - ✿ Seizures continue 15 minutes after giving Diastat or per the Health care provider's instructions.
 - ✿ The individual has needed Diastat more than 2 times in the last 24 hours.
 - ✿ The person has injured themselves
 - ✿ Changes in the skin color
 - ✿ Seizure behavior is different from other episodes
 - ✿ There is an increase in the frequency or severity of the seizure(s).
 - ✿ The individual has any difficulty in breathing or appears to be in distress.
 - ✿ There is any change in the level of consciousness.
- 14) Monitor individual for at least four hours. Individual will more than likely be very tired following the seizure. Do not send to Day program that day. Encourage rest.
- 15) Dispose of medication syringe after use:
- 16) Pull the plunger until it is completely removed from the syringe body.
 - ✿ Replace plunger into syringe body and gently push plunger while pointing into a sink or toilet until it stops.
 - ✿ Rinse sink or flush toilet to get rid of any gel that may have remained in the syringe after use,
 - ✿ Discard all materials into a garbage container that is not accessible by other individuals.
- 17)  Sometimes a second dose of Diastat is ordered. Read the order.

Documentation:

UAP must document administration of medication onto the MAR, in the electronic record, (progress notes) and in the communication book. The medication, because it is a controlled substance will also be documented on the controlled substance count sheet.

✂ **Report:** To Supervisor as soon as the individual is stable.

The most common side effects of Diastat Rectal Gel include:



- **Shakiness**
- **Unsteady gait**
- **Trembling**
- **Dizziness**
- **Drowsiness**
- **Poor muscles control or coordination**



✂ **Observe for and report** any signs or symptoms (changes) in the individual.





Division of Developmental Disabilities Services

Diastat Order Form

* Form can only be completed by a physician; preferably a Neurologist.

* Form must be reviewed at each appointment & rewritten within a 1- year period.

Name of Patient: _____ Date: _____

Seizure Diagnosis: _____

DOB: _____ MCI #: _____ Weight: _____

Usual Seizure Type/Seizure Clusters:

Diastat Medical Order: (should be the same as is on the prescription)

Diastat should NOT be given when:

After treatment with Diastat you must:

1. Stay with the person for at least 4 hours;
2. Make note and document the following:
 - a) Changes in resting breathing rate
 - b) Changes in skin color
 - c) Drowsiness that extends beyond the 4 hour period of observation
3. Other things to monitor include: _____

Call my office at telephone number (302) _____ - _____ if any of the following occur:

1. Seizure frequency or severity is different from other episode;
2. If you have given a dose of Diastat;
3. Other reasons to call: _____

Call 911 if any of the following happens after you have given a dose of Diastat:

1. Seizures continue 15 minutes after giving Diastat.
2. The person has needed Diastat twice within the last 24 hours.
3. The person has injured themselves or appears to be having unusual or serious problems.
4. The seizure behavior is different from other episodes.
5. You are alarmed by the skin color (blue, red, or pale) or the breathing pattern of the person.
6. You are alarmed by the frequency or severity of the seizure(s).

Physician's Sign

Date

Sign. Of Person Giving Informed
Consent

Date