LOUISIANA

DIRECT SERVICE WORKER

Medication Administration SAMPLE 16 Hour Program

ACKNOWLEDGEMENTS

The Medication Administration Core Curriculum was developed for use in Louisiana's Home and Community Based Services (HCBS) programs and Self Direction Programs.

The core curriculum is the outcome of a collaborative effort between the Department of Health and Hospitals, Health Standards Section (HSS), Office of Aging and Adult Services (OAAS), and Office for Citizens with Developmental Disabilities (OCDD), and the Louisiana State Board of Nursing (LSBN). The goal of this collaboration was to produce a competency-based, core curriculum that provides non-licensed staff with the basic knowledge, skill and guidance needed to ensure safe and effective medication administration and performance of noncomplex tasks.

This training curriculum is not all inclusive and should in no way substitute for the required, person-specific training and competency evaluation performed by the Registered Nurse (RN).

Bailey's Law

This medication administration curriculum was developed by the Office for Citizens with Developmental Disabilities (OCDD), Office of Aging and Adult Services (OAAS) and the Health Standards Section in conjunction with the Louisiana State Board of Nursing as directed by House Bill 185 (ACT 507) of the 2014 Legislative Session. The legislation also known as Bailey's Law was initiated by Mr. Jason Durham whose daughter Bailey Caroline Durham was a recipient of waiver services through the Department's Self-Direction Program. It recognizes the advocacy efforts on behalf of persons with disabilities to have the right to direct their own care and services. All direct service workers who provide supports and services to waiver clients in the Self-Direction Program and administer medications as part of the client's plan of care, must receive this training.

Rule: LAC 48:Chapter 92.
R.S. 37:1031-1034 and R.S. 40:2179-2179.2 Chapter 92 Subchapter D. Medication Administration and Noncomplex Tasks in Home and Community Based Settings:

Medication Administration for Direct Service Workers
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Introduction

The Louisiana Department of Health and Hospitals (DHH) is committed to assuring that individuals receiving Home and Community-Based Services (HCBS) receive safe, quality care. The Louisiana DHH recognizes the roles of both licensed nursing and trained, unlicensed personnel in the provision of care, including the administration of medication and performance of approved noncomplex tasks to HCBS Waiver participants. In recognition of these roles, the DHH shall insure that guidelines for a system of competency based training for unlicensed personnel are developed and implemented in accordance with in all applicable rules and regulations. These guidelines are designed to foster and enhance a uniform and consistent means of safe medication administration and the performance of approved noncomplex tasks by unlicensed d Direct Service Workers (DSW's) working in a HCBS Waiver and Self Direction settings.

Scope:

This training curriculum shall apply to unlicensed DSW personnel in the HCBS Waiver setting who administer medications and who perform approved, noncomplex procedures in HCBS Waiver programs.

The training is intended to encompass the components of the direct service registry rule published in the Louisiana Register, vol. 38 #12 December 20, 2012, Section 9245

In certain circumstances however it may be necessary for additional, supplemental training to be performed. This will be dependent on the waiver participant's specific condition and needs which may require approved noncomplex tasks not included in the basic medication administration course. The RN will determine if additional training is appropriate.

Course Participant Minimal Requirements:

Minimal requirements to successfully complete this training program include:

- DSW must be a least 18 years of age;
- DSW must have the ability to read, write and carry out directions competently as assigned and;
- DSW must have no finding on the registry that he/she has abused or neglected an individual being supported or misappropriate the individual's property or funds.

Goals of the Instruction Program:

1. Introduce the learners to concepts related to administering medications and the performance of approved noncomplex tasks

2. Provide learners with experiences in administering approved medications.
3. Provide consistency of basic medication administration and performance of approved noncomplex tasks by unlicensed DSW personnel throughout the state.

Evaluation:

The learner is required to pass the test following each training module with 80% accuracy. A certificate will be provided upon successful completion of the course and must be kept in the DSW's personnel file at the support coordination agency, the DSW may also have a copy of his/her certificate. This documentation must be readily available for inspection by the DHH or its designee.

Initial competency and subsequent annual competency evaluations will be performed by the delegating RN with documentation of ongoing competency also maintained and available for inspection by DHH or its designee.

Rule: Rule: LAC 48:Chapter 92.
R.S. 37:1031-1034 and R.S. 40:2179-2179.2 Chapter 92 Subchapter D. Medication Administration and Noncomplex Tasks in Home and Community Based Settings: Allows for the Person Specific Training of DSW's by an RN who has assessed the health status of the person and who has determined that the DSW can competently perform the tasks in a safe, appropriate manner.

R.S. 37:1031(A) and 1033(A) (Bailey's Law)

Training Process

- **Online Internet Based training-**Explanation of training and testing process for Internet training will be according to agency policies and procedures related to Self Direction
- ***On Line training is only available for Self Direction Program, this sample may be used in all HCBS programs.***

- **Modules**
  - Modules are consecutive
  - Each module ends with test questions
  - Staff must score 80% on each module before they may proceed to the next module

- **Skills demonstration –** RN will evaluate or monitor skills, proficiencies and competency.

Medication Administration Curriculum for Direct Service Workers

Course Objectives:

- To train DSW (non-licensed personnel) in:
  Methods of delivering medication

- Safely and accurately administering medication to ensure the safety of those individuals in your care

- Understanding intended effects of medications, as well as, the potential for adverse side effects

- Recognizing and differentiating side effects

- Properly reporting adverse side effects

- Following instructions given in response to adverse side effects

- Demonstrating competency

Course Goal:

This course is intended for non-licensed personnel who provide direct care of individuals receiving supports or services in the HCBS Waiver and Self Direction programs.

Upon successful completion of this course the non-licensed personnel would prove competency, as determined by a registered nurse, in administration of an individual's medication.

COURSE DESCRIPTION

This course is designed to include:

- online internet based: (*if used for Self Direction Program*
- Competency Skills testing
- RN oversight

Each module will contain a post examination to determine competency in understanding the information. A passing score of 80% is required on Module I, II, III and IV exams.
With successful completion of this course, non-licensed personnel will have increased knowledge of the following:

1. Accurate transcription of medication from the order/prescription on to the appropriate Medication Administration Record

2. Reviewing individuals history on Medication Administration Record (allergies and other co-existing medical conditions)

3. Using proper hygiene/universal precautions in medication preparation.

4. Accurate individual/medication identification by comparing medication label to the transcribed Medication Administration Record:

   a. Right Client

   b. Right Medication

   c. Right Time

   d. Right Dose

   e. Right Route

   f. Right Documentation

5. Educating individual on medications being administered

6. Application/Administration of:
    a. Oral Medications
    b. Eye Drops
    c. Ear Drops
    d. Topical Ointments/Creams

7. Correct use of oral and nasal inhalers

8. Observation of individuals during/after medication administration:
    a. For cheeked medication
    b. How to observe and report adverse effects

9. Taking vital signs as applicable:
    a. blood pressure
    b. temperature
    c. respirations
    d. and pulse

MODULE 1:

Legal Issues, Policies and Procedures

To the Non-Licensed Personnel

As a direct staff person working in the HCBS waiver program and Self Direction Programs, part of your duties may require that you assist with medication administration. It will be your responsibility to create an environment in which medications can be given safely. It will also be your responsibility to observe the people you support and report your observations to help determine if medications are working. This training will help you learn to administer/assist with medications in a safe, error-free manner.

Medications are given to treat or prevent health problems. Many of the medications taken by people you support are given to eliminate or decrease symptoms of a disease or behavior rather than to cure it. The goal of medication is to improve quality of life.

It is important to follow standard steps when administering medications. You must also remember to create a home- like environment for the people you support. In addition to following standard steps, you must get to know the people you support. This will allow you to recognize changes in their physical condition or behavior. It is recommended that you learn about their personality, physical conditions, current medications, and capabilities. Some of the people you support may not be able to communicate with you verbally. This will require you to communicate in ways that they recognize and understand.

Liability Issues Related To Medication Administration

Only physicians, dentists and advanced registered nurse practitioners may "prescribe" medication. Physicians, dentist and pharmacists, are licensed to "dispense" medications.

Nurses are licensed to "administer" medications and may delegate the task to administer oral and topical medications to persons who have completed a course such as this.

While there are similarities in the registered nurse (RN) practice and the licensed practical nurse (LPN) practice, the degree of educational preparation and the responsibilities of each differ.

In order to be eligible for either license, the candidate must have completed the required amount of education from either an RN or LPN accredited program. Once the accredited program has been successfully completed, the candidate is eligible to sit for the National Council Licensure Examination (NCLEX).

After successfully passing that first exam, ongoing education is required to ensure competency. Each nurse is required to complete approved continuing education each year, or provide documentation of the State Board approved alternative.

Registered nurses may work directly under the direction of physicians, dentists and advance practice nurses, while licensed practical nurses must also work under the direction of a registered nurse.

These and other laws are in place to govern the practice of nurses in the state of Louisiana, to ensure the health and welfare of those served. The law that pertains to non-licensed persons working under the authority of a licensed nurse.

This regulation explicitly spells out how tasks may be delegated to a non-licensed individual by a licensed nurse. In keeping with this regulation, it will be the responsibility of the Provider agency to ensure a registered nurse trains this course, and evaluates the competency of the individuals who have completed the course.

A registered nurse will also be responsible for ongoing training and competency evaluations of the non-licensed persons to safeguard the health and welfare of the individuals in care. This is a safe and prudent practice on behalf of the employing agency, as well as, the nurse. Each Provider agency must have policies in place to identify how and when this will take place.

Upon completion of this training, the non-licensed personnel will receive a certificate of completion which will be kept with the support coordination agency and available for inspection by the DHH or its designee.

Role of Non-Licensed Personnel in Medication Administration:

Where delegation is required the non-licensed personnel will perform medication administration as a delegated function under nursing supervision in accordance with LAC 48:Chapter 92. R.S. 37:1031-1034 and R.S. 40:2179-2179.2
Chapter 92 Subchapter D.

The following cannot be delegated:

- conversion or calculation of medication dosage
- assessment of an individual's need for or response to medication
- nursing judgment regarding the administration of PRN (medications given as ordered) medications

Non-licensed personnel will be permitted to follow a specific physician protocol for PRN medication and document effectiveness or ineffectiveness of the medication.

Example: if the physician wrote an order for Tylenol 350 mg for fever >100.0 F and the non-licensed personnel administered Tylenol for a fever of 101.0 then documented a decrease in the temperature or no decrease in temperature. The non- licensed staff is simply collecting information and documenting, not using nursing or medical judgment about an action or intervention.

The non-licensed personnel shall not perform a task that involves an individual who is not in a stable condition.

The non-licensed personnel should never accept a delegation that he/she knows is beyond his/her skill set or knowledge. Non-licensed personnel have the right and are encouraged to ask for assistance and/or additional training.

The non-licensed personnel has the responsibility to **ALWAYS** follow procedures of the self direction program and to report to the nurse if they have any reason to believe they have made a medication error. This should be reported as soon as possible.

The non-licensed personnel has the responsibility to **ALWAYS** report the following:

- signs or symptoms that appear life-threatening
- events that appear health threatening
- medication that produces no results or undesired results

Other Legal Considerations in Medication Administration

A. Packaging of medications:

Pharmacies have the responsibility of dispensing medications in a way that will ensure an individual's safety. Medications prescribed for individuals are often packaged in what are called unit doses (one dose of medication in each area of package).

The original manufacturer's label on over the counter medication has to be maintained to ensure legibility for accurate administration.

It is illegal to transfer ANY medication from one container to another container This includes both controlled and non-controlled substances.

B. Storage of medications:

ALL medications will be kept locked in accordance with agency policies and procedures following Drug Enforcement Agency (DEA) requirements.

Medications requiring refrigeration will be kept in a refrigerator. Medications must be stored in accordance with manufacturer's recommendations.

Medication Errors

A medication error occurs when one of the "six client rights" 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

Six 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. Non-licensed staff should explain that these medications are considered a part of their individualized treatment plan. Remember that each person may communicate in different ways and staff must be trained on how to communicate with each person they support.

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. DSW must notify family and support coordination agency as soon as possible after the occurrence.

Missed Medications

Clients will occasionally miss a dose of medication. This may cause a problem because missing a dose may make the medicine less effective, but taking subsequent doses too close together increases the risk of side effects. Reasons clients may miss a medication dose may include:

- Has forgotten to take or to be given the medication
- Has missed the correct time for a dose because they were at an appointment or away from home longer than expected
- Was asleep at the time the medication was due.

A missed medication does not include a client who refused to take their medication or has vomited their medication.

If a medication is missed, the DSW must document this on the medication administration record (MAR) by initialing and circling their initials. There should be documentation regarding why the medication was missed. The DSW should seek follow up instructions from the RN in the event a medication is missed.

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 rights of medication

There is a printable handout located on the handout page at the end of this module titled *Preventing and Reporting Medication Errors.*

Errors occur when staff

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

When an error occurs

- DSW must contact the family and the support coordination agency immediately.

Handouts attached:

- *RN vs. LPN*
- *Sample MAR*
- *Preventing and Reporting Medication Errors*
- *What is a Medication Error*

Registered Nurse and Licensed Practical Nurse: *What's the Difference?*

Similarities

Both the Registered Nurse and the Licensed Practical Nurse

- Must complete education requirements from an accredited program
- Must pass the National License Exam
- Must have ongoing education to ensure competence and complete the required number of Continuing Education Credits each year

Differences

The Registered Nurse:

- Must complete a higher degree of educational preparation
- Has greater responsibilities
- Works directly under the direction of physicians, dentists, or advance practice nurses

The License Practical Nurse:

- Must complete a lesser degree of education preparation
- Has a lesser degree of responsibilities
- Works both independently of and performs acts prescribed by physician, dentists or advance nurse practice nurse AND a Registered Nurse

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

Errors occur when staff:

- Do not follow the doctor's orders exactly
- Do not follow manufacturer's directions
- Do not follow accepted standards for medication administration

When an error occurs:

- Complete a medication error report

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

What is a Medication Error?

A medication error occurs when one of the "six client rights" has been violated.

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

- Administering wrong medication
- Administering wrong dose of medication
- Administering medication at the wrong time
- Medications may be administered per agency policy prior or per agency policy 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

Refusal of Medications:

It is a person's right to refuse medications. Individuals should understand the symptoms that medications are prescribed for, and also should be made aware of any common side effects. He/she should also be able to verbalize understanding that these medications are considered a part of treatment and that the Licensed Practitioner will be notified should he/she refuse the medication

Refusing medications is NOT considered a medication error.

End of Module 1

MEDICATION ADMINISTRATION
TEST - MODULE 1
Legal Issues, Policies and Procedures

KEEP COMPLETED TEST ON FILE

Staff:_____ Test Date:_____ Score: _____

1. The Medication Administration Course for HCBS and Self Direction Programs is intended to be taken by:

   A. non-licensed personnel who provide direct care to individuals receiving supports in the HCBS Waiver and Self Direction programs
   B Registered Nurse
   C. Licensed Practical Nurse
   D. Individual receiving HCBS Waiver services

2. As a direct staff person (non-licensed person) working in the HCBS and Self Direction Programs, part of your responsibilities is that you may be required to assist with medication administration

   A. True
   B. False

3. HCBS stands for:

   A. Home and Community Based Services
   B. Health Care Basic Services
   C. Home Care Best System
   D. None of the Above

4. As a direct staff person (non-licensed person) part of your responsibility when working will be to:

   A. Create an environment in which medications can be given safely
   B. Observe the people you support and report your observations to determine if medications are working.
   C. Follow standard steps when administering medications
   D. All of the above

5. As a direct staff person (non-licensed person) you may only administer those medications that the Registered Nurse can legally delegate you to administer

   A. True
   B. False

6. Medications that the Registered Nurse CANNOT delegate you to administer and are considered Complex tasks include:

   A. IM medications: medications given by injection in the muscle
   B. SC medications: medications given by injection in the subcutaneous tissue
   C. IV medications: medications given by injection in the veins
   D. All of the above

7. It is illegal to transfer ANY medication from one container to another container

   A. True
   B. False

8. Medication errors occur when one the "SIX RIGHT of medication administration" has been violated:

   A. True
   B. False

9. Which of the following lists the "SIX RIGHTS of medication administration"

   A. Right Person; Right Medication, Right Time, Right Dose, Right Route, Right Documentation
   B. Right Day, Right Month, Right Person, Right House, Right Order, Right Physician
   C. Right Person, Right Parent, Right Home, Right Date, Right Reactions, Right Chart
   D. None of the above

10. Medication errors occur when one the "SIX RIGHTS of medication administration" has been violated: Which of the following can result in a medication error?

   A. Administering wrong medication, Administering wrong dose of medication
   B. Administering medication at the wrong time, Administering medication in the wrong route (i.e. skin ointment administered to eye)
   C. Administering medication to the wrong individual, Failing to document medication was given or inaccurate documentation of medicine given
   D. All of the above

MODULE 2:

INFECTION CONTROL MEASURES

LOUISIANA
Department of HEALTH and HOSPITALS

INFECTION CONTROL UNIVERSAL PRECATIONS

01/09/2009

OBJECTIVES

- At the end of this session, the participants 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

01/09/2009

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)

01/09/2009

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

01/09/2009

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

01/09/2009

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

01/09/2009

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

01/09/2009

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

01/09/2009

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

01/09/2009

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

01/09/2009

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

01/09/2009

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

01/09/2009

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

01/09/2009

HAND HYGIENE VIDEO

- View these videos on hand hygiene:

  http://www.cdc.gov/CDCTV/HandsTogether/

Play entire video:
http://www.publichealthgreybruce.on.ca/Communicable/Handwashing/

Application of learning – student return demonstration

01/09/2009

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

01/09/2009

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

01/09/2009

WHEN SHOULD I CHANGE GLOVES?

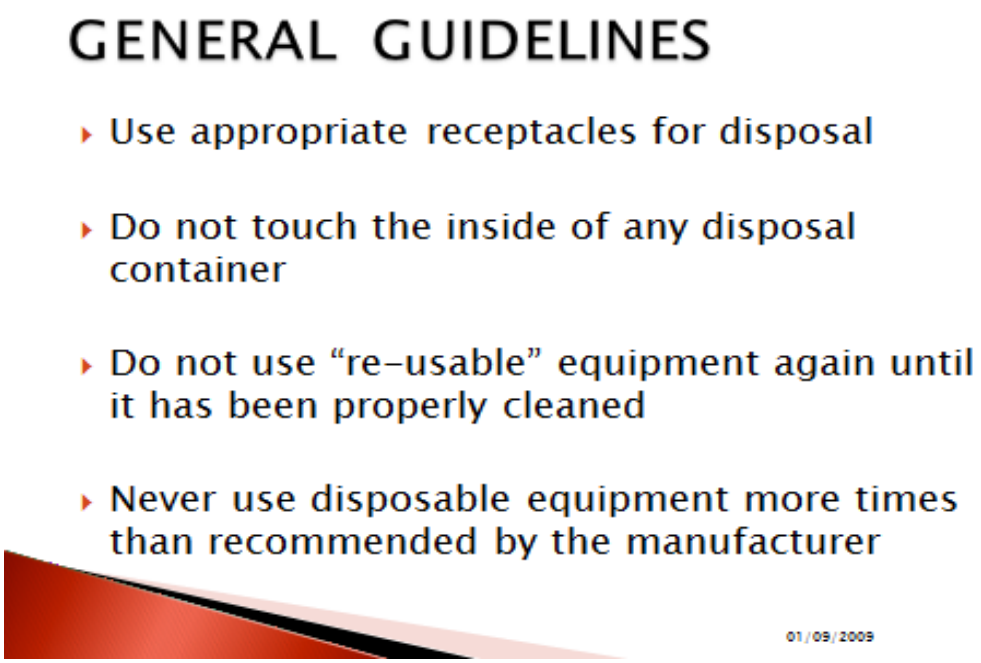
- When touching surfaces that may be contaminated
- Right before contact with mucous membranes or broken skin
- Immediately if they become wet, worn, soiled or torn

01/09/2009

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

01/09/2009


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
01/09/2009

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

01/09/2009

PUTTING ON GLOVES – VIDEO

- http://www.uams.edu/csc/programs/orientation/gloves/glovesOn.mov
- **Application of learning** – student return demonstration

01/09/2009

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).

01/09/2009

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.

01/09/2009

REMOVING CONTAMINATED GLOVES – VIDEO

- Click for video instruction for removing contaminated gloves:

  http://www.hse.gov.uk/mvr/myths/video/video9.htm

Application of learning – student return demonstration

01/09/2009

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

01/09/2009

End of Module 2

MEDICATION ADMINISTRATION
TEST - MODULE 2
INFECTION CONTROL MEASURES

KEEP COMPLETED TEST ON FILE

Staff:_____ Test Date:_____ Score: _____

2. Infection control is defined as a set of methods used to control and prevent the spread of disease:

   A. True
   B. False

2. The best ways to prevent the spread of disease is:

   A. Good hand washing
   B. Using alcohol-based hand cleaner in place of washing when soap and water not available
   C. Avoid touching your eyes, nose or mouth
   D. All of the above

3. When must you wear gloves?

   A. When you come in contact with blood
   B. When you come in contact with body fluids; secretions and excretions
   C. When you come in contact with broken or open skin, human tissue or mucous membranes
   D All of the above

4. When should you change gloves?

   A. When touching surfaces that may be contaminated
   B. Right before contact with mucous membranes or broken skin
   C. Immediately if they become wet, worn, soiled or torn
   D. All of the above

5. Contaminated means: dirty, soiled, unclean

   A. True
   B. False

6. Disinfection means: cleaning so germs (pathogens) are destroyed

   A. True
   B. False

7. Mucous membranes are: membranes that line body cavities that open to the outside of the body

A. True
B. False

8. Which of the following are MODES of transmission (the way germs are passed from one person to another)

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

9. Universal Precautions:

A. Infection control guidelines designed to protect workers from exposure to disease spread by blood and certain body fluids
B. State you must always treat blood, body fluids, broken skin and mucous membranes as if they were infected
C. Are to be followed because you cannot tell by looking at a person whether they have a contagious disease
D. All of the above

10. Common methods you can do to help prevent spread of disease

A. Cover your nose and mouth with a tissue every time you cough or sneeze
B. Throw used tissue in a wastebasket
C. If you do not have a tissue, sneeze or cough into your sleeve
D. Always clean your hands after coughing or sneezing
E. All of the above

MODULE 3:

Classification of Medications & Terminology

Prescribed Medications

Prescribed medications are those medications that a licensed practitioner (physician, dentist, and advanced registered nurse practitioner) has ordered for treatment of an individual's particular diagnosis or symptoms. These medications may include controlled/scheduled, non-controlled/scheduled and or over-the-counter.

Prescribed medications may be ordered on an as needed basis (PRN), on a routine basis, or as a one-time only order. How the prescribed medication is ordered will determine the Medication Administration Record that will be used to transcribe the order.(i.e. Routine prescribed medications and one time only orders will be transcribed onto the Routine Medication Administration Record. Medications prescribed on a PRN basis will be transcribed on to the PRN Medication Administration Record).

Controlled/scheduled Medications

"Controlled/Scheduled medications" are those medications potentially addictive and regulated under the Controlled/Scheduled Substance Act of 1970. Controlled/Scheduled medications CANNOT be obtained without a written prescription from a licensed practitioner.

When controlled/scheduled medicines are prescribed on an as needed basis (PRN) (i.e. hydrocodone) they will be transcribed and documented as given on the PRN Medication Administration Record.

When a controlled/scheduled substance is given on a routine basis (i.e. Ritalin) it will be transcribed and documented as given on the Routine Medication Administration Record.

Non-controlled/scheduled medications are all other (both prescribed and over the counter) medications that are not regulated by the DEA, but still require an order from a licensed practitioner.

All non-controlled/scheduled medications require an order from a licensed practitioner (physician, dentist, or ARNP).

Over the Counter Medications

Over the counter medications must be administered and documented at the time they are administered.

Classification of Medications

It is very important that the person administering medications **read the licensed practitioner's prescribed orders** on medications as to determine:

- name
- time
- route
- accurate dosage

Those medications that are given over-the-counter must be given according to specified time limits. OTC medications must be given in accordance with the licensed practitioner's order which must not require non-licensed staff to use judgment.

Non-licensed personnel will be responsible for educating themselves on medications prior to administration. This can be done by review of the *drug education sheet received from the pharmacy with the prescription*. This sheet comes from the pharmacy with the medication, and will explain why the medication is given and common side effects of the medication. It is recommended that all DSWs have an updated drug information/education sheet accessible at all times for review of any prescribed medications and/or over-the-counter medication.

Individual information is imperative to individual safety in medication administration/management.

This includes but is not limited to the following:

- individual's name
- date of birth
- sex
- height
- weight
- allergies

Controlled/Scheduled Medications

Those medicines that have been deemed potentially addictive are regulated under the Controlled Substance Act of 1970. Controlled medications are classified according to addiction potential with Schedule I being the highest potential and Schedule V being the least potential for addiction.

Non-Controlled/Non-Scheduled Medications

All other medications prescribed, including over the counter medication are not considered to be potentially addictive by the DEA.

Handouts:

- *Controlled/Scheduled Medications and Non-Controlled/Non-Scheduled Medications: What's the Difference?*
- *Common Medications*
- *Brand Names and Generic Names for Various Medications Used Frequently in Behavioral Health*
- *AVOID CONFUSION OF DRUGS WITH SIMILAR NAMES*
- *Glossary of Terms.*

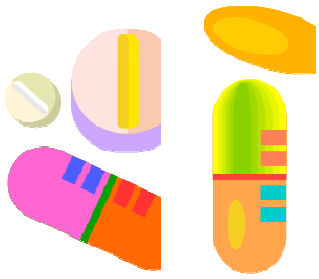
References:

ISMP List of Error-Prone Abbreviation, Symbols, and Dose Designations
http://www.ismp.org/Tools/errorproneabbreviations.pdf

ISMP list of Confused Drug Name List
http://www.ismp.org/Tools/confuseddrugnames.pdf

ISMP list of High Alert Medications
http://www.ismp.org/Tools/highalertmedications.pdf

Controlled/Scheduled Medications and Non-Controlled/Non-Scheduled Medications: *What's the Difference?*



Controlled/Scheduled Medications:

- Have been deemed potentially addictive and are regulated under the Controlled Substance Act of 1970
- Are classified according to addiction potential with Schedule I being the highest potential and Schedule V being the least potential for addiction

Non-Controlled/Non-Scheduled Medications:

- Any medications prescribed, including over the counter medications that are not considered potentially addictive by the DEA.

Common Medications

*** THIS IS NOT AN ALL INCLUSIVE LIST**

Medication Classification	Common Use	Common Names	Common Adverse Effects
Antibiotics *Pay close attention to any client allergies.	Infections caused by bacteria. Not commonly used for viruses.	Amoxicillin; Ampicillin; Penicillin; Cefaclor (ceclor); Ceftin; Biaxin; Zithromax; Erythromycin; Doxycycline; Cipro; Levaquin; Keflex; Bactrim DS	Nausea; diarrhea; rash; yeast infections; fever; sun sensitivity
Anti-Asthma Agents	Asthma; respiratory distress; Bronchitis; COPD	Advair; Albuterol; Singulair; Ipratropium; Combivent; Triamcinolone; Flunisolide	Nervous feeling; sweating; nausea; vomiting;
Antihistamines	Allergic reactions (i.e hay fever)	Tavist-D; Claritin; Singulair; Zyrtec; Allegra; Benadryl; Chlortrimeton	Drowsiness; insomnia; weakness;
Antifungal Agents	Fungal infections;	Nystatin; Diflucan; Nizoral; Miconazole; Lotrimin; Tinactin	Headache; nausea; diarrhea; vomiting
Anti-tuberculosis	Prevent tuberculosis;	INH; Rifampin; Pyridoxine (vitamin B-6)	Headache; fatigue; dizziness; seizure;
Antiviral Agents	Viral infections;	Ziagen; Symmetrel; Zovirax;	Mood disorders; nausea; diarrhea;
Analgesics	Pain relief;	Tylenol; Advil; Aspirin; Naprosyn; Lortab, Diclofenac; Tylenol with codeine; Percocet; Myoflex; Analgesic Cream; Capsaicin; Icy Hot	Stomach upset; tinnitus; nausea;
Anticoagulant/Anti-platelet	Blood thinning	Warfarin (coumadin); Lovenox; Plavix; Asprin	Dermatological, Bruising; Cramping; Nausea; Dizziness; Abnormal liver labs; Drug Interaction; Abnormal Bleeding; Allergy/hypersensitivity reactions

Anticonvulsants	Neurological disorders; seizures	Phenobarbital; Valporic Acid; Tegretol; Dilantin; Lamictal; Keppra; Gabapentin;	Dizziness; drowsiness; confusion; fainting; Gum/dental abnormalities; hypertension; weight gain; abdominal pain; sun sensitivity
Antidiabetics	To treat diabetes;	Insulins; Glucagon; Glucophage; Glipizide; Glyburide	Nausea; heartburn; fatigue; dizziness;
Antiparkinsonians	To treat Parkinsons disease;	Levodopa; Sinemet (carbidopa/levodopa); Eldepryl (Selegine); Mirapex; Comtan; Permex	Disorientation; confusion; depression
Cardiovascular	High blood pressure; irregular heart beat; heart failure;	Tenormin; Capoten; Catopres; Digoxin; Lisinopril, Metoprolol; Valsartan; Verapamil; Amlodipine; Nitroglycerin; Isosorbide	Dizziness; drowsiness; chest pain; loss of appetite; leg pain;
Cerebral Stimulants	Attention Deficit Disorder; Narcolepsy;	"CONTROLLED" Adderall; Ritalin;	Insomnia; irritability; decreased growth;
Contraceptives	Prevent Pregnancy; Birth Control Pills	Ortho-Cept; Zovia; Provera; Ovral	Depression; blood clots; weight gain; Migraine headaches
Cough/Anti-tussives	Cough Suppression; Expectorant	Robitussin (guaifenesin); Mucinex; Dextromethorphan	Nausea; Vomiting; Dizziness; Headaches; Drowsiness
Decongestants	Relives congestion	Tavist-D; Claritin; Flonase; Rhinocort; Sudafed	Nose bleed; nasal irritation; Hypertension; Hyperactivity
Dermatological	Skin infections; Burns; anti- inflammatory; protectants; anti-irritants	Bacitracin; Zovirax; Neosporin; Silvadene; Hydrocortisone cream; Triamcinolone cream; Flunisolone cream; Hydrophor; Hydrophil'	Rash; skin irritation; burning

	Gastrointestinal 1.Antacid 2.Anti-Ulcer 3.Anti-Diarrhea 4.Stool Softeners 5. Laxatives	1.Heartburn; Acid Reflux; 2.To treat ulcer condition. 3.To stop diarrhea. 4.To relieve constipation. 5.To relieve constipation	1.Tums; Mylanta; Maalox; 2.Tagamet; Pepcid; Zantac; Prevacid; Prilosec 3.Imodium; Lomotil; PeptoBismol 4.Colace; Surfak 5.Magnesium Citrate; Senna; Fleets; Metamucil (bulk laxative)	1.Constipation; bloating; 2.Dizziness; mild diarrhea; 3.Fatigue; dry mouth; nausea; 4.Cramping; dependency; 5.Cramping; dependency
	Neuropathy	Pain/discomfort due to neuralgias	Tegetrol; Gabapentin (Neurontin)	Dizziness; Drowsiness; Nausea; Vomiting; Personality Changes; Blood Disorders; Food/drug Interaction; Hypersensitivity Reactions
	Opthalmic	Irritation/infection; inflammation of the eye.	Polysporin; Neosporin; Liquifilm; Maxitrol; Acular; Tobrabex; Bacitracin; Polymyxin	Burning sensation; Itching; blurred vision;
	Otic	External Ear infections; wax removal	Boric Acid; Debrox; Cortisporin	Ear irritation; itching
	Psychotherapeutic Agents: 1. Antidepressants 2. Antipsychotic 3. Anti-mania	1. Depression; 2.Psychosis; behavior disorder; 1. Mood Disorders	1. Wellbutrin; Paxil; Zoloft; Celexa; Lexapro 2. Abilify; Risperdal; Haldol; Seroquel, Zyprexa 3. Lithium; Eskalith;	1. Weight gain; insomnia; nervous feeling; 2. Tardive dyskensia; sedation; 3. Tremors; drowsiness; thirst;
	Thyroid	Hypothyroidism	Levothyroxine (Synthroid, Levoxyl)	Diarrhea; burning in mouth; sore throat; headache; depression
	Vitamin/Mineral	Nutritional Deficiencies	Multivitamin; Vitamin A; Vitamin B/ Riboflavin; Vitamin C/Ascorbic Acid; Vitamin D; Vitamin E; Iron; Zinc; Magnesium; Selenium; thiamine Folic Acid; Calcium	Thirst; light head; discolored urine Faintness; diarrhea Black Stools; stained teeth

Frequently Used Medications
This list is not all inclusive

Brand Name	Generic Name	Brand Name	Generic Name
Abilify	Aripiprazole	Meladate ER, Metadate CD	Methylphenidate
Actifed	Pseudoephedrine/Triprolidine	Mellaril	Thioridazine
Adderall	Amphetamine Mixture	Motrin	Ibuprofen
Advil	Ibuprofen	Neurontin	Gabapentin
Atarax	Hydroxyzine	Paxil	Paroxetine
Ativan	Lorazepam	Prozac	Fluoxetine
Benadryl	Diphenhydramine HCL	Remeron	Mirtazapine
Buspar	Buspirone	Risperdal	Risperidone
Catapres	Clonidine	Ritalin, Ritalin SR, Ritalin EC	Methylphenidate
Celexa	Citalopram	Robitussin DM	Guaifenesin Dextromethorphan Hbr
Claritin	Loratadine	Seroquel	Quetiapine
Cogentin	Benztropine	Singulair	Montelukast
Colace	Docusate Sodium	Strattera	Atomoxetine
Concerta	Methylphenidate	Synthroid	Levothyroxine
DDAVP	Desmopressin acetate	Tegretol, Carbitrol	Carbamazepine
Depakote, Depakote ER, Depakene	Valproic Acid derivatives	Tenex	Guanfacine
Desyrel	Trazodone	Tofranil	Imipramine
Dexadrine	Dextroamphetamne Sulfate	Thorazine	Chlorpromazine
Effexor	Venlafaxine	Tinactin	Tolnaftate
Eskalith	Lithium	Topamax	Topiramate
Gabitril	Tiagabine	Desyrel	Trazodone
Gas-X	Simethicone	Trileptal	Oxcarbazepine
Geodon	Ziprasidone	Tylenol	Acetaminophen
Haldol	Haloperidol	Valium	Diazepam
Imipramine Hcl	Imipramine	Wellbutrin, Wellbutrin SR	Bupropion
Imodium	Loperamide	Xanax	Alprazolam
Lamictal	Lamotrigine	Zantac	Ranitidine
Lexapro	Escitalopram	Zoloft	Sertraline
Lithobid	Lithium	Zyprexa	Olanzapine
Lotrimin	Clotrimazole		
Luvox	Fluvoxamine		

Glossary of Terms:

Abrasion - Superficial scraping away of the skin

Acute – A sudden onset, the opposite of chronic

ADD - Attention Deficit Disorder. A disorder from childhood manifested by poor impulse control, distractibility and forgetfulness

ADHD - Attention Deficit Hyperactivity Disorder. ADD with added symptoms of hyperactivity.

Adverse Effects – An unexpected or unwanted reaction to a medication. It may be sudden or develop over time.

Allergic reaction – An immune response to a foreign substance resulting in inflammation and/or organ dysfunction. Symptoms may occur immediately or over time, such as redness, rash, hives, itching, swelling, and yellowing of skin and fever.

Analgesic - A medication for relief of pain.

Anaphylaxis – The most dangerous type of allergic reaction. Anaphylaxis is a life-threatening event that may include symptoms such as falling blood pressure, respiratory distress and unresponsiveness.

Angina – Chest pain

Angioedema – Large welts below surface of skin

Antianxiety - A medication that reduces the feelings of worry or apprehension.

Antibiotic - A medication that kills or slows the growth of bacteria.

Anticoagulant - A medication that hinders or slows the clotting of blood.

Antidepressant - A medication used to relieve or prevent depression.

Anti mania – A medication used to relieve the mental state of extreme excitement and activity (Manic or Bipolar disorders).

Antiparkinsonian - Medications that reduce the symptoms of Parkinson Syndrome such as slurred speech, shuffling gait, loss of facial expression, hand tremors.

Antipsychotic – A medication that reduces the symptoms of psychosis, such as delusions, hallucinations and distorted reality.

Antiseptic - Substance that stops or prevents growth of various microorganisms on the skin.

Ataxia - Unsteady clumsy motion, poor muscle coordination, and staggering gait.

Bacteriocidal – Substance that kills bacteria; usually refers to a substance used for cleaning the environment

Bacteriostatic – Substance that slows the growth of bacteria; usually refers to a substance used on person.

Binging - A period of excessive indulgence as in eating or drinking.

Bipolar Disorder – any of several mood disorders characterized usually by alternating episodes of depression and mania or by episodes of depression alternating with mild nonpsychotic excitement—called also *bipolar affective disorder, bipolar illness, manic depression, manic-depressive psychosis.*

Broad Spectrum Antibiotics - Medication used to treat a wide range of disease causing bacteria.

Cerebral stimulants - Medications prescribed for youth with ADD or ADHD often resulting in calmer behavior and better impulse control.

"Cheeked" - Refers to medication or other substance that has been hidden or attempted to be hidden inside the mouth, generally either in the cheek or under the tongue.

Chronic - A persistent or lasting health condition, or one that has developed slowly; opposite of acute.

Color Disturbances – Side effect of medication that may cause a distortion in how certain colors (usually yellow, green, or red) are seen.

Confidentiality – treated with privacy

Conjunctivitis - Itchy swollen eyes that may be caused by allergies, foreign body or bacterial or viral infection. Highly contagious. Also called 'pinkeye'.

Controlled Substances – Potentially addictive medications regulated by Federal laws.

Corticosteroids – (also called 'steroids') Medications prescribed to quickly reduce inflammation and pain. To maximize benefits, but minimize potential side effects, corticosteroids are usually prescribed in low doses or for short durations.

Cushing Syndrome – Set of symptoms caused by over activity of certain glands in the body or prolonged administration of large doses of some hormones; symptom may include weakness, fatigue, edema, excess hair growth, diabetes, or skin discoloration

Decongestant – A broad class of medications used to relieve nasal congestion. Generally, they work by reducing swelling of the mucous membranes in the nasal passages.

Dehydration - A condition in which the body contains an insufficient amount of water for functioning.

Delousing Solution – Substance applied to skin or hair to kill lice and their eggs (nits); may be toxic if left on skin too long or used too often – use caution.

Delusion - A false belief with no basis in reality.

Depreciation – To make remarks that devalue oneself or another person.

Dermal - Refers to skin

Dermatitis - Inflammation of the skin, the skin inflammation varies from mild irritation and redness to open sores, depending on the type of irritant, the body part affected, and sensitivity.

Diluents – Chemical or filler which, when added to a substance, makes it less concentrated or less potent

Disinfectant - Chemical used to kill bacteria or microorganisms on inanimate surfaces such as furniture or equipment (not skin!)

Disintegration - The process of breaking down into smaller particles, falling apart.

Duodenum - First part of small intestine, just after the stomach.

Dyspnea - Difficulty in breathing.

Dysurea - Difficult or painful urination.

Dyspepsia - Indigestion, heartburn

Dystonia - Severe contraction of the muscles of the neck, jaw or tongue; may be seen as a side effect of some antipsychotic medications.

Edema - Swelling

Enteric Coating - A substance covering a tablet or capsule that will not dissolve until reaching the small intestine.

Epi-Pen - A disposable pre-filled injectable medication prescribed for treating severe allergic reactions causing respiratory distress (anaphylaxis).

Epilepsy – A neurological disorder that causes recurrent seizures.

Euphoria – Exaggerated feeling of well being or mild elation

Excretion - The process of elimination of waste products from the body, through urine, feces, sweat, tears, etc.

Expectorant - Medication that loosens mucous from the respiratory tract.

Expectoration - Removal of mucous or phlegm from the throat or lungs, usually by coughing.

Extrapyramidal Symptoms (EPS) - Side effect/adverse reaction to medication. Characterized by involuntary movement, changes in muscle tone, or abnormal posturing.

Feces - Body waste, discharged from the intestine through the rectum; also called stool.

Finger cot - A close fitting sheath worn at the end of a finger as a device for the protection of the finger.

Flat Affect - Lack of emotional response; no expression of feelings; talking in monotone voice or having lack of facial expression.

Fungicidal – A medication used to kill fungus.

Fungistatic - Agent that slows growth of fungus.

Gait - Manner of walking, i.e., "staggering gait".

Gingival hypertrophy - Irreversible enlargement of gums, side effect of some medication.

Grandiosity – False or exaggerated belief in one's own worth

Grand Mal Seizure - A major epileptic seizure involving the entire body.

Granule - A small grain or pellet, often found in a capsule.

Hallucinations - Perceived sights, sounds, tastes, smells, or sensations that are not actually there.

Hiatal Hernia – Protrusion of the stomach above the diaphragm

HIPAA -The federal privacy act that protects the right of any patient in the US to have their medical information maintained in confidentiality and protected from being accessed by anyone outside the physician's office or treating facility.

Hypertension- High blood pressure readings above the 'normal' range appropriate for age.

Hypoglycemia - Abnormally low level of sugar (glucose) in the blood.

Hypotension - Blood pressure readings that are below the normal range and that may produce symptoms of lightheadedness, fainting, etc.

Hypothyroidism - A condition of the thyroid gland characterized by low energy, weight gain, and often can mimic depression.

Inflammation - A response of the immune system to injury or destruction of cells. Symptoms may include redness heat, pain and swelling.

Inhibitory Effect – Action caused by a substance or agent in which the activity or growth of another agent or substance is slowed or stopped

Insomnia - Decreased sleep caused by inability to fall asleep or frequent awakening at night.

Jacksonian Seizure – Type of seizure in which fine tremors begin in toes or fingers and spread up the extremity toward the body

Jaundice - (Icterus) Yellowing of the whites of the eyes, skin and body fluids.

Lacerations - Cuts or scratches on the body.

Laxatives - Medications that will cause evacuation of feces (stool) from the body.

Lethargic - Drowsy or sluggish; difficult to stay awake.

Maceration – The softening of a solid by soaking

Mania - Mental state of extreme excitement and activity. **(Manic)**

Medication Errors - Term used to describe the violation of any of the Six Rights in Medication Administration.

Microorganisms - Germs, bacteria, viruses, etc.

Narcolepsy - A condition characterized by uncontrollable periods of sudden deep sleep.

Nebulizer - A device used to administer medication in forms of a liquid mist to the airways.

Neurologic - Having to do with the nervous system.

Non-controlled medications - Medications with no history of addictive potential; not governed by the same laws and storage requirements as for controlled medications.

Obsessive thoughts - Unwanted, persistent ideas.

Ophthalmic - Pertaining to the eyes.

Oral Medications - Drugs given by mouth.

Orthostatic hypotension - A change/drop in blood pressure when rising from a sitting or lying down position to standing position; may result in a fall or loss of consciousness (fainting).

Otic - Pertaining to or concerning the ear.

Over the Counter (OTC) Medications - Medications that may be purchased without a prescription, such as Tylenol or Advil.

Palpitations of the Heart – Fluttering feeling of the heart

Paralytic Ileus - Paralysis or lack of passage of intestinal wall with extreme pain and bloating; can be serious side effect of psychotropic medications.

Paranoid disorder - An excessive anxiety or fear concerning one's own well being.

Paresthesia – Tingling sensation due to damaged nerve

Parkinson-like – Refers to having symptoms that mimic Parkinson's disease such as tremors of extremities, loss of facial expression, altered gait. Parkinson-like symptoms are potential side effect of psychotropic medications.

(See Pseudoparkinsonism) (Also see *Psychotropic Agents in the Common Medications* chart).

Peak Flow Meter - A device used to manage asthma by monitoring airflow and the degree of restriction in the airway.

Petit Mal Seizure - Used to describe a mild form of a seizure**;** may also be referred to as *absence seizure*.

Pharynx - Throat

Photosensitivity - Easily sunburned, often caused by medication or allergy. (Even eyes can be photosensitive with some medications).

Pill-rolling – A tremor in which the fingers and wrist move in a rhythmic manner; manipulation of small objects or pills in the hand.

Polydipsia - Excessive abnormally high intake of fluids by mouth**.**

Polyurea - Excessive production of urine.

Potentiate - Increase the strength or action of a drug.

Pressured Speech – Stressed, rapid speech

PRN medications – Medications ordered to be given only on an "as needed" basis, such as Tylenol for a headache.

Pseudoparkinsonism - A condition that mimics symptoms of Parkinson's disease; may include tremors of extremities, loss of facial expression, altered gait. Potential side effect of psychotropic medications.

Psoriasis - Chronic skin disease with scaly red patches.

Psychomotor Seizure - Episode of possible mental confusion, aggressive behavior, or impulsive outburst

Psychosis/Psychotic Episode - A condition characterized by a loss of contact with reality; may have delusions and hallucinations.

Psychotropic Medication – Medications used to treat mental disorders, may be prescribed to treat depression, psychosis or bipolar disorders.

Route of Administration – How a medication is to be given, such as by mouth, in the eye, in the ear, on the skin, etc.

Secondary Infection – Invasion of the body by a different organism than the one being treated.

Scabies - Highly contagious skin condition caused by the itch mite.

Scheduled medications – (Controlled Substances) **-** Medications with abuse potential, whose distribution, record keeping, and storage are controlled by law

Schizophrenia - Psychosis characterized by loss of contact with reality and breakdown of personality.

Sedation - Calming, soothing or tranquilizing effect brought on by medication.

Seizure – A brief, excessive discharge of electrical activity in the brain that alters one or more of the following: movement, sensitive, behavior, awareness.

Somatic Complaints - Reports about body functions that have no basis in fact.

Sphincter - A circular muscle that normally maintains constriction of a natural body passage or orifice and which relaxes as required by normal physiological functioning. While there are at least 42 different sphincters in the body, the most commonly discussed are: **Anal Sphincter** (rectum); **Urethral Sphincter** (urinary bladder); **Pyloric Sphincter** (lower end of stomach); **Cardiac Sphincter** (upper end of stomach).

Sputum - Substance ejected from the mouth containing saliva and mucous.

Steroid - Certain hormones, either manufactured in the body or the laboratory, that reduce inflammation.

Stool - Waste matter/ feces discharged from the bowels.

Tardive Dyskinesia (TD) - A neurological disorder that may be due to long term and/or high doses of some antipsychotic medications; characterized by abnormal repetitive, involuntary movement of the face, such as grimacing, lip smacking, or rapid eye blinking.

Therapeutic Level - The attaining of a concentration of a drug in the blood, that is high enough to control symptoms.

Tinnitus - A perception of sound, usually described as "ringing in the ear".

Topical medication - Medication applied to the skin or mucous membranes (eyes, nose, ears, etc.).

Tourette Syndrome - A neurological disorder characterized by unusual, involuntary movements or sounds, called tics. Common tics are throat-clearing and blinking. May occur with other neurological disorders such as ADHD, Obsessive-Compulsive Disorder (OCD), anxiety or depression.

Toxic level - Blood concentration of a drug that has become high enough to cause harm.

Transient Hypotension – Episode of low blood pressure that may be characterized by feelings of light headedness, dizziness, or weakness

Urinary Retention – When the bladder does not empty properly and holds urine.

Urticaria - Hives as a result of an allergic reaction.

END OF MODULE 3

MEDICATION ADMINISTRATION
TEST - MODULE 3
Classification of Medications & Terminology

KEEP COMPLETED TEST ON FILE

Staff:_____ Test Date:_____ Score: _____

1. Medications are classified according to what they are commonly used for

   A. True
   B False

2. Classification: Antibiotics are used for

   A. Infections caused by a bacteria
   B. Infections caused by a antibody
   C. Infections caused by a virus
   D. Infections caused by fungal infections

3. Classification: Psychotherapeutic Agents are used for:

   A. Depression
   B. Psychosis, behavior disorders
   C. Mood disorders
   D. All of the above

4. Classification: Cardiovascular agents are used for:

   A. High Blood Pressure
   B. Irregular heart beat
   C. heart failure
   D. All of the above

5. It is very important for you to **ALWAYS** read the label on the medication container; you must assure you are administering the right medication to the right person at the right time, the right dose, it is given by the right route and that you document the medication correctly, this is a statement of following the "SIX Rights of medication administration"

   A. True
   B. False

6. It is very important that any OTC (over the counter medications) be given as directed by the delegating RN; you as the non- licensed staff are not required to use your own judgment when deciding to use any OTC medications

A. True
B False

7. When administering or assisting with the administration of any medication you MUST **ALWAYS** know what the medication is used for and what adverse effects to look for

A. True
B. False

8. **Adverse** effect means:

A. An unexpected or unwanted reaction to a medication, which may be sudden or develop over time
B. False effects you were told about
C. Doing what the person wants it to do
D. The action the medication is intended to do

9. **Anaphylaxis** is defined as the most dangerous type of allergic reaction. It is life-threatening event that may include symptoms such as falling blood pressure, respiratory distress and unresponsiveness

A. True
B. False

10. **Epi Pen** is defined as a disposable pre-filled injectable medication prescribed for treating severe allergic reactions causing respiratory distress – and the only injectable medication allowed to be given by direct service workers in EMERGENCY situations only, and must be written in plan of care and reviewed by delegating RN.

A. True
B. False

MODULE 4:

Medication Preparation, Administration & Storage

Various Forms of Medication Administration

Medications are delivered for administration in many different forms.

1. Oral

A. Capsules:

Medication within a capsule may be in powder, granules, oils or liquids other than oil. Capsules may be coated with substances that permit delayed absorption of the content. This coating may also allow the medication to be released in small amounts over a prolonged period of time. The outer shell on the capsule is usually made of a gelatin substance. Once the gel substance mixes with stomach fluids, it disintegrates, therefore, releasing the medication inside. Sometimes contents of the capsule are quickly and easily absorbed into the system but when capsule content are micro-encapsulated they may have different absorption times.

Gel coated capsules are not to be broken. Do **NOT** break or crush any medications considered extended or controlled release (XR, ER, or CR).

Oral medication should not be crushed without a licensed practitioner's order.

B. Tablets:

Compression or molding (depending on content of tablet) creates the shape of tablets.
Tablets are delivered in either enteric coated or un-coated form. Un-coated tablets can be scored to allow for splitting; however, enteric coated tablets **should not** be scored or split due to not being able to ensure accurate dosage of medication.

NOTE: Unscored tablets should not be split without a licensed practitioner's order. Only a tool designed for splitting tablets should be used for this purpose. This device should be cleaned after each use.

C. Liquid Medication:

Some medications come in liquid form. The major concern with liquid medications is measuring accurate dosage. To ensure accurate dosage of liquid medications using a plastic marked cup, oral syringe or dropper, pay close attention to the order and the markings on the container to ensure accurate dosage.

When using a measuring cup, place the cup on a solid, level surface and then bend to look at it at eye level to ensure the correct amount has been poured. The medication should be poured **away** from the label (to do this hold the bottle so the label is in the palm of your hand) to prevent spillage to the label causing it to be illegible.
When pouring liquid medications, place the cap of the bottle upside down on a surface to avoid contaminating the inside of the cap.

Some liquid medications are suspensions and require shaking before being administered.

2. Topical

Note: Gloves should be worn when administering any of the following medications.

A. Ointments:

Medications delivered in ointment form are most often prescribed for dermal or ophthalmic conditions. Ointments are used to retain body heat and/or provide prolonged medication contact. Use standard precautions at all times when applying ophthalmic or dermal ointments. Cleanse skin prior to application of dermal ointment. As always, observe for any adverse effects such as worsening of the condition.

B. Creams

Cream is a more semi-solid form, and is used to lubricate dry or diseased skin as well as to prevent water loss. When applying cream, make sure the skin is clean and dry before thoroughly massaging into the skin, and observe for any adverse effects such as irritation to the area.

3. Ophthalmic (application of eye drops)

Prior to applying eye drops, wash your hands. The individual should be sitting up straight and looking at the ceiling with eyes open. Pull down on the lower lid with a gloved hand not holding the bottle. Place one drop inside the lower eyelid. If you are unsure a drop went in, **wait five minutes** before instilling another drop.

4. Otic (application of ear drops)

DO NOT USE EAR DROPS IN THE EYE. Store ear drops at room temperature. Prior to applying ear drops, wash and completely dry hands. Gently shake the bottle before using. Hold the bottle in your hands for a few minutes to warm it. The dropper should be held with the dropper tip down at all times. This prevents the medicine from flowing back to the bulb where there may be germs. Avoid touching the dropper against anything else.

Have the individual lie down or tilt his/her head to one side. In adults, the earlobe should be held up and back. Holding the ear with one hand and the dropper in the other, place the correct number of drops into the ear.
DO NOT SQUEEZE THE DROPPER TOO HARD.
Replace the dropper in the medicine bottle right away. Do not rinse off.
Press the ear flap and have the individual keep their head tilted back for several minutes to give the drops ample time to coat the ear. Wash your hands.

5. Inhalers and Nebulizers

A. Nasal Inhaler – Before using a nasal inhaler, the individual should blow the nose. Block one nasal passage with a finger on one side of the nose, gently insert the nozzle of the inhaler into the other nostril and aim the inhaler so that the spray is directed 45 degrees upward and slightly outwards and away from the mid line.

B. Aqueous Nasal Inhalers – Gently insert the nozzle as far as possible into the nose before spraying. Wait 30 seconds and then lean forward with your head between your knees for one minute, while pinching your nose.

If nose bleeding starts to occur after starting nasal spray treatment, clean the inside of the nostrils with a cotton swab to remove excess drug after each use of the spray.

C. Metered Dose Inhalers – Wash your hands, shake the inhaler several times. Ask the individual to hold their head up straight and exhale out. Assist with placing the mouthpiece of the inhaler between their teeth and ask them to close their lips around the mouthpiece. Staff should ask the individual to inhale, then press down once on the canister to release a dose. Ask them to continue to breathe slowly through an open mouth over 4 to 5 seconds, until the lungs are full of air. The individual should then breathe for 10 seconds. If more than one puff is required, repeat the above for each required puff.

D. Spacer Devices for Metered Dose Inhalers – Spacer devices have a chamber that receives the aerosol before it is inhaled. They serve two functions: 1) to overcome difficulties in coordinating the timing of the inhaler actuation and inhalation and 2) to slow down the speed of delivery of the aerosol into the mouth so that less of the drug impacts in the throat.

There is a printable handout located on the reference page at the end of this module that explains how to use inhalers and spacers.

E. Peak Flow Meter – A peak flow meter is a tool that measures how well air moves out of the lungs. To use a peak flow meter, place the indicator at the base of the numbered scale. Ask the individual to stand up or sit up straight and take a deep breath. Place the meter in their mouth and ask them to close their lips around the mouthpiece. Remind them not to put their tongue inside the hole. Ask them to blow out as hard and fast as they can. Write down the number you get. Repeat two more times. Write down the highest of the three numbers achieved. The doctor will give you the numbers to instruct you what to do based on the peak flow results.

6. Suppositories

A. Rectal Suppository – A rectal suppository is a medicine shaped like a cone or cylinder that is inserted into the rectum. It is made of a waxy substance that melts easily. To administer a rectal suppository, wash your hands thoroughly. If the suppository is soft, hold it under cool water to harden it before removing the wrapper. Remove the wrapper. If you are to use half of the suppository, cut it lengthwise. Put on a finger cot or a disposable glove. Lubricate the suppository tip with a water-soluble lubricant such as KY Jelly. Assist the individual to lie on their left side with their lower leg straightened out and upper leg bent forward toward their stomach. Lift upper buttock to expose the rectal area. Insert the suppository, pointed end first, with your finger until it passes the muscular sphincter of the rectum, about 1 inch in adults. If not inserted past the sphincter, the suppository may pop out. Hold buttocks together for a few seconds. Ask the individual to remain lying down for about 15 minutes to avoid having the suppository come out. Discard used materials and wash your hands thoroughly.

B. Vaginal Suppository – To use vaginal cream or suppository, first wash your hands thoroughly. To use the cream, fill the applicator that comes with the cream to the level indicated. To use the suppository, unwrap it, wet it with lukewarm water, and place it on the applicator shown with the accompanying instructions. Assist the individual to lie on their back with knees drawn upward and spread apart. Insert the applicator high into the vagina (unless they are pregnant), and then push the plunger to release the medication. If they are pregnant, insert the applicator gently. If you feel resistance (hard to insert), do not try to insert it further; notify the doctor. Withdraw the applicator. Pull the applicator apart and clean it with soap and warm water after each use. Wash your hands thoroughly.

NOTE: The dose should be applied when you lie down to go to bed. The medicine works best if you do not get up again after applying it. You may wish to provide a sanitary napkin to protect clothing against stains.

7. Epi Pen

Epi Pen is defined as a disposable pre-filled injectable medication prescribed for treating severe allergic reactions causing respiratory distress – and the only injectable medication allowed to be given by direct service workers in EMERGENCY situations only, and must be written in plan of care and reviewed by delegating RN.

The Provider agency/ Support Coordinator Agency is responsible for ensuring that non-licensed staff is trained to address the individualized needs of each person they support or assist.

Observation and administration of an individual's medications is a procedure that should be completed in the best of environmental circumstances. In order to avoid errors and confusion it is recommended that a designated area be used to prepare and administer medications.

These areas must be, clean, free from clutter and well lighted.

Proper Hand Washing: Infection Control

Good hand washing techniques include washing your hands with soap and water or using an alcohol-based hand sanitizer.

Hand washing steps:

- Remove rings
- Wet your hands with warm, running water and apply liquid soap
- Lather well
- Scrub all surfaces, including the backs of your hands, wrists, between your fingers and under your fingernails
- Rub hands together for 20 seconds (sing "Happy Birthday" twice)
- With water running, dry hands with a paper towel
- Use paper towel to turn of the faucet
- Dispose of paper towel.

Alcohol-based hand sanitizers are an excellent alternative to hand washing. However, if your hands are visibly soiled, wash with soap and water.

Alcohol-based hand sanitizer:

- Apply ½ tsp of the sanitizer to the palm of your hand
- Rub hands together, cover all surfaces of your hands until they are dry

Use gloves when instilling eye or ear medications. Make sure you have verified whether the individual is allergic to latex prior to using a latex glove. (Be sure to wash off powder from gloves)

There is a printable handout located on the reference page at the end of this module explaining proper hand washing.

Oral Medications

All oral medications should be given with at least four ounces of water or other liquid that allows for easy swallowing. A medication dispensing device or oral syringe should be available to prepare liquid medications. Remember to pour the medication away from the label, and to have container eye level when measuring to ensure accurate dosage.

NOTE: Pay close attention to the order on the container and markings used for measurement to ensure accurate dose.

After the individual has taken the medication it is very important that you make sure he/she has swallowed the medication. This practice will ensure they are not hoarding or 'cheeking' medications.

This is especially important for someone who has a history of choking or aspiration. Offering a snack, something additional to drink, or spending extra time with this person to allow for increased monitoring will assist the non-licensed staff to ensure that the medication has been safely swallowed.

There is a printable handout located on the reference pages explaining the Heimlich maneuver.

Medication Administration

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

For disposal of unused medication or expired medication:

- For pills: pour glue into pill container, after glue is hardened, container may be thrown into garbage can
- For liquids: pour cat litter or sand into container and wait for it to set-up, after it becomes hardened, it may be thrown into garbage can
  Disposal of medication must be documented on the medication record to verify it was destroyed, sign, date and have a witness also sign and date.
- Items such as inhaler canisters may be placed in a sharps container or disposed of according to OSHA.

Do not flush the meds or pour down drain.

Contact the RN to identify the process for disposing of unused, damaged, or expired medications.

Ensuring Accurate Administration of Medication

Six Rights of Medication Administration

To safely manage and administer individuals medications one must fully understand the "six rights of medication administration". These six rights are as follows:

1. Right Person
2. Right Medication
3. Right Dosage
4. Right Route
5. Right Time
6. Right Documentation

Right person:

It is important to identify the right person when administering medications. An example of this might be referring to the photograph inside the record, and/or having the person state his/her name if possible. It is imperative that the "right person" has been identified prior to administering medications.

Right medication:
Giving the right medication to the right person is imperative for safety. Ensure that the medication label coincides with the Medication Administration Record.

Agencies must have in place policies and/or procedures regarding how medication errors are handled. Research has proven that medication errors are more readily reported if the action taken is weighted with education as opposed to strict disciplinary measures. The agency's policies must be in accordance with current regulations for reporting medication errors.

Right dose:
Read the label on the medication container and compare it to the transcribed order. Pay close attention to the dosage amount.

Right route:
Read the label on the medication container and compare it to the transcribed order. Pay close attention to the route. Ensure that ear (otic) drops are never given in the eye.

Right time:
Your agency should have a policy in place that provides a time frame for which it is acceptable to give medications (example: 60 minutes before or 60 minutes after the scheduled time).

Right documentation:
Each medication must be documented **when** it is given. If a medication has been given, and it has not been documented that it was given, the process for administration is incomplete. This has the potential of causing a serious medication error, (overdosing) if the medicine were to be re-administered. This could cause a very serious medication error of overdosing. It is very important to remember once the medication has been administered you should initial in the area indicated on the Medication Administration Record. Inaccurate medication counts are also considered as incomplete documentation, which constitutes a medication error.

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

Note: Medications are not to be preset for all individuals. Only set up and administer one individual's medication at a time.

Medication Errors:
A medication error occurs when one of the "six client rights" 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 person
- Failing to document medication was given or inaccurate documentation of medicine given, including inaccurate pill counts
- Medication errors may result in adverse reactions to the person. These reactions could range from a rash to death.

Refusal of Medications:

It is a person's right to refuse medications. Each individual should be told why the medication is being used, and also any common side effects.

NOTE: Follow the agency's policy/ contact the RN for notifying the licensed practitioner of refused medications.

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.

Understanding Effects of Medications/Adverse Drug Effect

It is very important to familiarize yourself with any medication that is being administered. Pharmacies are required to provide a "medication" education sheet with each drug dispensed. The sheet contains the most common side effects of that medication. Another way to learn the side effects of medications is to review the medication in a current drug handbook. These books are updated on an annual basis and contain the most current information on medications.
Observing the individual after a medication has been administered is crucial in identifying any adverse reactions to that medication. Any and all reactions should be reported according to agency policy. Severe reactions should be treated as emergencies and staff should be familiar with agency protocol regarding how emergencies are handled within that agency.

Medication Education

Education of each individual should be performed per agency policy and should include:

- Name of prescribing practitioner
- Trade and generic name of medication.
- Reason medication was prescribed (diagnosis or symptoms)
- Dosage of the medications
- Time the medication will be given
- How long the medication is prescribed for
- Most common side effects of medication

Each individual should be encouraged to ask for and receive information regarding the medications prescribed. Education is to be documented in the agency specific manner.

END OF MODULE 4

MEDICATION ADMINISTRATION
TEST - MODULE 4
Medication Preparation, Administration & Storage

KEEP COMPLETED TEST ON FILE

Staff:_____ Test Date:_____ Score: _____

1. Medications are delivered for administration in many different forms: The following are the forms the non licensed staff **MAY ADMINISTER** after proper training and delegation by a Registered Nurse

   A. Capsules, Tablets, Liquid Medications
   B. Ointments, Creams, Eye Drops, Ear Drops
   C. Inhalers, nebulizers via a premeasured dose system, suppositories
   D. IM injections, SC injections, IV injection
   E. A, B, and C ONLY

2. You must use gloves when administering (instilling) eye or ear medications

   A. True
   B. False

3. Before you administer any medications you must:

   A. Know what the medication is used for
   B. Know what the main side effects/ adverse effects of the medication are
   C. Read carefully any and all directions on the bottle
   D. Follow the "Six Rights of Medication Administration"
   E. All of the above

4. After you administer any oral medication it is very important that you make sure

   A. The medication has been swallowed
   B. The individual is not "cheeking" the medication
   C. The individual is not trying to hoard the medication
   D. All of the above

5. A major concern when administering medication in a liquid form is measuring accurate dosages: to ensure accurate dosage you must make sure you use a plastic marked cup, oral syringe or dropper and pay close attention to the order and the markings on the container to ensure accurate dosage

   A. True
   B. False

6. Enteric coated Tablets may be broken in half

   A. True
   B. False

7. If a liquid medication is the form of a suspension what must you do before administering it?

   A. Shake it
   B. Stir it
   C. Pour it
   D. None of the above

8. Before a person uses a nasal inhaler you should have them

   A. Lay down
   B. Blow his/her nose
   C. Squeeze the inhaler
   D. Insert the nozzle of the inhaler into one nasal passage

9. Rectal Suppositories are usually kept in the refrigerator.

   A. True
   B. False

10. An Epi Pen is a premeasured dose of epinephrine and is only used for EMERGENCY, Life threatening conditions

   A. True
   B. False

MODULE 5:

VITAL SIGNS

VITAL SIGNS

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

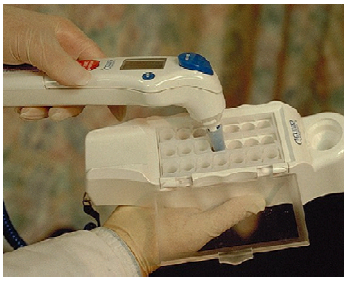
Vital signs are key indicators used to determine the person's overall condition.

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</u> <u>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:

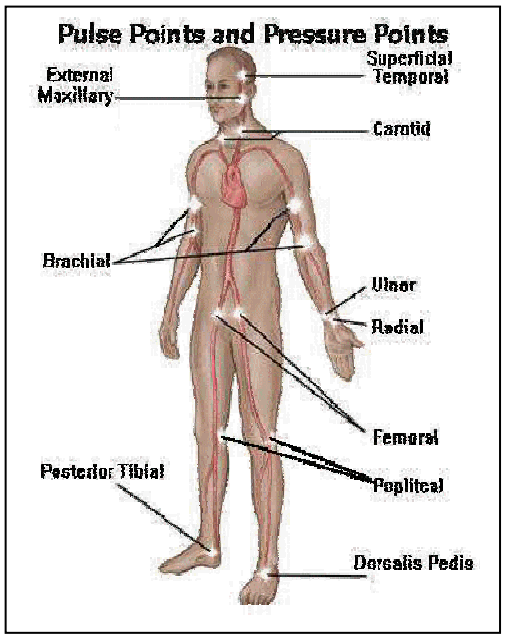
- Radial Pulse (wrist)
- Carotid Pulse (throat)
- Brachial Pulse (inside of elbow)

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 one full minute 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 course.

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.

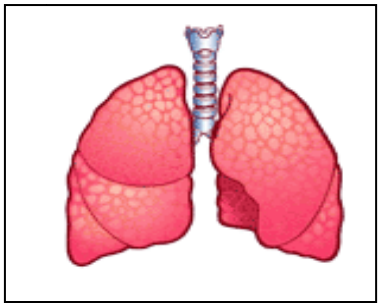
Terms used to describe the strength of a pulse are:

- **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 in one minute 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 course.

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:

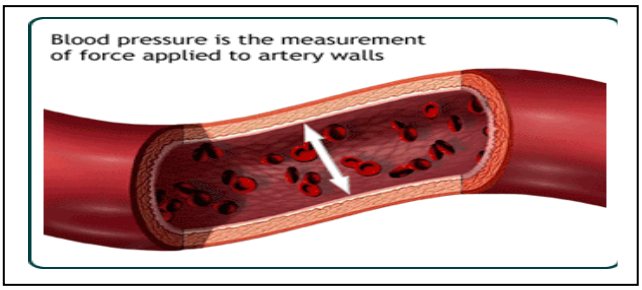
- Rate – number of respirations per minute.
- Rhythm – regular or irregular
- Quality – type of breathing noted: labored (noisy, difficult respirations) or unlabored: (quiet, without effort)

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 course.

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 3/5/2011

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.

Handouts:

- *Preparing for Medication Administration*
- *Six Rights of Medication Administration*
- *Proper Hand Washing*
- *How to Apply Cream or Ointment*
- *How to Use Inhalers/ Spacers*
- *How to Apply Eye Drops*
- *How to Apply Ear Drops*
- *How to use an Epi Pen*
- *How to Use Suppositories*

- *How to Perform the Heimlich maneuver*
- *How to Check Vital Signs (Skills Procedure Review)*

Preparing for Medication Administration

A. Use a designated area to prepare and administer medications. The area must be:

- Clean & free from clutter
- Well lit
- Have adequate supplies available

B. Practice good hand hygiene and/or universal precautions

- Wash your hands prior to preparing medications and anytime there has been any physical contact
- Use gloves when instilling eye or ear medications
    - Be aware of allergies to latex
    - Wash your hands to remove powder from gloves

C. Educate Yourself on the Medication

- Provide adequate amount of water for easy swallowing
- Review medicines that require checking of vital signs

D. Follow the Six Client Rights When

- Removing the medication from storage
- Removing the medication from it's container
- Returning the medication to storage

E. Identify yourself and what you are doing

F. When measuring liquid medications

- Have available a medication dispensing device or oral syringe
- Pour the medication away from the label
- Have the container eye level when measuring
- Pay close attention to the order and the measurement markings on the container

G. Give the medication and observe the client taking it

- Monitor for cheeking (holding meds on side of mouth, not swallowing meds)

H. Document

I. Observe the client after they have taken the medication & report to the Nurse:

- As soon as possible, any change in the patient's normal condition

Six Rights of Medication Administration:

1. **Right Client**
   Always have at least two (2) client identifiers when administering medications.

2. **Right Medication**
   Verify that the medication label coincides with the Medication Administration Record.

3. **Right Dose**
   Read the label on the medication container and compare it to the transcribed order.
   Pay close attention to the dosage amount.

4. **Right Route**
   Read the label on the medication container and compare it to the transcribed order.
   Pay close attention to the route.

5. **Right Time**
   Follow directions for when to give the medication. Refer to agency policy for the time frame acceptable to give medications (example: 60 minutes before or 60 minutes after the scheduled time).

If a medication has been given, but not documented there is potential for overdosing.

6. **Right Documentation**
   Each medication must be documented when it is given.

Proper Hand Washing

Good hand washing techniques include washing your hands with soap and water or using an alcohol-based hand sanitizer.

Washing Hands Using Soap and Water

- Remove rings
- Wet your hands with warm, running water and apply liquid soap
- Lather well
- Scrub all surfaces, including the backs of your hands, wrists, between your fingers and under your fingernails
- Rub hands together for 20 seconds (sing "Happy Birthday" twice)
- With water running, dry hands with a paper towel
- Use paper towel to turn of the faucet
- Dispose of paper towel

Washing Hands with an Alcohol-Based Hand Sanitizer

- Apply ½ tsp of the sanitizer to the palm of your hand
- Rub hands together, cover all surfaces of your hands until they are dry

Alcohol-based hand sanitizers are an excellent alternative to hand washing. However, it your hands are visibly soiled, wash with soap and water.

How to Apply Cream or Ointment

When applying cream or ointment, follow the directions on the label, and the following:

- Wash hands thoroughly
- Put on gloves
- Cleanse the skin with warm water and soap
- When opening the container, place the cap so that the grooved side is up
- Apply the cream or ointment as directed by the label or the doctor's order

NOTE: When transcribing orders for applying ointments, be sure to indicate where the ointment should be applied.

- Notify the nurse if you notice: a change in the amount, color, consistency, or odor of the drainage or if there is any swelling or redness

How to Use Inhalers

Aqueous Nasal Inhalers

- Blow the nose
- Wash hands
- Block one nostril with a finger
- Insert the nozzle of the inhaler into the other nostril
- Aim inhaler so the spray is directed 45 degrees upward and slightly outwards and away from the mid line
- Client should not inhale
- Squeeze the inhaler quickly and firmly
- Repeat as directed and for the other nostril

Metered Dose Inhalers

- Wash hands
- Shake the inhaler several times
- Stand and hold head straight up
- Exhale all the way
- Place the mouthpiece between teeth and close lips around it
- Breath through the mouth and immediately press down on the canister to release the medicine
- Breath slowly through open mouth for 4 to 5 seconds, until lungs are full of air
- Hold breath for 10 seconds
- Repeat as directed

Peak Flow Meter

- Wash hands
- Place the indicator at the base of the numbered scale
- Stand up
- Take a deep breath
- Place the meter in the mouth and close lips around the mouthpiece
- **DO NOT PUT TONGUE INSIDE THE HOLE**
- Blow out as hard and fast as you can
- Record the reading
- Repeat two more times
- Record the highest of the three numbers achieved
- The doctor will instruct you what to do given your peak flow results

How to Use Inhaler Spacers

Sit up straight, or stand up, and lift the chin to open the airways.

- Remove the cap from the mouthpiece of the inhaler and shake the inhaler vigorously.
- If you haven't used the inhaler for a week or more, or it is the first time you have used the inhaler, spray it into the air before using it to check that it works.
- Insert the inhaler mouthpiece into the hole in the end of the spacer (the inhaler should fit snugly and without difficulty - see below).
- Take some deep breaths and then put your teeth around the spacer mouthpiece (not in front of it and do not bite it), and seal your lips around the spacer mouthpiece, holding it between your lips.
- Press down on the canister in the inhaler to spray one puff of medicine into the spacer.
- Breathe in slowly and deeply, then hold your breath for 10 seconds or as long as is comfortably possible.
- Breathe out, then breathe in deeply again through the mouthpiece of the spacer and hold your breath. You should take two deep-held breaths from the spacer for each puff from your inhaler.
- If you need another dose, wait 30 seconds, shake your inhaler again then repeat steps 4 to 8.
- Don't spray more than one puff at a time into the spacer. This makes the droplets in the mist stick together and to the sides of the spacer, so you actually breathe in a smaller dose.

NOTE: Follow manufacturer’s instructions for cleaning all of the above.

How to Apply Eye Drops

When applying eye drops, follow the following guidelines:

NEVER USE EAR DROPS IN THE EYE

- Wash hands thoroughly
- Client should be sitting up straight and looking at the ceiling
- Pull down the lower lid
- Place one drop inside the lower lid
- If you are not sure that a drop went in, WAIT 5 minutes before instilling another drop.

How to Apply Otic (Ear) Drops

When applying ear drops, follow these guidelines:

- Wash hands and dry completely
- Gently shake the bottle
- Hold the bottle in your hands for a few minutes to warm the drops
- Hold the dropper tip down at all times
- Tilt the head to one side
- In adults, hold the earlobe up and back
- In children, hold the earlobe down and back
- Place the correct number of drops in the ear – **DO NOT SQUEEZE THE DROPPER TOO HARD**

- Return the dropper to the medicine bottle right away
- Press the ear flap and keep head tilted for several minutes
- Insert a cotton plug
- Wash hands

How to use an EpiPen

Epinephrine stops anaphylaxis very nicely. Anaphylaxis can be fatal if not treated quickly and properly, and epinephrine is the first line of defense. Many patients of anaphylaxis carry automatic injectors of epinephrine -- the most common brand is an EpiPen. Depending on laws in your state and the level of training a first aid provider has, it may be permissible for a first aid provider to administer an EpiPen to a victim of anaphylaxis. The EpiPen must already be prescribed to the patient in order for it to be used.

1. Remove the EpiPen

Unscrew the yellow cap from the container and slide out the EpiPen.

2. Remove the Gray Safety Cap

Take off the gray safety cap from the back of the EpiPen. It won't work unless this cap is removed.

3. Inject the Epinephrine

Grasp the EpiPen in a fist and press the black, rounded tip hard into the thigh. Hold the EpiPen in place while slowly counting to 10. The pen can inject right through clothing.

4. Call 911 and Discard the EpiPen

Once the EpiPen is used, call 911. Anaphylaxis is a life-threatening condition, and using epinephrine is only a temporary fix. It may be necessary to give a second dose of epinephrine.

The EpiPen now must be properly discarded. The ambulance crew will be able to throw the used EpiPen away in their sharps container or you may need to discard it in its original container.

How to Use Suppositories

To Use a Rectal Suppositories

- Wash your hands
- If the suppository is soft, hold it under cool water to harden it before removing the wrapper
- Remove the wrapper.
- If you are to use half of the suppository, cut it lengthwise.
- Put on a finger cot or a disposable glove.
- Lubricate the suppository tip with a water-soluble lubricant such as KY Jelly
- Lie on your side with your lower leg straightened out and your upper leg bent forward toward your stomach
- Lift upper buttock to expose the rectal area
- Insert the suppository, pointed end first, with your finger until it passes the muscular sphincter of the rectum, about ½ to 1 inch in infants and 1 inch in adults
- Hold buttocks together for a few seconds
- Remain lying down for about 15 minutes
- Discard used materials
- Wash hands

To Use Vaginal Suppository or Cream

- Wash your hands thoroughly
- To use the cream, fill the applicator that comes with the cream to the level indicated
- To use the suppository, unwrap it, wet it with lukewarm water, and place it on the applicator
- Lie on your back with your knees drawn upward and spread apart
- Insert the applicator high into the vagina (unless you are pregnant), and then push the plunger to release the medication
- If you are pregnant, insert the applicator gently. If you feel resistance (hard to insert), do not try to insert if further; call your doctor.
- Withdraw the applicator
- Pull the applicator apart and clean it with soap and warm water after each use
- Wash your hands

How to Perform the Heimlich Maneuver

Step One
Ask the choking person to stand if he or she is sitting.

Step Two
Place yourself slightly behind the standing victim.

Step Three
Reassure the victim that you know the Heimlich maneuver and are going to help.

Step Four
Place your arms around the victim's waist.

Step Five
Make a fist with one hand and place your thumb toward the victim, just above his or her belly button.

Step Six
Grab your fist with your other hand.

Step Seven
Deliver five upward squeeze-thrusts into the abdomen.

Step Eight
Make each squeeze-thrust strong enough to dislodge a foreign body.

Step Nine
Understand that your thrusts make the diaphragm move air out of the victim's lungs, creating a kind of artificial cough.

Step Ten
Keep a firm grip on the victim, since he or she can lose consciousness and fall to the ground if the Heimlich maneuver is not effective.

Step Eleven
Repeat the Heimlich maneuver until the foreign body is expelled.

Tips & Warnings:

- If a victim is coughing strongly or able to talk, let the person try to expel the foreign body using his or her own efforts.
- If the choking victim displays a weak or ineffective cough, this indicates that air exchange is minimal and that you should start the Heimlich maneuver.
- To avoid breaking bones, never place your hands on the victim's breastbone or lower rib cage when performing the Heimlich maneuver.
- If choking persists call 911 immediately.

End of Module 5

MEDICATION ADMINISTRATION
TEST - MODULE 5
Vital Signs

KEEP COMPLETED TEST ON FILE

Staff:_____ Test Date:_____ Score: _____

1. The term "Vital Signs" refers to the person's

   A. Temperature
   B. Pulse
   C. Respirations
   D. Blood Pressure
   E. All of the above

2. It is important to know a person's temperature to determine the cause of the person's condition and or to determine the effectiveness of treatment

   A. True
   B. False

3. All of the following are factors that affect temperature EXCEPT:

   A. Drinking/eating/ hot/cold liquids or food
   B. Smoking
   C. Infection or illness
   D. Exposure to extreme heat or cold
   E. Driving a car

4. When counting a pulse, which is the rhythmical throbbing of arteries produced by the contractions of the heart, and tells how fast the heart is beating, you must always count the pulse for

   A. 1 full minute
   B. ½ a minute
   C. 5 full minutes
   D. None of the above

5. The three most common Pulse points are the: Radial Pulse (wrist), Carotid Pulse (throat), and Brachial Pulse (inside of elbow)

   A. True
   B. False

6. How do you document the Pulse rate

   A. Document the rate: number of beats per 1 full minute
   B. Document the rhythm: regular or irregular
   C. Document the volume (strength): weak or strong
   D. All of the above

7. Respiration is the process of inhaling and exhaling (breathing)

   A. True
   B. False

8. Which Factors affect Blood Pressure (BP):

   A. Asleep or awake – usually lower when sleeping
   B. Body Position – lying, sitting, standing can either increase or decrease BP
   C. Emotional state – stress and anger can increase BP
   D. Activity level – not moving to extreme exertion can increase or decrease BP
   E. All of the above

9. High Blood Pressure is called HYPERTENSION, and is known as the Silent Killer

   A. True
   B. False

10. Low Blood Pressure is called HYPOTENSION, and can cause the brain, heart, and kidney to not function normally which may cause permanent damage

   A. True
   B. False

MODULE 6:

Documentation

OBJECTIVES:

- Explain the purpose of reporting and documentation.
- **Describe the purpose of care and support plans**.
- Explain the importance of correctly documenting information during a physician visit.
- **Prepare written documentation following guidelines.**
- **Purpose and Importance of Observing and Reporting**
- **MAR – MEDICATION ADMINISTRATION RECORD**

The purpose of observing, reporting, and documenting is to communicate any changes or status that may be occurring with the person we are serving 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 person you are serving's LIFE!

- ***Recognizing Changes*** **OBSERVATION:**

Early identification of changes in an individual's daily routine, behavior, ways of communicating, appearance, general manner or mood, or physical health can save his or her life !

You get to know a person by spending time with him or her and learning what is usual for them.

If you do not know what is normal for a person, you will not know when something has changed.

- **Care Plans and Support Plans:**
- A care or support plan (ISP), is a written plan created to meet the needs of the consumer.

- The plan is usually created during an in-home assessment of the consumer's situation; the strengths, the weaknesses and care being provided by family and friends is reviewed.
- The plan defines the needs and objectives/goals for care.
- The plan lists the actions to be provided by the DSW.
- **Care Plans and Support Plans:**
- Any deviations from a care or support plan may put the Direct Service Worker at risk for disciplinary actions, Therefore, any changes need to be approved by the supervisor.
- Care/support plans are reviewed by the care team. The DSW working with the consumer may be asked for input as to how the plan is working. Reporting and documenting are very critical in evaluation whether the plan is working or if it needs revision.
- **REPORTING:**
- **Reporting** is the verbal communication of observations and actions taken to the team or supervisor, usually in person or over the phone. A verbal report is given to a supervisor when the need arises, or for continuity of care, e.g. giving a verbal report to the next shift.
- It is always better to **report** something than to risk endangering the consumer, the agency, and yourself by not reporting it.
- **Reporting** helps your supervisor act accordingly.
- **DOCUMENTING:**

Documenting is the **written** communication of **observations** and **actions** taken in the care of the consumer.

REMEMBER:

If it was not documented, it was <u>not</u> done

Your job is not <u>over</u> until the paperwork is finished!

The consumer's record is a <u>legal document!</u>

- **Significance of Documentation:**
- A record of what was **done**, **observed**, and how the consumer **<u>reacted</u>.**
- Used for **evaluation** by other team members working on the care plan.
- Used to **clarify** complaint issues.

- **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.
- **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.
- Make entries in a logical and sequential manner.
- **Documentation Guidelines:**
- Be descriptive. Avoid terms that have more than one meaning.
- Document any changes from normal or changes in the consumer's condition. Also document what you informed the consumer's physician or your supervisor as indicated.
- Do not omit any information.
- **Specific Forms**
- Your agency will tell you about policies and procedures you need to know. Some agencies have specific forms you need to use for daily documentation.
- You will also need to learn other specific rules for reporting information regarding **incidents** that your agency will give you more information on.
- **COMMUNICATING WITH THE PHYSICIAN**
- **Tips for talking with Health Care Professionals**
- 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 most cases, when what appears to be miscommunication, a few **strategies/tips** that may help you clearly and efficiently communicate concerns and questions are as follows:
- **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.
- **List of Tips:**
- Make sure you **ALWAYS** know why you are with the consumer, Why are 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.
- **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.
- **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.

- 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.

- **Tips:**

Most importantly, know that you have resources if you feel that you or the person you support has been unfairly or even abusively treated due to a disability status.

All states have a Protection and Advocacy agency – see the National Disability Rights Network website at www.napas.org to find out more information.

- **REVIEW: The TOOLS to Use**

- **Observation** – Use all of your senses; sight, hearing, touch and smell.

- **Communication** – Ask questions and listen to answers. A good listener hears the words and notices other ways of communication, including noticing changes in behavior.

- **Written Forms –** Document on Forms designed to help you address needed information that you need to share with other staff and or agencies.

- **WHAT WOULD YOU DO?**

- **What would you do if you are new and do not know the person you are serving well?**

- **How can you assure that you are reporting and documenting correctly?**

- **What If only a Family Member goes on a Physician Visit?**

- It is important that we, who provide services to our consumers know that the person we serve was seen by a physician and what was done or ordered.

- It is still our responsibility to document any changes so that the plan of care can be updated. Case managers 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.

End of Module 6

MEDICATION ADMINISTRATION
TEST - MODULE 6
Documentation

KEEP COMPLETED TEST ON FILE

Staff:_____ Test Date:_____ Score: _____

1. The purpose of observing, reporting and documenting is to communicate any changes or status that may be occurring with the person you are serving and/or the family

   A. True
   B. False

2. Early identification of changes in an individual's daily routine, behavior, ways of communicating, appearance, general manner or mood, or physical health can save his or her life

   A. True
   B. False

3. Documentation is the written communication of observations and actions taken in the care of the person you are working with

   A. True
   B. False

4. Your job is not over until the paperwork is finished, if it was not documented it was not done

   A. True
   B. False

5. What is the Significance of Documentation

   A. A record of what was done, observed, and how the consumer reacted
   B. Used for evaluation by other people who will be working with the person
   C. Used to clarify complaint issues
   D. All of the above

6. Which of the following are Documentation Guidelines

   A. Always use ink
   B. Sign all entries with your name, date and time
   C. Make sure writing is legible and neat
   D. 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
   E. All of the above

7. There may be a time that you accompany the person you are working with when they visit a Health Care Professional: What is important to remember during the visit

   A. It is best to support self-advocacy rather than advocating for someone
   B. Always know why you are with the person on the visit – what is the reason for the visit
   C. Make sure you understand the Health Care Professional orders when leaving
   D. All of the above

8. The person you are working with may not be aware of changes going on with them, it is vitally important for you to communicate changes you observe with the family as appropriate

   A. True
   B. False

9. Proper Documentation on the MAR – (Medication Administration Record) is an important part of communication

   A. True
   B. False

10. If you do not know what is normal for the person you are working with, you will not know when something has changed, it may take some to learn what is usual for them, do not be afraid to ask questions

   A. True
   B. False

COMPENTENCY SKILLS CHECKLIST
and Test Answer Keys

This section is for the RN oversight

Please note that the following pages will be for the nurse only.

Appendix A

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.

This participant's condition will be reassessed each time there is a change in health status.

RN Signature: _____

Date: _____/_____/_____

II. Teaching Process - Rationale – Evaluation/Teaching Outcomes

Teaching Process used includes (check all methods used):
☐ DSW completion of on-line training in medication administration and infection control
☐ Client specific training
☐ Return demonstration by the DSW
☐ Time for further discussion, including question and answer time
☐ Other: _____

The ***rationale for determining that the skill*** of the DSW is appropriate to the participant's condition is 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. RN Determination of Competency

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
for (participant's name): _____

I assure that I will provide oversight of the above-named DSW's performance of this task. RN Signature: _____.

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: _____/_____/_____

Appendix B

Answer Keys for Test Modules

MEDICATION ADMINISTRATION
TEST - MODULE 1
Legal Issues, Policies and Procedures
ANSWERS

Staff:_____ Test Date:_____ Score: _____

1. A
2. A
3. A
4. D
5. A
6. D
7. A
8. A
9. A
10. D

MEDICATION ADMINISTRATION
TEST - MODULE 2
INFECTION CONTROL
ANSWERS

Staff:_____ Test Date:_____ Score: _____

1. A
2. D
3. D
4. D
5. A
6. A
7. A
8. D
9. D
10. E

MEDICATION ADMINISTRATION
TEST - MODULE 3
CLASSIFICAITON OF MEDICATION & TERMINOLOGY
ANSWERS

Staff:_____ Test Date:_____ Score: _____

1. A
2. A
3. D
4. D
5. A
6. A
7. A
8. A
9. A
10. A

MEDICATION ADMINISTRATION
TEST - MODULE 4
MEDICATION PREPARATION, ADMINISTRATION & STORAGE
ANSWERS

Staff:_____ Test Date:_____ Score: _____

1. E
2. A
3. E
4. E
5. A
6. B
7. A
8. B
9. A
10. A

MEDICATION ADMINISTRATION
TEST - MODULE 5
VITAL SIGNS
ANSWERS

Staff:_____ Test Date:_____ Score: _____

1. E
2. A
3. E
4. A
5. A
6. D
7. A
8. E
9. A
10. A

MEDICATION ADMINISTRATION
TEST - MODULE 6
DOCUMENTATION
ANSWERS

Staff:_____ Test Date:_____ Score: _____

1. A
2. A
3. A
4. A
5. D
6. E
7. D
8. A
9. A
10. A

DEVELOP INDIVIDUAL CERTIFICATE
THAT CAN BE KEPT IN DSW FILE

RN DELEGATION FORMS ARE ALSO TO BE KEPT IN THE DSW'S FILE AS WELL AS A COPY FOR THE RN TO ASSURE DELEGATION HAS BEEN COMPLETED