DEPARTMENT OF HEALTH & SOCIAL SERVICES
(DHSS)

Division of Developmental Disabilities Services (DDDS)

Limited Lay Administration of Medications **(LLAM)**

DDDS Module for Instructors

July 1, 2024

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Introduction

The goal of the **Limited Lay Administration of Medication (LLAM)** course is to prepare unlicensed assistive personnel (UAP) for the role and responsibility of administering medications safely. The Delaware Board of Nursing's (BON) LLAM Core Curriculum Training Course will be augmented by the Division of Developmental Disabilities Services (DDDS) LLAM Module approved by the BON presented here and the policies, protocols, and procedures of DDDS.

When an agency assumes responsibility for the support of individuals with disabilities, it requires them to provide learning opportunities for staff to achieve a consistently safe and supportive environment. The knowledge and skill obtained in this course will enable the LLAM trained UAP to administer medications safely in an environment that values individual independence and encourages quality of life supports.

After completing this module, the Learner will:

- Observe and identify changes in the physical or behavioral condition of the individual and report/communicate them appropriately.
- Document correctly using the required forms.
- Identify and respond appropriately to the Fatal Five health issues that occur more frequently in individuals with developmental disabilities.
- Communicate effectively with the healthcare provider, pharmacist, nurse, supervisor, and other staff on the behalf of the safety of the individual.
- Identify the three different types of orders.
- Identify and respond appropriately to emergency events.

DDDS LLAM Module Definitions

LLAM WORDS	***LLAM DEFINITIONS***
1. Annual	For purposes of LLAM training or re-training, annual shall mean within the month that it is due ***(Example:*** *initial LLAM training end date 10/15/2022, re-cert due by 10/31/2023)*.
2. Documentation	Written communication that provides a record of everything that was done regarding the individual's support and care. The purpose of complete and accurate individual record documentation is to foster quality and continuity of care. Complete and accurate documentation is an essential component of medication administration. Medical record documentation is the 6th "Patient Right" and is a legal document.
3. Electronic Medication Administration Record(eMAR)	The record within DDDS's client data management system (CDMS) that lists the names of all current ordered medications/treatments, dosages, routes, times of administration, and any special instructions for the individual. The eMAR is signed/initialed after each individual has taken and/or received the appropriate medication/treatment.
4. Individual	Refers to the population served by the Division of Developmental Disabilities Services and Provider Agency staff. Also, sometimes referred to as client, resident, patient, consumer, or individual.
5. Label	Information on the medication package; referred to also as medication label or prescription label.
6. Order/Prescription	Any written, electronic, and/or signed statement from a licensed, Delaware practitioner, for the preparation and administration of medication/treatments, including MAIR (Medical Appointment Information Record), DAIR (Dental Appointment Information Record), PAIR (Psychiatric Appointment Information Record), etc.
7. Over-the-Counter Medication (OTC)	Non-prescription medications: medications which can be purchased or obtained without a prescription. ***No medications, including OTC medications may be administered to DDDS individuals without a written order from a HCP.***

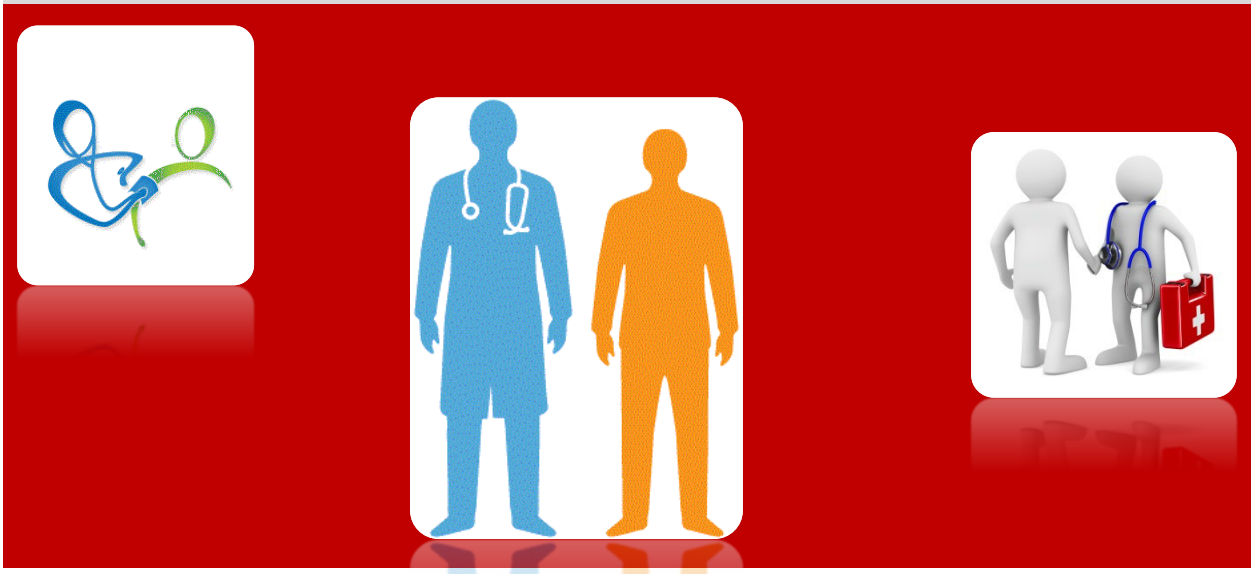
DDDS LLAM Module Definitions

LLAM WORDS	*LLAM DEFINITIONS*
8. Policy	A policy is defined as a course of action, or a plan adopted by an organization to guide decisions and practices. DDDS and agency policies provide staff with direction and support for what, where, when, and how to do something. Policies dictate practices, procedures, and protocols.
9. Practitioner/Healthcare Provider (HCP)/Primary Care Provider (PCP)	A physician/doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or a clinical social worker who is authorized to practice by the State and performing within their scope of practice. These terms are used throughout the DDDS LLAM curriculum.
10. PRN Orders	A non- routine medication that is given per HCP order when an individual requests it, or demonstrates behaviors outlined in the written HCP order designating when the medication may be given. The PRN order is very specific to targeted signs and symptoms outlined in the written order and indicates further instructions if the medication is administered.
11. Provider Agency	An agency authorized by DDDS to provide Home and Community Based services to individuals eligible for DDDS services.

SECTION

1

CARING FOR THE INDIVIDUAL



Observe, Communicate, Document

You will observe for changes that may indicate a health problem, **promptly** report changes that you have observed, communicate effectively with other staff, and sometimes provide an emergency action.

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 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. 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, and medication effects or reactions.

When an individual can communicate only in a limited way, you 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.

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.

You will need to **OBSERVE**, **COMMUNICATE**, and **DOCUMENT** 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. It is essential that the LLAM trained UAP communicates the noted changes promptly so that appropriate interventions can occur.

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. If there are any physical, emotional, or behavioral changes, you will report and communicate them.

OBSERVE

Observe the Individual

- 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.

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

The above list of **SIGNS** and **SYMPTOMS** identifies a few of the possible changes.

- **SIGNS** and **SYMPTOMS** help a health care provider diagnose problems.
- Your job is to **OBSERVE** changes and **COMMUNICATE** them.
- You will use your **4 SENSES** to detect change.
- Always **ASK** questions and **LISTEN** carefully to what the individual is saying.

Communicate

All changes in the individual, physical or behavioral, are important as even minor conditions can rapidly develop into urgent or emergency health crisis. All changes need to be **promptly** 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. How you do this will depend on what it is that you have observed.

#1 example: 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 document this information in the electronic record and pass it 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.

#2 example: Ellen is guarding her left side this morning and grimacing. You would call to schedule an appointment with the HCP immediately, as Ellen is showing signs of pain and holding her side indicates something is going on. If the HCP is unavailable, or if the symptoms worsen, Ellen would be transported to a medical aide unit (walk-in) or taken to the ER. You would communicate your findings to your supervisor and other staff as well, so that all are aware and know that appropriate action has been taken. Document in the electronic record exactly what your findings are and actions taken.

#3 example: Antione 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.

Tips for Effective Communication

- A complete report is to be given to oncoming staff that includes any changes, needed follow-up, appointment information, etc.
- In the event of an emergency, the HCP, supervisor/administrator, the consultative nurse, day program (as appropriate), legal guardian, and the emergency contact should be notified.
- Always notify the HCP as indicated by the HCP order, and for any changes/updates. Call the HCP or consultative nurse with any questions or if guidance is needed. Notify your supervisor *(before or after as indicated)* after any calls to nurse or HCP.

Ask yourself: what was different about this day, what was different about the individual? What do I need to remember to communicate to oncoming staff, HCP, supervisor to ensure the individual is safe and his or her care/ support is uninterrupted?

ꕥ Recognizing Urgent vs Life Threatening Situations

When an individual has signs or symptoms of illness or injury it is important to know what you should do. All observations may not be life threatening but could become so if unattended. Urgent situations require immediate HCP notification, and life-threatening situations, require an immediate call to 911.

When in doubt, always call the Healthcare Provider or follow agency's policy. If HCP is unavailable and/or if symptoms worsen call 911.

Urgent Situations

- ***Call the HCP immediately if:***
  - Any change in abilities *(walking, swallowing, cognitive ability)*
  - Any change in physical appearance, behaviors, habits, mood *(sleepy, sad)*
  - Any change in elimination, eating, drinking
  - Refusing or requesting medications *(pain, agitation)*

Examples:

- Any change in behavior
- Sleeping more than usual
- Holding abdomen
- Incontinent of urine or stool
- Diarrhea or vomiting
- Sore throat
- Swelling
- Holding one or both ears
- Fever
- Signs of infection at site of injury site

Life Threatening Situations

- ***Call 911immediately if:***
  - Complaint of chest pain, or difficulty breathing
  - Has pressure in chest
  - Has become unresponsive
  - Changing level of consciousness
  - Choking, shortness of breath, or not breathing
  - Has head or severe injury
  - Has numbness, paralysis, confusion, or change in speech
  - Has new seizure or increased/prolonged seizure activity
  - Has anaphylactic reaction
  - Unwitnessed fall

Be prepared to administer CPR

important

If you need to call 911, tell them who you are, where you are, what has happened and when it has happened. Give as much information as you can to emergency staff to include list of medications.

important

Call **Poison Control** if you feel the individual may have been poisoned.

(1-800-222-1222) **Get advice and then call 911.**

Document

You will document on the Medication Administration Record (MAR) or the Electronic Medication Administration Record (eMAR) each and every time you administer medication. You will also document in the client data management system (CDMS) the individual's responses to medications, as well as any changes which you have observed in the individual. These observations include but are not limited to physical, behavioral, cognitive, and emotional changes. You will also document what you have reported, who, when, and where you reported the information.

Your documentation should be clear, and in chronological order *(as events happen).* Your documentation 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
  - Example: "Shavon was being manipulative and hit her head against the car window because we didn't have time to stop at McDonald's for a milkshake. When we got home, she whined that she had a headache. I gave her Tylenol per her OTC order, even though it was her own fault her head hurt."

- Objective Documentation
  - Provides an unbiased account of an event based on observations.
  - Uses direct quotes from an individual or conversation with another person.
  - Not influenced by the writer's opinions.
  - Example: "Shavon hit her head on the car window on the way home when she was told we did not have time to stop at McDonald's for a milkshake. When we got home, Shavon said "I have a headache." She did not have a bruise or red mark on her head where she hit it on the window. I gave her Tylenol per her OTC order and will recheck in an hour to see if it helped."

Guidelines for Documentation

- 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. Double check all of the electronic records for documentation completion before you leave your shift.

- All medications and treatments must be as ordered and recorded in the MAR/eMAR with the exception of sunscreen and liquid thickening agents.

- All calls to the HCP are documented on the CDMS as indicated by the agency policy. All orders received should be written and placed in the CDMS. LLAM trained UAPs are **NOT** allowed to accept verbal orders from anyone.

- After the individual is stable or received by emergency medical services, all emergencies are documented in the CDMS promptly and completely. Be sure to include specifics (what happened and what you did, any medications that were given, dates and times).

If it's not documented, it's not done!

Principles of Documentation

Proper documentation is needed to support the safety of the individual and the LLAM trained UAP staff when basic principles of documentation are followed.

- For Electronic MARs:
  - Only document medications YOU administer.
  - Documentation errors can be corrected in the eMAR system. Every keystroke is saved for future reference, so if you change something, there is a record of the change.
- For Paper MARs:
  - Write neatly and accurately.
  - Use black ink only. No pencil.
  - Only document medications that YOU administer.
  - No white out or scribbling or attempt to erase an error.
  - Correct documentation errors by drawing a single line through the error, write "error", initials, and date.

Medical Alert Form

The Medical Alert Form is completed by the Consultative Nurse for every individual receiving Nurse Consultation services. All potentially life threatening, or medically significant health issues, possible signs and symptoms of those conditions and the actions which should be taken by staff are to be documented on this document. If the individual does not have any identified life threatening or medically significant health issues "NONE" should be documented on the form and filed as outlined. The Medical Alert Form is completed upon admission, updated at the time of the annual person-centered plan meeting, and updated as changes occur.

This form is printed on bright green paper and filed in the front of the Medication Administration Record if living where one is used. If the residential provider utilizes the eMAR, the Medical Alert Form should be attached to the Medication History module and a physical copy printed out and stored at the house with the medications. A copy must also be sent by the nurse to the individual's day service program. Please refer to Medical Alert Form Guidelines below for additional information.

MEDICAL ALERT FORM - GUIDELINES

- Completed for every individual receiving Nurse Consultation services. All potentially life threatening, or medically significant health issues are to be documented on this document. These may include but are not limited to: aspiration risk; fall risk; seizures; order for Diastat or other seizure rescue med; history of bowel obstruction; significant allergies; cardiac issues; asthma or pain management concerns.
- If an individual does not have any potentially life threatening or medically significant health issues "NONE" should be documented on the form and filed as outlined.
- Must be kept updated by the nurse as conditions warrant.
- Completed form must be printed on bright green paper to be more visible and easier to locate.
- Completed form must be filed in the front of the hard-copy medication administration record (MAR) or attached to the Medication History module if the residential provider utilizes the eMAR and printed out and stored with the medications in the home.
- Copy of the completed form must also be sent to day service provider.
- Form is to be reviewed as needed, but minimally each year at the time of the person-centered plan review meeting.
- Forms are to be reviewed by each staff member.

The Fatal FIVE

There are five major health issues that occur more frequently and with more intensity in individuals with developmental disabilities. They are referred to as the **Fatal Five** 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 may make a difference in health outcomes of the individuals we serve.

The "Fatal Five" are:

✓ *Aspiration* ✓ *Constipation* ✓ *Dehydration* ✓ *Seizure* ✓ *Sepsis*

Aspiration

Aspiration is a common problem among those with **dysphagia**, a condition which where the individual has difficulty chewing or swallowing. Aspiration means that food or fluids that should go into the stomach go into the lungs instead.

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
- ✓ Trouble chewing/swallowing
- ✓ Coughing when lying flat
- ✓ Complaining of something caught in throat
- ✓ A gurgling voice during or after eating or drinking
- ✓ Getting tired while eating
- ✓ Taking a very long time to finish a meal
- ✓ Being hoarse

In the event an individual is noted to be showing signs or symptoms of aspiration while eating or taking medications, the LLAM trained UAP will report this to the supervisor and the consultative nurse. An aspiration assessment will be completed by the consultative nurse to determine if a visit to the HCP is warranted. The HCP may order further testing or may choose to change the diet and form of medication being given. The medication may be changed to liquid or the HCP may order for it to be crushed and given in some form of food or drink. Aspiration precautions will be documented on the Medical Alert form and are to be followed at **all** times.

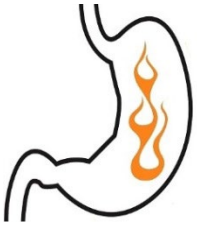
Aspiration Pneumonia

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. These include but are not limited to:

- ✓ Frequent and possibly painful cough or chest pain
- ✓ Foul smelling sputum that may be yellow/green, contain pus, or steaks of blood.
- ✓ Shortness of breath/noisy breathing/wheezing
- ✓ Increased heartbeat
- ✓ Fevers and/or sweating
- ✓ Trouble swallowing
- ✓ Cognitive changes

It is worthy to note here that a common digestive disorder called *Gastroesophageal Reflux Disease (GERD)*, can contribute to aspiration or aspiration pneumonia. It can allow food and stomach acids to reflux or return back up into the esophagus and can then be aspirated into the lungs. Although GERD itself isn't a life-threatening condition, it can lead to more serious health issues and complications if it's left untreated.

Signs and Symptoms of Gastroesophageal Reflux Disease (GERD) include:



- ✓ Dyspepsia (Indigestion)
- ✓ Chronic Cough
- ✓ Hoarse Voice
- ✓ Bad Breath
- ✓ Sore Throat
- ✓ Regurgitation
- ✓ Burning in the chest

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 designated as medium or high risk on aspiration assessment will have an **aspiration risk** listed on their **medical alert form**. These individuals are to remain 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). Extra time may be needed at mealtimes, and ensure the individual is closely observed while eating or drinking. Read orders carefully, adhere to instructions on medical alert form, and always observe for signs or symptoms of aspiration. ***Constipation***

Constipation is defined as infrequent bowel movements or difficult passage of hard, dry stool. Constipation occurs when stool passes through the large intestine too slowly. When stool stays in the intestine too long, the intestine removes too much water, the stool becomes hard and dry. The normal length of time between bowel movements varies widely from person to person. Some individuals have bowel movements three times a day while others, 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
- ✓ Eating large amounts of Dairy Products
- ✓ Neurological Conditions Such as Parkinson's Disease or Multiple Sclerosis
- ✓ Disruption of Regular Diet or Routine
- ✓ Irritable Bowel Syndrome
- ✓ Resisting having Bowel Movements
- ✓ Antacids with Calcium of Aluminum
- ✓ Medicines (especially Narcotics, Antidepressants, or Iron Pills)

Common Signs of Constipation:

- ✓ Hard dry stools
- ✓ Abdominal pain/cramping
- ✓ Long periods between bowel movements
- ✓ Bloated abdomen
- ✓ Blood in stools
- ✓ Painful/Difficult bowel movements

Signs and symptoms of constipation that are severe changes in normal bowel habits, regardless of duration, should be evaluated by a healthcare provider. Severe constipation can result in serious complications including fecal impaction and bowel obstruction. 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. 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.

Any individual receiving medication for constipation will have a medical alert form completed by the consultative nurse and bowel documentation recorded. Day programs **MUST** communicate bowel movements to the homes for said individuals to ensure proper tracking and appropriate medication administration.

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 or bowel disorders that cause fluid to move through the body 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, consultative nurse, and/or HCP, especially if there is any fever, vomiting, or diarrhea.

Signs and Symptoms of Dehydration include:

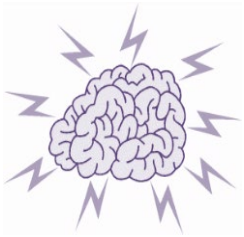
- ✓ Dry sticky mouth
- ✓ Dizziness or lightheadedness
- ✓ Dry skin
- ✓ Few or no tears when crying
- ✓ Headache
- ✓ Lack of sweating
- ✓ Rapid heartbeat
- ✓ Rapid breathing
- ✓ Thirst
- ✓ Very dry mouth, skin, and mucous membranes
- ✓ Sleepiness or tiredness
- ✓ Fever
- ✓ Constipation
- ✓ Delirium and/or unconsciousness
- ✓ Low blood pressure
- ✓ No or decreased urinary output (eight hours without urination)

important

Eight glasses of water *(8 ounces each)* 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.

NEVER RESTRICT FLUID WITHOUT A DOCTOR'S ORDER TO DO SO.

Seizure Disorder (Epilepsy)



Seizures of all types are caused by disorganized and sudden electrical activity in the brain. 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. 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. Symptoms may stop after a few seconds or minutes or continue for 15 minutes. They rarely continue longer.

Causes of Seizures can include:

- ✓ Low Blood Sugar
- ✓ Stroke
- ✓ Brain infection
- ✓ Choking
- ✓ Very high blood pressure
- ✓ Venomous bites and stings
- ✓ Heat illness/intolerance/stroke
- ✓ Abnormal levels of sodium or glucose in the blood
- ✓ Heart Disease
- ✓ Brain injury/tumor
- ✓ Poisoning
- ✓ Kidney or liver failure
- ✓ High fever
- ✓ Drug Abuse
- ✓ Withdrawal from certain drugs and alcohol

Signs of Seizure may include:

- ✓ Eye Movements
- ✓ Sudden Falling
- ✓ Grunting or Snorting
- ✓ Teeth Clenching
- ✓ Shaking of the entire body
- ✓ Loss of bladder or bowel control
- ✓ Drooling or frothing at the mouth
- ✓ Temporary halt in breathing
- ✓ Muscle spasms with twitching and jerking limbs
- ✓ Brief blackout, with time lost, followed by confusion
- ✓ Sudden change in behavior such as picking at one's clothing
- ✓ Sudden mood changes such as anger, unexplainable fear, joy, panic, or laughter

Seizures MUST be timed starting when the first signs of seizure activity are noted.

Aura

A person may have warning symptoms, sometimes called an aura prior to the start of a seizure. Not all individuals who experience seizures will have an aura. Symptoms may include:

- ✓ 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 individual has had a seizure
- A seizure lasts more than 5 minutes or as otherwise directed by HCP
- The individual does not awaken or return to typical behavior after a seizure
- Another seizure starts soon after a seizure ends
- The individual had a seizure in water, is injured, or has diabetes
- There is anything different about a seizure compared to the individual's usual seizures
- As outlined in the individual's Seizure Rescue Medication orders *(as applicable)*

All staff who work with an individual who has a seizure disorder are required to be informed of the individual's diagnosis, as well as the proper care and reporting of events.

Infection/Sepsis

An infection is the invasion and growth of germs in the body. The germs may be bacteria, viruses, yeast, fungi, or other microorganisms. Infections can begin anywhere in the body and may spread all through it. Sepsis is an extreme response to an infection and is a silent killer. The body sends a flood of chemicals into the bloodstream to fight the threat. This causes widespread inflammation which, over time, can slow blood flow and damage organs. Sometimes sepsis can be life-threatening, especially if it moves to its later stages -- severe sepsis or septic shock. Every hour that passes without treatment raises death risk by 10%.

Causes of Infection can be:

- Bacteria or several infectious agents invading the bloodstream and spreading throughout the body
- Virus
- Protozoa or parasites
- Fungal organisms
- Open wound
- Pneumonia
- Urinary Tract Infection

Signs and symptoms of Infection may Include:

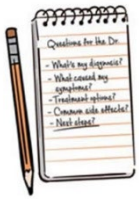
- Fever (this is sometimes the only sign of an infection)
- Chills and sweats
- Change in cough or a new cough
- Sore throat or new mouth sore
- Shortness of breath
- Nasal congestion
- Stiff neck
- Burning or pain with urination
- Rapid pulse
- Low blood pressure
- Redness, swelling, and heat in area of wound
- Colored or foul-smelling pus

Signs and symptomsof Sepsis may Include:

- Rapid breathing and heart rate
- Shortness of breath
- Confusion or disorientation
- Extreme pain or discomfort
- Fever, shivering, or feeling very cold
- Clammy or sweaty skin

What to Take to the Healthcare Provider Office

You will be taking the individual you support to his/her healthcare provider for annual and sick visits. Your role during the visit is very important. You might need to be an advocate to ask questions for the individual to ensure his/her medical needs are met or you may need to speak up for the individual you are accompanying to ensure they are being treated with dignity and respect.



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 ensure that the treatment occurs?

Information to take to the healthcare provider:

- ☑ ***Reason for the Visit***. Put this in writing on the appropriate ***Medical Appointment Information Form (MAIR)*** and add ***any other questions*** you want to ask.
- ☑ ***Important recent health information***. If you are taking an individual to a new patient appointment with a new health care provider, be prepared to share the individual's medical history.
- ☑ Copy of the individual's current ***medication administration record (MAR)*** or printout of current eMAR.
- ☑ ***List*** of any ***Allergies*** the individual may 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.***
- ☑ Personal funds to pay any ***Co-pay*** the individual might have associated with their health insurance.

There are also Dental Appointment Information Records (DAIRs), Psychiatric Appointment Information Records (PAIRs), Counseling Appointment Information Records (CAIRs), and the Annual Physical form to use for the respective appointments.

DEPARTMENT OF HEALTH & SOCIAL SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
COMMUNITY SERVICES

Medical Appointment Information Record (MAIR)

Name: _____ **MCI**: _____ **Date of Visit**: _____

Healthcare Provider Seen: _____ **Specialty**:_____

Known Drug Allergies: _____

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

Symptoms Present:_____

_____

Physical findings:_____

_____

_____

Tests Completed During Visit:_____

_____

_____

Diagnosis and Prognosis:_____

_____

Restrictions:_____

_____

Prescriptions, Treatments & Diagnostics Ordered:_____

_____

Return Appointment Date:_____

Signature of Healthcare Provider: _____ **Date:** _____

Address: _____

_____

Phone: _____

NAME:_____ **MCI:** _____

STAFF TO COMPLETE PRIOR TO APPOINTMENT
Medical Appointment Checklist
This form must be completed and taken on every healthcare provider's appointment:

- **The following items must accompany you on this appointment:**

☐ Medical Appointment Information Record (MAIR)	☐ Health Information
☐ Physical Exam form and Standing Medical Orders (for annual physical only)	☐ Copy of Current MAR

- **The following questions must be answered prior to the healthcare provider's appointment:**

What is the nature (purpose) of this appointment?
☐ An annual physical ☐ A follow up appointment ☐ An illness

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 to help with this condition?

_____

_____

Signature/Title:_____ Date:_____

At the end of the appointment:

Are all orders clear and complete?

- Do you know the desired effect of any new medications/treatments if ordered
- Any possible side effects to be concerned about
- Are affected areas to be treated specified in the order
- Are signs and symptoms specified for as needed orders
- If labs, diagnostics, X-rays, etc. are ordered is the date to be completed documented

PARC Approved: 11/15/04
Revised: 07/21/08, 6/2023 Form #12/Admin

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
COMMUNITY SERVICES

Dental Appointment Information Record (DAIR)

Name: _____ **MCI:**_____ **Date of Visit:**_____

Hygiene: **Good** ☐ **Fair** ☐ **Poor** ☐

Comments:_____

Cancer Check: **Normal** ☐ **Abnormal** ☐

Comments:_____

SBE Prophylaxis: **Yes** ☐ **No** ☐
(Antibiotic prior to appointment)

Comments: _____

Recommended Frequency of Dental Visits: **3 months** ☐ **6 months** ☐ **Yearly** ☐

Other: _____

Dental Work Completed: _____

_____

_____

Home Care Instructions: _____

_____

Prescriptions/Treatments: _____

_____

Needed Follow-Up: _____

Next Appointment Date: _____

Comments: _____

_____

_____ _____

Signature **Date**

Print: **Name of Provider:**_____

Practice:_____

Address:_____

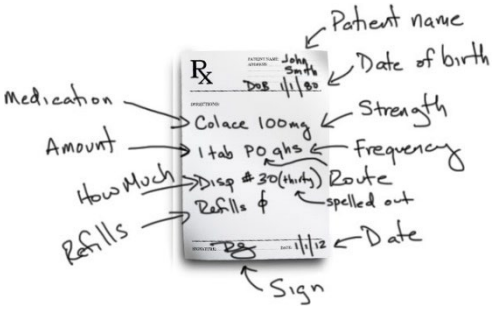
_____

Phone: _____ Revised 6/2023

Information to get from the healthcare provider:

- A written prescription/order for each new medication or treatment for the pharmacy. This may be sent electronically by the HCP to the pharmacy.
- A written order for each new medication or treatment for the **home**. This order must be signed by the healthcare provider. Orders written on the MAIR are acceptable. A signed electronic printout is also acceptable.
- BEFORE leaving the office review the electronic office note and all received paperwork to ensure you understand and have it clearly documented any medication changes, additions, discontinuations, needed follow-up, lab orders, diagnostic testing, and/or referrals. ASK QUESTIONS IF YOU DO NOT UNDERSTAND THE ORDER(S).
- Notify the nurse, pharmacist, or prescribing healthcare provider directly if needing assistance in obtaining documentation of the prescriber's orders.

The order may also be written on a prescription slip. However, each order must specify the following:



- Name of the individual
- Date ordered, including the year
- Name of the drug
- Dosage
- Route of administration
- Frequency, and duration of administration
- Healthcare Provider's signature (physical or electronic signature acceptable)
- Pre-test medication orders must specify the period of time of pre-test administration **(*e.g., one* hour *before EEG*)**
- If applicable for the individual, specific instructions in the order to crush the medication **(e.g., may crush and place in food)**

important

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 to the questions on the **MAIR** for both you and other staff. You will not remember this information once you leave the visit so write it down immediately as the health care provider shares it with you.

After the visit:

- Document any other information about the visit on the correct forms, which may include notes in the CDMS and agency communication logs.

- Obtain the medication from the pharmacy.

- Houses have 3 days to obtain medication from the pharmacy either by pick-up or via pharmacy delivery to the residence. If not electronically ordered, the order/prescription for medication **MUST** be sent to the pharmacy the day it is received. If after two days the medication is not received, there **MUST** be documentation in the electronic system noting why the delivery of the medication is delayed. Any communication with the pharmacy, healthcare provider, and/or consultative nurse regarding obtaining the medication **MUST** be documented in the CDMS, as well as what is being done in order to obtain the medication.

    - Medications are to be received from the pharmacy in a container with a pharmacy label.
    - Antibiotics, pain medications, EpiPen, and any other medication indicated by the healthcare provider **MUST** be obtained within 24 hours.
    - Medications **MUST** be dispensed in a way that is ready for consumption. **Medications may NOT be split, cut, or altered in any way by LLAM trained staff.**

  After medication is obtained from the pharmacy, all orders for medications/treatments must be IMMEDIATELY transcribed onto the **medication administration record (MAR)** or entered into the **Electronic Medication Administration Record (eMAR)** according to LLAM policy. Instructions on how to accurately and safely transcribe mediations onto the MAR will be discussed later on in the course.

- Medication information sheets which include the medication side effects are to be kept in the MAR. The eMAR has medication side effects loaded into the eMAR, accessed by clicking "Drug Details."

When medication is received, speak with the pharmacist, or follow your agency's policy to ensure you understand how medication is to be administered. Check the medication label to ensure it matches the healthcare provider's order. If it does not, RETURN medication to pharmacy.

Medication Refills

All orders from the healthcare provider are good for a maximum time of one (1) year. If medication label reads no refills, contact healthcare provider for further instructions.

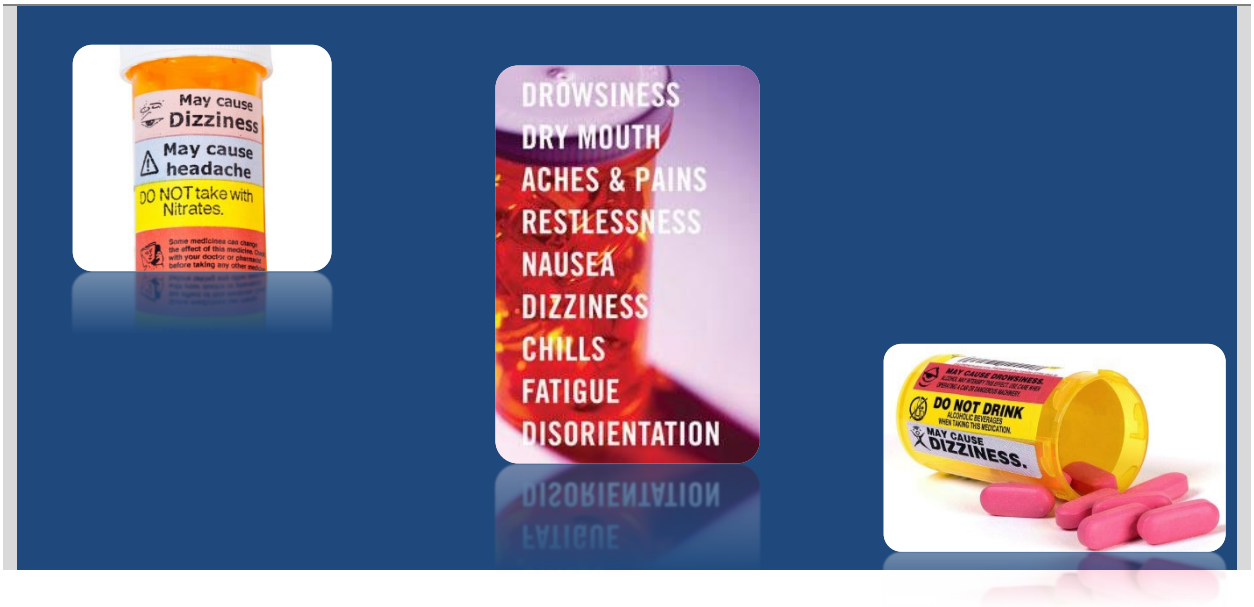
- Individual prescriptions will be re-ordered or "refilled" before the individual is out of the medication. Over-the-counter medications may be purchased but cannot be given without a practitioner's order.
- At a minimum, a 3-day supply of medications must be kept in the homes all times.
- When possible, use same pharmacy for all refills and new prescriptions.
- Orders for refills should be called in when there is no less than a 7-day supply of the medication remaining. The pharmacy will then complete the refill for the medication when indicated.

- The LLAM trained UAP only deals with the written order. ***The LLAM trained UAP may not receive a verbal or telephone orders.*** Orders may be faxed to the residence. A registered nurse may take a verbal order and transcribe it for the MAR/eMAR, in accordance with their license.

SECTION

2

MEDICATION FUNDAMENTALS



Responding to Medication

Medications are given with the purpose of bringing about a change in one or more systems in the body. When the medication goes into the body, by one of several routes, it begins to act on body processes either locally or systemically. It is absorbed, usually by the digestive system, distributed to the targeted areas, metabolized to produce the appropriate effect and then excreted through elimination.

The way a person responds to a medication depends on:

- **Age** — All drugs have standard doses that are considered safe for infants, children and adults.
- **Size** — A larger individual may require a larger dose than a smaller one.
- **Diet** — Certain foods can alter the desired effect of the medication. *(**i.e.,** grapefruit juice may inhibit effect of certain medications; some medications cannot be taken with milk products and some may require they be given with or without food for proper absorption or to avoid stomach upset)*
- **Sex** — Biological women may react more strongly to medication than biological men do. *(related to size and body fat)*
- **Genetic Factor** — Some people are more sensitive to medications because of the way they are made up.
- **Disease Processes** — Diseases can impair organs necessary for metabolism and excretion. *(**i.e.,** kidney failure, Liver Disease)*
- **Route of Administration** — Affects how quickly the medication is absorbed.
- **Time of Administration** — Some medications are ordered at mealtimes to avoid irritation on an empty stomach, others need a time when food is not in the stomach to absorb properly; some at bedtime because of the effect of drowsiness; and others in the morning for many reasons.

Crushing Medication

The legal obligation of a LLAM trained UAP is to stay within the legally defined role in the delivery of medication. When a determination is made that it would be appropriate to "crush medication" for the individual **a written HCP order must first be obtained.** There are no exceptions to this policy.

Healthcare Provider Order (HCP) is to:

- Identify specifically the medication that may be crushed.
- **No more than 1 ounce of food or fluid should be used unless otherwise specified by healthcare provider order.**

****IMPORTANT****
Do not place medication in a plastic bag and crush with an object. This is not safe, as the bag can be punctured, and it becomes difficult to assess medication loss when this occurs.

Precautions when Crushing Medication:

Crushing medication without a HCP order could lead to adverse reactions *(harm)* and even death to an individual ***(i.e.,*** *slow release, extended release, enteric coated medication).*

Crushing medication cannot be used to trick or deceive the individual into taking medication that they would otherwise refuse to take. Give crushed medication as soon as prepared.

When a medication is altered in any way from the way it is ordered, the legal implication should an adverse reaction happen would rest with you, not the HCP, pharmacist or drug manufacturer.

If the individual you support has swallowing difficulties, let the HCP know at the time the medication is being prescribed if possible, as alternate forms of the medication are frequently available.

Individuals MUST have their own labeled pill crushing device. Devices are NEVER to be shared amongst individuals. Use crusher according to manufacturer's recommendations. Clean crushers AFTER EACH USE according to agency policy.

important

Points to remember:

- PO (by mouth) meds can be crushed together unless contraindicated by the HCP or pharmacist *(as long as there is a written order for each medication to be crushed)*.

- Observe that all of medication is consumed. Never leave medication unattended.

Documentation:

- Make sure the written order to **"crush medication"** has been transcribed from label to MAR/eMAR *(special instructions)*.

- If medication is not completely consumed, it needs to be documented on the MAR/eMAR and in the CDMS.

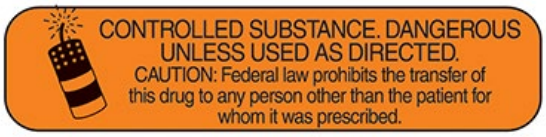
SECTION 2 - CONTROLLED SUBSTANCES

Controlled Substances

Controlled substances are drugs that are regulated by state and federal laws that aim to control the danger of addiction, abuse, physical and mental harm, the trafficking by illegal means, and the dangers from actions of those who have used the substances. Such drugs may be declared illegal for sale or use but may be dispensed under a physician's prescription. These medications are stored under double locks and must be inventoried and accounted for in compliance with federal and state laws, as well as facility policy.

Identifying Controlled Medications

1. Containers containing controlled substances must contain an accessory label as shown below.



Examples: Oxycodone, Xanax, Ritalin, etc.

2. Pharmacists dispensing controlled medication may provide information and necessary Controlled Medication Count Sheet to help with the accountability and documentation.
3. A pharmacy, agency or DDDS Controlled Medication Count Sheets may be used.

Storage and Security of Controlled Substances

1. Controlled Drugs must be kept under double lock and key. Utilizing lock boxes, locked money bags, locked filing cabinets, and locked cabinets.
2. One key must **NOT** operate both locks. Each lock **REQUIRES** different keys.
3. Keys are to be maintained in a secure location in the home.

Controlled Substance Count and Documentation

1. The medication administration record (MAR) or the eMAR is to be completed and signed each time the medication is administered.
2. Off going UAP staff must count controlled medication in the presence of the oncoming UAP staff at shift change when both staff are present. In the event that there is no oncoming/off going staff, staff present will perform the count. A count **MUST** occur between oncoming and off going staff within a minimum time frame of every 24 hours.
3. Controlled substance records (CSR) or count sheets, **MUST** be updated as medication is given. Counts are to be verified by the UAP when medication is administered. **Use one (1) count sheet per prescription of controlled medications.** These sheets should contain:
    - Name of the Individual
    - Prescription number
    - Name of medication

- Strength of medication
- Beginning quantity
- Quantity used
- End quantity

4. Count sheets should be kept onsite for a period of one year and stored along with the individual's MARs. Afterwards, all documentation should be sent to the office of Health Information Management for the DDDS.
5. If using the eMAR, the count will be recorded in the CDMS on the eMAR using the "Detail Mode" data entry function. Each staff will need to log-in the system to record the count.
6. Agencies **MUST** save the bubble packs if the nurse consultant requests it. Errors should be reported to the supervisor or administrator. Off going shift personnel are to remain until the error is resolved or staff is excused by the supervisor/administrator. Follow agency policy for medication error reporting and documentation.
7. For individuals who self-administer controlled substance medications-a count sheet must be maintained if staff have ANY interaction with the controlled substance, such as re-ordering meds or picking up refills from the pharmacy.

Count Discrepancy vs Diversion

A count discrepancy occurs when the number of a controlled substance medications is not matching with documentation of what should be present. This can happen if there is too much or too little present of the substance. **ALL** instances of a count discrepancy **MUST** be immediately reported to your supervisor, reported to DDDS through the Wellsky portal as a potential medication error, and a GER completed.

- Some count discrepancies are easily resolved such as incorrect addition/subtraction or a missed documentation of a medication administered or wasted. This **MUST** still be reported to your immediate supervisor so that the appropriate documentation and follow-up can occur.

Drug diversion is defined as any act or deviation that removes a prescription drug from its intended path from the manufacturer to the patient. Diversion (theft) of any medication is illegal and punishable under that law. Any and all instances of suspected diversion will be promptly reported to the Delaware State Police, reported to DDDS through the Wellsky portal as a potential medication error, and a GER completed. In addition, theft or diversion of controlled substances or other medications will be handled according to agency policy.

Disposal of Controlled Substances

ALL controlled medications, including suppositories and refused medications, are to be counted and double locked until disposed of by the nurse consultant and a LLAM trained UAP in kitty litter, used coffee grounds, bio-hazardous container, or as directed by FDA instructions. Document the date, time, quantity disposed, and disposal method on a count sheet and in the electronic medical record. Both the nurse and LLAM trained UAP are to sign the count sheet. Discarded medication containers must have all identifying information removed and destroyed prior to discarding.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF DEVELOPMENTAL DISABLITIES SERVICES
COMMUNITY SERVICES

Controlled Substance Count Sheet

Name:_____ **MCI #:**_____

Medication:_____ **Dosage:** _____

Prescription Number:_____ **Quantity Received:**_____

DATE	TIME	AMOUNT ON HAND	AMOUNT GIVEN	AMOUNT	SIGNATURE
					/
					/
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Off-going staff MUST count controlled medication in the presence of the on-coming staff at each shift change. In the event, there is no on-coming staff, the off-going staff will perform the count. However, the count will occur between on coming and off-going staff within a minimum time frame of every 24 hours.

6/2023

Counting Non-Controlled Loose Medications

All loose routine medications (**i.e.,** not in a blister pack) should be counted and documented as well. Medications in packaging that cannot be documented on must also 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 received from the pharmacy, and when the medication is administered to the individual. Counting loose medication does not require two people to count, but any discrepancy is reported to DDDS through the Wellsky portal as a potential medication error and a GER is generated.

Creams, gels, liquids, aerosols, etc. do not need to be counted. However, the medication does need to be monitored by supervisors and consultant nurses to ensure the medication is being administered appropriately (i.e., is the liquid amount decreasing over time as it is documented as being administered.) If it appears the medication is not being administered appropriately, it must be reported to DDDS through the Wellsky portal as a potential medication error and a GER is generated.

Medication Loss

A medication loss occurs any time medication is missing and cannot be accounted for. The medication loss must be documented on a General Event Report (GER) and reported to DDDS through the Wellsky portal as a potential medication error.

Disposal of Expired, Discolored, Damaged, or Inappropriately Labeled Medications

Medications bearing an expiration date should not be dispensed or distributed beyond the manufacture's expiration date. Expired, discolored, damaged, or inappropriately labeled medications should be disposed of per FDA guidelines and documented in a t-log in the CDMS and on the controlled substance record if applicable.

Strength vs Volume

There is a difference between **mg** and **ml**.

- ✓ The ***strength*** of a medication is measured in **mgs**.
- ✓ The ***volume*** of the medication is measured in **mls**.

Example: There is **20 mg** of medication in **5 ml** or **20 mg/5 ml**

If you are to give **10 ml** of this cough syrup how many **mg** would be given?

Oxygen

Oxygen is also and 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 oxygen.

Injectable Medications

- Individuals who are prescribed insulin must be independent with all aspects of the administration of the medication. The LLAM trained UAP may record the observed administration, but **CANNOT** assist with any other aspects of giving the medication. The UAP may assist with finger sticks to test blood sugar levels.

- LLAM regulations do not allow for the administration of any injectable medications with the exception of the EpiPen and glucagon following training from a LLAM trained nurse. DDDS allows only EpiPen injection in life saving emergencies.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
COMMUNITY SERVICES

Non-Controlled Medication Count Sheet

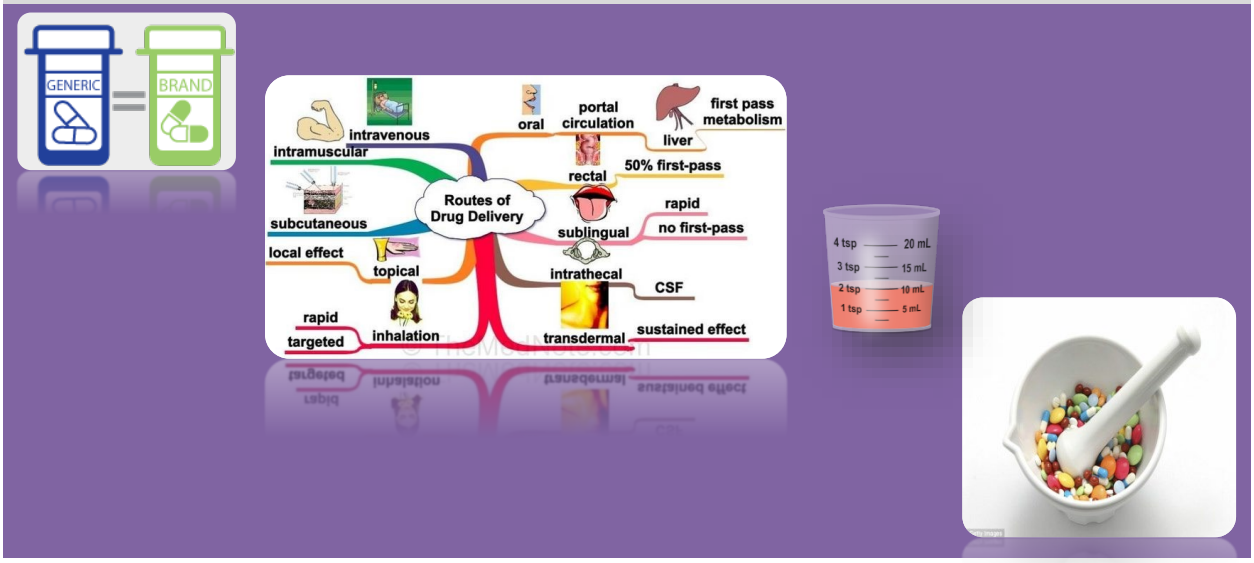
Name: _____ **MCI #:** _____
Medication: _____ **Dosage**: _____
Healthcare Provider: _____

DATE	TIME	AMOUNT ON HAND	AMOUNT GIVEN	AMOUNT REMAINING	SIGNATURE

SECTION

3

DAY PROGRAM MEDICATIONS



Day Program Medication Guidelines

- If an individual is in a day program and needs medication while there, the pharmacy must properly prepare and label the medications for this in addition to the home medications. A registered nurse can also re-label a medication label, in accordance with their license, but a properly labeled bottle/blister pack/tube, etc. from the pharmacy is preferred.

- The residence has the responsibility to deliver medication to the day program with a copy of the corresponding healthcare provider's order. Both the residence and the day program must keep documentation of the medication that they administer. For medications administered at the day program, a **medication information/side effect sheet** must be maintained at the day program, or available through the eMAR.

- The Day Program staff must notify the individual's residential staff when down to a seven (7) day supply of medication.

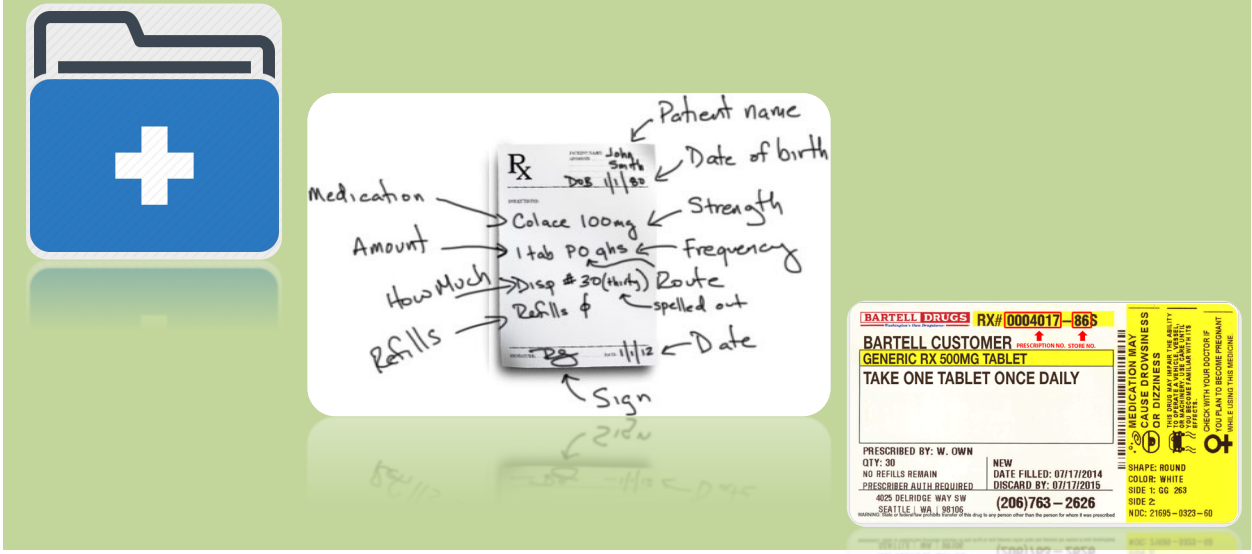
- The residence is responsible for notifying the day program as soon as possible of any medication changes and for supplying a copy of the order.

Medications for day programs must be prepared and put into pharmacy containers labeled by the pharmacy, prescribing practitioner or RN. LLAM trained UAP's are not permitted to create or alter medication labels.

SECTION

4

PREPARING TO ADMINISTER MEDICATIONS



ORDER, LABEL, AND MEDICATION ADMINISTRATION RECORD

When preparing to administer medications, the LLAM trained UAP, must ensure that the information contained on the healthcare provider's **order**, **pharmacy label**, and **medication administration record (MAR)/eMAR**, all match prior to administering the medication to the individual. Five (5) of the six rights of medication administration, the right individual, medication, dose, time, and route, originate from the healthcare provider's order. These five pieces of information, follow thru to the pharmacy, when they fill the prescription, and then to the medication administration record, when the order is transcribed. The sixth right, the right documentation, occurs when the LLAM trained UAP, initials the medication administration record showing that the medication has been administered.

1) **Order:** Must always be written by a healthcare provider who is registered with the state of Delaware to prescribe medication. Medication can never be given without an order.

2) **Label:** Once the order is received, the pharmacy then prepares and dispenses the medication in a container that is labeled. Medication can never be given without a label.

3) **Medication Administration Record (MAR):** All medications that are administered are recorded. This requires ensuring that the order and the label match exactly, and that the medication order is correctly transcribed on the MAR/eMAR.

Types of Orders

The information on the healthcare provider**'s order**, **pharmacy label**, and **medication administration record (MAR)/eMAR**, must **ALL MATCH BEFORE** you can administer the medication. Everything documented on the MAR/eMAR is the result of information received from the HCP order. For every medication, an HCP order is sent to the pharmacy, and a label is generated. Then the label is compared to the order for accuracy. The label information is then transcribed onto the MAR/eMAR or received into the eMAR from a pharmacy interface message. Once the MAR/eMAR has been reviewed for accuracy, you are ready to begin the process of medication administration. **All healthcare provider orders MUST be kept in the MAR book or attached to the eMAR using the "Medication Review" Module in the Health Tab.** There are three types of orders:

Types of Orders:

- Routine Order
- PRN Order **(As Needed)**
- OTC Order **(Over-the-Counter Order)**

Routine 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. Keep doses 4 hours apart. The order may or may not offer specific times but may use terms like AM, PM, BID/TID, or every eight hours. Specific **numerical times** for administration must be assigned when the medication is transcribed to the MAR.

Example: Accupril 5 mg by mouth 2 times per day

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

Medications may be given up to 60 minutes before or up to 60 minutes after the indicated time. Follow the directions on the label for exceptions, and/or contact the healthcare provider, pharmacy, or consultative nurse with questions. 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. Staff must pass written reminders to the next shift when medications are due at other than routine times. Individual preferences will be considered and outlined in plan of care.

Medications not given and documented on the MAR within the assigned time window (60 min before and 60 min after the assigned time) are considered medication errors.

a) When a medication has been missed and the incident is discovered after the 60-minute window the consultative nurse must be notified for guidance.

b) Notify the healthcare provider if the consultive nurse is unavailable or there is no consultative nurse assigned.
c) The incident must also be reported to the supervisor to ensure the proper documentation is completed.
d) The individual's responsible party is to be notified as per the agency's policy.
e) The error must be documented by completing a General Event Report (GER), entering the error into the Wellsky incident reporting portal, a T-log entered in the CDMS and including the error on the Monthly Medication Error Report for LLAM.

Medication is not to be given if outside the allotted 60- minute window without direction from the consultative nurse or HCP. The consultative nurse **may** direct the UAP to administer medication(s) outside the 60-minute window if the administration of the medication is still within the parameters of the HCP's order. The consultative nurse is responsible for ensuring the direction(s) he/she gives the UAP takes into consideration any medication contraindications, medication times, and any special instructions, i.e., take on an empty stomach. The consultative nurse shall document the directions given to the UAP in the T logs of the CDMS.

Example:

- Order: Zocor 40 mg once daily
- House time for daily: 8 am, can give from 7 am – 9 am
- At 9:15 am the UAP realizes they did not give the Zocor and calls the consultative nurse. The nurse can instruct the UAP to administer the medication as this is still within the parameters of the HCP's orders of once daily.
- This is still considered a medication error and must be documented as such.

a) The consultative nurse may also receive orders from the HCP and instruct staff regarding early, late, or totally missed medications. If the consultative nurse receives a verbal order, he/she shall document the order/instructions in the T-logs. The consultative nurse must obtain the written order within two (2) full business days and place in the individual's CDMS.

b) If any medication was missed, circle initials on the MAR and document on the back of the MAR and follow the documentation/reporting as outlined in (e.) above.

c) Missed medications are to be documented on the eMAR through the "Detail Mode" data entry function. The UAP selects "missed" in the "Record Type field", and then can enter comments in the Comments box. The box on the eMAR will turn red, indicating the med was missed and follow the documentation/reporting as outlined in (e.) above.

d) If a medication is missed due to a recurring commitment speak with the HCP about changing the medication time.

PRN Order (As Needed)

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. However, due to the population served in DDDS, some individuals may not be able to verbally request medication due to their level of comprehension/understanding. Instead, the individual may exhibit signs/symptoms

through behaviors which indicate medication should be received. Thus, **all PRN orders must clearly include target signs or symptoms, which the LLAM trained UAP can observe to know that the PRN medication is needed.**

Example: May give Motrin 400 mg by mouth every 6 hours PRN for earache, as indicated by pulling on ear, grimacing.

PRN Medication Guidelines

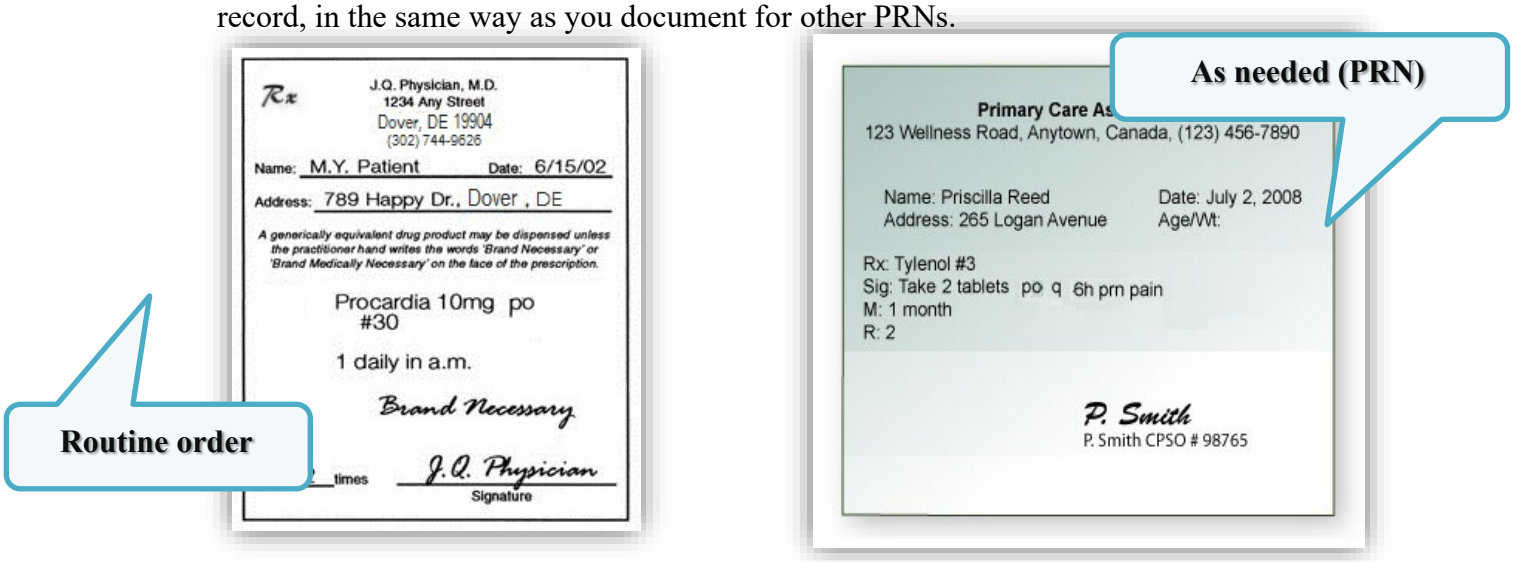
- ALL PRN medications require an HCP order, whether over the counter or prescription. For non-prescription medications, be sure to follow the maximum dosage per day on the package.
- The order must outline the exact amount to be administered. **Range orders such as 1-2 tablets, or every 4-6 hours are NOT acceptable.** The order must be exact.
- PRN medications will be in 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, or if the individual is in crisis, call 911.
- Frequent use of an emergency medication such as an asthma inhaler must be reported to the consultative nurse and/or the prescribing practitioner.
- PRN medication should be listed separately from routine medications on the MAR/eMAR.
- When administering PRN medication, you must sign and time the front of the MAR, document reason given and effectiveness/follow-up on the back of the MAR within 2 hours, and document in client data management system. When documenting in the eMAR for PRN administration, you must document the reason given and effectiveness/follow-up in "detail mode."
- The consultative nurse will review the MAR/eMAR for any PRN medications that have been administered during the health and medication audits. At this time the nurse will ensure the HCPs orders were followed and all required documentation completed.
- If the individual is not relieved by the medication and is **NOT** in **crisis**, **contact the consultative nurse and/or prescribing practitioner** for guidance.
- If the individual is not relieved by the medication and appears or states he/she is **in crisis**, **call 911**.

Over-the-Counter Order (OTC)

Over-the-Counter Medications Orders form are completed by the HCP for individuals in residential services. The HCP may change or add orders for over-the-counter medications to the OTC form. Guidelines for the OTC form completion are as follows:

- This form is updated at minimum 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, and 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/eMAR, and documentation occurs each time medication is administered. Documentation for OTC orders follow the same guidelines as prn documentation.
- Always check the OTC order with the MAR/eMAR before administering medication.
- A copy of the OTC form is kept in the MAR/eMAR. For the eMAR, attach using the "Medication Review" module in the Health Tab.
- When using OTC medication, you must document usage and effectiveness in the electronic record, in the same way as you document for other PRNs.



DELAWRE HEALTH AND SOCIAL SERVICES DIVISION
OF DEVELOPMENTAL DISABILITIES SERVICES
COMMUNITY SERVICES

OVER THE COUNTER MEDICATION ORDERS

Name: _____ **MCI Number:** _____

Drug Allergies: _____

ATTENTION STAFF: **Whenever you assist with any of the medications from this form, you must document on the MAR, and document usage and effectiveness in the Client Data Management System (CDMS).**

NON-EMERGENCY CONDITIONS: Non-Prescription Medications

1. HEADACHE OR MINOR ACHES AND PAINS:

Acetaminophen — Dose: Two 325 mg Tablets — Frequency: Every 4 hours as needed
Route: By Mouth

Seek medical attention if headache persists for 24 hours, if it occurs more than 3 times per week, or if it becomes intense, incapacitating, or no relief is obtained from the medication. Also, seek medical attention if body aches continue over 24 hours.

2. MENSTRUAL CRAMPS: (Females Only)

Ibuprofen — Dose: Two 200 mg Tablets — Frequency: Every 4 hours as needed
Route: By Mouth

3. TEMPERATURE ELEVATION:

Acetaminophen — Dose: Two 325 mg Tablets — Frequency: Every 4 hours as needed
Route: By Mouth

To be given when oral temperature is over 100° F or axillary or temporal temperature is over 99°F. Seek medical attention if fever persists over 24 hours or if it is accompanied by vomiting and / or diarrhea, increased coughing or congestion, headache, or abdominal pain that does not stop.

Seek medical attention sooner if an increased temperature / fever is accompanied by increased coughing, congestion, or difficulty breathing.

4. MINOR ABRASIONS OR CUTS:

Clean area with soap and water then apply Antibiotic ointment topically to the area. May cover with a bandage if needed. Apply twice a day until healed.

If affected area worsens (increased redness, drainage, warmth, swelling, etc.) during above treatment, seek further medical attention.

_____ _____

Prescribing Health Care Provider's Signature **Date**

Revised: 5/26/16, 6/2023

Medication Administration Record (MAR) (Inclusive of eMAR)

LLAM trained UAP staff are responsible to ensure that orders have been properly transcribed to the MAR, before administering the medication. **No medication may be administered until it has been transcribed onto the MAR.** This includes current medications, changes in orders, new medications, and over-the-counter medication orders. MARs are filled according to agency policy. They may be filed separately for each individual residing in the home. eMARs will be located within the CDMS.

Although the MAR can vary by agency, each MUST contain at least the following:

- Individuals name
- Date of Birth
- Allergy Status - "No Known Allergies" (NKA) if no allergies. **Do not leave blank.**
- Month & Year

Each individual medication transcribed to the MAR must include:

- Name of the medication (one medication per block)
- Specific dose to be given
- Frequency medication is to be given
- Route medication is to be given
- Numerical times medication is to be given
- Date the medication to **START**, if applicable
- Date the medication to **STOP**, if applicable
- Date medication transcribed to MAR
- Initial of LLAM trained UAP staff transcribing medication to MAR
- Special Instruction – **Example: Mix in 8oz liquid or crush and place in food**
- Signature verification by 2nd LLAM trained UAP staff within 24 hours of transcription to MAR (or CDMS verification by 2nd LLAM staff, if eMAR)

Example:

Tegretol 200mg PO daily

and

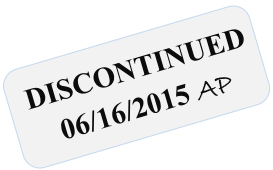
Tegretol100 mg daily at 1pm

Same medication with different dosages **REQUIRE** separate entries.

Documentation

- Document the administration of medications **AFTER** giving the ordered medication and within the 60 minute before/after indicated time window.
- Document if the individual refuses taking the medication after 3 attempts.
- Medication errors including omissions need to be documented.
- Document target symptoms for PRN/OTC medications in all required areas.
- Document effectiveness of PRN/OTC medications in all required areas.
- Date and Initial next to each blister of medication dose punched.
- If MAR was not initialed always check the blister card to ensure that day's dose was not punched.
- Document start date on **ALL** medication when first opened.

MAR Documentation

KEY	MEANING
Your Initials 	Are written in the indicated box/square under the correct day and time you administered the medication. Ensure signature key completed each month.
Medication Refusal or Missed 	**Medication refusals and a medication not given for any reason are documented by circling your initials.** A subsequent explanation on the back on the MAR is required explaining reason for circled initials.
V = ***Vacation*** 	This code is to be used anytime that an individual is scheduled to be away from their primary residence. 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 that the medication is not due/given. **It is not used for refusals.** For routine medications not given, ensure explanation is given on back of MAR.
Discontinued Medications 	To discontinue a medication, use a yellow highlighter and highlight the **whole entry** from left to write, top to bottom. Then write across the indicated order that the medication is **DISCONTINUED** with the date it was discontinued and your initials.

eMAR

After you have selected the appropriate Program and Individual from the lists, the eMAR of the Individual for that month will be displayed. You may either record data in "Quick Mode" or "Detail Mode" on the eMAR.

Quick Mode

To enter data in "Quick Mode" click on the appropriate cell that corresponds to the relevant scheduled time. For Scheduled Medications, the cells of the time schedules for when the medication is to be administered appears GREEN. By clicking the cell, the scheduled time is automatically set as the "Serving Time", and the current user is entered in the "Administered By" field. Simply click on the GREEN box and it will register that you administered this medication at this date and time. The "Time Slots" for medications/treatments that are not active for that particular time period will appear GRAY. An error message will appear if the user tries to record data.

Detail Mode

Using the "Detail Mode", a user can enter additional details about each eMAR entry. Click on the blue "Switch to Detail Mode" link at the top right corner of the eMAR. To record data in "Detail Mode" click on the appropriate cell that corresponds to the relevant scheduled time for the medication. This will open the "Detail Data" pop up window. Record Type can be entered as "**Missed**", "**Refused**", "**LOA**", "**On Hold**", "**Deleted**", and "**Administered**". Other details such as "Administered Date", "Administered Time", "Administered By", and "Comments" can be entered. Click the "Save" button to save the entry.

SECTION 4 – 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 Limited Lay Administration of Medication (LLAM) trained Unlicensed Assistive Personnel (UAP).

A medication error occurs specifically when there is failure for the ***right individual*** to receive the ***right medication*** of the ***right dose*** at the ***right time*** or the ***right route***, and/or omission of prescribed medication(s), inaccurate transcription, administering expired medication, unavailable medication due to staff neglecting to reorder, or by an incident of diversion of medication *(theft)*.

A medication error may fall under multiple medication error categories. In this instance, the medication error should be evaluated to determine what initially caused the error. For example: the UAP gave Suzie a med cup with Johnny's medications in it. This mistake could be considered wrong individual, wrong medication, wrong dose, wrong time, etc. But for documentation and reporting the medication error, it should be categorized as wrong individual, because that was the *primary mistake*.* It would be counted as (1) one medication error.**

However, a UAP can also make multiple medication errors during the same medication pass. For example: Lonnie is prescribed 50mg of Trazodone in the AM and 100mg of Trazodone in the PM. Lonnie is also prescribed calamine lotion to be applied to the rash on her foot every morning. The UAP accidentally gave Lonnie 100mg of Trazodone at 8AM and also forgot to put the calamine lotion on her foot at 8AM. This is (2) two separate medication errors because two separate mistakes were made. The Trazodone would be categorized as wrong time, because even though it was also the wrong dose, the amount given was prescribed to Lonnie but not for the time it was given. The neglected calamine lotion application would be categorized as omission. These would be counted as (2) two medication errors.

Wrong Individual:

- If an individual receives medication(s) that was prescribed for another individual in the home. If one or more medication(s) was given to (1) one wrong individual during a single medication pass, *the entire event for that individual would be considered (1) one medication incident/error*. A GER, T-log, and a Wellsky report would be completed for the individual describing the event and all medications that were given in error.
- If more than one individual was given the wrong medications, *each wrong individual would be considered (1) one medication incident/error*. A GER, T-log, and a Wellsky report would be completed for *each* individual describing the event and all medications that were given in error.

Wrong Medication:

- If an individual receives medication that was not prescribed to them (such as an Over-the-Counter/OTC medication that has not been prescribed for that individual) or has been discontinued. *Each* wrong medication that was given would be *considered (1) one medication incident/error*. A GER, T-log, and a Wellsky report would be completed for the individual listing all incorrect medication administered.

Wrong Dose:

- If an individual receives an incorrect dose of a medication prescribed to them. *Each* wrong dose of a medication would be *considered (1) one medication incident/error*. A GER, T-log, and a Wellsky report would be completed for the individual listing all medications given in the wrong dosage, and what dosage was given.

Wrong Time:

- If an individual receives his/her medications outside the 60-minute window (prior or post) of the prescribed medication time. *The entire event would be considered (1) one medication incident/error*. A GER, T-log, and a Wellsky report would be completed for the individual describing the event and all medications that were given in error.
- If medications were given outside the 60-minute window (prior or post) to multiple individuals during a single medication pass, *each* individual who did not receive medications would be *considered (1) one medication incident/error*. A GER, T-log, and a Wellsky report would be completed for *each* individual who did not receive prescribed medications.

Wrong Route:

- If an individual receives a medication by a route that does not match the prescribed route. *Each* medication given by the wrong route would be *considered (1) one medication incident/error*. A GER, T-log, and a Wellsky report would be completed for the individual listing all medications given by the incorrect route and describing how the medication was the incorrectly administered.

Wrong Documentation:

- If a staff does not document on the medication administration record (MAR/eMAR) immediately after the administration/within the 60-minute window (prior or post) of the assigned time of an individual's medication. If more than one medication was not initialed during a single medication pass, *the entire event would be considered (1) one medication incident/error*. A GER, T-log, and a Wellsky report would be completed for the individual describing the event and all medications that were not documented.
- If medications were not documented for multiple individuals during a single medication pass, *each* individual who did not receive medications would be *considered (1) one medication*

incident/error. A GER, T-log, and a Wellsky report would be completed for *each* individual who did not receive prescribed medications.

Omission:

- Not giving medication(s) that was prescribed for the individual at all. If one or more medication(s) was not given to (1) one individual during a single medication pass, *the entire event would be considered (1) one medication incident/error*. A GER, T-log, and a Wellsky report would be completed for the individual describing the event and all medications that were not administered.
- If medications were not given to multiple individuals during a single medication pass, *each* individual who did not receive medications would be *considered (1) one medication incident/error*. A GER, T-log, and a Wellsky report would be completed for *each* individual who did not receive prescribed medications.

Transcription Error:

- When a staff transfers the information from a pharmacy label to the MAR/eMAR incorrectly. *Each* medication transcribed incorrectly to the MAR/eMAR would be considered (1) one medication incident/error. A GER, T-log, and a Wellsky report would be completed for the individual listing all medication transcribed incorrectly.

Diversion (Theft):

- Diversion (theft) of medication, including diversion of controlled substances. *Each* medication that cannot be accounted for would be considered (1) one medication incident/error. A GER, T-log, and a Wellsky report would be completed for the individual listing all medication missing/stolen. In addition, theft or diversion of controlled substances or other medications will be handled according to DDDS/agency policy.

Administering Expired Medication:

- When a staff administers a prescribed medication to the right service recipient, at the right time, right dose, etc, but the medication has expired. *Each* expired medication administered would be considered (1) one medication incident/error. A GER, T-log, and a Wellsky report would be completed for the individual listing all medications that were given after expiration.

Unavailability of a Prescribed Medication:

If a prescribed medication is not available to administer due to the staff not reordering in a timely manner (when 7 days of medication remains). *Each* medication that is not available for administration would be *considered (1) one medication incident/error*. A GER, T-log, and a Wellsky report would be completed for the individual listing all medication that was not available. See exception below.

Incidents NOT considered a Medication Error:

- Medication dropped on the floor. Proper documentation and disposal are required.
- Individual refuses medication(s). Proper documentation is required.
- Medication not available to administer due to being unavailable from the pharmacy/manufacturer. Proper documentation is required.

**When in doubt about how to categorize a medication error, use your best judgement and report it. Categorization mistakes will be corrected.*

*** The DDDS Office of Incident Resolution (OIR, PM #46) may substantiate a medication error under multiple categories and still consider it one medication error.*

SECTION

5

SKILLS

Refer to skill # 1
Hand Hygiene Medication Administration Competency Skills Checklist

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 or an alcohol-based sanitizer (*waterless antiseptic product)* to clean hands. 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 preparing food.
- 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.
- Lather hands for at least 20 seconds (long enough to sing "Happy Birthday" 2x)

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 prepares food and/or 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.
- Lather hands for at least 20 seconds (long enough to sing "Happy Birthday" 2x)

****Important****
When an individual displays hand to mouth behavior, alcohol-based hand sanitizers/wipes shall NOT be used. Hand hygiene using soap and water must be completed.

Other aspects of hand care and protection:

Glove Use:

- Gloves are to be worn when there is potential for contact with blood or body fluids.
- Gloves will be used in addition to, not a substitute for, hand washing.
- Hand hygiene is always performed after removing gloves.
- 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 sensitive to Latex or other 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.

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

Skill # 1

Hand Hygiene Medication Administration Competency Skills Checklist

STAFF NAME: _____ **DATE:** _____

OBSERVED BY: _____

SKILL	SATISFACTORY	NOT SATISFACTORY	COMMENTS
1. Stand so clothes do not touch sink.			
2. Turn on the water and adjust temperature. Leave the water running.			
3. Wet wrists and hands. At all times keep the level of the hands lower than the elbow.			
4. Apply soap or cleaning agent to hands.			
5. Wash both hands and wrists using friction for at least 20-30 seconds or one minute if soiled with blood or bodily fluids. Pay special attention to knuckles, sides/between fingers, and under the nails.			
6. Rinse both hands and wrists properly under running water with fingertips pointing down. Leave water running.			
7. Dry hands with paper towel(s) and discard or use air dryer.			
8. Use clean paper towel to turn off faucet and discard.			
9. Completed task without contaminating hands, such as by not touching sink or paper towel holder after washing.			

Skills were observed and completed accurately: (CIRCLE) **YES** **NO**

SIGNATURE OF OBSERVER: _____ **DATE:** _____

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

Limited Lay Administration of Medications (LLAM)

Skill # 2

Medication Administration Competency Skills Checklist

STAFF NAME: _____ **DATE:** _____

OBSERVED BY: _____

SKILL	SATISFACTORY	NOT SATISFACTORY	COMMENTS
1. New medication orders are reviewed and transcribed carefully to the Medication Administration Record and checked to ensure accuracy per agency protocol.			
2. Complete hand hygiene.			
3. Gather supplies.			
4. Review the MAR for medication(s) due (name, dosage, purpose and possible side effects) and allergy status.			
5. Identify **right individual** according to agency policy.			
6. Explain procedure to the individual.			
7. Prompt/assist the individual to complete hand hygiene.			
8. Provide for privacy.			
9. Prepare adequate fluids/food for medication administration.			
10. At the **right time,** unlock storage area, obtain the **right medication**, and compare the prescription label to the MAR to make sure they match. Check expiration dates (**First Check**).			
11. Before pouring or removing medication from the package, check the prescription label against the medication order to make sure they match (**Second Check**).			
12. If prescription label, medication order and MAR do not agree, **STOP** and notify Supervisor. Do not give medication until problem is resolved.			

SKILL	SATISFACTORY	NOT SATISFACTORY	COMMENTS
13. Prepare the medication. Do not touch medications with hands. Initial and date blister card.			
14. After preparing the medication but before administering, compare the pharmacy label to the MAR again to make sure they match (**Third Check**).			
15. Crush oral medications **only** with direction received in prescribing practitioner's order. Notify prescribing practitioner if individual cannot swallow medication as ordered.			
16. Measure liquid with appropriate measuring device and read the amount of medication in container on a flat surface at eye level. Wipe the rim of bottle with clean paper towel after pouring. Stop if unsure about the measurement and notify Supervisor.			
17. Assist individual to an upright position to prevent choking.			
18. Administer the medication using 5 of the 6 rights (**right individual, right medication, right dose, right route, and right time)** one hour before to one hour after scheduled time.			
19. Observe the individual taking the medication. Never leave individual during administration. Medication is never left unattended.			
20. Document medication administration on MAR. (**6th right**).			
21. Return and lock medications in designated storage area.			
22. Complete hand hygiene.			
23. State who to contact for medication questions.			
24. Describe process to follow for medication error reporting.			
25. State 6 rights of medication administration.			

Skills were observed and completed accurately: **YES** **NO**

SIGNATURE OF OBSERVER: _____ **DATE:** _____

4/2023

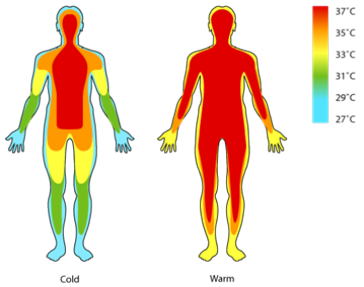
Vital Signs

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. Whenever an individual's vital signs are taken in the home or day program, they should be documented on the MAR/eMAR.

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. **Rectal temperatures in adults should only be taken with an order to do so.**



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 or has a sore mouth
- Is unconscious
- Has had surgery or an injury to the face, neck, mouth, or nose
- Is receiving Oxygen

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

- Has ear drainage
- Has an ear disorder

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. 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.

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. **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. Biologicaly women usually have lower blood pressures than biological men do but blood pressures rise in women after menopause.

Points to remember:

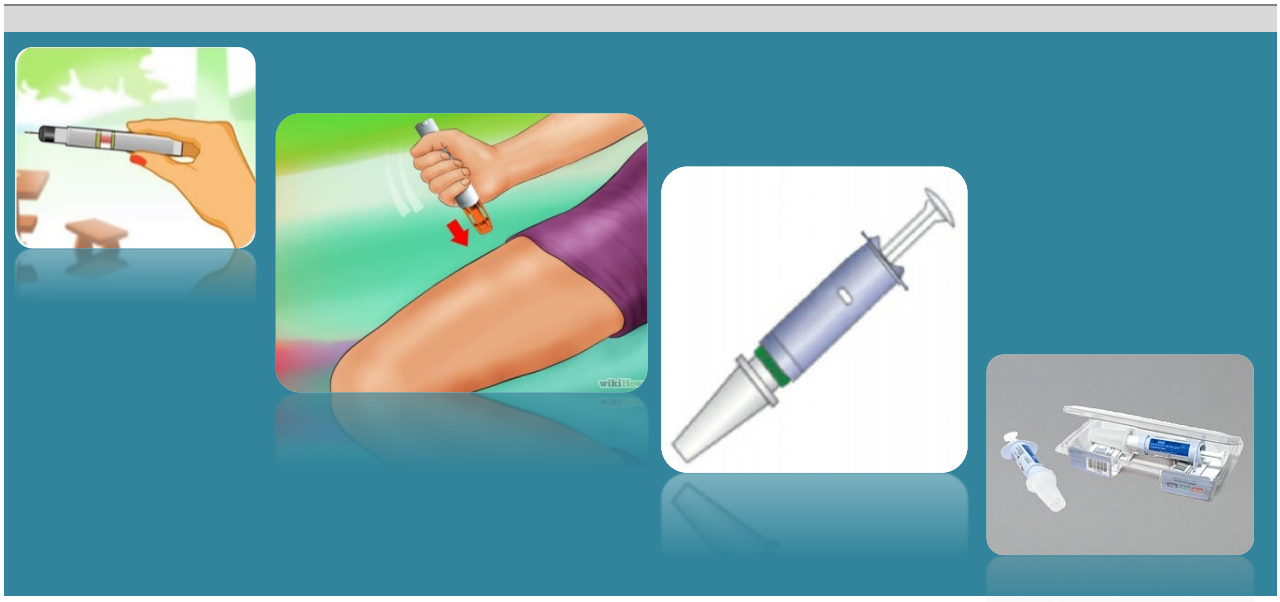
- Ensure blood pressure cuff size is appropriate. Cuff should be snug and not loose fitting
- Apply the cuff to a bare arm or wrist, clothing can affect the measurement
- Do not take pressure in an arm that has a cast or other injury or a dialysis access site

Do not take blood pressure on the side of breast surgery, lymph node removal, or stroke

SECTION

6

ADMINISTERING EMERGENCY MEDICATIONS



SECTION 6- ADMINISTERING EMERGENCY MEDICATIONS

Allergy Status

ALLERGY

When you are reading the medical record, be certain that you note the "allergy status" of the individual you are caring for. It is critical that you are aware of whether the individual has any allergies before you give medication. Check the individual's allergy status each time you go to give medication. Giving medication to an individual who is allergic to the medication can cause serious injury or even death. The allergy status of the individual must be documented on the MAR as well.

All changes in an individual should be noted and communicated both verbally (during shift change report), and in the medical record. Signs of illness should be reported to your supervisor immediately, and, if advised, to the individual's health care provider. If you have any questions about the condition or behavior of the individual you care for, get help, either by reporting to your supervisor or by calling 911. You will probably be the first person to observe change in the individual you care for; this is why your job is so important to the safety and well-being of those you serve.

EpiPen Auto-Injector

- 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.
- Epinephrine is prescribed as an emergency injection for an individual experiencing a life- threatening allergic reaction.
- The LLAM trained UAP may administer epinephrine to an individual in an allergic crisis by administering an epinephrine IM injection (auto-injector or Epi-Pen).

Symptoms Include:

Skin
- Rash
- Itching
- Hives
- Redness
- Swelling

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

Throat
- Itching
- Tightness/closure
- Coughing
- Hoarseness

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

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

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

Stomach
- Vomiting
- Nausea
- Diarrhea
- Cramps

Severe reactions can happen anytime, anywhere.
Know the 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/eMAR at the start of the shift
- ☑ Know Emergency Contact Information
- ☑ Know medications currently being taken
- ☑ Know 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:

- DIAL 911
- Notify First Responders of time Epinephrine was administered.
- The remaining liquid that is left after this fixed dose cannot be further administered and should be discarded.
- Expired/used auto-injector should be placed in red, biohazardous sharps container, taken to healthcare provider's office, pharmacy, or hospital, or given to the First Responders for proper disposal. **Do not throw away in regular trash.**
- Notify the supervisor and consultative nurse as soon as possible after administration.
- Document administration and time on the MAR/eMAR and enter a T-log in the client data management system.

➢ Reorder:

- Epinephrine Auto-Injector before the expiration date on the label and after use.

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

Diastat Rectal Gel, Valtoco Nasal Spray and Nayzilam Nasal Spray

Seizure rescue medications are medications prescribed to stop prolonged seizures and clusters of increased seizure activity. They are packaged as a one-time delivery system. Diastat is a medication that comes in a pre-packaged rectal delivery system and Valtoco and Nayzilam are medications that come in a pre-packaged nasal delivery system. They work much more quickly than oral medications and are much easier to give than IV medications. They have been shown to begin having an effect in as little as 5-15 minutes. Diastat, Valtoco, and Nayzilam are intended and approved for use in emergency situations by the LLAM trained UAP.

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

Responsibilities of Caregivers when Seizure Rescue Medications are ordered.

- Staff members who accompany the individual to medical appointments must take with them a copy of the Seizure Rescue Medication Order Form.
- Ask the healthcare provider to review the Seizure Rescue Medication Order Form with you.
- A copy of the Seizure Rescue Medication Order Form is then faxed or emailed 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 the Consultative Nurse. At the time of the training the nurse will review and verify the Healthcare Providers orders, medications received from the pharmacy and the transcribed orders on the MARs/eMARs. He/she will also be available for questions or technical support if needed.
- Only staff trained in LLAM may administer a seizure rescue medication.

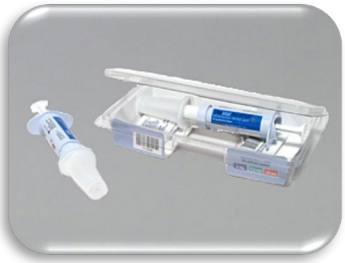
Responsibilities of the Agency when a Seizure Rescue Medication is ordered.

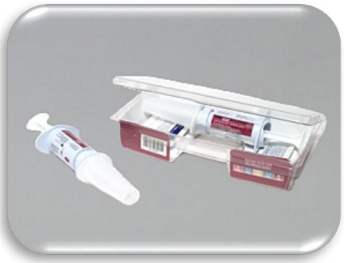
- To ensure that program supervisors collaborate with the prescriber for clear guidelines on when to call a physician when a seizure rescue medication has been administered. Program supervisors are to verbally inform the consultative nurse, and other provider agencies that a dose of a seizure rescue medication has been given to an individual.
- To monitor adherence to the instructions on the Seizure Rescue Medication Order Form.
- To ensure the UAP documents administration of the seizure rescue medication onto the MAR/eMAR, in the electronic client data management system record as a T-log, and in the communication book. This includes a description of the seizure, length of seizure, time and dose of seizure rescue medication given, and the response of the individual to the medication and side effects noted. The medication, because it is a controlled substance must also be documented on the controlled substance count sheet. Additionally, the Seizure Module in the electronic client data management system should be completed each time a individual has a documented seizure.

- The supervising house manager will check the seizure rescue medication when it comes from the pharmacy:
  - ☑ Remove the medication from the container.
  - ☑ Confirm the dose matches that written by the prescriber on the Seizure Rescue Medication Order Form. Do this for each medication container.
  - ☑ For Diastat, confirm that the green **"READY"** band is visible. Do this for each of the syringes.
  - ☑ Return medication(s) to their container.
  - ☑ The Consultative Nurse will review these items when he/she performs his/her on-site training session and during his/her Medication and Health Audit.

Preparing To Administer

Seizure Rescue Medications by the LLAM Trained UAP:





➢ *Identify the right individual*

- The individual must have an order for the seizure rescue medication on the medication administration record.
- Read the prescription label.
- Explain the Procedure to the individual.

➢ *Identify the medication*

- Review Healthcare Provider's order prior to each shift and compare with label and MAR/eMAR
- Make sure medication has been stored appropriately
- Make sure medication is not expired
- Remove medication from package
- Confirm that prescribed dose is correct.
- For Diastat:
    - Ensure the Green "Ready" band is visible
- For Valtoco:
    - Do Not Test or Prime nasal spray device

- For 5 mg and 10 mg doses there is one nasal spray device for administration into one nostril.
- For 15 and 20 mg doses there are TWO nasal spray devices. One nasal spray device is to be administered into each nostril to give the full dose of Valtoco.

◈ 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
3) Gently place individual on his/her side 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) Dispose of medication syringe after use:
    - Diastat is disposed of in the setting it was used by the consultative nurse and a LLAM trained UAP. Documentation is completed on the Controlled Substance Record and a t-log is completed.
    - 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.

Administration of Valtoco Nasal Spray by the LLAM trained UAP

1. Begin timing seizure
2. Open the blister pack by peeling back the corner tab with the arrow. Remove the nasal spray device from the blister pack.
3. Place the individual on his/her side facing you.
4. Hold the nasal spray device with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle. DO NOT PRESS PLUNGER YET. If you press the plunger now you will lose the medicine.

5. Insert the tip of the nozzle into 1 nostril until your fingers, on either side of the nozzle, are against the bottom of the nose.
6. Press the bottom of the plunger firmly with your thumb to give VALTOCO. The individual does not need to breathe deeply when VALTOCO is given.
7. Remove the nasal spray device from the nose after giving VALTOCO.
8. Dispose of the nasal spray device and packaging after use.

Administration of Nayzilam Nasal Spray by the LLAM trained UAP

1. Begin timing seizure.
2. Peel open the blister packaging. On the foil backing, find the "Peel Here" tab and pull down. Remove the nasal spray unit carefully.
3. Place the individual on his/her side facing you.
4. Hold the nasal spray unit with your thumb on the plunger and your middle and index fingers on each side of the nozzle. DO NOT PRESS PLUNGER YET. If you press the plunger now, you will lose the dose.
5. Insert the tip of the nozzle into 1 nostril until your finger, on either side of the nozzle, are against the bottom of the nose.
6. Press the bottom of the plunger firmly with you thumb to deliver the dose of Nayzilam. The individual does not need to breathe deeply when Nayzilam is given.
7. Remove the nozzle from the nostril after giving the Nayzilam.
8. Dispose of the nasal spray unit and packaging.

After Giving a Seizure Rescue Medication Call 911 if:

1. If seizure continues after giving rescue medication longer than indicated on the individual's Seizure Rescue Medication Order Form by the health care provider.
2. If a seizure rescue medication is needed more times in the indicated number of hours as outlined on the individual's Seizure Rescue Medication Order Form by the healthcare provider.
3. The individual has injured themselves.
4. Changes in the skin color
5. Excessive sleepiness
6. Seizure behavior is different from other episodes
7. There is an increase in the length, frequency or severity of the seizure(s).
8. The individual has any difficulty in breathing (shallow, slowed, and/or stops breathing) or appears to be in distress.
9. There is any change in the level of consciousness.

Special Consideration:

- Visually monitor the individual for at least four hours after he/she has received a seizure rescue medication. The individual will more than likely be very tired following the seizure. Do not send to Day program that day. Encourage rest.

- Sometimes a second dose of a seizure rescue medication maybe ordered. Read and follow the healthcare provider's order.

- Remember to reorder when a seizure rescue medication is used.

Documentation:

The UAP must document administration of the seizure rescue medication onto the MAR/eMAR, in the electronic client data management system record in a T-log, and in the communication book. The medication, because it is a controlled substance will also be documented on the controlled substance count sheet. Additionally, the Seizure Module in the electronic client data management system should be completed each time an individual has a documented seizure.

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

The most common side effects of Seizure Rescue Medications (benzodiazepines) include:

- **Shakiness**
- **Unsteady gait**
- **Trembling**
- **Dizziness**
- **Drowsiness/Sleepiness**
- **Poor muscles control or coordination**
- **Headache**
- **Nasal Discomfort**

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

Division of Developmental Disabilities Services
Community Services
Seizure Rescue Medication Order Form

Name: _____ Date: _____
Date of Birth: _____ MCI Number: _____

When to call 911:

- Seizure continues _____ minutes after giving rescue medication
- Rescue medication is needed more than _____ in ___ hours (24, 48, 72) (**Circle One**)
- Other care needed: _____ _____
- Seizure in water
- The seizure behavior is different from other episodes (frequency/severity)
- Difficulty breathing; change in skin color
- Serious injury occurs or suspected

Seizure Type	What Happens	How Long it Lasts	How Often

Seizure Rescue Medication(s) Order: (List in order of Administration)

Medication Name	Dosage	Route	Administer After (cluster, # or length)

(Should be the same as on the prescription)

After Rescue Medication you MUST:

- Stay with the person
- Make note and document the following
  - Changes in breathing rate
  - Changes in skin color
  - Drowsiness that exceeds beyond the 4-hour period of observation
- Other things to monitor: _____

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

- Seizure frequency or severity is different from other episodes
- If you have given a dose of rescue medication
- Other reasons to call: _____

_____ _____
Healthcare Provider Signature **Date**

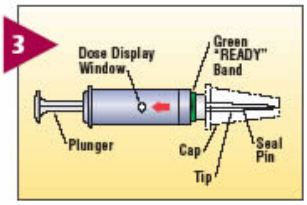
Form must be reviewed at each appointment and rewritten within a 1-year period.
Form must be attached to the Risk Section of the Person-Centered Plan and Documented on the Significant Medical Conditions and Medical Alert form.

How to Administer and Disposal DIASTAT® AcuDial™

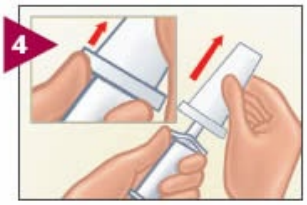
(diazepam rectal gel)

Put person on their side where they can't fall.

Get medicine.

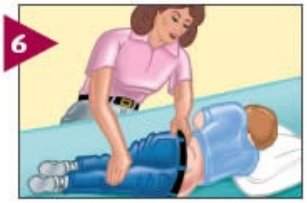


Get syringe.
Note: Seal Pin is attached to the cap.

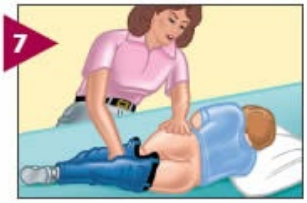


Push up with thumb and pull to remove cap from syringe. **Be sure Seal Pin is removed with the cap.**

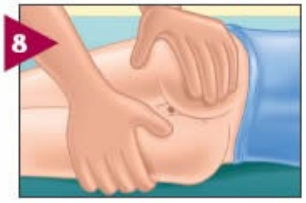
Lubricate rectal tip with lubricating jelly.



Turn person on side facing you.

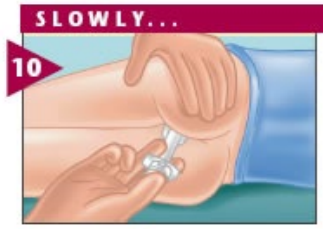


Bend upper leg forward to expose rectum.



Separate buttocks to expose rectum.

Gently insert syringe tip into rectum.
Note: Rim should be snug against rectal opening.

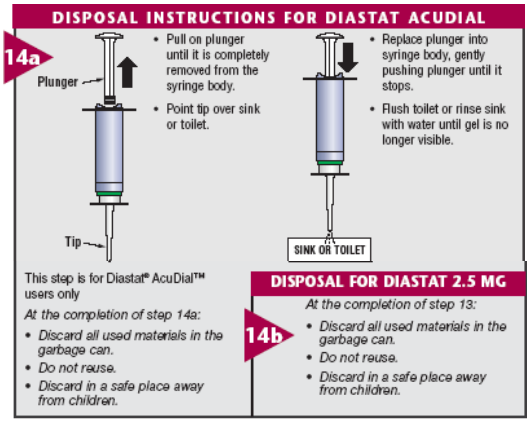


Slowly count to 3 while gently pushing plunger in until it stops.

Slowly count to 3 before removing syringe from rectum.

Slowly count to 3 while holding buttocks together to prevent leakage.

Keep person on side facing you, note time given and continue to observe.



Call for Help if any of the Following Occur	
Seizure(s) continues 15 minutes after giving DIASTAT or per the doctor's instructions: _____ • Seizure behavior is different from other episodes • You are alarmed by the frequency or severity of the seizure(s) • You are alarmed by the color or breathing of the person • The person is having unusual or serious problems	**Local emergency number:** _____ *(please be sure to note if your area has 911)* **Doctor's number:** _____ **Information for emergency squad:** *Time DIASTAT given:* _____ *Dose:*

INSTRUCTIONS FOR USE

For 5 mg and 10 mg Doses

VALTOCO® (diazepam nasal spray) CV

You, your family members, caregivers, and others who may need to give VALTOCO should read these Instructions for Use before using it. Talk to your healthcare provider if you, your caregiver, or others who may need to give VALTOCO have any questions about the use of VALTOCO.

Important: For Nasal Use Only.

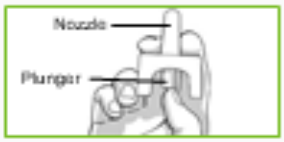
Do not test or prime the nasal spray device. Each device sprays one time only.
Do not use past the expiration date printed on box and blister pack.
Do not open blister pack until ready to use.

Each blister pack contains
1 nasal spray device.
1 dose = 1 nasal spray device.

To give VALTOCO nasal spray:

Step 1: **Open the blister pack** by peeling back the corner tab with the arrow.

Remove the nasal spray device from the blister pack.



Step 2: **Hold the nasal spray device** with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle.

Do not press the plunger yet. If you press the plunger now, you will lose the medicine.

Step 3: **Insert the tip of the nozzle into 1 nostril** until your fingers, on either side of the nozzle, are against the bottom of the nose.

Step 4: **Press the bottom of the plunger firmly** with your thumb to give VALTOCO. The person does not need to breathe deeply when VALTOCO is given.

Remove the nasal spray device from the nose after giving VALTOCO.

After giving VALTOCO nasal spray:

Throw away (discard) the nasal spray device and the blister pack after use.

Call for emergency help if any of the following happen:

- Seizure behavior in the person is different from that of other episodes.
- You are alarmed by how often the seizures happen, by how severe the seizure is, by how long the seizure lasts, or by the color or breathing of the person.

Make a note of the time VALTOCO was given and continue to watch the person closely.

Time of first VALTOCO dose: _____ Time of second VALTOCO dose (if given): _____

The healthcare provider may prescribe another dose of VALTOCO to be given at least 4 hours after the first dose. If a second dose is needed, repeat Steps 1 through 4 with a new blister pack of VALTOCO.

For more information about VALTOCO, visit www.valtoco.com or call 1-866-696-3873. Report side effects of prescription drugs to the FDA by visiting www.fda.gov/medwatch or by calling 1-800-FDA-1088.

These Instructions for Use have been approved by the U.S. Food and Drug Administration. Issued: 02/2022

NEURELIS

INSTRUCTIONS FOR USE

For 15 mg and 20 mg Doses

VALTOCO® (diazepam nasal spray) CV

You, your family members, caregivers, and others who may need to give VALTOCO should read these Instructions for Use before using it. Talk to your healthcare provider if you, your caregiver, or others who may need to give VALTOCO have any questions about the use of VALTOCO.

Important: For Nasal Use Only.

Do not test or prime the nasal spray devices. Each device sprays one time only.
Do not use past the expiration date printed on box and blister pack.
Do not open blister pack until ready to use.

Each blister pack contains
2 nasal spray devices.
1 dose = 2 nasal spray devices.

To give VALTOCO nasal spray:

Step 1: **Open the blister pack** by peeling back the corner tab with the arrow.

Remove the first nasal spray device from the blister pack.

Step 2: **Hold the nasal spray device** with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle.

Do not press the plunger yet. If you press the plunger now, you will lose the medicine.

Step 3: **Insert the tip of the nozzle into 1 nostril** until your fingers, on either side of the nozzle, are against the bottom of the nose.

Step 4: **Press the bottom of the plunger firmly** with your thumb to give VALTOCO. The person does not need to breathe deeply when VALTOCO is given.

Remove the nasal spray device from the nose after giving VALTOCO.

Step 5: **You have not given the full dose of VALTOCO yet.**

Remove the second nasal spray device from the blister pack.

Repeat Steps 2 through 4, using the second nasal spray device in the other nostril to give the full dose of VALTOCO.

After giving VALTOCO nasal spray:

Throw away (discard) both nasal spray devices and the blister pack after use.

Call for emergency help if any of the following happen:

- Seizure behavior in the person is different from that of other episodes.
- You are alarmed by how often the seizures happen, by how severe the seizure is, by how long the seizure lasts, or by the color or breathing of the person.

Make a note of the time VALTOCO was given and continue to watch the person closely.
Time of first VALTOCO dose (first dose equals 1 spray in each nostril): _____ / _____
Time of second VALTOCO dose (if given, second dose equals 1 spray in each nostril): _____ / _____

The healthcare provider may prescribe another dose of VALTOCO to be given at least 4 hours after the first dose. If a second dose is needed, repeat Steps 1 through 5 with a new blister pack of VALTOCO.

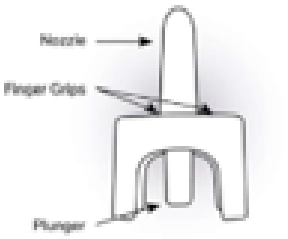
For more information about VALTOCO, visit www.valtoco.com or call 1-866-696-3873. Report side effects of prescription drugs to the FDA by visiting www.fda.gov/medwatch or by calling 1-800-FDA-1088.

These Instructions for Use have been approved by the U.S. Food and Drug Administration. Issued: 02/2022

NEURELIS

Instructions for Use
NAYZILAM® (NAY-zil-am)
(midazolam) nasal spray, CIV

You and your family members or caregivers should read this Instructions for Use before you start using NAYZILAM nasal spray and each time you get a refill. There may be new information. This information does not take the place of talking to your healthcare provider about your medical condition or treatment. If you and your family members or caregivers have any questions about NAYZILAM ask your healthcare provider or pharmacist.



Important: NAYZILAM is for use in the nose only.

- There is only 1 dose of NAYZILAM in the nasal spray unit.
- Do not try to test or prime the nasal spray unit before use. You will lose the dose.
- Do not open the blister packaging until ready to use.
- Do not use if the nasal spray unit appears damaged.
- Do not use past the expiration date printed on the blister packaging.
- Throw away (dispose of) the nasal spray unit after use.

How to use NAYZILAM nasal spray:

Step 1: Peel open the blister packaging

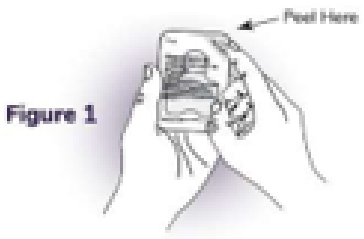


Figure 1

- When ready to use, open the blister packaging.
- Hold blister packaging in the palm of your hand.
- On the foil backing, find the "Peel Here" tab and pull down (See Figure 1).
- Remove the nasal spray unit carefully.

Step 2: Hold the nasal spray unit

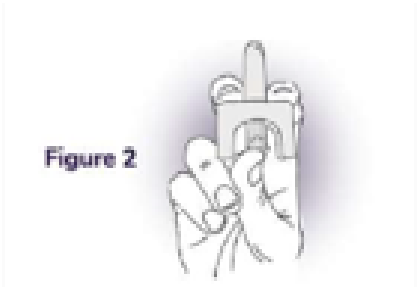


Figure 2

- Hold the nasal spray unit with your thumb on the plunger and your middle and index fingers on each side of the nozzle (see Figure 2).
- Do not press the plunger yet. If you press the plunger now, you will lose the dose.

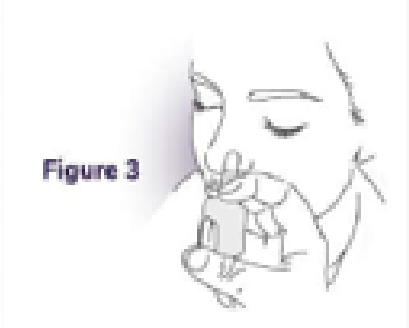


Figure 3

Step 3: Place the tip into 1 nostril

- Place the tip of the nozzle into 1 nostril until your fingers on either side of the nozzle touches the bottom of the nose (see Figure 3).

Step 4: Press the plunger

- Press the plunger firmly to deliver the dose of NAYZILAM nasal spray (see Figure 4).
- Make sure to firmly press the plunger using 1 motion.

The patient does not need to breathe deeply when you give them the medicine.

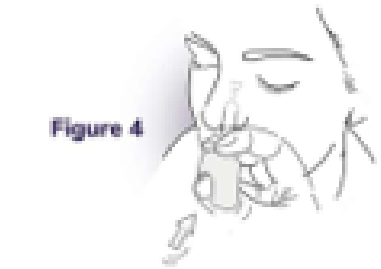


Figure 4

What to do after the NAYZILAM nasal spray has been used:

Remove the nozzle from the nostril after giving the dose.

Note: The plunger will remain inside the nasal spray unit after the dose is given.

Throw away (dispose of) the nasal spray unit and blister packaging in the trash.

What to do if a Second Dose is needed:

Important: If the seizure cluster is continuing 10 minutes after the first dose of NAYZILAM, a second dose of NAYZILAM may be used if you have been told to do so by your healthcare provider.

If you need to give a second dose of NAYZILAM, follow the instructions in this Instructions for Use using a new nasal spray unit in the other nostril. (Repeat Step 1 through Step 4)