DEPARTMENT OF HEALTH AND HOSPITALS

GUIDELINES for the DIDACTIC TRAINING AND ESTABLISHMENT OF COMPETENCY

PART 2 OF 2

OFFICE OF AGING, OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES AND HEALTH STANDARDS HAVE INCLUDED THE FOLLOWING SAMPLE FORMS AND TRAINING MODULES THAT MAY PROVE HELPFUL TO PROVIDERS AND REGISTERED NURSES IN COMPLYING WITH THE PROCESS REQUIREMENTS

SECTION ONE.

I. RN Competency Assessment of the DSW Performance: Required documentation to be placed in the DSWs personnel file (SAMPLE FORM)

SECTION TWO.

II. Instructions to the DSW: Required written guidance to be left as in-home reference for DSW (PERSON-SPECIFIC EXAMPLES)

A. Blank Sample of Instructions to the DSW
B. Sample #1: Instructions to the DSW: Medication Administration
C. Sample #2: Instructions to the DSW: Clean Intermittent Catheterization
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SECTION THREE: MEDICATION ADMINISTRATION TRAINING AND CORE CURRICULUM: 16 HOURS

I. Medication Core Curriculum Requirements
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SECTION ONE:

RNs Competency Assessment of the DSW Performance:

Required documentation to be placed in the DSWs personnel file (SAMPLE FORM)

SAMPLE
RN Competency Assessment of the DSW to Perform Medication Administration and/or Non-Complex Task(s)

Date: _____/_____/_____
DSW: _____
Participant Name: _____
Participant-Specific Task:
_____
_____

RN: _____

I. Participant Assessment

After assessing the above-named participant's condition, I have determined that his/her condition is stable and predictable.

I have considered the complexity, risks, and the skill necessary to perform this task and it is my determination that it is acceptable to delegate

This participant's condition will be reassessed every
_____
for continued appropriateness of delegating this task.

RN Signature:
_____

Date: _____/_____/_____

II. Written Instructions – Teaching Process - Rationale – Evaluation/Teaching Outcomes

The ***written instructions*** for the above task, including risks, side effects, and the appropriate [participant] response have been reviewed with the DSW and are located
_____.

Teaching Process used includes (check all methods used):
☐ Review and discussion of the written material
☐ Review of potential risks and side effects of the task

☐ Demonstration of the task by the RN
☐ Return demonstration by the DSW
☐ Time for further discussion, including question and answer time
☐ Written test (optional)
☐ Other:

_____

☐ Name and Title of Trainer:

_____

The ***rationale for determining that the skill*** of the DSW is appropriate to the participant's condition as based on the following:
☐ The participant's condition is stable and predictable.
☐ The DSW has a good understanding of the task, its risks and side effects and how to manage them.
☐ The DSW can safely and accurately perform the task.

Evaluation/Teaching Outcomes

1. Level of understanding of task, risks and side effects and how to manage them:

   _____ Acceptable _____ Needs Improvement
   _____Unacceptable

2. Return demonstration of task:
   _____ Acceptable _____ Needs Improvement
   _____Unacceptable

3. Written test, if applicable: _____N/A
   _____ Acceptable _____ Needs Improvement
   _____Unacceptable

Comments:
_____
_____
_____
_____
_____

III. Delegation Approval – Supervision Statement

The DSW has been instructed in the correct method of performing the above task and has successfully demonstrated understanding of the task, its risks/side effects and how to manage them. It is my determination that he/she can safely perform the task in my absence. I thereby take responsibility for delegation of the participant-specific task: _____ _____ _____

for (participant's name):

_____

to (DSW's name):

_____.

I assure that I will provide supervision of the above-named DSW's performance of this task for as long as I am supervising the delegation of this task. Ongoing supervision will occur _____.

IV. DSW Statement

I understand that there are potential risks/side effects involved in the performance of this task and I am prepared to effectively deal with the consequences of them.

I have been instructed that performing this task is specific to (participant's name)

_____

and is not transferrable to other persons or DSW's.

DSW Signature:

_____

Date: _____/_____/_____

SECTION TWO:

Instructions to the DSW:

Required written guidance to be left as in-home reference for DSW (BLANK FORM and PERSON-SPECIFIC EXAMPLES)

INSTRUCTIONS TO THE DSW

BLANK SAMPLE

Participant's Name**:** _____ Last 4 of SSN**:** _____
Date: _____
Following an assessment of the participant and through conversation and observation, I believe _____ **(DSW)** is capable of satisfactorily performing the skill of _____ as noted below. The Registered Nurse may delegate a task to unlicensed Direct Service Worker (DSW), specific to one participant, under the following conditions:

- The participant's condition is stable and predictable;
- The participant has the ability to make decisions about his/her own care and actively participant in the planning and directing of that care, or he/she resides in a residence where there is daily monitoring by a family member or other health care provider;
- The participant has an approved plan of care; and
- The participant receives periodic assessment by a RN based on the person's health status and specified within the plan of care; in no case shall the periodic assessment be less than annually.

The Registered Nurse shall provide initial direction by teaching the task of Medication Administration or Noncomplex Procedures, including:

Medication List (if applicable)		
Medication	**Dosage**	**Route**

o **The proper procedure (Step by Step Instructions):**
o **Why the task is necessary (RN explains the purpose for each medication/task):**
o **When task is to be performed (RN identifies the specific times each individual medication/task is to be performed):**

o **Anticipated risks/side effects/Points of Emphasis for each medication or task (May list or refer to attached Pharmacy or other print-out on side effects):**
o **Documentation of medication/task (Instructions on how to document performance of the medication/task):**
o **Who to Notify in case of an Emergency:**

Initial reassessment is to occur within ____ days from initial delegation. Ongoing intervals between delegation visits to be determined by RN, not to exceed 365 days.
Next Due: _____

RN Name (print): _____

RN Signature: _____ Date: _____

RN Contact Phone #:_____

I, _____ **(DSW)** have received the above information and understand that the procedure taught is specific to the above named participant and is not transferable to another participant. I understand the procedure for notification should problems arise.

Direct Service Worker Signature: _____

INSTRUCTIONS TO THE DSW

SAMPLE #1: MEDICATION ADMINISTRATION

Participant's Name**:** **Howard Johnson** Last 4 of SSN: **XXXX**

Date: **8/13/2013**

Following an assessment of the participant and through conversation and observation, I believe **Mary Brown** is capable of satisfactorily performing the skill of **Medication Administration for the medications noted below.**

The Registered Nurse may delegate a task to unlicensed Direct Service Worker (DSP), specific to one participant, under the following conditions:

- The participant's condition is stable and predictable;
- The participant has the ability to make decisions about his/her own care and actively participate in planning and directing of that care, or he/she resides in a residence where there is daily monitoring by a family member or other health care provider;
- The participant has an approved plan of care; and
- The participant receives periodic assessment by a RN based on the person's health status and specified within the plan of care; in no case shall the periodic assessment be less than annually.

The Registered Nurse shall provide initial direction by teaching the task of Medication Administration or Noncomplex Procedures, including:

Medication List (if applicable)		
Medication	**Dosage**	**Route**
Quinapril	One 5 mg tablet per day	By mouth
Furosemide	One 40 mg tablet per day	By mouth
Klor-Con (potassium chloride) Extended Release	One 600 mg tablet	By mouth

- **The proper procedure (Step by Step Instructions):**

1. Wash hands. Administration of medication is a clean (not sterile) procedure, unless otherwise specified.
2. Gather necessary items.
3. Remove medication from storage area.
4. Always prepare and give medications in a well-lit area.
5. Check the label for participant's name, name of medication, dose, time and route.
6. Prepare the correct dosage of medication without touching medication, if

possible.

7. While preparing the medication for administration, once again check the label for participant's name, name of medication, time, dose and route.
8. Do not leave medication unattended.
9. Provide equipment and supplies (e.g., glass of water).
10. Explain the procedure to the participant.
11. Position the participant properly for medication administration.
12. Administer medication according to the six rights (right participant, right time, right medication, right does, right route, and right documentation).
13. Carefully observe participant during and after medication is administered.
14. Record the time, medication, dose, route, person administering the medication, and any unusual observations.
15. Ensure accurate documentation of all medications.
16. Return medication to storage area.
17. Clean/dispose of equipment as appropriate.
18. Wash hands.

- **Why the task is necessary (RN explains the purpose for each medication/task):** To treat participant's high blood pressure.
- **When task is to be performed (RN identifies the specific times each individual medication/task is to be performed):** Participant is to receive the following three (3)medications by mouth once per day at 9 a.m. every day:
  - Quinapril, **one** 5 mg tablet;
  - Furosemide, **one** 40 mg tablet; and
  - Klor-Con (potassium chloride) Extended Release, **one** 600 mg Tablet.
- **Anticipated risks/side effects/Points of Emphasis for <u>Quinapril, Furosemide, and Klor-Kon:</u>**
  - REFER TO <u>ATTACHED</u> PHARMACY PRINT-OUT ON THE SIDE EFFECTS Of EACH MEDICATION
- **Documentation of Task (Instructions on how to document performance of the medication/task):**
  - Document and place your initials on the medication log indicating the time the medication was administered for each medication you administered ;
  - Document how individual tolerated the medication;
  - Document your observations regarding any abnormalities (e.g., "Participant became very lightheaded when she tried to get up immediately after receiving Furosemide medication. I assisted participant to sit down and the lightheadedness quickly stopped.").
- **Who to Notify In case of an Emergency:**
  - **Immediately** notify your supervisor and the RN if you are unable to administer anyone of the medications noted above.
  - **Immediately** notify your supervisor and the RN if you notice any of the side effects noted above.

Initial reassessment to occur within **30** days from initial delegation. Ongoing intervals between delegation visits to be determined by RN, not to exceed 365 days. Next Due: _____

RN Name (print): **Martha Blue**

RN Signature: _____ Date: _____
RN Contact Phone #:_____

I, **Mary Brown** have received the above information and understand that the procedure taught is specific to the above named participant and is not transferable to another participant. I understand the procedure for notification should problems arise.
Direct Service Worker (DSW) signature:_____
Date: _____

INSTRUCTIONS TO THE DSW

SAMPLE #2: CLEAN INTERMITTENT CATHETERIZATION

Participant's Name**:** **Betty Jones** Last 4 of SSN: **XXXX**

Date: **8/08/2013**

Following an assessment of the participant and through conversation and observation, I believe **Hope Green, DSW,** is capable of satisfactorily performing the skill **Clean Intermittent Catheterization.**

The Registered Nurse may delegate a task to unlicensed Direct Service Provider (DSP), specific to one participant, under the following conditions:

- The participant's condition is stable and predictable;
- The participant has the ability to make decisions about his/her own care and actively participate in planning and directing of that care, or he/she resides in a residence where there is daily monitoring by a family member or other health care provider;
- The participant has an approved plan of care; and
- The participant receives periodic assessment by a RN based on the person's health status and specified within the plan of care; in no case shall the periodic assessment be less than annually.

The Registered Nurse shall provide initial direction by teaching the task of Medication Administration or Noncomplex Procedures, including:

Medication List (if applicable)		
Medication	**Dosage**	**Route**

- **The proper procedure (Step by Step Instructions):**

1.Gather equipment in a clean, private area:
- Gloves.
- Catheter.
- Soap, water, and cotton balls or disposable wipes.
- Water-soluble lubricant (e.g. K-Y Jelly, never Vaseline).
- Container to collect urine, if individual is unable to use the toilet for positioning
- Towel to place under individual if individual is unable to use the toilet for positioning.

2. Provide privacy
3. Maintain Standard (Universal) Precautions throughout procedure. Wash hands before and after the procedure.

4. Explain the procedure to the individual as it is being carried out.
5. Position the individual, assisting with removal or adjustment of clothing. Have the individual (female) maintain a sitting position on the toilet whenever possible, otherwise position the individual on her back with feet flat on bed,, knees flexed and apart.
6. Put on gloves.
7. Squeeze lubricant onto tip of catheter; leave in protective wrapper if available, otherwise place on clean paper towel, putting the large end of catheter in a collection container if individual not on toilet.
8. With the thumb and middle finger of the nondominant hand, gentle separate the labia, exposing the ureteral meatus. Maintain separation with slight backward and upward tension.
9. With the opposite hand, cleanse around the meatus using cotton balls saturated with soap and water or disposable wipes. Make three, single, downward strokes, using clean cotton ball or wipe for each stroke.
10. While continuing to separate the labia with one hand, use the other hand to pick up the catheter approximately 3 inches from the tip; insert the catheter into the meatus until urine begins to flow; then advance the catheter another one or two inches. Never force the catheter. Hold in place until urine stops flowing.
11. Remove the catheter, pausing if urine begins to flow again. (Urine may start and stop with changes in position of the catheter.)
12. Assist the individual to redress or to adjust clothing.
13. If collection container was used, observe urine for signs of abnormality, measure the amount and document, then discard.
14. If reusing the catheter, wash with warm soapy water, rinse, and dry. Place in clean plastic bag, or other container.
15. Wash collection container with soap and water, rinse and dry. Dispose of wipes or cotton balls.
16. Remove gloves and discard.
17. Wash hands.
18. Document procedure and results. Promptly report any abnormalities to the individual, family, and your supervisor.

- **Why the task is necessary (RN explains the purpose for each medication/task):** To ensure periodic emptying of urinary bladder.
- **When task is to be performed (RN identifies specific times each individual medication/task is to be performed):** Clean, intermittent catheterization to be performed by DSW at 8 a.m., 11 a.m. and 1 p.m. Individual's family will perform all other catheterizations as ordered by physician.
- **Anticipated risks/side effects/Points of Emphasis (May refer to attached Pharmacy or other print-out on side effects):**
  - The individual's bladder can become over distended if not routinely emptied.
  - Introduction of bacteria in to the bladder via use of unclean equipment/process may lead to bladder infections.
  - Use standard procedures while dealing with body fluids. Use approved hand-washing technique.
  - Gloves must be used for protection against body fluids.
  - Use terms the individual understands.
  - Lubrication prevents trauma.
  - Be sure you are familiar with anatomical landmarks.
  - Front to back cleansing prevents contamination.
  - Slight resistance as the catheter passes through the urinary sphincter may be met as you advance the catheter into the bladder. If strong resistance is met, do not force the catheter. Remove the catheter and immediately notify the individual, family and your supervisor.
  - Observe and document the color, clarity and odor of collected urine.
  - If reusing catheter, using friction to clean catheter and creating a dry

environment for storage will retard growth of germs on catheter.
o **Documentation of Task (Instructions on how to document performance of the medication/task):** o Document and place your initials on log indicating the time the procedure was done ; o Document how individual tolerated the procedure; o Document your observations regarding any abnormalities (e.g., urine odor and clarity, or variance in amount of urine).
o **Who to Notify In case of an Emergency:** o **Immediately** notify your supervisor and the RN if you are unable to complete this task.

Initial reassessment to occur within **30** days from initial delegation. Ongoing intervals between delegation visits to be determined by RN, not to exceed 365 days. Next Due: _____

RN Name (print): **Martha Blue, RN**
RN Signature: _____ Date: _____
RN Contact Phone #:_____

I, **Hope Green, DSW,** have received the above information and understand that the procedure taught is specific to the above named participant and is not transferable to another participant. I understand the procedure for notification should problems arise.

Direct Service Worker (DSW) signature: _____
Date: _____

INSTRUCTIONS TO THE DSW

SAMPLE #3: GASTROSTOMY TUBE FEEDING

Participant's Name**:** **Edna Gray** Last 4 of SSN: **XXXX**

Date: **8/14/2013**

Following an assessment of the participant and through conversation and observation, I believe **Joan Smith , DSW,** is capable of satisfactorily performing the skill of **Gastrostomy Tube Feeding.**

The Registered Nurse may delegate a task to unlicensed Direct Service Provider (DSP), specific to one participant, under the following conditions:

- The participant's condition is stable and predictable;
- The participant has the ability to make decisions about his/her own care and actively participate in planning and directing of that care, or he/she resides in a residence where there is daily monitoring by a family member or other health care provider;
- The participant has an approved plan of care; and
- The participant receives periodic assessment by a RN based on the person's health status and specified within the plan of care; in no case shall the periodic assessment be less than annually.

The Registered Nurse shall provide initial direction by teaching the task of Medication Administration or Noncomplex Procedures, including:

Medication List (if applicable)		
Medication	**Dosage**	**Route**

- **The proper procedure (Step by Step Instructions for Bag Method):**

1. Provide privacy
2. Explain the procedure to the individual as it is being carried out.
3. Review medical record/prescription for formula, amount and time.
4. Always wash your hands and apply gloves **before** toughing the G-Tube, food or water.
5. Assemble equipment (syringe, prescribed formula, IV pole/wall hook, and pump, if applicable).
6. Make sure feeding tube formula is at room temperature.
7. Fill bag with prescribed amount of formula.
8. Position participant on right side in upright position with head raised 80-90 degrees. Participant's head should remain elevated **during** feeding and for at least **30-45 minutes after** feeding to avoid aspiration.
9. Check feeding tube placement and residual (amount of stomach contents left over from

the last feeding) by inserting syringe into adapter port and pulling back until no more fluid comes out. Measure the amount of fluid and record/document it. If the residual exceeds the amount the doctor ordered, hold feeding until residual diminishes. Return contents back into the stomach through feeding tube by gently pushing on the syringe plunger.
10. Administer tube feeding.
11. Hang bag on IV pole or wall hook and attach tubing.
12. Open the clamp slowly and fill the tube to remove air and to adjust the speed of the feeding (the rate will be determined by the doctor's order/prescription).
13. Insert the tip of the tube from the bag into the feeding tube.
14. The feeding should last approximately 30-45 minutes.
15. If choking occurs or person has difficulty breathing during the feeding, STOP and call your supervisor immediately.
16. When the feeding is completed, fill the bag with the amount of water the doctor ordered. This provides fluids and flushes out the tube.
17. After the water is given, roll the clamp down to turn off and disconnect the bag and insert the G-Tube plug.
18. Wash out the bag after each use. Use dishwashing liquid and water to wash the container. Rinse the container thoroughly. Use a clean bag for each feeding.
19. Wash and dry your hands.

- **Why the task is necessary (RN explains the purpose for each medication/task):** To ensure the participant receives the appropriate amount of nutrients and fluids as ordered by his/her physician.
- **When task is to be performed (RN identifies the specific times each individual medication/task is to be performed):** G-Tube feeding to be performed by DSW as ordered by physician at **(be specific regarding times tube feedings are to occur).**
- **Anticipated risks/side effects/Points of Emphasis (May refer to attached Pharmacy or other print-out on side effects):**
  - The following are signs and symptoms experienced by the participant that should be reported **immediately** to your supervisor who will contact the RN:
    - Diarrhea
    - Constipation
    - Any vomiting
    - Signs of dehydration: thirst, dry mouth, weakness, fever, or small amounts of dark strong-smelling urine
    - Losing or gaining more than 2 pounds per week
    - Fever, weakness
    - Missing feedings
    - Skin around the stoma becomes red or swollen
    - Feeding tube falls out, or appears to be displaced
- **Documentation of Task (Instructions on how to document performance of the medication/task):**
  - Document and place your initials on log indicating the time the procedure was done ;
  - Document how individual tolerated the procedure;
  - Document your observations regarding any abnormalities (e.g., "Participant felt nauseated at first, but feeling subsided within 4 to 5 seconds of initial feeding.")
- **Who to Notify In case of an Emergency:**
  - **Immediately** notify your supervisor and the RN if you are unable to complete this task for any reason.

Initial reassessment to occur within **30** days from initial delegation. Ongoing intervals between delegation visits to be determined by RN, not to exceed 365 days. Next Due: _____

RN Name (print): **Martha Blue, RN**

RN Signature: _____ Date: _____
RN Contact Phone #:_____

I, **Joan Smith, DSW,** have received the above information and understand that the procedure taught is specific to the above named participant and is not transferable to another participant. I understand the procedure for notification should problems arise.

Direct Service Worker (DSW) signature: _____

Date: _____

SECTION THREE

MEDICATION ADMINISTRATION TRAINING AND CORE CURRICULUM SAMPLES:

16 Hour Training

These are only samples of a few trainings Registered Nurses can use as a guide, there is also a full 16 hour Course Available for Registered Nurses working in the HCBS programswhich they may chose to use, and which can be found on the LDH/OCDD DSW website.

DSWs shall attain proficiency in the fundamentals of medication administration.

DSWs shall receive at least sixteen (16) hours of medication administration training which has been coordinated and approved by an RN and which shall include, **at a minimum**, the following:

I. Medication Administration Core Curriculum Requirements

Medication Administration Core Curriculum:

1) legal aspects of administering medication;
2) roles and responsibilities of medication administration;
3) medical terminology;
4) classification and identification of drugs
5) measuring medications
6) effects and side effect of medications;
7) distribution and routes of medication administration;
8) medication interactions;
9) handling and storage of medications;
10) six fundamental rights of administering medications:
    a. give the right medication;
    b. give the right dose;
    c. give the medication to the right individual;
    d. give the medication by the right route;
    e. give the medication at the right time;
    f. provide the right documentation.

II. Documentation Training Requirements

Documentation Training: DSWs shall attain proficiency in documentation which includes:

1) the contents of chart or record;
2) the importance of record keeping;
3) the rules for charting, including time limits;
4) documenting vital signs, as applicable;
5) documenting the condition of the person receiving care, including significant changes; and
6) the name of the medication, dose, route, and time of administration.

III.Skill Proficiency Training Requirements

Skill Proficiency Training: DSWs shall attain proficiency in the following skill areas, either by physical or verbal demonstration to the RN:

1) universal precautions and infection control;

2) vital signs, as applicable:

    a. counting pulse;
    b. counting respirations;
    c. taking blood pressure; and
    d. taking oral, rectal or axillary temperature.

IV. Medication Administration Training Core
Selected Curriculum Samples

A. Sample Table of Contents

Medication Administration Training Core Curriculum

Table of Contents (Sample)

B. Sample Training Module 1: Universal Precautions

INFECTION CONTROL
UNIVERSAL PRECATIONS

- At the end of this training module, direct service workers will be able to:
  - Verbalize definitions related to infection control
  - List modes of transmission of infections and portals of entry of bacteria
  - Explain universal precautions
  - Explain the worker's role in preventing spread of infections
  - Demonstrate proper hand washing techniques, application and removal of gloves
  - Describe appropriate techniques for cleaning up spills

DEFINITIONS

- Infection control – the set of methods used to control and prevent the spread of disease
- Infections – are caused by pathogens (germs)
- Communicable disease – disease spread from one person to another
- Infectious disease – disease caused by a pathogen (germ or bacteria)

DEFINITIONS

- Contaminated – means dirty, soiled, unclean
- Disinfection – cleaning so that germs (pathogens) are destroyed
- Mode of transmission – the way germs are passed from one person to another
- Mucous membranes – membranes that line body cavities that open to the outside of the body

MODES OF TRANSMISSION

- Body fluids – tears, saliva, sputum (mucus coughed up), urine, feces, semen, vaginal secretions, pus or other wound drainage, blood
- Touching the infected person or their secretions
- Touching something contaminated by the infected person.
- Droplets – coughing, sneezing, laughing, spitting, talking

PORTALS OF ENTRY

- Any body opening of an uninfected person which allows pathogens to enter
- Nose, mouth, eyes, rectum, genitals and other mucous membranes
- Cuts, abrasions or breaks in the skin

WHO IS AT RISK??

- Anyone whose resistance to disease decreases
- Reasons for lowered resistance: age, existing illnesses, fatigue and stress
- The elderly have weaker immune systems and a lower resistance to pathogens
- Elderly are hospitalized more often, increasing the chance for hospital-acquired infections
- Recovery longer in the elderly

UNIVERSAL PRECAUTIONS

- Universal precautions are infection control guidelines designed to protect workers from exposure to diseases spread by blood and certain body fluids.
- Always treat blood, body fluids, broken skin and mucous membranes as if they were infected
- Always follow Universal Precautions because you cannot tell by looking at a person whether they have a contagious disease

UNIVERSAL PRECAUTIONS

- Use practical, common sense
- Wash your hands before putting on gloves and immediately after removing gloves
- Do not touch clean objects with contaminated gloves

UNIVERSAL PRECAUTIONS

- Wear gloves if you may come in contact with blood, body fluids, secretions and excretions, broken or open skin, human tissue of mucous membranes
- Bag all disposable contaminated supplies
- Clean all surfaces that may be contaminated with infectious waste, such as beds, wheelchairs and shower chairs

WHAT CAN I DO??

- Good hand washing is the most effective method to prevent the spread of infection
- May use an alcohol-based hand cleaner in place of washing with soap and water
- Avoid touching eyes, nose or mouth

WHAT CAN I DO??

- Cover your nose and mouth with a tissue every time you cough or sneeze
- Throw used tissue in a wastebasket
- If you don't have a tissue, sneeze or cough into your sleeve
- Always clean your hands after coughing or sneezing

HAND WASHING

- Remove any jewelry or watch
- Wet hands with warm, running water
- Add soap
- Rub hands vigorously for 20 seconds, washing all surfaces (about the time it takes to sing "Happy Birthday" twice)
- Rinse, keeping fingers pointing down
- Dry with paper or clean cloth towel
- Turn off faucet with towel and open door with towel

WATERLESS HAND SANITIZER

- Make sure all visible dirt is removed from your hands
- Apply a dime sized amount of waterless hand sanitizer to the palm of one hand or use a waterless hand sanitizer wipe
- Rub hands together covering all surfaces of hands and fingers
- Rub until waterless hand sanitizer is absorbed
- Remember, waterless sanitizers are not effective if dirt is visible on your hands

WHEN SHOULD I USE GLOVES ?

- When you may come in contact with blood or any body fluids, open wounds, or mucous membranes
- Performing or helping with mouth care
- Performing or helping with perineal care
- Performing care on a consumer who has broken skin

WHEN SHOULD I USE GLOVES ?

- When you have open sores or cuts on your hands
- When shaving a consumer
- When disposing of soiled bed linens, gowns, dressings and pads

WHEN SHOULD I CHANGE GLOVES?

- When touching surfaces that may be contaminated
- Right before contact with mucous membranes or broken skin
- Immediately if they become wet, worn, soiled or torn

GENERAL GUIDELINES

- Wear gloves when handling soiled linens
- Fold or roll linen so that the dirtiest area is inside
- Hold and carry dirty linen away from your body
- Do not shake dirty linen or clothes

GENERAL GUIDELINES

- Use appropriate receptacles for disposal
- Do not touch the inside of any disposal container
- Do not use "re-usable" equipment again until it has been properly cleaned
- Never use disposable equipment more times than recommended by the manufacturer

PUTTING ON GLOVES

- 1. Remove any sharp jewelry
- 2. Remove glove from box. Gloves come in small, medium and large. Most are rubber latex and are pre-powdered. Those who are allergic to latex should use vinyl gloves.
- 3. Hold glove with your thumb and forefinger and insert hand into gloves
- 4. Work fingers into proper places

REMOVING GLOVES WITHOUT CONTAMINATING YOUR HANDS

- 1. Pinch the palm of one glove and pull away from the palm.
- 2. Push the fingers of the pinching hand up inside the other glove, stretching the material of the glove towards the cuff of the other glove until it emerges by the wrist.
- 3. Pull the fold down until the glove is almost off (you will be pulling the glove inside-out).

REMOVING GLOVES WITHOUT CONTAMINATING YOUR HANDS

- 4. DO NOT take the glove completely off.
- 5. Hook the ungloved thumb between the wrist and the skin of the other gloved hand and pull down, pulling both gloves off. (Both gloves will now be inside out.)
- 6. Dispose of the gloves properly.

SPILLS

- Put on clean gloves
- Wipe up immediately by cleaning from the outside (cleanest) to the inside (dirtiest)
- Use the appropriate cleaning agent
- Never pick up glass, even with gloved hands
- Dispose of gloves and cleaning equipment and supplies

C. Sample Training Module 2 Documentation

DOCUMENTATION

Objectives:

At the end of this module the DSW will be able to:

- Define Communication
- Define Person Centered Documentation
- Describe the DSW's role within their agency as it relates to communication and documentation
- Discuss the importance of clear communication with Health Care, other Service Providers and the family
- Explain the importance of objectively documenting and reporting vital information to your supervisor
- Demonstrate the ability to document on a Progress Note and a Physician Visit Communication Note
- Explain the parts of the Medication Administration Record (MAR)
- Demonstrate the ability to document appropriately on the MAR
- Discuss possible causes of Medication Errors

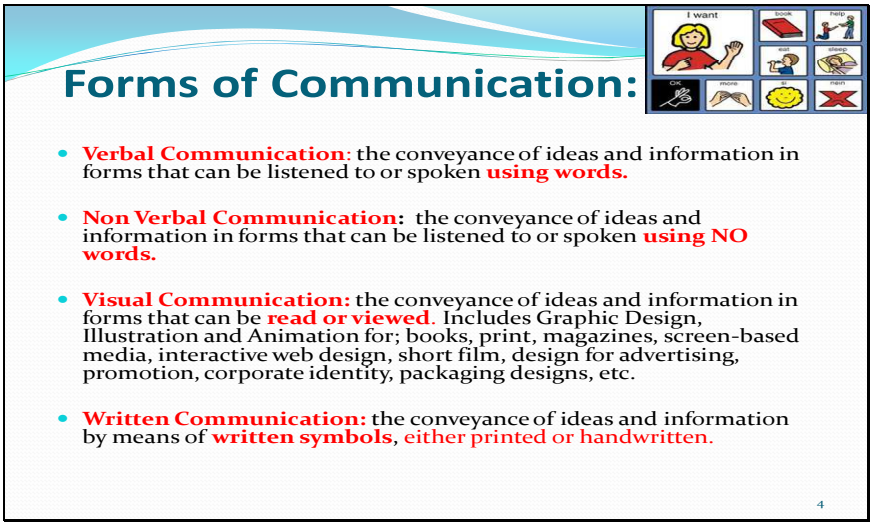
This module is intended to describe the various ways in which people communicate their thoughts, desires, feelings, and possible discomfort and the importance of being able to do so. You will learn that there are many ways to communicate. Documentation is a form of communication that is vital to the welfare of the person you are working with. You will learn the proper methods of objective documentation.

You will learn that when an individual is unable to communicate their most basic desires or how they may be feeling, they may become frustrated and engage in behaviors that are inappropriate.

You will also learn how to appropriately document on the participants Medication Administration Record (MAR)

Communication is the exchange of information between people by means of speaking, writing, or using a common system of signs, symbols or behavior.

Communication sets the foundation for all observable activities that are attempted with people with disabilities.



All people use a common system of symbols, signs or behaviors.

Some common systems we use include: talking, gestures (such as a shoulder shrug , beckoning with the hand, a raised hand for “stop”, pointing), sign language, body language, facial expressions, manual sign language, augmentative, and written communication.

Verbal Communication
Many people with disabilities use speech to communicate. This is called verbal communication. People may use single words, phrases, or complete sentences. Because some people have difficulties using their speech musculature, they may have difficulty making their speech intelligible to others. Speech musculature includes those muscles that affect breathing, breath control, tongue, lips, cheeks, vocal cords, etc. If this is the case, people may need some assistance to make their meaning understood by others.

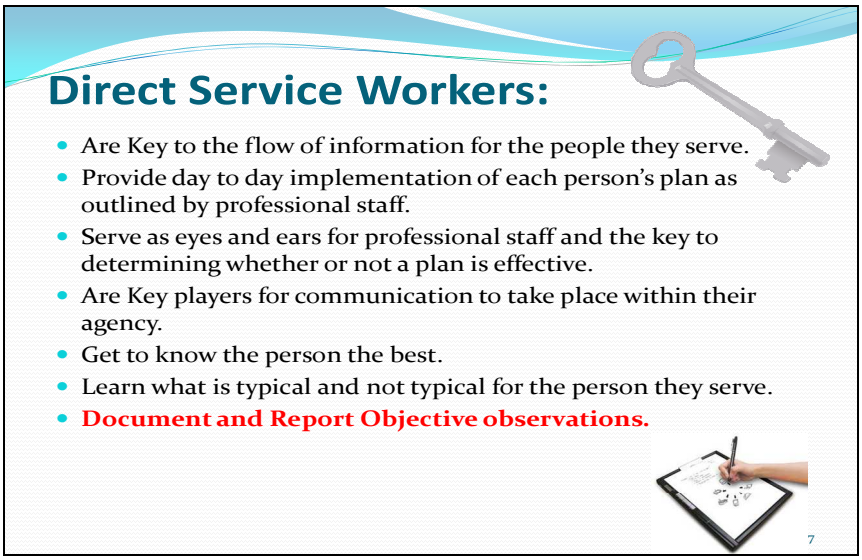
Nonverbal Communication
Nonverbal communication is any kind of communication not involving words. When the term is used, most people think of facial expressions and gestures, but while these are important elements of nonverbal communication, they are not the only ones. Nonverbal communication can include vocal sounds that are not words (vocalizations) such as grunts, sighs, and whimpers. Even when actual words are being used, there are nonverbal sound elements such as voice tone, pacing of speech and so forth.

Body language is a form of Non Verbal Communication
Body language is a form of communication that is performed subconsciously. It occurs almost constantly, and will almost always give the correct impression that a person has of someone else, the environment, or the situation at hand. Body language makes it easy to know if someone is nervous, scared, interested, or focused, among many other feelings that could be happening.

Learning to read body language can be as simple as paying attention to your own body when feeling specific emotions. For example, if you are able to notice the unconscious things that your body does when you are nervous, then it should be simple for you to be able to see when another person is nervous in a certain situation. Often, reading the body language of another person will tell you more than having an actual conversation would, especially if the conversation has the potential to be uncomfortable or is something that no one wants to acknowledge.

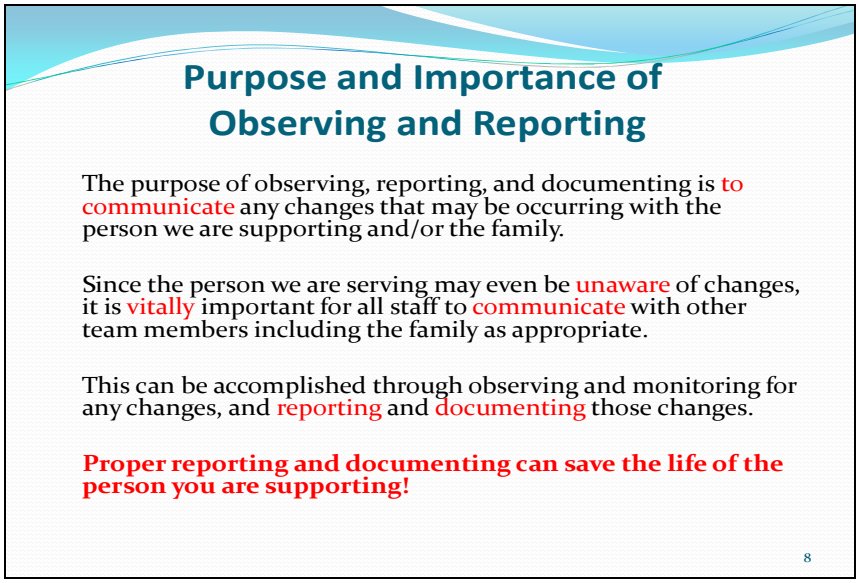
Visual Communication
Visual communication as the name suggests is communicating through visual aid and is described as the conveyance of ideas and information in forms that can be read or looked upon. Visual communication solely relies on vision.

Written Communication
Written communication is using written symbols (either printed or handwritten). Written communication in the form of documentation will play a vital role for the DSW in reporting objective observations to your supervisor.



As a Direct Service Worker, you are the key to the flow of accurate information. Of all professionals providing services to the individual it is the DSW who spends the most time with the individual, thus are in the best position to identify when a change in the person has occurred.

It is important that the DSW utilize their time spent with the individual in observation.



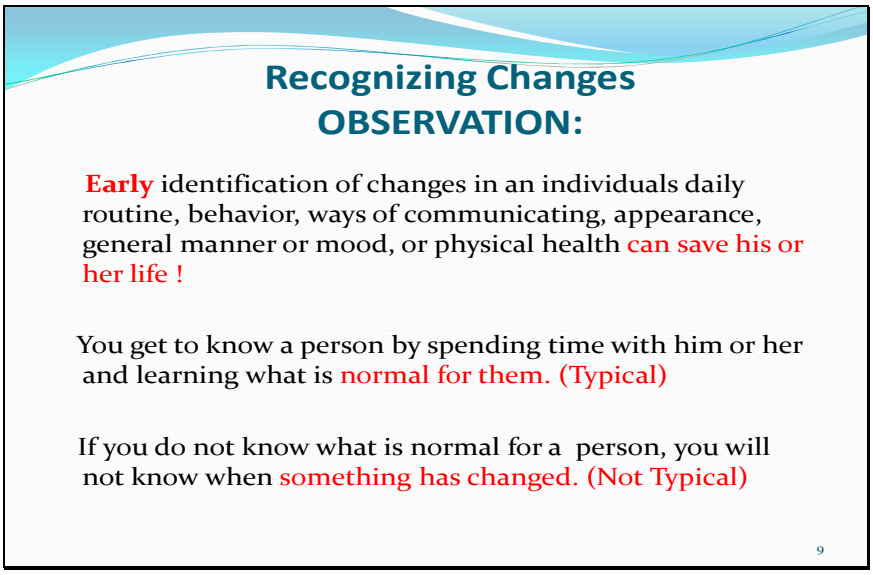
Purpose and Importance of Observing and Reporting

- The purpose of observing, reporting, and documenting is to communicate any changes that may be occurring with the person we are supporting and/or the family.

- Since the person we are serving may even be unaware of changes, it is vitally important for all staff to communicate with other team members including the family as appropriate.

- This can be accomplished through observing and monitoring for any changes, and reporting and documenting those changes.

- **Proper reporting and documenting can save the life of the person you are supporting!**



Observation:

Recognizing changes is one of the most important aspects in determining potential problems the individual may be having. The DSW should consider any changes that are not normal (typical) for the person they are serving.

If you are working with a new individual you may have to ask the family, other workers, your supervisor, or their health care professionals what is normal (typical) for that person. You can only report changes once you know what is typical for that person.

Every aspect of the individual should be considered. This includes physical, behavioral and emotional.

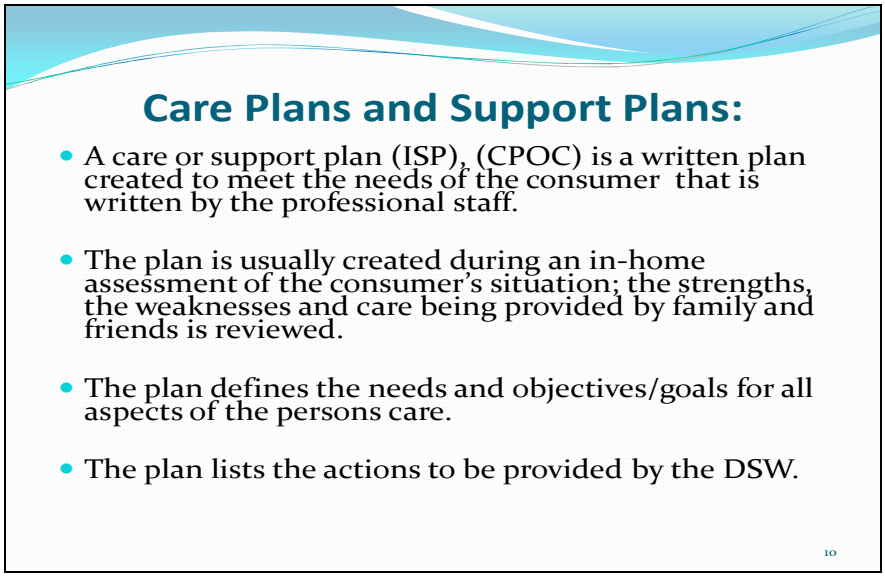
Some Potential changes to observe for:
Changes in physical aspects:

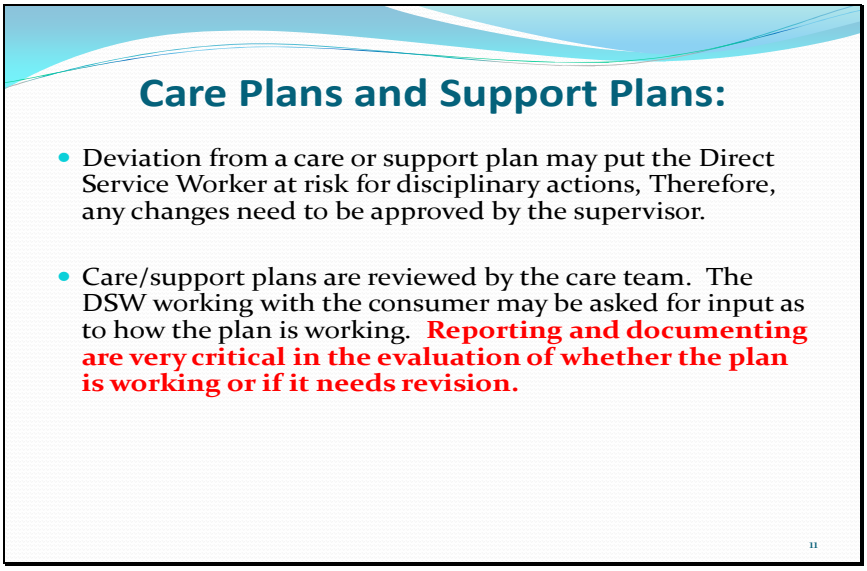
- Breathing: Coughing, any changes or difficulty in breathing, hoarseness.

- Mobility: Changes in walking, feeding self, putting on clothes.

- Skin: Changes in skin condition, temperature, color, rashes, unexplained bruising.

- Any Drainage: Drainage from eyes, ears, nose, mouth, skin, vagina, penis.
- Elimination: Changes in bowel or bladder patterns.
- Sleep patterns. Are they sleeping more, are they sleeping less? Are they sleeping during the day?
- Eating patterns: Are they eating more? Are they eating less? Are they complaining of stomach pain, cramps, etc.
- Changes in emotional or behavior changes: Is a normally outgoing person becoming withdrawn? Is a normally compliant person becoming defiant?
- Vital signs if these are ordered to be part of the plan of care: Is there a change in their vital signs, Heart Rate, Blood Pressure, Respiratory rate?
- Level of Consciousness: Consciousness does not only refer to being alert or unresponsive. Is the individual unable to perform a task they previously could do? Do they appear confused?
- These are but a few potential changes to observe for. Remember that ANY DEVIATION from what is normal for the individual needs continued observation and reporting to your supervisor. Your supervisor will notify the Nurse who will then contact the physician.



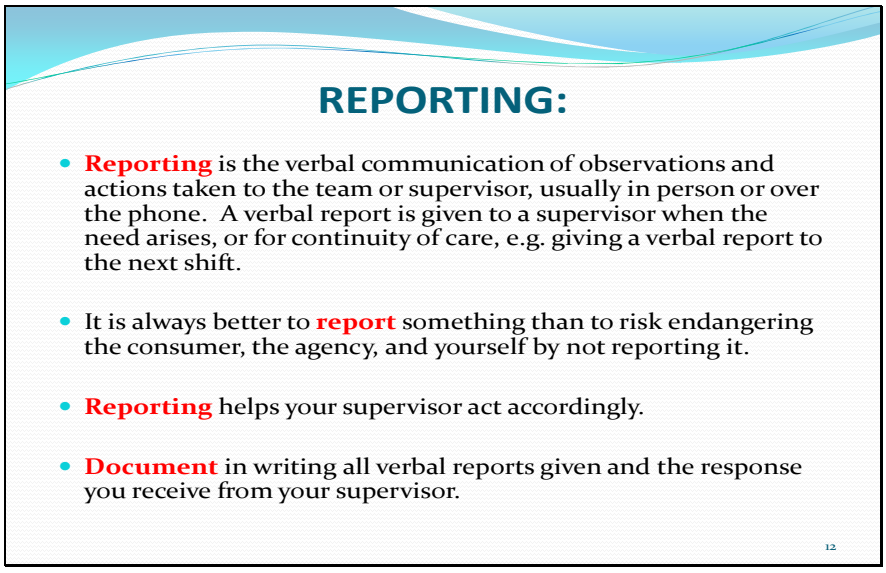


Person Specific Documentation:

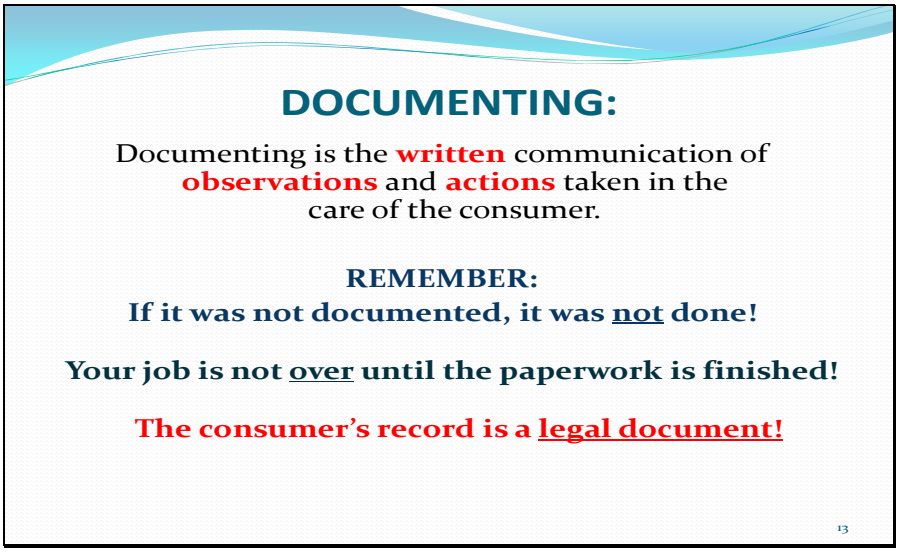
Agencies must follow certain guidelines in gathering material for their records;

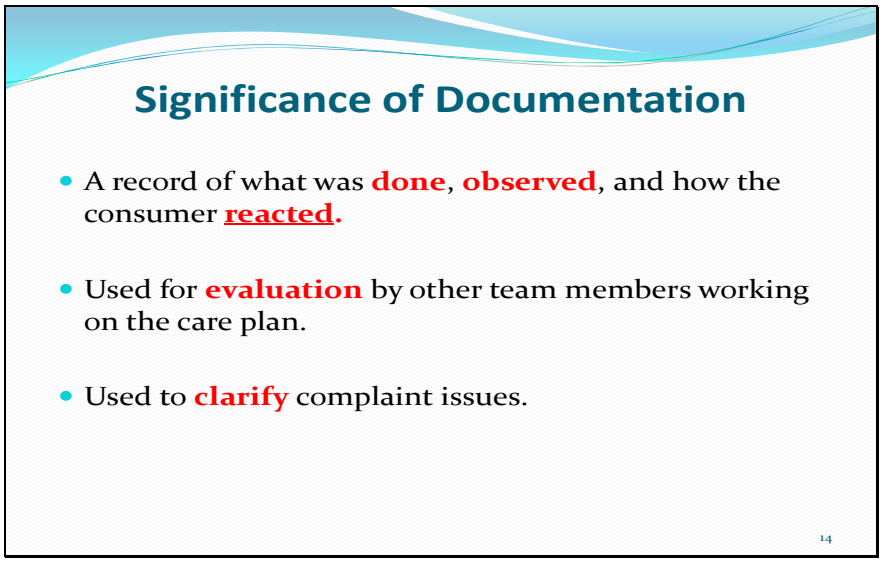
- Keep information that is only relevant to each individual
- Inform individual from whom it collects information from
- Explain purposes for which information will be used
- Documentation is purposeful and specific to the individuals care and needs

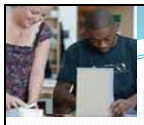
This is accomplished by following the person's Care Plan/Support Plan (ISP) Individual Service Plan/ (CPOC) Comprehensive Plan of Care



The Observations you will make must be reported to the supervisor and documented appropriately.







Documentation Guidelines:

- Always use ink.
- Sign all entries with your name and title, and the date and time.
- Make sure writing is legible and neat.

- Use correct spelling, grammar and abbreviations.
- Never erase or use correction fluid. If you make an error, cross out the incorrect part with one line, write error over it, initial it and rewrite that part.

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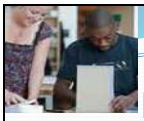

Documentation Guidelines:

- Do not skip lines. Draw a line through the blank space of a partially completed line or to the end of the page, this prevents others from recording in a space with your signature.
- Be accurate, concise, and factual. Do not record judgments or interpretations. Objective reporting only!
- Make entries that are logical.

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Documentation Guidelines:

- Be descriptive. Avoid terms that have more than one meaning.
- When documenting the persons inappropriate behavior describe only what the person is doing or saying.
- Document any changes from normal or changes in the consumer's condition.
- Also document what and to whom you reported as well as the response you received.
- Do not omit any information.

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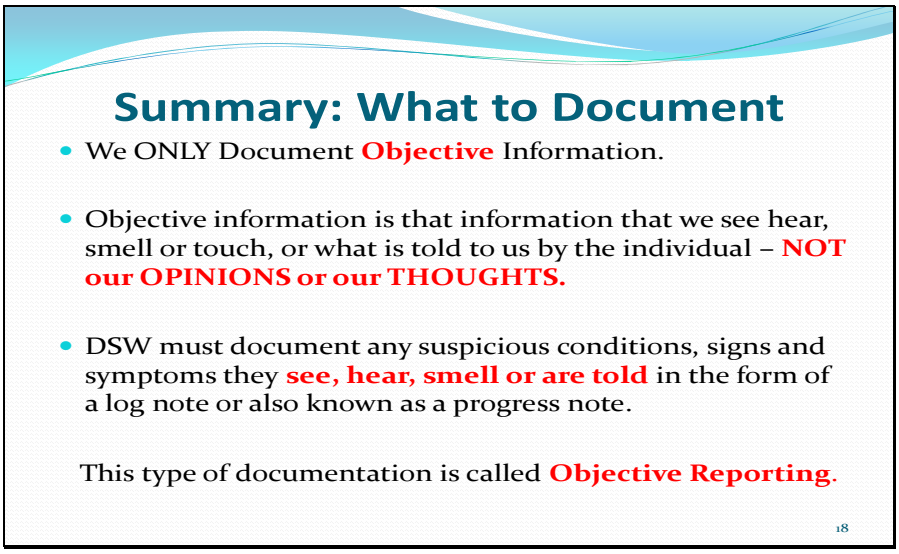
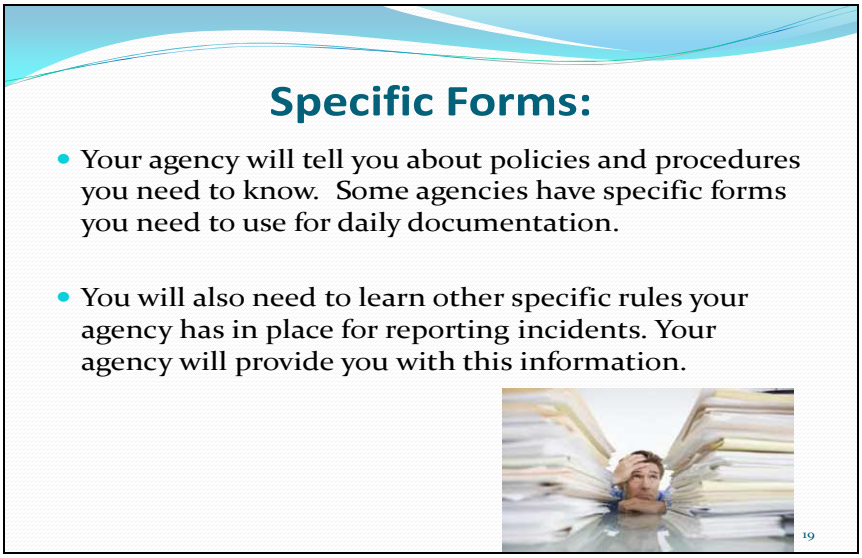


Summary: What to Document

- We ONLY Document **Objective** Information.
- Objective information is that information that we see hear, smell or touch, or what is told to us by the individual – **NOT our OPINIONS or our THOUGHTS.**
- DSW must document any suspicious conditions, signs and symptoms they **see, hear, smell or are told** in the form of a log note or also known as a progress note.

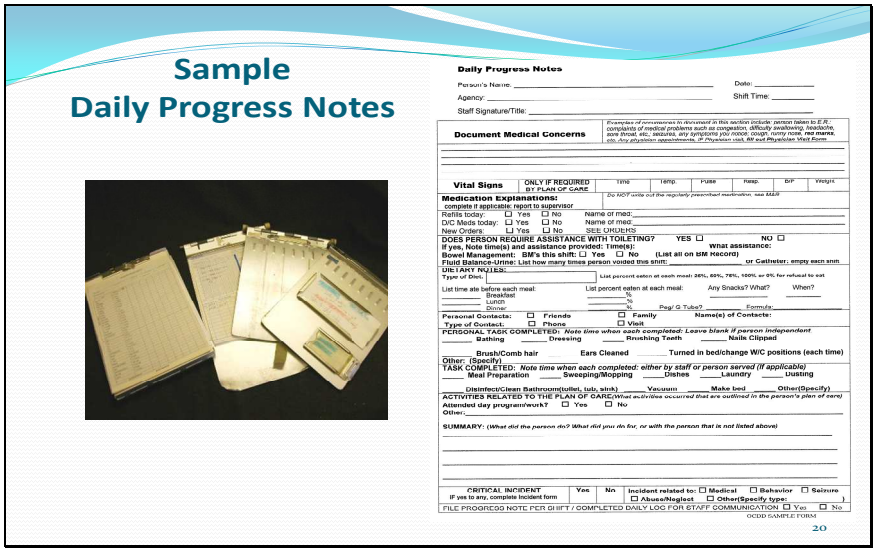
This type of documentation is called **OBJECTIVE DOCUMENTATION.**



Specific Forms:

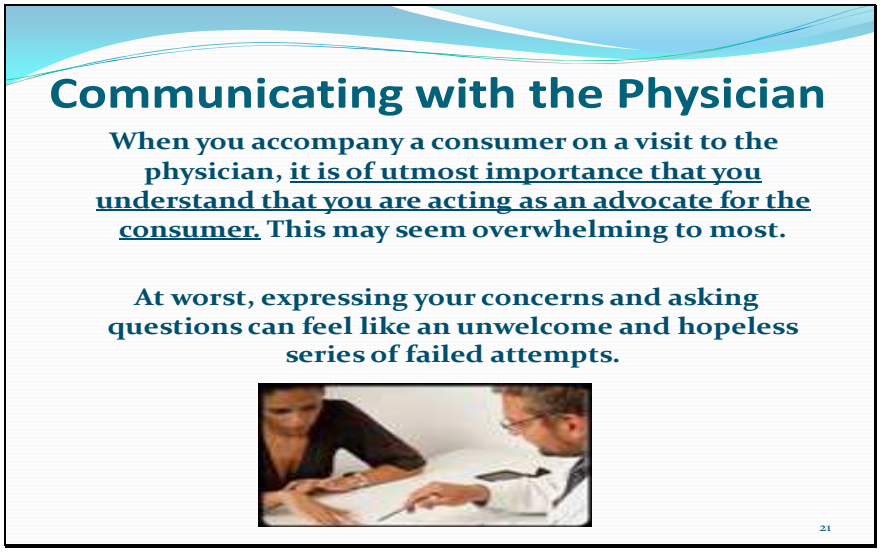
- Your agency will tell you about policies and procedures you need to know. Agencies have specific forms you need to use for daily documentation.

- You will also need to learn other specific rules your agency has in place for reporting incidents. Your agency will provide you with this information.



Sample Daily Progress Notes:

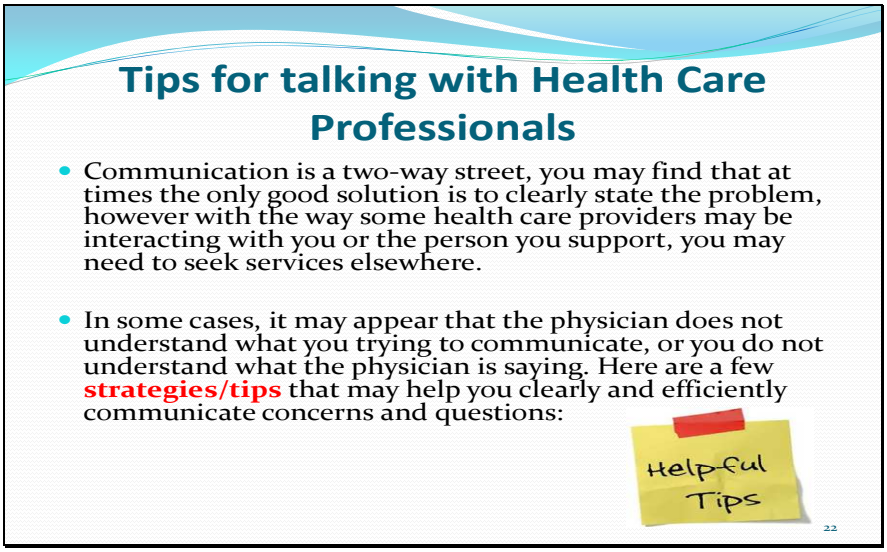
We will review a sample form that will give you a guideline to assist in documenting valuable information that is needed when you are observing the individual you support. We will also review your agency's progress notes at the end of the module.



Communicating with the Physician

When you accompany a consumer on a visit to the physician, it is of utmost importance that you understand you are acting as an advocate for the consumer. This may seem overwhelming to most.

At worst, expressing your concerns and asking questions can feel like an unwelcome and hopeless series of failed attempts.



Communication is a two-way street, you may find that at times the only good solution is to clearly state the problem, however with the way some health care providers may be interacting with you or the person you support, you may need to seek services elsewhere.

In some cases, it may appear that the physician does not understand what you trying to communicate, or you do not understand what the physician is saying. Here are a few strategies/tips that may help you clearly and efficiently communicate concerns and questions:

List of Strategies and Tips:

- It is best to support **self-advocacy** rather than advocating for someone.
- In emergency situations, it is not always possible to take the time to prepare and plan for self-advocacy, but it is a desirable approach for most appointments.

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List of Tips:

- Make sure you **ALWAYS** know **why you going with** the consumer. Why is the person going to see this physician, **What is the reason for this visit?**
- Call the office prior to the appointment if accommodations may be necessary, e.g. some consumers have great difficulty waiting for their appointment, and may become agitated as time goes by in the waiting room. Some consumers may have physical impairments that may require special accommodations for exams or tests.

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List of Tips:

- **Role-play** asking questions and expressing concerns. This helps you or the person you support to feel more familiar and comfortable with the process, and may enable you to identify barriers to clear communication before the appointment takes place.
- If you or the person you support has a great deal of anxiety about the visit, a **pre-visit** can be helpful. During a pre-visit the person has the opportunity to meet the office staff and see the clinic so that it is not unfamiliar at the time of the appointment.
- Try to **stay calm**. Sometimes this is very difficult, particularly if the physician or office staff just does not seem to get your message, or if someone in the office makes an offensive statement. It is important to **remain firm** and be **clear** in what it is you are doing there.

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List of Tips:

- If you feel rushed into making a decision, or if the person you support appears to feel pressured, **it is okay to ask for some private time to discuss the options**. You may even need to call back with an answer at a later date. This is a perfectly acceptable way to ensure that you or the person you support has freely been provided informed consent.
- Always make sure that **you understand the physicians orders** and know what was done at the visit so that it can be **documented** in the consumers record and reported to your supervisor.
- It is **OK to ask the physician or the office staff** for clarification, it is the only way to ensure that you will be communicating the proper information to your supervisor.

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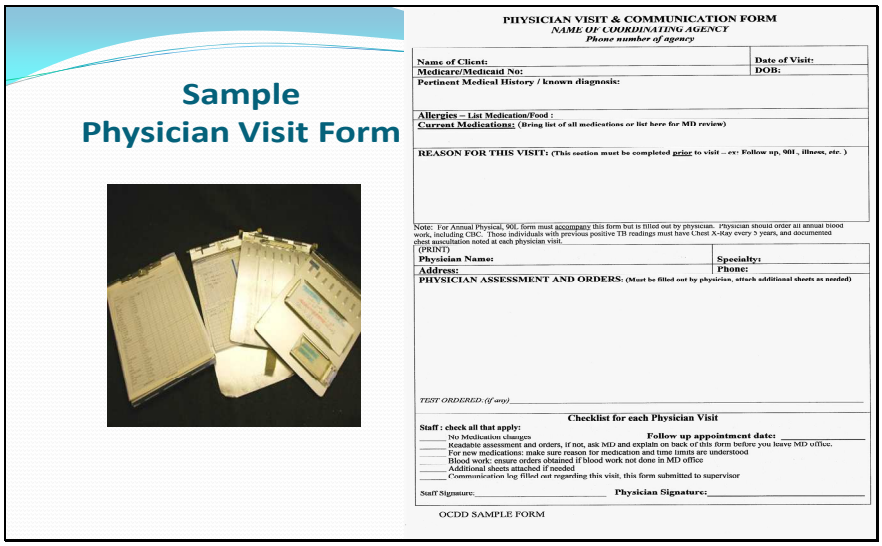

Sample Physician Visit Form:

We will review a sample form that will give you a guideline to assist in documenting valuable information that is needed when and if you accompany an individual on a visit to a physician or other health care provider at the end of the module. Your agency may already have a form that is in place. It is extremely important that it be filled out completely.

Review

- **Observation** – Use all of your senses; sight, hearing, touch and smell. (Objective Reporting)
- **Communication** – Ask questions and listen to answers. A good listener hears the words and notices other ways of communicating, including changes in behavior; and using the appropriate ACC device when it is needed.
- **Written Forms** – Document on forms that help you address important information that you will need when reporting to your supervisor.

Always write legibly and meaningfully.

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We have learned that we have many skills to develop and tools to be utilized when we are working with people with disabilities.

Our skills of observation and communication are very important. It is essential to report and document our observations in written form.

The tools (written forms) that you will use will be provided to you by your agency supervisor. They are essential in providing a clear and accurate picture of the individual's health status. They may also be utilized by all professional staff who may also provide care to the individual.

What would you do?

1. **What would you do if you are new and do not know what is typical for the person you are supporting ?**
2. **What would you do if you notice ANY change in the person you are supporting?**

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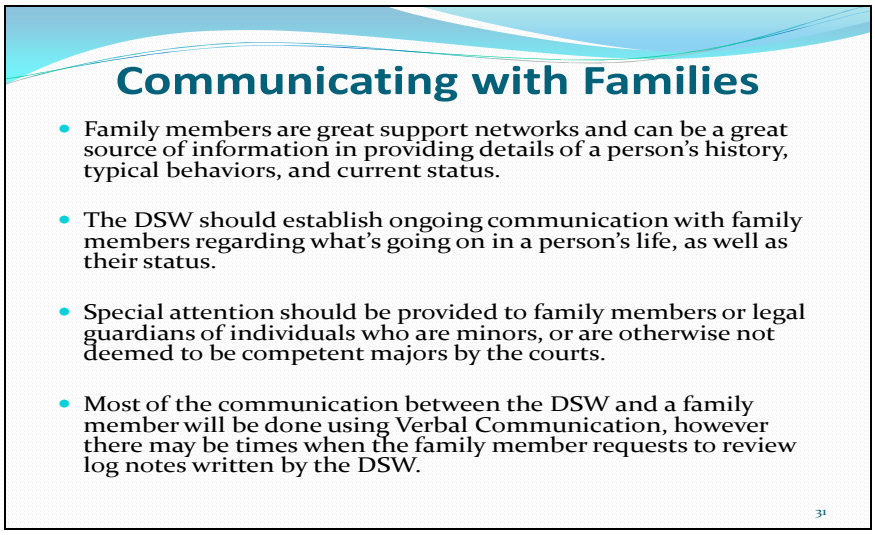
Class Discussion

1. What would you do if you are new and do not know what is typical for the person you are supporting?

2. What would you do if you notice ANY change in the person you are supporting?



Communicating with Families

- If the person had a visit with a physician or other health care provider and they were accompanied by a family member, it is important that the DSW inquire to what was done or ordered by the professional.
- It is still our responsibility to document any changes so that the plan of care can be updated. Case managers and Supervisors cannot do their proper job without proper communication of any changes that may indicate a need for additional services.
- Document what the family tells you about the visit to the physician, and or emergency room, and report this to your supervisor.

ACTIVITY : Progress Note Documentation

Purpose: The goal of this activity is to have DSW utilize objective documentation.

Outcome: Given a scenario the DSW will use appropriate objective documentation in reporting consumer status.

Materials: Sample forms: Daily Progress Note, and or the Progress Notes the individual agency uses.

Instructions:

1. The instructor will distribute a Progress Note(s) to each individual DSW
2. The instructor will give the following scenarios to the class.

Scenario: After bathing the consumer is seated at the table having breakfast. You notice that after eating 2 bites of food he clasps his hands over his abdomen and begins rocking back and forth. (Instructor provides a visual demonstration.)
The class is now asked to document objectively.

Answer: The DSW will report what they see, what the consumer tells them, not what they think or feel is going on. Did the DSW question the consumer as to what might be wrong?

In this scenario when using the attached Daily Progress Note the DSW could document the information in the Medical Concerns section or in the Summary section. They would also document the amount of food eaten in the Dietary Note section. Depending on the type of Progress Note the agency is using the placement of information may be different, but this basic information must be present.

Did the DSW use ink? Did the DSW make an error and know how to correct the error correctly?

Correct the DSW if they use Subjective Documentation.

Scenario 2: The consumer attends a physician appointment with a family member. The family reports that one medication has been discontinued and a new medication has been ordered. Ask the DSW to document this on the Daily Progress Note.

Answer: The DSW should note this information in the Medication Explanation section of the sample form, and know that they must report this to their supervisor. If using the agency Progress Note, is the DSW able to objectively describe the above mentioned information, which must be present.

SAMPLE Daily Progress Notes

Person's Name: _____ Date: _____

Agency: _____ Shift Time: _____

Staff Signature/Title: _____

Document Medical Concerns	*Examples of occurrences to document in this section include; person taken to E.R.; complaints of medical problems such as congestion, difficulty swallowing, headache, sore throat, etc,; seizures, any symptoms you notice; cough, runny nose, **red marks**, etc. Any physician appointments, IF Physician visit, **fill out Physician Visit Form***

_____

_____

Vital Signs	**ONLY IF REQUIRED BY PLAN OF CARE**	Time	Temp.	Pulse	Resp.	B/P	Weight

Medication Explanations: **complete if applicable**	*Do NOT write out the regularly prescribed medication, see MAR*

Refills today: ☐ Yes ☐ No Name of med:_____

D/C Meds today: ☐ Yes ☐ No Name of med:_____

New Orders: ☐ Yes ☐ No SEE ORDERS

DOES PERSON REQUIRE ASSISTANCE WITH TOILETING? YES ☐ NO ☐

If yes, Note time(s) and assistance provided: Time(s): What assistance:

Bowel Management: BM's this shift: ☐ Yes ☐ No

Fluid Balance-Urine: List how many times person voided this shift: _____ or Catheter: empty each shift

DIETARY NOTES:

Type of Diet: _____ **List percent eaten at each meal: 25%, 50%, 75%, 100% or 0% for refusal to eat**

List time ate before each meal:	List percent eaten at each meal:	Any Snacks? What?	When?
_____ Breakfast	_____%	_____	_____
_____ Lunch	_____%		
_____ Dinner	_____%	Peg/ G-Tube? _____	Formula:_____

Personal Contacts: ☐ Friends ☐ Family Name(s) of Contacts:

Type of Contact: ☐ Phone ☐ Visit

PERSONAL TASK COMPLETED: ***Note time when each completed: Leave blank if person independent***

_____ Bathing _____ Dressing _____ Brushing Teeth _____ Nails Clipped

_____ Brush/Comb hair _____ Ears Cleaned _____ Turned in bed/change W/C positions

Other: (Specify)_____

TASK COMPLETED: ***Note time when each completed: either by staff or person served (If applicable)***

_____ Meal Preparation _____ Sweeping/Mopping _____Dishes _____Laundry _____ Dusting

_____ Disinfect/Clean Bathroom(toilet, tub, sink) _____ Vacuum _____ Make bed _____ Other(Specify)

ACTIVITIES RELATED TO THE CPOC/ISP: ***(What activities occurred that are outlined in the person's CPOC)***

Attended day program/work? ☐ Yes ☐ No

Other:_____

ACTIVITIES: (*What did the person do, who did they see?)*

List Contacts with community:

_____

ACTIVITIES RELATED TO THE CPOC: ***(What activities occurred that are outlined in the person's CPOC)***

Attended day program/work? ☐ Yes ☐ No

Other:_____

ACTIVITIES: (*What did the person do, who did they see?)*

List Contacts with community:

Any Incidents: - incident form filled out: related to: ☐ Medical ☐ Behavior ☐ Seizure

☐ Abuse/Neglect ☐ Other(Specify type:)

FILE PROGRESS NOTE PER SHIFT / COMPLETED DAILY LOG FOR STAFF COMMUNICATION ☐ Yes ☐ No

SAMPLE PHYSICIAN VISIT & COMMUNICATION FORM

Agency Name, Address and Phone Number

Name of Waiver Participant:	Date of Visit:
Medicare/Medicaid No:	DOB:
Pertinent Medical History / known diagnosis:	
Allergies – Medication/Food – (listed on current MAR attached)	
Current Medications: **PLEASE SEE CURRENT MAR ATTACHED (Medication Administration Record)**	
REASON FOR THIS VISIT: (Staff must complete this section prior to visit – ex: Follow up, 90L, illness)	

Note: For Annual Physical, 90L form must accompany this form and filled out by physician. Physician should order all annual blood work, including CBC. Individuals with previous positive TB reading must have Chest X-Ray every 5 years, and documented chest auscultation noted at each physician visit.

(PRINT) **Physician Name:**	**Specialty:**
Address:	Phone:

PHYSICIAN ASSESSMENT AND ORDERS: (attach additional sheets as needed)

*TEST ORDERED:(if any)*_____

Staff : check all that apply:

_____ No Medication changes Follow up date: _____

_____ Readable assessment and orders

_____ For new medication: make sure time limits are understood

_____ Blood work: ensure copies of results are sent to Provider Agency

_____ Additional sheets attached if needed

_____ Progress note and communication logs filled out regarding this visit

Staff Signature:_____ **Physician Signature:_____**

Staff Checklist for each Physician Visit

DSW: use this form as reminder of all components needed when visiting the physician

Please complete the following checklist:

_____ Copy of Medicaid/Medicare card, MAR and this form given to physician.
(If annual physical, make sure you also bring 90L form)

_____ Make sure physician completes appropriate sections of Physician Visit form.

_____ Make sure physician writes prescriptions for medication changes, including discontinuation (D/C order) of any medication(s).

_____ Secure a written prescription from the physician before leaving the office, if applicable, and clarify all recommendations and orders.

_____ After visit, make copy of prescription or D/C order, if applicable per your agency policy, and copy of Physician Visit form; give original orders and forms to your supervisor who will notify the Nurse of medication changes that need to be made to MAR as well as any recommendations and tests noted.

_____ Copy of all orders and this form are to be filed in participants chart immediately per agency policy

_____ Supervisor will assure new medications are ordered.

_____ Write in the staff communication log the details of medication changes as well as on the Daily Progress note, do not forget to add other orders that were made and sign so the next shift can review and be aware of changes that have occurred.

Staff and Supervisor are to sign below once they have completed and checked each of the above steps as applicable.

Staff Signature:_____ Date: _____

Supervisor:_____ Date: _____

Waiver Participants name:_____ Date of visit: _____

Documentation:
Medication Administration Record (MAR)

Medication Administration Records should be developed per agency specific protocol. In some instances, pharmacies may generate medication records for facilities who administer an abundant amount of routine and/or PRN medications.

Routine Medication Administration Record (MAR)

Contains ongoing medication orders; i.e. medicines given on a daily basis.
Also contains medication that is ordered on a one time only basis.

The following are examples of information to include on the MAR:

- Month and year that the Medication Administration Record represents
- Date order was given
- Date and time medication was administered
- Initial of the person transcribing the order
- Initial of the person giving the medication
- Name of medication, dosage, route, time
- An area for staff signatures & initials

- Sample acronyms describing reasons why medications were not given
  - R=refused
  - H=hospital
  - D=destroyed

- Identification
  - Name of participant
  - Date of birth
  - Gender
  - Height
  - Weight

- ALLERGIES (list in RED)
  - Attending practitioner
  - Nutritional Information
  - special diet
  - list of current diagnosis

- Other necessary medical information (i.e. seizure disorder, asthma)

- Other necessary behavioral information (i.e. cheeking, binging, purging, etc.)

PRN (when necessary) Medication Administration Record

Contains medications that have been ordered on an "as needed basis". This record should contain the same additional information as the routine MAR. In addition, as this medication is given on "an as needed basis", it is imperative the effectiveness also be documented.

PRN medications are given on an as needed basis per the licensed practitioner's order. For this reason, it is very important that the PRN Medication Administration Record has documentation of time and amount administered to ensure the order is adhered to.

Ongoing observation, inquiry, and documentation within two hours after administration will determine effective or ineffective results of the medication. Additional acronyms that need to be added to the PRN MAR to describe the results of administration of PRN medications include I/E: I=ineffective; E=effective.

Over The Counter Medication Administration Record

ALL medications should have a practitioner's order. Over the counter medications such as Tylenol, Maalox, and Benadryl do not require prescriptions for purchase, but should be included on the practitioner's medication order.

This record should contain the same information as on the PRN Medication Administration Record in addition to an area to document "why" the medication was given (i.e. complaints of headache).

It is important to compare medications transcribed to medications on hand when preparing monthly Medication Administration Records.

Transcribing Medication Orders

Once a medication has been ordered and that medication has been dispensed by the pharmacy, it will be the responsibility of the DSW to ensure accurate and timely transcription of the medication onto the correct Medication Administration Record according to agency protocol.

Writing legibly is very important when transcribing medications. This can prevent medication errors and ensure individual safety in medication administration.

Only agency approved abbreviations should be used when transcribing medications (see reference section for example).

All orders should be transcribed exactly as written. If an order is written with an unapproved abbreviation, the prescribing practitioner must be called for clarification. DSW should follow agency policy.

The prescription from the licensed practitioner, the label on the medication, and the information on the MAR must match exactly.

The label on a medication cannot be changed by anyone. If the licensed practitioner changes the dosage on a prescribed medication, a new prescription must be filled by the pharmacy. The old medication cannot be administered and must be discarded per agency policy.

How to Read Prescription Orders

Reading Prescriptions

- Medication prescriptions are written by Licensed Practitioners.
- The Practitioner's handwriting may be difficult to read however, it is the responsibility of the Pharmacist to ensure clarity of the prescription order.
- Prescription labels should be clear and concise and abbreviations should be discouraged for consumer safety in medication administration
- It is recommended that all agencies have a list in place of what they consider approved and unapproved medical abbreviations.
- You cannot alter a medicine label.

NOTE: Medication Labels cannot be altered, they must be re-written.

Prescription labels will contain:

- Generic and/or trade name of the medication.
- Frequency & dosage of the medication.
- Number of doses of medication that are in the package/container.
- Number of times this medication may be refilled.
- Possible food, drink, or other drug interactions
- Special instructions (i.e. allergy warnings, possible side effects, etc.)
- Name of prescribing licensed practitioner
- Expiration date

NOTE: If a person is pregnant or you think she may be, you should consult a physician for special instructions prior to administering any medication.

Transcribing Medication Orders:

- Once a medication has been ordered and dispensed by the Pharmacy, it will be the responsibility of the DSW to ensure accurate and timely transcription of the medication onto the correct Medication Administration Record, according to agency protocol.
- Writing legibly is very important when transcribing medications. This can prevent medication errors, and ensure client safety in medication administration.

- Only agency approved abbreviations should be used when transcribing medications

- All orders should be transcribed exactly as written. If order is written with an unapproved abbreviation, your supervisor must be called, the supervisor will call the RN who will call the prescribing practitioner for clarification.

It is important to compare medications transcribed to medications on hand when preparing monthly Medication Administration Records.

Medication Errors
A medication error occurs when one of the "six fundamental rights of medication administration" has been violated. Examples of these would be:

- Administering wrong medication
- Administering wrong dose of medication
- Administering medication at the wrong time (Medications may be administered per agency policy prior to or past the time ordered, and still be considered to be on time).
- Administering the medication in the wrong route (i.e. dermatological ointment administered to eye)
- Administering medication to wrong individual
- Failing to document medication was given or inaccurate documentation of medicine given

Medication errors may result in adverse reactions to the individual. These reactions could range from a rash to death.

Always Check the Rights of Medication

- When removing the medication from storage
- When removing the medication from its container
- When returning the medication to storage

Review of the Six Fundamental Rights

a. Right Person
b. Right Medication
c. Right Time
d. Right Dose
e. Right Route
f. Right Documentation

Refusal of Medications

It is an individual's right to refuse medications. Individuals should understand, to the best of their ability, the symptoms that medications are prescribed for and any common side effects. DSW should explain that these medications are considered a part of their individualized treatment plan. Remember that each person may communicate in different ways and the DSW must be trained on how to communicate with each person they support.

The DSW must notify the supervisor, who will contact the nurse. The nurse will notify the licensed practitioner when a medication has been refused.

Refusing medications is NOT considered a medication error, and should be documented on the Medication Administration Record as a "refusal of medication". This documentation ensures the individual has been offered the medication as ordered, and also proves staff competency in management/administration of medications.

Preventing and Reporting Medication Errors

Knowing the following before administering medications will help prevent medication errors:

- Name (generic and trade)
- Purpose
- Effect
- Length of time to take effect
- Side effects
- Adverse effects
- Interactions
- Special instructions
- Where to get help
- Six fundamental rights of medication administration

Errors occur when the DSW

- Does not follow the doctor's orders exactly
- Does not follow manufacturer's directions
- Does not follow accepted standards for medication administration
- Does not observe the **"six fundamental rights"** of medication administration

When an error occurs

- Contact your supervisor, who will contact the nurse
  - Complete a medication error report in accordance with regulations and agency policies.

The DSW has the responsibility to **ALWAYS** follow agency policy and procedure to report, if they have any reason to believe they have made a medication error. This should be reported as soon as possible to the supervisor.

ACTIVITY : MAR Documentation Practice (next 2 pages)

Purpose: The goal of this activity is to have DSW utilize proper documentation on a Medication Administration Record (MAR)

Outcome: Given a scenario the DSW will use appropriate documentation steps to assure medication is documented correctly.

Materials: Sample MAR forms: attached or agency specific

Instructions:

1. The instructor will distribute a MAR to each individual DSW
2. The instructor will give the following scenarios to the class.

Scenario: The physician ordered Dilantin 100 mg twice a day starting on the 5th of the month.

Scenario: The participant refused his medication, Dilantin on the 10th of the month.

Scenario: The medication Dilantin 100 mg twice a day was changed to once a day by the physician on the 25th of the month.

Scenario: The DSW forgot to give the medication Dilantin 100 mg on the 15th of the month.

Did the DSW use ink?
Did the DSW correctly indicate the medication was refused, was the supervisor notified?
Did the DSW document correctly when the medication was changed to one time a day, and did the DSW notify the supervisor?
Did the DSW also remember to make note on the Progress note regarding medication changes?
Did the DSW correctly note on the MAR that the medication was not given on the 15th of the month and, did the DSW understand the need to fill out a medication error report per agency policy and notify the supervisor? Did the DSW indicate on the MAR med not given?

INSTRUCTOR: add additional scenarios to assure DSWs understanding of MAR Documentation. Assure that the DSW also understands that all pertinent participant information needs to be listed on the MAR, i.e.; name, allergies, illness etc.

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR	1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31
MEDICATIONS	HOUR	1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTION ON REVERSE SIDE

CHARTING FOR MONTH:		Page of
Primary Care Physician:		Telephone No.
Specialist(s):		Telephone No.
Allergies: Adverse Drug Reactions:	Pharmacy:	Telephone No.
Diagnosis:		
Medicaid Number	Medicare Number	Complete entries checked By: Title: Date:
Patient:		Location:

INSTRUCTIONS: a. Put initial in appropriate box when medication given
b. Circle initials when medication refused
c. State reason for refusal on nurse's notes.
d. PRN Med: Reason given and results should be noted on Nurse's Medication Notes.

CHARTING CODES:
A-Charted in error
B-Patient refused
C-Patient out of facility
D-Drug not given. Indicate reason in Nurse's Medication Notes.
E-See Nurse's Notes
F-Patient did not retain medication

DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	DATE
Temperature/ Pulse																																Temperature/ Pulse
Blood Pressure																																Blood Pressures

NURSE'S MEDICATION NOTES

PATCH SITE/ INFECTION SITE CODES:
1-RIGHT DORSAL GLUTEUS
2-LEFT DORSAL GLUTEUS
3-RIGHT VENTRAL GLUETEUS
4-LEFT VENTRAL GLUTEUS
5-RIGHT LATERAL THIGH
6-LEFT LATERAL THIGH
7-RIGHT DELTOID
8-LEFT DELTOID
9-RIGHT UPPER ARM
10-LEFT UPPER ARM
11-RIGHT ANTERIOR THIG
12-LEFT ANTERIO THIGH
13-UPPER BACK LEFT
14-UPPER BACK RIGHT
15-UPPER CHEST LEFT
16-UPPER CHEST RIGHT

Date/Hour	Medication/Dosage	Reason	Results/Response	Hour/Initials

SAMPLE ASSESSMENT DOCUMENTATION

1. What best describes a communication interaction?
   A. A speaker and a listener.
   B. Exchange of information
   C. Gestures
   D. All of the above

2. If a person is non-verbal, it is acceptable for a DSW to initiate physical contact without communicating the procedure to the person.
   A. True
   B. False

3. People use different methods to express themselves. Some of them are:
   A. Body language
   B. Gestures or signs
   C. Facial expression
   D. All of the above

4. What best defines Person Specific Documentation?
   A. Documentation is purposeful and specific to the individuals care and needs
   B. Person documents their own care
   C. Each person has a different form to use
   D. Documentation that describes what the DSW thinks or feels

5. Documentation following a physician visit when a family member is present is always completed by the family member
   A. True
   B. False

6. What are the two most important actions the DSW is responsible for when they observe changes in the individual they are supporting:
   A. Objective Documentation
   B. Reporting to your supervisor
   C. Calling the Nurse
   D. Both A and B

7. As a DSW, you are responsible for both documentation of a problem and reporting the situation to your supervisor?
   A. True
   B. False

8. If the DSW accompanies the individual they are supporting on a physician visit they MUST know the reason the individual is going on the appointment.
   A. True
   B. False

9. Medication errors occur when:
   A. The DSW does not follow any one of the six fundamental rights of medication administration
   B. The participant refuses to take a medication
   C. The participant is in the hospital
   D. The Nurse explains to the DSW that the medication has been discontinued

10. When administering PRN (as needed) medications the DSW must always;
   A. Document the reason the medication is being given for
   B. Document the actual time the PRN medication is given
   C. Observe the participant and document within 2 hours after administration of the PRN medication if the medication was effective or ineffective
   D. All of the above

DSW Signature: _____

RN Signature: _____

Date: _____

D. Sample Training Module 3: Vital Signs

VITAL SIGNS
Temperature, Pulse, Respiration and Blood Pressure

Objectives:

At the end of this module, the DSW will be able to:

- Demonstrate how to correctly obtain a person's temperature, respiratory rate, pulse and blood pressure (per automatic digital blood pressure cuff)
- Discuss factors that affect vital signs
- Demonstrate proper documentation of vital signs
- Explain when to obtain vital signs
- Discuss proper communication of vital signs to supervisors who will communicate with nurse.

IMPORTANT TO KEEP IN MIND

1. This training is presented for the purpose of providing information and should not be taken as medical advice.
    a. It may provide information on pertinent changes that may take place in the person with a disability and allow for early intervention. It is impossible to review proper care and management guidelines for all health conditions the direct service worker or administrator will encounter in brief training sessions.
2. It is highly recommend that you discuss specific protocols and health care guidelines with your supervisor for further training on specific issues.
    a. This can only be done once you have reviewed the individual's health records.
    b. Each individual is unique and care plans can be very different for individuals with the same chronic health condition.
3. Always remember that **ANY** change in the person's condition or behavior must be reported.
    a. You must <u>document change</u> in the progress notes, <u>report</u> to your supervisor who must report to the Nurse. The Nurse with your agency will then report this to the physician.
4. The lines of communication will be altered in the case of emergencies, as you will call 911 first.

VITAL SIGNS are measurable life signs. The term "vital signs" usually refers to the person's temperature, pulse, respirations, and blood pressure.

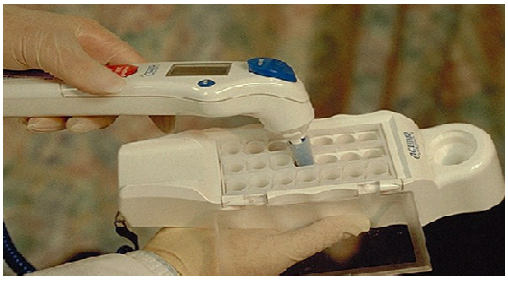
<u>Vital signs are key indicators used to determine the person's overall condition.</u>

Temperature:

Measures the amount of heat in the body. The 3 locations normally used in determining the body temperature are the mouth (oral temperature), the armpit (axillary), and the ear (tympanic).

If you measured a person's body temperature using all three of these methods, you would obtain three slightly different temperatures. The axillary (armpit) temperature would be slightly lower than the oral (mouth) temperature while the tympanic (ear) temperature would be slightly higher than the oral temperature.

For safety of the consumer we will use digital ear thermometers for measuring temperatures in community settings.



The following measurements apply:

Average normal range for infants less than 3 months
98.6˚F – 100.4 ˚F
Average normal range for infants over 3 months:
98.6 ˚F - 101 ˚F
Average normal range for adults:
98.6 ˚F - 100 ˚F

The average body temperature of a healthy adult is 98.6ºF. This does not mean that everyone should always have a temperature of 98.6ºF. An individual's normal temperature may be slightly higher or slightly lower. A body temperature between 96.8ºF and 100ºF is considered to be within the normal temperature range unless otherwise specified. A person can have a body temperature that is slightly above or below 98.6ºF and still be normal and healthy. People have different "normal" temperatures. *What is normal for the person you support?*

When a person becomes ill, one of the first things that must be done is to determine what disease, injury, or other factor is responsible. Some problems, such as pneumonia and heatstroke, cause the body to become warmer than normal. Some problems, such as generalized hypothermia and some forms of shock, cause the body to become cooler than normal. Determining whether the person's temperature is normal, higher than normal, or lower than normal can be important in determining what is wrong with the person.

Why is it important to know a person's temperature?

- **TO DETERMINE the CAUSE of the PERSON'S CONDITION**
- **TO DETERMINE the EFFECTIVENESS of TREATMENT**

Factors affecting Temperature:

- Drinking/eating hot/cold liquids or food
- Smoking
- Infection
- Dehydration
- Exercise
- Constipation
- Coughing or hiccupping
- Dyspnea (difficulty breathing)
- Environment
- Emotions
- Time of day

Fever can be caused by infection or illness; this is the body's way of fighting the infection. Certain diseases, such as arthritis, hyperthyroidism and leukemia may also cause elevated body temperature.

Exposure to extreme heat or cold can change body temperature. Hot weather, especially with high humidity, can result in heat exhaustion and even heat stroke, which elevates temperature to dangerously high levels. Sunburn can also cause fever. Exposure to cold temperatures can result in hypothermia, or a body temperature that is dangerously low.

Body temperature is at its lowest point early in the day. As the day progresses, body temperature rises

Signs of Fever

When a person’s body temperature is not within the normal range, the cause is usually an infection or a dangerous environmental condition.
Signs of a fever include:

- Flushed face
- Bright glistening eyes
- Hot skin
- Thirst
- Restlessness

Methods of Obtaining the Temperature:

There are several methods of obtaining a temperature:

- Oral (by mouth)
- Axillary (under the arm)
- Rectal
- Tympanic Membrane (The tympanic membrane is the ear drum)

Procedure for using Ear Thermometer

There are many kinds of ear thermometers. Carefully read the instructions before using your thermometer.

- Explain to the person what you will be doing.
- Wash hands.
- Position person in upright sitting position with head turned to side, away from you (*Infants and children can be held in arms or on lap)*
- Remove thermometer from container and attach probe cover to ear thermometer.
- Turn person's head to one side: For an adult, pull outer part of the ear upward and back; for a child, pull down and back. Gently insert probe into ear canal.
- Leave in place until beep is heard (usually2 seconds).
- Remove probe after reading is displayed on digital unit.
- Discard used probe cover in trash, do not reuse.
- Return ear thermometer to storage unit.
- Share your finding with the person.
- Wash hands
- Document reading on progress note or vital sign record.

The DSW will now demonstrate the appropriate method of taking a temperature using an ear thermometer during this time and again at the end of the course.

The DSW will use the appropriate form for documenting the temperature that is required by their agency.

When to notify your supervisor:

Inform your supervisor if:

- Temperature is very high or very low. Above or below what the norm is for the person you support
- If earwax is seen on the probe cover.
- If you are unable to get a temperature due to:
    - Person refuses
    - Person is uncooperative
    - There is a machine malfunction

PULSE:

The rhythmical throbbing of arteries produced by the regular contractions of the heart. The pulse measures how fast the heart is beating and is known as the rate. It should be counted for <u>one full minute</u>.

A pulse is created when the left upper chamber (ventricle) of the heart contracts. When this happens, blood is suddenly pushed from the ventricle to the main artery of the body (aorta). This sudden forcing of blood from the heart into the arteries causes two things to happen.

- The artery expands: The sudden rush of blood increases the volume of blood in the arteries. In order to accept this increased volume, the arteries expand (stretch).
- As the arteries quickly contract (go back to normal size), blood is forced from the arteries, through the capillaries, and into the veins.
- In addition to the expansion of the arteries, a "wave" travels through the arteries. This wave is the pulse and can be felt at various locations in the body. All arteries have a pulse, but the pulse is easier to feel (palpate) when the artery is near the surface of the body.

The Pulse Measures how fast the heart is beating

Normal Results for resting heart rate:

- Newborn infants: 100 - 160 beats per minute
- Children 1 to 10 years: 70 - 120 beats per minute
- Children over 10 and adults (including seniors): 60 - 100 beats per minute
- Well-trained athletes: 40 - 60 beats per minute

Factors affecting Pulse:

- **Age:** Before birth 140 – 150
  At birth 130 – 140
  Childhood 80 – 115
  Adult 72- 80
  Later years 60 -70

- **Height:** generally a tall person's pulse is slower.

- **Sex:** a female's pulse is usually faster.

- **Exercise:** exercise increases the need for oxygen and therefore increases the pulse.

- **Fever:** increases the pulse.

- **Medication:** can increase or decrease the heart rate.

- **Acute pain:** increases the pulse **and chronic pain** decreases the pulse.

- **A failing heart:** increases the heart rate as the heart has to pump faster to circulate oxygen to the body.

- **Hemorrhage and blood loss:** increases the pulse, but the pulse is weak.

- **Brain injuries:** e.g. stroke – may slow the pulse.

- **Fear , worry, anxiety:** increases the pulse

Pulse Points: There are several sites on the body where a pulse is normally taken. All arteries have a pulse, but it is easier to palpate (feel) the pulse at certain locations.

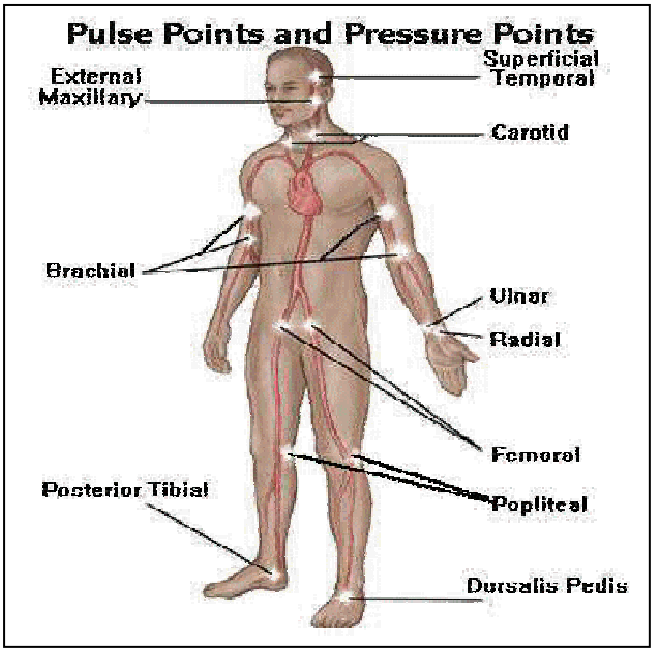
The three most common sites are:

- Radial Pulse (wrist)
- Carotid Pulse (throat)
- Brachial Pulse (inside of elbow)

Radial – The radial pulse (using the radial artery) is taken at a point where the radial artery crosses the bones of the wrist. If the person's hand is turned so that the palm is up, the radial pulse is taken on the thumb side of the top side of the wrist.

Carotid – The carotid pulse is taken on either side of the trachea (wind pipe). The best locations are in the grooves located to the right and to the left of the larynx (Adam's apple).

Brachial – The brachial pulse is taken in the depression located about one-half inch above the crease on the inside (not the bony side) of the elbow. This site is also used when taking the person's blood pressure.



Procedure for Counting a Pulse:

- Explain to the person what you will be doing
- Wash hands.
- Place your index and middle fingers on the inner aspect of person's wrist over the radial artery (the wrist point)
- Apply light but firm pressure until pulse is felt. **(Do not use thumb)**
- Count for <u>one full minute</u> using second hand on watch.
- Share your finding with the person.

- Document reading on progress note or vital sign record.

The DSW will now demonstrate the appropriate method of counting pulse during this time and again at the end of the module.

The DSW will use the appropriate form for documenting the pulse that is required by their agency.

Documenting the Pulse:

- Document the rate: number of beats per minute
- Document the rhythm: regular or irregular
- Document the volume (strength): weak or strong

Example:
Pulse 100, irregular, weak

RATE: The normal adult has a pulse rate of about 72 beats per minute. Infants have higher average pulse rates. The normal pulse rate ranges are based upon age and physical condition.

RHYTHM: A regular pulse will have the same interval between beats. An irregular pulse (uneven pattern) will have a skipped or missed beat or it may have an additional beat.

Volume or Strength: The strength (force) of the pulse is determined by the amount of blood forced into the artery by the heartbeat. A normal pulse has a normal strength. You will be able to identify a normal strength pulse with practice.

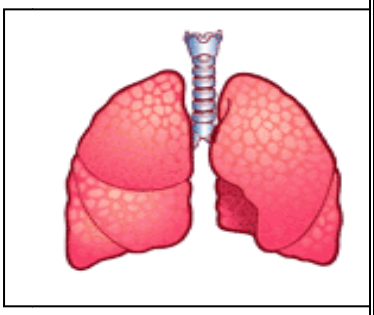
Terms used to describe the strength of a pulse are:

- **Bounding** (very strong)
- **Weak** (weak, feeble, thready)
- **Strong** (stronger than a normal pulse but less than a bounding pulse)

Documenting all of these factors is essential when recording the pulse. It provides a more accurate description of the person's cardiovascular status.

It is important for the DSW to use the appropriate agency form for documentation.

RESPIRATION: the process of inhaling and exhaling (breathing).



Measures the number of times <u>in one minute</u> that the <u>chest rises and falls</u>.

- **Normal- Adults: aged 18 and over**
  12-20 beats per minute
- **Normal- Children: 6-12 years of age**
  22-30 beats per minute
  Normal- Infant: birth – 1 year
  30-60 beats per minute

WHAT IS BREATHING?

Basically, breathing is ventilation. Ventilation is the mechanical act of moving air in and out of your lungs. When you inhale (breathe in), fresh air enters your lungs, the lungs take oxygen from the air.

When you breathe out (exhale) you add carbon dioxide to the air. When you exhale, you force the air from your lungs back into the environment. You do not however, force all the air out of your lungs when you exhale. A person takes in about 500 ml. of air when he inhales normally and exhales the same amount. After a normal exhale, the lungs will still contain about 2300 ml. of air. This is referred to as residual air.

Factors affecting Respirations:

- Body position
- Exercise
- Smoking
- Acute pain
- Anxiety
- Medication
- Disease conditions
- Brainstem injury

Procedure for counting Respirations:
The cycle for respirations: one inhalation and one exhalation equals one respiration, = the rise and fall of the chest (*this can be done by counting each time the chest or the abdomen rises)*

- Person should be lying down, or in sitting position.
- Make sure chest movement is visible.
- Do not let the person know you are counting the respirations (it will affect their Breathing rate)
- Count with the first breath in while looking at the second hand of a watch.
- Count for one full minute.
- Document results on progress note or vital sign record.

The DSW will now demonstrate the appropriate method of counting respirations during this time and again at the end of the module.

The DSW will use the appropriate form for documenting the respiratory rate that is required by their agency.

Documenting Respirations: The DSW will use the appropriate form required by their agency to document the individual's respirations.

It is important to document the following:

- Rate – number of respirations per minute.
- Rhythm – regular or irregular
- Quality – type of breathing noted: labored (noisy, difficult respirations) or unlabored: (quiet, without effort)

Example: Respirations – 12, irregular; labored

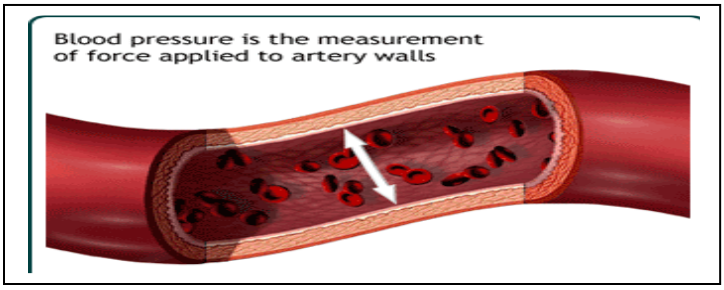
ASSESSING A PERSON'S RESPIRATIONS

You normally assess the person's breathing when you are taking the pulse. Take the pulse in such a manner that you do not need to move in order to observe their breathing also. When you finish counting the person's pulse rate, count the person's breaths (the rising and falling of their chest) before recording their pulse rate. Continue to hold their wrist as though you were still counting their pulse rate. Count the number of complete breaths (the sequence of inhalation and exhalation is one breath) that occur during a 60 second period.

As you count the person's breaths, look and listen for abnormalities (rapid or slow breathing, shallow or deep breathing, irregular breathing, noises, indications of pain, coughing, and so forth). If you are not taking their pulse, observe their breathing when they are at rest (usually sitting or lying down) and not aware that you are observing their breathing.

Breathing should be effortless and barely noticeable. If it is labored or noisy, too fast, or too slow, then it is not normal and should be REPORTED immediately so that it can be treated immediately.

BLOOD PRESSURE:



Blood pressure (BP) is the pressure exerted by circulating blood upon the walls of the blood vessels. During each heartbeat, BP varies between a maximum (systolic) and a minimum (diastolic) pressure. **Systolic** pressure is when the heart is *contracting* (working) and **Diastolic** pressure is when the heart *is at rest.*

All blood vessels – large or small, artery or vein- have blood pressure. However, the term blood pressure normally refers to the blood pressure of a major artery. Unlike the other vital signs discussed previously, the blood pressure involves two numbers, the systolic pressure and the diastolic pressure, to describe this vital sign.

Basically, the systolic pressure is the greatest pressure that the blood exerts against the walls of the blood vessel (and will be noted as the top number of the reading) while the diastolic is the lowest pressure that the blood exerts against the walls of the vessel (and is indicated by the bottom number of the reading).

A person's blood pressure depends upon:

- The force of the heart's pumping action
- The degree to which the blood vessel will stretch
- The amount of blood in the blood vessel

The arteries are under the greatest pressure when the heart pumps blood into them. The extra blood that is forced into the arteries make them stretch. The arteries are under the least pressure from the blood when the heart is at rest (between pumps or beats) and the arteries have returned to their normal size.

Factors affecting Blood Pressure:

- **Asleep or awake** – usually lower when sleeping
  Body position – lying down, sitting or standing can either increase or decrease Blood Pressure
- **Emotional state** – such as stress and anger can increase BP
- **Activity level** – from not moving to extreme exertion can increase or decrease Blood Pressure
- **Smoking** – increases BP

There are many factors that can affect a person's blood pressure. Some are only temporary, others are long-term effects. A condition in which the blood pressure is considerably above normal is called "hypertension". If the blood pressure is too low, it is called "hypotension". A primary factor influencing a person's blood pressure is the condition of their cardiovascular system (heart and blood vessels).

Other factors affecting blood pressure include the following:

- **Age**: A person's blood pressure readings tend to increase as they grow older.
- **Gender**: men tend to have higher blood pressure than women of the same age.
- **Physical illness**: People who are physically fit tend to have more normal blood pressure than people who are out of shape.
- **Obesity:** People who are very overweight usually have higher blood pressure than people who are within their ideal weight range
- **Disease:** any disorder that affects the arteries or kidneys will result in a higher blood pressure. Diseases that weaken the heart will usually result in a lower blood pressure.

Blood Pressure Ranges:

Normal B/P Range	90/60	to	119/79
Pre-Hypertension	120/80	to	139/89
Hypertension Stage	140/90	to	159/99
Hypertension Stage 2	> 160/100		
Average B/P Range for children:	80/34	to	120/75

Remember, it is important for the DSW to know what is normal for the person they support.

High Blood pressure, which is called *hypertension,* is a condition in which the force of the blood is high enough against the artery walls that it may eventually *cause health problems such as heart disease and stroke.*

Blood pressure is determined by the amount of blood the heart pumps and the amount of resistance to blood flow in the arteries. The more blood the heart pumps and the narrower the arteries, the higher the blood pressure. Uncontrolled high blood pressure increases the risk of serious health problems, including heart attack and stroke.

High Blood Pressure = Hypertension

Most people with high blood pressure have no signs or symptoms, and the reason this condition is known as the ***SILENT KILLER***.

Possible Early Signs and Symptoms of Hypertension may include:

- Above normal blood pressure reading
- Dull headaches
- Dizzy Spells
- Nosebleeds

Early detection and treatment may save a person's life!

Low Blood Pressure = Hypotension

Low blood pressure (hypotension) is pressure so low it causes symptoms or signs due to the low flow of blood through the arteries and veins.

When the flow of blood is too low to deliver enough oxygen and nutrients to vital organs such as the brain, heart, and kidney, the organs do not function normally and may be temporarily or permanently damaged.

Many people with low blood pressure have dizziness and fainting or serious heart, endocrine or neurological disorders. Severely low blood pressure can deprive the brain and other vital organs of oxygen and nutrients, leading to a life- threatening condition called shock.

Although blood pressure varies from person to person, a blood pressure reading of 90 or less systolic (the top number) or 60 or less diastolic (bottom number) is generally considered low blood pressure.

The causes of low blood pressure can range from dehydration to problems with the way the brain signals the heart to pump blood. Low blood pressure is treatable, but it's important to find out what's causing the condition so that it can be properly treated.

Unlike high blood pressure symptoms, which are poorly defined and often totally absent, low blood pressure has several classic, easily recognized symptoms.

The development of symptoms is considered an indicator that the person should be evaluated to discover the cause of the low blood pressure and to rule out any underlying problems. Generally, blood pressure must fall to a fairly low value before symptoms develop.

Signs and Symptoms of Hypotension (low blood pressure) may include:

- Below normal blood pressure reading
- Dizziness, or feeling like you're standing on a rocking boat
- Fainting
- Changes in mental status (difficulty concentrating, confusion) or a sense of "impending doom" or anxiety
- Changes in breathing patterns (fast, shallow breathing is common during an episode of low blood pressure)
- Nausea
- Suddenly feeling cold or clammy, or a rapid onset of pale skin

Early detection and treatment may save a person's life!

Types of Blood Pressure Monitors:

The majority of home monitors are digital blood pressure monitors. These monitors are easier to use than the manual monitors. The technology of digital monitors has improved rapidly and now they are considered only very slightly less accurate than manual blood pressure monitors.

Digital blood pressure monitors have sensors that detect the sounds of blood in the artery in the cuff. Therefore, generally, for home use, digital monitors are recommended. Most of the popular models are automatic and inflate the cuff. This leads to less variability and more accurate readings.

It will be important for you to carefully read the directions on the monitor that you will be using for the individual that you support, as each monitor is different.

Using a Digital Blood Pressure Monitor:

There are many kinds of B/P Monitors. Carefully read the instructions before using your B/P Monitor.

- Person should sit with back supported or lying with arm stretched out, level with the heart.
- Person should sit with legs uncrossed.
- The person should avoid eating, drinking alcohol, smoking, exercising or bathing for 30 minutes before taking their blood pressure.

Procedure for Measuring Blood Pressure:

- Wash hands and gather equipment: automated digital blood pressure cuff, pen note pad or log to write on.

- Position the person, or have the person position arm in desired appropriate position

- Blood pressure is normally taken in the upper arm. The person can stand, sit or lie down. Normally the person will sit with the arm resting on table or lie down with arm resting on bed.

- Expose the site; move clothes above elbow, assist the person if needed.

Have the person extend his/her arm in a palm up position. The arm should be about the same level as the heart. Support the arm on the bed, table, etc. If the person is sitting upright, feet should be flat on the floor, legs uncrossed. Encourage the person to remain still.

- Wrap the cuff comfortably, and securely around the upper arm, just above the elbow

- Press the ON/OFF START Button to turn machine on. Reading begins automatically.

- Document reading. Record the systolic and diastolic readings. The systolic is written first and is separated by a diagonal line: Ex “120/80” Both readings are documented.

- Press the ON/OFF START Button again to turn machine off.

- Remove cuff from around the person arm.

- Assist the person if needed with clothes.

- Return equipment to the proper storage.

The DSW will now demonstrate the appropriate method of taking a blood pressure using a Digital B/P Monitor during this time and again at the end of the module.

The DSW will use the appropriate form for documenting the Blood Pressure that is required by their agency.

Documentation of Blood Pressure Measurement

The DSW will use the appropriate form required by their agency to record the blood pressure reading.

- Systolic number (top number)
- Diastolic number (bottom number)
- Time and date
- Site

Example:
120/80 (Systolic # / Diastolic #)
Left arm
11 AM on 9/3/2013

When to Check Vital Signs:

- When given instruction by your supervisor or by the health care provider.
- When you notice the person is not feeling well or may be ill.
- After someone has had a seizure.

When to Report Vital Signs

- When vital signs are out of the normal for the individual
- When instructed by the health care professional (doctor, nurse, etc.)

DOCUMENT and REPORT to your supervisor.

Your supervisor will report to the RN. The Nurse will report to the physician.

NOTE: A sample Vital Sign Basics Assessment and Skills Procedure Review is included at the end of the module.

KEY TERMS & GLOSSARY

- **Blood Pressure** refers to the force (pressure) with which the blood presses against the walls of the blood vessel. All vessels – large or small, artery or vein—have blood pressure. However, the term blood pressure normally refers to the blood pressure of a major artery. Unlike the other vital signs, it takes two numbers—the systolic pressure (top number) and the diastolic (bottom number)—to describe this vital sign. Basically, the systolic pressure is the greatest pressure that the blood exerts against the walls of the blood vessels when the heart pumps blood into them while the diastolic is the lowest pressure that the blood exerts against the walls of the vessels when the heart is at rest (between pumps or beats). A person's blood pressure depends upon the force of the heart's pumping action, the degree to which the blood vessel will stretch, and the amount of blood in the blood vessels.

- **Pulse** is the rhythmical expansion and contraction of an artery produced by waves of pressure caused by the ejection of blood from the left ventricle of the heart as it contracts.

- **Respiration** the physical and chemical processes (as breathing and diffusion) by which an organism supplies its cells and tissues with the oxygen needed for metabolism and relieves them of the carbon dioxide formed in energy-producing reactions

- **Temperature** the degree of heat that is natural to a living body <a normal oral *temperature* of about 98.6°F

- **Vital Signs** the pulse rate, respiratory rate, body temperature, and blood pressure of a person. Referred to as a person's measurable life signs. The vital signs are key indicators that are used to determine a person's overall condition.

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VITAL SIGN BASICS SKILLS PROCEDURE REVIEW					1 of 3
DSW WILL DEMONSTRATE KNOWLEDGE OF OR SKILL IN THE AREAS SPECIFIED BELOW Place a check (**√**) mark in the "YES, "NO" or "NA" box					
	ACTIVITIES	**YES**	**NO**	**NA**	**COMMENTS**
1.	**DEMONSTRATES SKILL IN THE PREPARATION OF THE PARTICIPANT** • Explain to the person that you will taking be his/her Vital Signs. Explain the Vital Sign Procedure you will performing: Temperature, Pulse, and Blood Pressure. (Telling the person that you are taking his/her respirations many times causes false readings, count Respirations without informing participant) Answer any questions the person may have.				
2.	**DEMONSTRATES SKILL IN TAKING TEMPERATURE (Ear Thermometer)** • Wash hands • Position person in upright sitting position with head turned to side, away from you (Infants and children can be held in arms or on lap) • Remove thermometer from container and attach probe cover to ear thermometer. • Turn person's head to one side: For an adult, pull outer part of the ear upward and back; for a child, pull down and back. Gently insert probe with gentle pressure into ear canal. • Leave probe in place until beep is heard (usually 2 seconds). • Remove probe after reading is displayed on digital unit. • Discard used probe cover in trash, do not reuse. • Return ear thermometer to storage unit. • Share your findings with the consumer. Document reading on progress note or vital sign record.				
3.	**DEMONSTRATES SKILL IN TAKING PULSE & DOCUMENTING (Radial Pulse)** • Place your index and middle fingers on the inner aspect of the person's wrist over the radial artery (wrist point) • Apply light but firm pressure until pulse is felt (Do not use thumb) • Count for <u>one full minute</u> using second hand on watch • Document reading on progress note or vital sign record. • Document the rate: **number of beats per minute** • Document the rhythm: **regular or irregular** Document the volume (strength): **weak or strong**				

DSW WILL DEMONSTRATE KNOWLEDGE OF OR SKILL IN THE AREAS SPECIFIED BELOW

Place a check (**√**) mark in the "YES, "NO" or "NA" box.

	ACTIVITIES	YES	NO	NA	COMMENTS
4.	**DEMONSTRATES SKILL IN COUNTING RESPIRATORY RATE & DOCUMENTING** • Person should be lying down or in sitting position • Count with the first breath in, while looking at the second hand of watch • Counts one full respiration; one inhalation and one exhalation is one respiration(rise & fall of chest) • Document rate on progress note or vital sign record • Document the rate: number of respiration in 1 full minute • Document the rhythm: **regular or irregular** Document the quality (type) **labored**: (noisy, difficult respirations) or **unlabored**: (quiet, without effort)				
5.	**DEMONSTRATES SKILL IN TAKING BLOOD PRESSURE USING DIGITAL MONITOR & DOCUMENTING** • Understands there are different types of B/P monitors: must read instructions for individual type that will be used. Position the person, or have the person position arm in desired appropriate position (arm stretched out, level with heart) or in bed, with arm at side • Blood pressure is normally taken in the upper arm. The person can stand, sit or lie down. Normally the person will sit with the arm resting on table or lie down with arm resting on bed. • Expose the site, move clothes above elbow, assist the person if needed. • Have the person extend his/her arm in a palm -up position. The arm should be about the same level as the heart. Support the arm on the bed, table etc. If the person is sitting upright, feet should be flat on the floor, legs uncrossed. • Encourage the person to remain still. • Wrap the cuff comfortably and securely around the upper arm, just above the elbow. • Press the ON/OFF START Button to turn machine on. Reading begins automatically. • Document reading. Record the systolic (top#) and diastolic (bottom#) readings on the progress note or vital sign record. • Systolic & Diastolic are separated by a diagonal line • Document the time, date and site. E.g.: 120/80, left arm, 11 am on 9/5/2013 • Press the ON/OFF/START button again to turn machine off. • Remove the cuff from around the persons arm.				

VITAL SIGN BASICS SKILLS PROCEDURE REVIEW					3 of 3
DSW WILL DEMONSTRATE KNOWLEDGE OF OR SKILL IN THE AREAS SPECIFIED BELOW Place a check (**√**) mark in the "YES, "NO" or "NA" box					
	• Assist the person if needed with clothes				
	• Return equipment to the proper storage.				

DSW Signature: _____

RN Signature: _____

Date: _____

SAMPLE ASSESSMENT

VITAL SIGNS

1. Constipation is a factor that affects temperature.
    A. True
    B. False

2. Factors that affect blood pressure:
    A. High temperature
    B. Age
    C. Sleep apnea
    D. All of the above

3. One factor that affects the respiratory rate is anxiety.
    A. True
    B. False

4. When should you report vital signs?
    A. When vital signs are out of the normal for the individual.
    B. When instructed per health care provider.
    C. At the beginning of the month.
    D. A and B

5. Who will you report you report abnormal findings?
    A. Supervisor
    B. Nurse
    C. Doctor
    D. Case manager

6. The recommended site for obtaining a blood pressure is:
    A. Brachial artery (upper arm)
    B. Radial (wrist)
    C. Finger

7. A pulse is the rhythmic expansion and contraction of the arteries. _____ measures how fast the heart is beating.
    A. Pulse
    B. Radial
    C. Brachial

8. If an abnormal respiratory rate and rhythm are noted on your shift and this is a change in the person's usual condition you should:

A. Call your supervisor and document
B. Tell the person to take a nap
C. Give the person a bath
D. Nothing, wait until your supervisory calls you

9. When counting the pulse and respiratory rate is alright to count for 30 seconds and divide by 2.

A. True
B. False

10. Early detection and treatment of a potential problem can save a person's life.

A. True
B. False

DSW Signature: _____

RN Signature: _____

Date: _____