Illinois Department of Human Services
Division of Developmental Disabilities

MEDICATION ADMINISTRATION IN THE COMMUNITY COURSE PREREQUISITE INFORMATION

1

Nurse-Trainer Webinars

- To complete the Nurse-Trainer course by GoToMeeting Webinar you will have to pre-register for Webinars 1 and 2 on the day scheduled for the Medication Administration in the Community course. The links are on the DHS website for Webinars 1 and 2.
- Webinar 1 on 7/29/15 - 9:30 am – 11:30 am
- Webinar 2 on 7/29/15 - 12:45 pm – 2:45 pm
- Please see more details on the DHS Nurse-Trainer Webinars and for registering at: http://www.dhs.state.il.us/page.aspx?item=76322.

2

Course Credit

- Full course completion of all 3 Webinars must be confirmed by our office prior to assigning the post-test on myNetLearning.
- Five hours of Continuing Education Credits are awarded for full course attendance. No partial credit is given.

3

Prerequisite for N-T Class

- This prerequisite course contains information necessary for attending Medication Administration Webinars 1 & 2.
- This recorded Webinar reviews the:
  - Basis for Administrative Rule 116
  - Medication Administration course materials
  - Nursing Services Packet completion

4

TO BECOME A NURSE-TRAINER

- Besides attending all three Webinars, being an RN in Illinois and having RN clinical experience, you must
- Request to become a nurse-trainer and
- complete the open book internet based test administered by the Division of Developmental Disabilities with a score of 90% or better.

5

Rule 116 History

- Omnibus Budget Reconciliation Act (OBRA) of 1987 – Money dispersal requirements
  - Place ID/DD individual in community
  - Habilitation based on need
  - Have least restrictive environment

6

OBRA Implementation

- Federal government evaluated providers (large nursing facilities & homes) with questions regarding money dispersal:
  - Do the individuals you have need your level of (nursing) care?
  - If not, placement (in community) must be where needs are met

7

CILAs and Assumptions

- First CILAs took those needing minimal assistance in community AND were **independent in self-medication**. So CILAs often did not have nurses.
- Many came from State "Hospitals" & Large Private Nursing Homes; where nurses were part of the staff.

8

Health Care Finance Administration

- 1998 – HCFA visited Illinois DD Providers
- Unlicensed staff administering medications
- HCFA stated that the Illinois Nurse Practice Act was being violated
- Threat to Federal Medicare (OBRA) funds. A plan was developed to resolve the issue.

9

Illinois Senate Bill 965

- Passed May 14, 1999 & signed into law August 1999 as PA 91-630 to amend the:
  - Nurse Practice Act [section 50-15 (b) (12)]
  - Mental Health & Developmental Disabilities Act [section 15.4]
  - Rule 115, the “CILA” Rule (115.240)

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Nurse Practice Act Amendment

- Section 50-15: Policy; application of Act. (b) This Act does not prohibit the following:
- (12) Delegation to authorized direct care staff trained under Section 15.4 of the Mental Health and Developmental Disabilities Administrative Act consistent with the policies of the Department.

11

MHDD Act – Section 15.4

- Title: Authorization for nursing delegation to permit direct care staff to administer medications.
- (a) DHS shall develop training of staff to administer oral & topical medications under supervision & monitoring of professional nurse.

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"Print Out" Sections

- Section 1: N-T Application and Course Evaluation
- Section 2: Administrative Rule 116
- Section 3: Memos and Letters

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Division of Developmental Disabilities
Bureau of Clinical Services

Section 4

Sample Nursing Assessment Form

Training Program
for
Authorized Non-licensed Direct Care Staff

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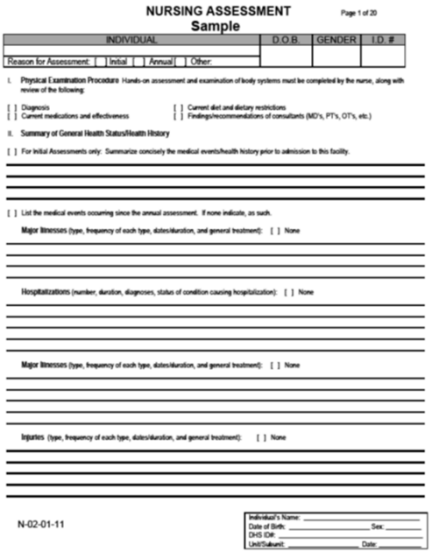

NURSING ASSESSMENT Page 1 of 20

Sample

INDIVIDUAL	D.O.B.	GENDER	I.D. #

Reason for Assessment: [ ] Initial [ ] Annual [ ] Other:

I. **Physical Examination Procedure** Hands-on assessment and examination of body systems must be completed by the nurse, along with review of the following:

[ ] Diagnosis
[ ] Current medications and effectiveness
[ ] Current diet and dietary restrictions
[ ] Findings/recommendations of consultants (MD's, PT's, OT's, etc.)

II. **Summary of General Health Status/Health History**

[ ] For Initial Assessments only: Summarize concisely the medical events/health history prior to admission to this facility.

[ ] List the medical events occurring since the annual assessment. If none indicate, as such.

Major Illnesses (type, frequency of each type, dates/duration, and general treatment): [ ] None

Hospitalizations (number, duration, diagnoses, status of condition causing hospitalization): [ ] None

Major Illnesses (type, frequency of each type, dates/duration, and general treatment): [ ] None

Injuries (type, frequency of each type, dates/duration, and general treatment): [ ] None

N-02-01-11

Individual's Name: _____
Date of Birth: _____ Sex: _____
DHS ID#: _____
Unit/Subunit: _____ Date: _____

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Illinois Department of Human Services

Division of Developmental Disabilities
Bureau of Clinical Services

Section 5

RN Delegation of Medication Administration Tasks

RN PRESENTER'S GUIDE
for

Training Program
for
Authorized Non-licensed Direct Care Staff

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Skill Standard A Authorized direct care staff recognizes concepts supporting, safe medication administration, and demonstrates task performance consistent with these conceptual principles.

Informational Competencies

Authorized direct care staff must know:

- routes of medication administration.
- medication forms.
- basic medication actions.
- basic medication side and adverse effects
- basic medication interactions (desired and harmful).
- basic medication categories.
- methods and concepts of medication counts.
- basic medication dosage concepts.
- principles of weights and measures.
- basic medication care.
- medication destruction methods.
- basics of physician orders.
- medical abbreviations related to physician orders.
- basics of medication administration records (MAR) and its relationship with documentation
- basic medication administration methods.
- self-administration medications levels.
- the seven rights of medication administration.

Interventional Competencies

Authorized direct care staff must be able to:

- name medication routes.
- identify and recognize medication forms.
- recognize, describe and report basic side and adverse effects of medications (harmful and non-harmful.
- recognize the difference between prescription and non-prescription drugs.
- know what medications are "controlled" drugs.
- name medication generic and trade names.
- identify safe and appropriate methods of caring for and storing medications.
- identify agency procedure for destruction of medications.
- identify agency procedure for counting medications.
- identify agency guidelines for physician's orders.
- recognize and know the meaning of medical abbreviations.
- list the seven rights of medication administration.
- use household equivalents to metric weights and measures.
- read and match pharmacy labels with physician's orders.
- accurately chart on the Medication Administration Record (MAR).
- identify levels of self-administration of medications.
- demonstrate how individuals with a developmental disability can be assisted with their self-administration of medication program.
- appropriately use agency policies concerned with medication administration.

Skill Standard B Authorized direct care staff recognizes the composition of body systems and know what medications and medication classes have effects on those systems. They must be able to distinguish, document and report those effects to the RN Nurse-Trainer for follow-up and direction.

Informational Competencies

Authorized direct care staff must know:

- muscular and skeletal system and related medication classifications.
- nervous system and related medication classifications.
- circulatory system and related medication classifications.
- respiratory system and related medication classifications.
- reproductive system and related medication classifications.
- urinary system and related medication classifications.
- gastrointestinal system and related medication classifications.
- endocrine system and related medication classifications.
- integumentary system and related medication classifications.
- sensory (special senses) system and related medication classifications.

Interventional Competencies

Authorized direct care staff must be able to:

- name the reasons for the use of each medication given to each individual in terms of body system affected.
- identify observations that should be reported to the RN Nurse-Trainer for each medication and by medication class.
- state special considerations and warnings for each medication and by medication class
- describe basic health problems/conditions of each individual in terms of body systems.
- relate medications to the body system they are prescribed to treat.
- list an individual's care needs resulting from their prescribed medications.
- list an individual's care needs related to their basic health problems.

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Skill Standard C Authorized direct care staff documents and safely administers medications to identified individuals, using appropriate administration techniques.

Informational Competencies

Authorized direct care staff must know:

- oral medication procedures.
- topical medication procedures.
- eye medication procedures.
- ear medication procedures.
- nasal medication procedures.
- inhaled medication procedures.

Interventional Competencies

Authorized direct care staff must be able to:

- identify aspects of developmental disabilities that determine approaches to medication administration for individuals with developmental disabilities.
- demonstrate oral medication administration.
- demonstrate topical skin medication administration.
- demonstrate instillation of eye medication.
- demonstrate instillation of ear medication.
- demonstrate nasal medication administration.
- demonstrate inhalant medication administration.
- demonstrate accurate documentation of administration on an MAR (Medication Administration Record).
- correctly document medication given.

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Skill Standard D Authorized direct care staff recognized medication errors and/or incidents and follow agency specific policies and procedures to insure the individual's health and safety.

Informational Competencies

Authorized direct care staff must:

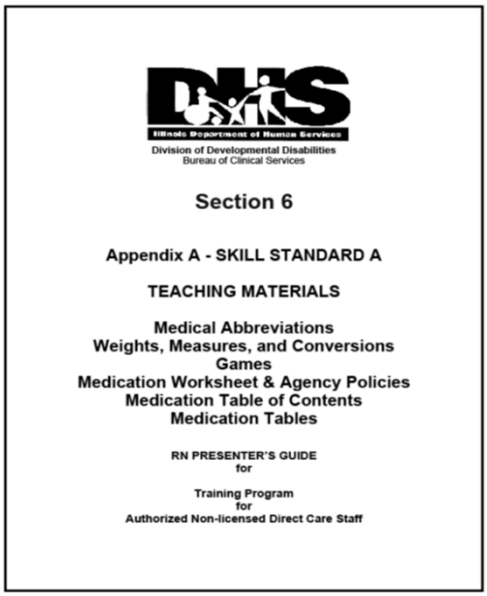
- know the definition of medication error.
- know any violation of the seven "rights" (person, time, medication, dose, route, texture/ consistency, record).
- identify a medication omission error.
- know how to contact the RN Nurse-Trainer.
- know agency specific policies and procedures for medication errors.

Interventional Competencies

Authorized direct care staff must be able to:

- identify how medication errors can occur.
- identify how medication errors can be prevented.
- identify accurate documentation of errors.
- identify error reporting procedures.
- identify potential observations to be made and reported to the RN Nurse-Trainer due to a medication error.
- state responsibilities to the individual when an error occurs.
- describe the reporting method to the RN Nurse-Trainer.
- identify agency error policies and procedures.
- demonstrate accurate documentation of errors.
- state the reason for behaviors that prevent medication errors during medication administration.
- demonstrate behaviors that prevent medication errors during medication administration.

Notes to Presenters	*Script*
It is desirable to greet each person at the door. At that time have each person sign-in to the class and distribute copies of their learning materials. Have them sign-out at the end of the class. This is important documentation that needs to be kept on file. See the suggested documentation in Appendix F of your Nurse-Trainer information for a suggested class roster form. • Tell them the location of bathrooms. • Verify that all persons have the necessary pre-requisites to become authorized. • Explain class timing, (length, lunch, breaks) Overhead: Prerequisites for Authorization to Administer Medications for Direct Care Staff Overhead: Concepts of Medication Administration Use the information presented to you during your Nurse-Trainer class to the depth you feel is necessary to show the reasons and importance of the training you are doing.	**Introduction** **Housekeeping** Before we begin our class, let's make sure everyone is in the right place. (Suggest use Overhead showing the "Prerequisites for Authorization to Administer Medications for Direct Care Staff" Overhead. **Setting the Stage** During this class we will discuss the concepts of 1) safe medication administration; 2) body systems, their anatomical function and how medications affect them; 3) safe medication administration techniques; 4) medication errors, their prevention and documentation. (The need to present these concepts is based on laws and standards that include Administrative Rules 115 (The "CILA" Rule) and 116, and the Nurse Practice Act. Let's look at "how did we get here?" Let's discuss why non-licensed staff, like you, are now administering medications.



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INSTRUCTIONS TO THE INSTRUCTOR:

1. Using YOUR Medication Administration Record (MAR), create a mock/sham MAR with medications commonly used by your agency.
2. It is suggested that no more than five and ten medications be placed on the mock MAR with the appropriate information. According to Administrative Rule 116.70 that information includes: the individual's name (use a name such as "Jane Doe"), name of the prescribing person, medication name (generic and trade), dose, schedule, route, most recent order date, allergies to medication and special considerations. If you have any other medication information regularly on you MAR, include these in your mock MAR. (Adverse/side effects are a highly desirable part of an MAR.)
3. To help in the student's learning to read and interpret an MAR and follow the "Seven Rights", it is suggested that the usual individual served information be included on the MAR. This is, the individual's name, physician's name allergies, etc. These, of course, will be made up.
4. Using the medication information source typically used in your company/provider, have the student/staff member complete a "Medication Worksheet". (This is on the next page. Use a copy of the page.)
5. Learning Objectives: The student/staff member will be able to:
   a. Use medication information provided at your company/provider to gather pertinent information about medications.
   b. Read and interpret information from the MAR.
   c. Note the importance of knowing generic names to medications instead of just trade names.
   d. Find special instructions in the medication information provided at your company/provider to properly administer medications.

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Classification(s)	Medication Names		Indications/Use	Adverse/Side Effects	Special considerations
	Trade	Generic			
Non-narcotic analgesic , antipyretic	Tylenol, Anacin 3, Arthritis Pain Formula, Aspirin Free Panadol	Acetaminophen	Pain (including arthritis pain) and fever	Rare: anemia, jaundice, rash	Caffeine containing food may increase analgesic effect, discourage use with alcohol

Division of Developmental Disabilities
Bureau of Clinical Services

Section 7

Appendix B - SKILL STANDARD B

TEACHING MATERIALS

BODY SYSTEMS

RN PRESENTER'S GUIDE
for
Training Program
for
Authorized Non-licensed Direct Care Staff

Division of Developmental Disabilities
Bureau of Clinical Services

Section 8

Appendix C - SKILL STANDARD C

TEACHING MATERIALS

Considerations for Medication Vehicle Selection

Administration of Medication Check Lists

RN PRESENTER'S GUIDE
for

Training Program
for
Authorized Non-licensed Direct Care Staff

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Considerations in Selection of a Vehicle for Medication Administration

	Vehicle	Options
Texture	Too course	Chop vehicle until it is the desired texture or select another vehicle.
	Too fine	DO NOT USE. Obtain vehicle of the appropriate texture.
Consistency	Too sticky	Add liquid, condiments, or fats. i.e., add mayonnaise to pasta salad; add butter or milk to mashed potatoes.
	Too runny	Fruits and vegetable that are processed are often too runny. Drain off fluid, add unflavored gelatin, add cookie crumbs (to fruit), add bread crumbs, cracker crumbs, or brand powder.
	Too wet	Blot the vehicle (food) with a paper towel or napkin (before adding medication!) or add bread, cookie crumbs or brand powder.
	Too dry	Add a binder, liquids, condiments, or fats.

Adapted from Beckman & Roberts (1992)

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Administration of Oral Medications Practice

Student Name: _____ Date:_____/_____/20 _____

Scoring Key: ✓ = Successful completion ✗ = Unsuccessful completion NA = Not Applicable

IF INDIVIDUAL IS NOT INDEPENDENTLY SELF-MEDICATING the authorized staff person:

Pre-Preparation

( ) 1. Chooses an area appropriate to administer medications. (May be done verbally in the classroom.)

( ) 2. Attends to task of administering medications even with distraction.

( ) 3. Reviews Individual Service Plan (ISP)/Training Program for individual in Self-Administration of Medication.

Preparation

( ) 4. Gathers necessary materials for administering oral medication(s). (Medication/calibrated cup(s), measuring spoon, fluids, medication "vehicles".)

( ) 5. Removes medication from locked storage and re-locks storage cabinet/container.

( ) 6. Obtains the correct Medication Administration Record (MAR) for the individual receiving medication(s).

( ) a. Matches the individual's name on the MAR with the individual's name on the medication containers/cards.

( ) b. Identifies individual by checking and matching the name/picture on the MAR. (Uses the most appropriate identification method considering any communication limitations.)

( ) c. Checks the MAR for allergies to make sure the individual is not allergic to the medication.

( ) d. Checks the MAR for required pre-administration procedures (pulse, B/P, etc) and completes it/them before administering medication(s).

( ) e. Checks the MAR for any restrictions related to medication administration.

( ) 7. As appropriate, teaches self-administration procedure to individual according to the ISP/Training Program Protocol.

( ) 8. Observes the individual before administration for later documentation and for conditions that may preclude safe administration. If such conditions are present, does not administer the medication, reports the condition immediately to the nurse and follows agency policy. If conditions indicate that medication administration is safe, continues the medication administration process.

( ) 9. Washes hands before preparing the medication(s).

Administration of Medication

( ) 10. Checks, by reading/matching MAR information and stating aloud (or murmuring), the "7 Rights" of Medication Administration (Individual/Person, Record, Drug, Dose, Time scheduled, Route, Texture) At each of the following steps.

( ) a. When removing medication container from box/basket/cabinet.

( ) b. Just before pouring/punching out the correct dose into a medication cup.

( ) c. Just before returning medication container to box/basket/cabinet.

( ) 11. Administers the medication correctly by:

( ) a. shaking liquids as appropriate to mix them, crushing tablets as necessary, mixing medication with "vehicle", or pouring accurately into calibrated cups as indicated.

( ) b. instructing the individual on the proper consumption of medication (oral – swallowing with the assistance of a liquid (water) or mixed with a "vehicle"; sublingual – placing medication under the tongue and permitting it to dissolve there; Troche/Lozenge held in mouth until dissolved.)

( ) c. administering her/his medication.

( ) d. assisting the individual as needed.

( ) 12. Observes the individual for immediate reaction to the medication

( ) 13. **Documentation** – marks the MAR for each medication immediately following medication administration indicating the individual has taken the medication.

( ) 14. Cleans up area and secures the medications in the locked container/storage/cabinet.

IF INDIVIDUAL IS SELF-MEDICATING the authorized staff person:

( ) 1. Observes the individual before administration for later documentation and for conditions that may preclude safe administration. If such conditions are present, does not permit the individual to consume the medication, reports the condition immediately to the nurse and follows agency policy. If conditions indicate that medication administration is safe, continues the medication administration process

( ) 2. Assists the individual to remove her/his medication from the secured/locked storage as needed.

( ) 3. If necessary, reviews the safe procedure for administering oral medications with the individual.

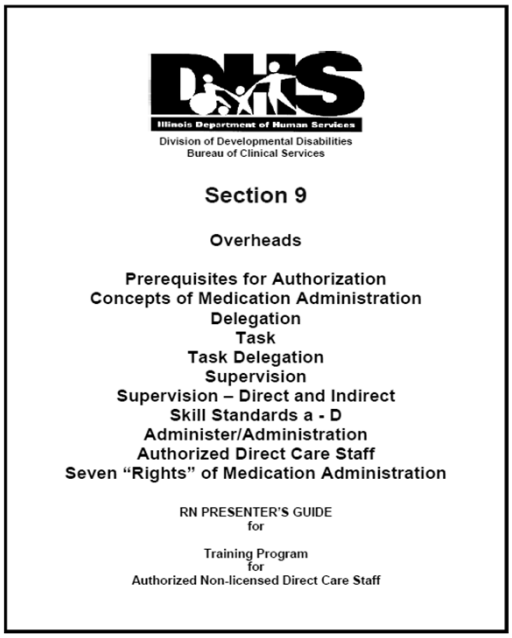
( ) a. observes the individual to shake liquids as appropriate to mix them, crush tablets as necessary, mix medication with "vehicle", or pour accurately into calibrated cups as indicated.

( ) b. observes the individual properly consume of medication (oral – swallow with assistance liquid such as water or mixed with a "vehicle"; sublingual – place medication under the tongue and let it to dissolve there; Troche/Lozenge hold in mouth until dissolved.)

( ) 4. Observes the individual to insure the medications is administered properly and for immediate reaction to the medication. If the authorized staff person observes an error in technique, if possible, she/he prevents the error and instructs the individual in the correct method of administration.

( ) 5. **Documentation** – follows agency policy and procedure for documenting medication consumption for an individual who is self-medicating.

( ) 6. Follows the ISP, makes sure the area is cleaned and the medications are re-secured in a locked container/storage/cabinet.


Illinois Department of Human Services
Division of Developmental Disabilities
Bureau of Clinical Services
Section 9
Overheads
Prerequisites for Authorization
Concepts of Medication Administration
Delegation
Task
Task Delegation
Supervision
Supervision – Direct and Indirect
Skill Standards a - D
Administer/Administration
Authorized Direct Care Staff
Seven "Rights" of Medication Administration
RN PRESENTER'S GUIDE
for
Training Program
for
Authorized Non-licensed Direct Care Staff

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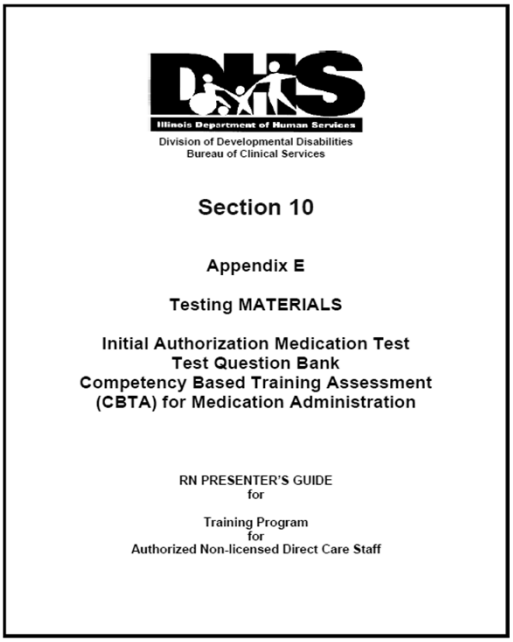
Illinois Department of Human Services
Division of Developmental Disabilities
Bureau of Clinical Services
Section 10
Appendix E
Testing MATERIALS
Initial Authorization Medication Test
Test Question Bank
Competency Based Training Assessment
(CBTA) for Medication Administration
RN PRESENTER'S GUIDE
for
Training Program
for
Authorized Non-licensed Direct Care Staff

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Training Program

Medication Administration Module
Skill Standard E Testing Materials

INITIAL AUTHORIZATION MEDICATION TEST

KEEP THIS COMPLETE TEST ON FILE

Staff: _____ Test Date: _____ 20_____ Score: _____/45

This staff member has successfully completed the didactic portion of Medication Administration in the Community training and has passed the written test by at least 80%. See the completed CBTA form for successful medication task proficiency, medication administration authorization and a list of individuals to whom s/he can administer medication according to Administrative Rule 116 and _____ Policies and Procedures.
(Agency/Provider Name)

_____ RN Nurse-Trainer Date: _____ 20___
(Signature)

DIRECTIONS: Choose the BEST answer and circle its letter.

1. Authorized Direct Care Staff are responsible for _____ when giving medications.
   A. initialing the box on the individual's Medication Administration Record (MAR) indicating the individual has taken the medication
   B. notifying the doctor that the medication was given after administering medication to the individual
   C. instructing the individual to tell the RN Nurse-Trainer that the medication was given
   D. calling the RN Nurse-Trainer to complete the medical record
2. Authorized Direct Care Staff should only perform those medication administration tasks:
   E. that the RN Nurse-Trainer has trained them to do.
   F. that the doctor asked them to do.
   G. they feel is necessary.
   H. all the above
3. Forgetting to administer a medication on time is an example of:
   a. Malpractice B. unethical behavior C. slander D. neglect
4. What is the FIRST thing you should do if you make a medication error?
   a. Isolate the individual. C. Call 911.
   b. Page/call the RN Nurse-Trainer D. Just watch the individual closely.

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Competency Based Training Assessment (CBTA) for Medication Administration by Non-licensed Direct Care Staff in the Community for those with a Developmental Disability

Signature of Staff to be Authorized to Pass Medications: _____

Date(s) of **initial** Authorization training & testing _____, _____, _____, _____

RN Nurse-Trainer Name: _____ IL License # 041- _____

Provider Name: _____

Directions: To successfully complete the tasks of medication administration for authorization to administer medications, non-licensed direct care staff must, under the direct supervision of a RN Nurse-Trainer, pour, administer and record **ERRORLESSLY**. This will be done by the staff member named above, for the individuals identified on this form. This evaluation includes demonstrating knowledge of each individual's disability, medication, dose, schedule, route, and expected effects and possible side effects. A list of the medications administered to the individuals identified on this form, such as a Medication Administration Record (MAR), must be attached. There must be a documenting procedure that reflects new medications (including dosage changes) the staff member is authorized to administer.

Scoring Key: + = Successful Completion - = Unsuccessful Completion NA = Not Applicable

General Requirements/Preparation (If necessary, attach additional sheets for additional comments.)

( ) 1. Chooses appropriate place to dispense medications and makes sure the dispensing area is clean.

( ) 2. Focuses on preparing and administering medications regardless of unavoidable distractions/interruptions.

( ) 3. Assembles equipment necessary for pouring, administering and recording medications to be given (paper & medicine cups, measuring devices, vehicles such as applesauce/pudding, etc.

( ) 4. Procures appropriate MARS and medications from locked storage.

( ) 5. Matches individual's name on MAR with label on medication containers.

( ) 6. Shakes liquid medications and or mixes crushed/liquids with appropriate fluids or foods.

( ) 7. Cleans up the medication area after each individual as necessary to prevent possibility of contamination.

	INDIVIDUALS															
TASK	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Appropriately obtains individual's medications																
Reviews the MAR for allergies & medication changes or any conflicts before pouring medications																
Identifies individual. Checks and matches individual's name/face with name/picture on MAR																
When/If indicated, checks pulse, blood pressure, temperature, etc.																
Washes/disinfects hands before pouring medications for each individual																
Check for correct drug administration by stating aloud (or murmur) 7 rights of Medication Administration																
(1) when removing specific drug container from box/cabinet																
(2) before pour/punching out an accurate dose																
(3) before returning drug container to box/cabinet																
Selects correct medication, dose, date, time, route & consistency																
Assists individuals to receive/consume medication as necessary																
Observe individuals to insure consumption/correct application of medication(s)																
Follow ISP/Self-Medication Program to maximize self-med independence																
Immediately documents med on MAR for each individual following administration																

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Comments: _____

( ) PASSED Medication Administration CBTA with 100% Accurate Performance _____/_____/20_____ (date)

( ) DID NOT PASS Medication Administration CBTA with 100% Accurate Performance _____/_____/20_____ (date)

_____, has successfully completed the classroom and CBTA components
(Name of non-licensed staff – print legibly or type)

for Authorization of Non-Licensed Direct Care Staff. He/She is authorized to administer medications to the clients/ individuals identifies below. _____ _____/_____/ 20_____
(Signature of Nurse-Trainer)

Individual's Name or Identification	Individual's Name or Identification
1. _____	9. _____
2. _____	10. _____
3. _____	11. _____
4. _____	12. _____
5. _____	13. _____
6. _____	14. _____
7. _____	15. _____
8. _____	16. _____

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Illinois Department of Human Services
Division of Developmental Disabilities
Bureau of Clinical Services

Section 11

Appendix F

Suggested Documentation

Attendance Sheet for
Initial Medication Administration Class
Evaluation for Authorized Direct Care Staff
Documentation Check List

RN PRESENTER'S GUIDE
for
Training Program
for
Authorized Non-licensed Direct Care Staff

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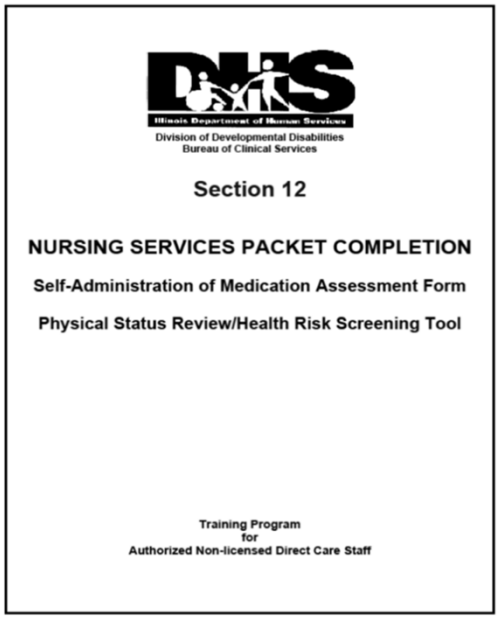

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COMPLETION OF THE NURSING SERVICE PACKET

Division of Developmental Disabilities

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Rod R. Blagojevich, *Governor*

Illinois Department of Human Services

Carol L. Adams, Ph.D., *Secretary*

319 E. Madison • Springfield, Illinois 62701-1035

MEMORANDUM

DATE: May 4, 2005

TO: Executive Director
Community Providers

FROM: Scott Kimmel, Bureau Chief
Bureau of Community Reimbursement

SUBJECT: Nursing Services Packets (NSP) for Adult Residential Supports

Effective July 1, 2005, the Division of Developmental Disabilities, Bureau of Community Reimbursement (DDD/BCR) is discontinuing the requirement to submit the NSP annually. NSP assessments should continue to be conducted annually but only submitted to DDD/BCR whenever a significant medication administration and/or nursing treatment change occurs.

Provider agencies are still required to keep current nursing treatment and self-administration of medication assessments on file in their agency per *Rule 115.240 f)*. An updated individual NSP may be submitted to DDD/BCR anytime there is a significant change in the individual's medications or nursing treatment needs. Providers should determine what constitutes a significant change and if it is relevant to a change in the nursing component of the individual's rate. However, the annual submission of the NSP to DDD/BCR is no longer required for individuals receiving residential support programs. Those programs are as follows:

- **Community Integrated Living Arrangement (CILA) (60D)**
- **Purchase of Service (POS) CILA (61D)**
- **Hourly CILA (65H)**
- **Community Living Facility (CLF) (67D)**
- **Home/Individual Program (HIP) (68D)**

Initial placement packets still require submission of the NSP if nursing supports are part of the individual's service plan and needs. Once the initial packet and NSP are processed, it will only be necessary to submit an updated NSP to report significant changes (increases or decreases) in the individual's medications or nursing treatments. DDD/BCR staff will, if appropriate, adjust the nursing component of a rate upon receipt of an updated NSP when submitted with a *CILA Turnaround & Rate Review Form* or the *POS Turnaround Form*. This change becomes effective July 1, 2005.

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This notice changes how and when DDD/BCR will need to receive the individual NSP from community agencies in the future. Please take the time to share this information and instructions with the appropriate staff in your organization.

Per Rule 115.240 f) community agencies are required to conduct the annual NSP assessments and keep them on file in the agency. Agencies are not required to submit to DDD/BCR the annual NSP, but may submit whenever a significant change in the individuals needs would justify a review by the department.

Thank you for your continued support of individuals with developmental disabilities. If you have any questions, please feel free to contact your Network Facilitator or you may call Sandy Easdale, Manager POS Unit or George Bengel, Manager CILA Rates Unit at (217) 782-0632, or you may contact the CILA Rates Unit by email at DHSCILA@dhs.state.il.us, and the POS Unit at DHSPOS@dhs.state.il.us.

cc: Jeri Johnson, Director
Mary Spriggs Ploessl, Deputy Director, Community Services
Network Coordinators, Facilitators, and Representatives
Dr. Theodore Sunder, Clinical Services
Arden Gregory, RN, Clinical Services
George Bengel, CRU
Sandy Easdale, POSU

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SELF-ADMINISTRATION OF MEDICATION ASSESSMENT

"SAMA" form

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SELF-ADMINISTRATION OF MEDICATION ASSESSMENT
Illinois Department of Human Services
Office of Developmental Disabilities

Client Name:_____ SS#_____-_____-_____ Medicaid ID #_____

Provider Name:_____ ID # _____ DHS Network: _____

General Instructions:

1) For all responses to items, place the **letter** of the choices immediately below in the "**HOW**" box to indicate how the answer to the question was obtained.

W) In writing/reading
Pa) By a physical action
O) Orally
S) By signing
Sg) By Signaling
U) Unable to answer

1) For all responses to items, place the **letter** of the choices immediately below in the "**MANNER**" box to indicate how the client demonstrated their capability.

C) Chooses correct performance of activity
D) Directs performance of activity by another
P) Performs activity

If a "NO" answer occurs for program participation or any assessment item or the client refuses to participate in a self-medication program, independent capability and functioning cannot be confirmed. The client and interdisciplinary team should, as appropriate, develop and implement a self-medication training program or a training program in preliminary skills attainment. A detailed DHS self-medication training instrument is available upon request for evaluation of medication training program needs at Bureau of Clinical Services, 319 East Madison, Suite 2A, Springfield, IL, 62701.

The "Self-Administration of Medication Assessment (SAMA) Report Page," (page 3 of this form) is the only page of the SAMA form you need submit to DHS if you are a community provider. SODC and community providers should retain all of this form for your records.

DOMAIN	Program Participation	YES	NO	HOW
Preference	Indicates willingness to participate in a medication self-administration program.			

If answer is **YES:** Proceed to Assessment

If answer is **NO** or client is unable to answer:
1) STOP and complete page 3.
2) Re-assess in one year, or as indicated.

When program participation preference is "NO;" qualified persons must administer medications.

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CLIENT NAME: _____ DATE: _____

HOW		MANNER
W) In writing/reading	**S**) By signing	**D**) Directs performance or activity
Pa) By a physical action	**Sg**) By signaling	**C**) Chooses correct performance of activity
O) Orally	**U**) Unable to answer	**P**) Performs activity

SELF-ADMINISTRATION OF MEDICATION ASSESSMENT (SAMA)

When all items below are accomplished (answered "YES"), the individual is independent in self-administration of medications. Tasks must be performed at the individual's medication storage site under visual supervision of a qualified person. Physical adaptations, supports, and/or accommodations should not prevent "YES" ratings on item performance when cognitive capacity is sufficient to support understanding.

ITEM	YES	NO	HOW	MANNER
1. Person identifies rules for safe self-administration of medication: a. Indicates will not share medication with others. b. Indicates will not take someone else's medication.				
2. Person performs the necessary sanitary procedures before administration of medications: a. Wash or clean hands. b. Obtain clean utensils or containers.				
3. Person identifies and/or is able to recognize need to follow any special instructions that may arise connected with particular medications (i.e. Take on empty stomach, take with meals, avoid dairy products, etc.)				
4. Person obtains the correct items for taking medications (i.e. water, applesauce, thicken, etc.)				
5. Person identifies correct time of day to take (administer) each of their particular medications.				
6. Person removes the correct medication from the medication supply for that particular administration time.				
7. Person removes the correct amount of the correct medication from the medication supply for that particular administration time.				
8. Person takes the medication in the prescribed way.				
9. Person returns medication container (supply) to the storage unit.				
10. Person performs the necessary sanitary procedures after administration of medications: a. Disposing or cleaning used utensils or containers. b. Refrigerating necessary items (i.e. applesauce).				
11. Person identifies how to keep track of medications and how to obtain medication refills.				

If all items are answered "**YES**" proceed to page 3 of the SAMA, complete all appropriate sections including the "Certification of Independence".

If "**NO**" to one or more of the above items:

1) Is Self-medication training appropriate? If "**NO**" - Institute preliminary skills training and re-assess in one year.
If "**YES**" - Develop and implement Self-Medication Training Program.

2) Complete "Self-Medication Administration Assessment" Report Page, (page 3 of this form).

When a client is "Not Independent" qualified persons must administer medications and supervise any self-medication training programs.

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Self-Administration of Medication Assessment Report Page

DESCRIPTIVE INFORMATION (Complete for all clients)

You **MUST** submit this page as part of any Nursing Service Packet. Do **NOT** include any of the previous pages of the Assessment. Retain them for your records.

Client Name: _____ SS# _____-_____-_____ Medicaid ID #:_____

Provider:_____ ID # _____DHS Network: _____

Program Type: (circle one): CILA (Program 60) ICFDD/MR SNF/Peds

Purchase of Service: Program Code_____

INDEPENDENCE: (Complete for all clients. Check only one.)

[ ] **Independent** - Complete "CERTIFICATION OF INDEPENDENCE" immediately below

[ ] **NOT Independent** - Appropriate for self-medication training (Develop and implement Self-Medication Training Program)

[ ] **NOT Independent** - NOT Appropriate for self-medication training (Institute preliminary skills training.)

CERTIFICATION OF INDEPENDENCE (Complete only for persons "Independent.")

I, _____, (please print) _____/_____/_____(Date) being a duly licensed professional registered nurse, do hereby certify that I have reviewed the procedure and documentation used in the self-medication assessment of this individual. I further declare that I have observed the individual perform self-medication tasks in a natural setting and I have indicated my professional opinion regarding this person's capabilities in self-medication and self-medication training as indicated above.

Attach the following document or check the boxes below as appropriate:

Medication Administration Record (MAR) [ ] This individual does not take medications. No MAR is attached.

Treatment Administration Record (TAR) [ ] This individual receives no treatments. No TAR is attached.

Completed by: _____ **RN** Date: _____/_____/20_____

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Physical Status Review

“Health Risk Screening Tool”

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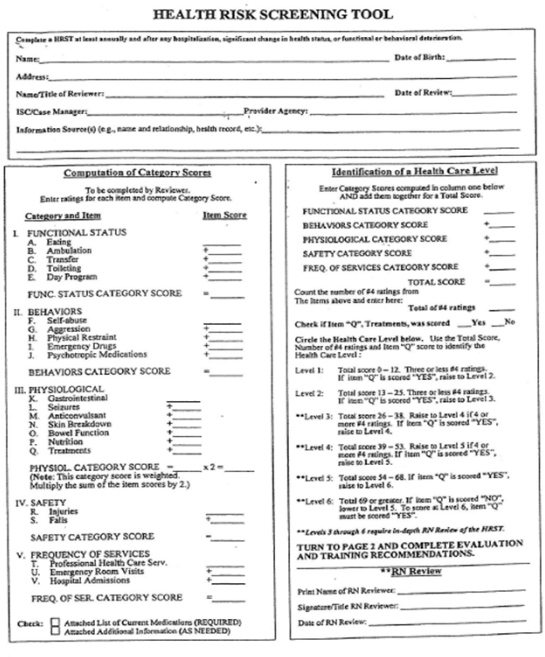

HEALTH RISK SCREENING TOOL

Complete a HRST at least annually and after any hospitalization, significant change in health status, or functional or behavioral deterioration.

Name:_____ Date of Birth:_____

Address:_____

Name/Title of Reviewer:_____ Date of Review:_____

ISC/Case Manager:_____ Provider Agency:_____

Information Source(s) (e.g., name and relationship, health record, etc.):_____

Computation of Category Scores

To be completed by Reviewer.
Enter ratings for each item and compute Category Score.

Category and Item	Item Score
I. FUNCTIONAL STATUS	
A. Eating	_____
B. Ambulation	+_____
C. Transfer	+_____
D. Toileting	+_____
E. Day Program	+_____
FUNC. STATUS CATEGORY SCORE	=_____
II. BEHAVIORS	
F. Self-abuse	_____
G. Aggression	+_____
H. Physical Restraint	+_____
I. Emergency Drugs	+_____
J. Psychotropic Medications	+_____
BEHAVIORS CATEGORY SCORE	=_____
III. PHYSIOLOGICAL	
K. Gastrointestinal	_____
L. Seizures	+_____
M. Anticonvulsant	+_____
N. Skin Breakdown	+_____
O. Bowel Function	+_____
P. Nutrition	+_____
Q. Treatments	+_____
PHYSIOL. CATEGORY SCORE	=_____ x 2 =_____
(Note: This category score is weighted. Multiply the sum of the item scores by 2.)	
IV. SAFETY	
R. Injuries	_____
S. Falls	+_____
SAFETY CATEGORY SCORE	=_____
V. FREQUENCY OF SERVICES	
T. Professional Health Care Serv.	_____
U. Emergency Room Visits	+_____
V. Hospital Admissions	+_____
FREQ. OF SER. CATEGORY SCORE	=_____

Check: ☐ Attached List of Current Medications (REQUIRED)
☐ Attached Additional Information (AS NEEDED)

Identification of a Health Care Level

Enter Category Scores computed in column one below AND add them together for a Total Score.

FUNCTIONAL STATUS CATEGORY SCORE	_____
BEHAVIORS CATEGORY SCORE	+_____
PHYSIOLOGICAL CATEGORY SCORE	+_____
SAFETY CATEGORY SCORE	+_____
FREQ. OF SERVICES CATEGORY SCORE	+_____
TOTAL SCORE	=_____

Count the number of #4 ratings from The Items above and enter here: Total of #4 ratings _____

Check if Item "Q", Treatments, was scored ___Yes ___No

Circle the Health Care Level below. Use the Total Score, Number of #4 ratings and Item "Q" score to identify the Health Care Level :

Level 1: Total score 0 – 12. Three or less #4 ratings. If item "Q" is scored "YES", raise to Level 2.

Level 2: Total score 13 – 25. Three or less #4 ratings. If item "Q" is scored "YES", raise to Level 3.

**Level 3: Total score 26 – 38. Raise to Level 4 if 4 or more #4 ratings. If item "Q" is scored "YES", raise to Level 4.

**Level 4: Total score 39 – 53. Raise to Level 5 if 4 or more #4 ratings. If item "Q" is scored "YES", raise to Level 5.

**Level 5: Total score 54 – 68. If item "Q" is scored "YES", raise to Level 6.

**Level 6: Total 69 or greater. If item "Q" is scored "NO", lower to Level 5. To score at Level 6, item "Q" must be scored "YES".

***Levels 3 through 6 require in-depth RN Review of the HRST.*

TURN TO PAGE 2 AND COMPLETE EVALUATION AND TRAINING RECOMMENDATIONS.

RN Review

Print Name of RN Reviewer: _____

Signature/Title RN Reviewer: _____

Date of RN Review: _____

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Name:_____

Reviewer Recommendations

Compare individual item rating scores with the Evaluation and Training matrix.
Check the needed Evaluation, Services and Training below.

Evaluation/Services:
__ *Baseline data collection
__ Behavioral
__ Dental
__ Medical
__ *Medical specialty (psychiatry, neurology, etc.)
__ Nursing
__ Nutritional/Clinical Dietitian
__ Oral Motor (OT/Speech)
__ Personal Support Team
__ Pharmacological
__ Physical Management (PT/OT)
__ Respiratory
__ *TD Screen, standardized

*Specify in Reviewer Recommendations Section below

Training
__ Behavioral interventions
__ Emergency First Aid/CPR
__ Health Care Protocols
__ Mealtime Management – Basic (Includes: preparation, adaptive equipment, food texture and positioning)
__ Mealtime Management – Advanced (Includes: assistive techniques, emergency intervention, oral motor techniques, and troubleshooting mealtime problems)
__ Medication Administration
__ Physical Management – Basic (Includes: body mechanics, lifting and transfers)
__ Physical Management – Advanced (Includes: therapeutic positioning and specialized transfers)
__ Seizure Recognition and Management
__ Signs/Symptoms/Emergencies
__ TD Screen (DISCUS, AIMS, etc.)
__ *Individual Specific Training

*Specify in Reviewer Recommendations Section below

Reviewer Recommendations (Sign all entries):

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Name: _____

INSTRUCTIONS

1. Complete a HRST at least annually and after any hospitalization, significant change in health status, or functional or behavioral deterioration.
2. Print all the demographic information (name, date of birth, etc.) at the top of page 1.
3. Write the person's NAME on page 2 and 3 of the instrument.
4. Remove pages 1 and 2 from the instrument. Place these pages next to the instrument in order to record item scores as they are rated.
5. The instrument is divided into 5 categories. The CATEGORIES are FUNCTIONAL STATUS, BEHAVIORS, PHYSIOLOGICAL, SAFETY AND FREQUENCY OF SERVICES. Each CATEGORY contains several ITEMS to be rated for a total of 22 ITEMS.
6. Each ITEM includes 5 possible RATING AREAS (0, 1, 2, 3 and 4). Read ALL the RATING AREAS under each item BEFORE scoring.
7. For each of the 22 ITEMS, score ONLY one rating area, 0, 1, 2, 3 or 4, by checking the box next to the RATING AREA of that ITEM. Enter the ITEM SCORE in column one, *Computation of Category Scores*, on Page 1 in the designated blank.

• Check the box next to ITEM's RATING:

A. Eating
☐ 0. Eats independently. May require simple adaptive equipment (hand splints, special utensil). Able to eat without assistance. Exception: meal preparation (cutting meat).
☐ 1. Requires intermittent physical assistance AND/OR verbal prompts to eat. Has difficulty attending to task and/or needs direct physical help due to motor limitation. With assistance, is able to safely complete meal.
☐ 2. Requires constant verbal and physical help to complete a meal. Has difficulty attending to task or motor limitations which require constant physical AND/OR verbal assistance. With constant physical assistance, is able to safely complete meal.
☒ 3. Requires constant physical assistance and mealtime intervention to eat safely. Unable to obtain adequate calories and fluids without assistance. May have difficulty breathing/swallowing while eating or condition that impairs ability to eat safely. Interventions are required (specific positioning support, eating devices, presentation techniques, modifications in food/fluid consistency). May have enteral (feeding) tube, but maintains some level of oral eating.
☐ 4. Receives all nutrition through an enteral tube (gastrostomy, jejunostomy). Unable to swallow safely. All nutrition given through the tube.

• Enter the ITEM rating Score in column one on page 1:

Category and Item	Item Score
I. FUNCTIONAL STATUS	
A. Eating	3
B. Ambulation	+ 3
C. Transfer	+ 3
D. Toileting	+ 4
E. Day Program	+ 2

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INSTRUCTIONS (Continued)

8. Use the COMMENTS section after each CATEGORY to explain or justify ratings. Label all entries in the COMMENTS section with the letter of the ITEM, e.g., A. Eating. Initial all entries.

9. After rating each item and entering the ITEM rating score in column one, compute the CATEGORY SCORES. Four of the CATEGORY SCORES (i.e., I. Functional Status, II. Behaviors, IV. Safety and V. Frequency of Services) are determined by simply adding each of the ITEM SCORES in the category and placing the sum in the appropriate CATEGORY SCORE blank (=____).

   The PHYSIOLOGICAL CATEGORY SCORE is WEIGHTED BY TWO. For CATEGORY III, PHYSIOLOGICAL, add each of the ITEM SCORES in the category and place the sum in the appropriate blank (=_____). Multiply this sum by 2 and enter in the appropriate blank (x 2 =_____).

II. BEHAVIORS	
F. Self-abuse	1
G. Aggression	+ 0
H. Physical Restraint	+ 1
I. Emergency Drugs	+ 1
J. Psychotropic Medications	+ 0
BEHAVIOR CATEGORY SCORE	= 3

III. PHYSIOLOGICAL	
K. Gastrointestinal	2
L. Seizures	+ 3
M. Anticonvulsant	+ 2
N. Skin Breakdown	+ 1
O. Bowel Function	+ 2
P. Nutrition	+ 1
Q. Treatments	+ 0
PHYSIOL. CATEGORY SCORE (Note: This category score is weighted. Multiply the sum of the item scores by 2.)	= 11 x 2 = 22

10. Attach a List of the person's Current Medications. Check the box to indicate the list has been attached. Attaching a medication list is REQUIRED.

Check: ☐ Attached List of Current Medications (REQUIRED)

11. Attach any Additional Information needed to clarify or support ratings (e.g., active and inactive problem list, medical specialty consultation report, etc.). Check the box to indicate Additional Information has been attached.

☐ Attached Additional Information (AS NEEDED)

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INSTRUCTIONS (Continued)

12. In column 2, *Identification of Health Care Level*, on page 1, enter each of the CATEGORY SCORES from column one. Add them together for a TOTAL SCORE.

Identification of a Health Care Level

Enter Category Scores computed in column one below
AND add them together for a Total Score.

FUNCTIONAL STATUS CATEGORY SCORE	15
BEHAVIORS CATEGORY SCORE	+ 3
PHYSIOLOGICAL CATEGORY SCORE	+ 22
SAFETY CATEGORY SCORE	+ 1
FREQ. OF SERVICES CATEGORY SCORE	+ 3
TOTAL SCORE	= 44

13. Count the number of #4 ratings for all 22 ITEMS and enter in the TOTAL of #4 ratings blank.

Count the number of #4 ratings from
the Items above and enter here:
Total of #4 ratings 1

14. Check yes or no. Was ITEM "Q", TREATMENTS, scored ?

Check if Item "Q" Treatments was scored ___ Yes _X_ No

15. Use the TOTAL SCORE, TOTAL of #4 ratings, and ITEM "Q" score to identify the HEALTH CARE LEVEL 1 through 6. Circle the identified Level. If the HEALTH CARE LEVEL is 3 through 6 an in-depth review of the HRST by an RN Reviewer and completion of STEPS 16 and 17 are REQUIRED.

Circle the Health Care Level below: Use the Total Score, Number of #4 ratings and Item "Q" score to identify the Health Care Level.

Level 1: Total score 0 – 12. Three or less #4 ratings. If item "Q" is scored "YES", raise to Level 2.

Level 2: Total score 13 – 25. Three or less #4 ratings. If item "Q" is scored "YES", raise to Level 3.

**Level 3: Total score 26 – 38. Raise to Level 4 if 4 or more #4 ratings. If item "Q" is scored "YES", raise to Level 4.

**Level 4: Total score 39 – 53. Raise to Level 5 if 4 or more #4 ratings. If item "Q" is scored "YES", raise to Level 5.

**Level 5: Total score 54 – 68. If item "Q" is scored "YES", raise to Level 6.

**Level 6: Total 69 or greater. If item "Q" is scored "NO", lower to Level 5. To score at Level 6, item "Q" must be scored "YES".

***Levels 3 through 6 require in depth RN Review of the HRST.*

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INSTRUCTIONS (Continued)

16. Turn to page 2, *Reviewer Recommendations*. Compare individual ITEM RATINGS with those found on the two charts at the end of the instrument:
    - *Evaluation and Service Requirements Based on HRST Rating Results*
    - *Training Requirements Based on HRST Rating Results*

    Check those Evaluation/Services and/or Training needs identified based on the rating of individual ITEMS. Provide written individualized recommendations for the areas indicated, e.g., Individual Specific Training, Medical specialty, etc. Sign all entries.

Reviewer Recommendations

Compare individual item rating scores with the Evaluation and Training chart.
Check the needed Evaluation, Services and Training below.

Evaluation/Services:	Training
__ *Baseline data collection	__ Behavioral interventions
__ Behavioral	✓ Emergency First Aid/CPR
__ Dental	✓ Health Care Protocols
__ Medical	✓ Mealtime Management – Basic (Includes: preparation, adaptive equipment, food texture and positioning)
✓ *Medical specialty (psychiatry, neurology, etc.)	__ Mealtime Management – Advanced (Includes: assistive techniques, emergency intervention, oral motor techniqu and troubleshooting mealtime problems)
✓ Nursing	✓ Medication Administration
✓ Nutritional/Clinical Dietitian	✓ Physical Management – Basic (Includes: body mechanic lifting and transfers)
__ Oral Motor (OT/Speech)	__ Physical Management – Advanced (Includes: therapeutic positioning and specialized transfers)
__ Personal Support Team	__ Seizure Recognition and Management
__ Pharmacological	✓ Signs/Symptoms/Emergencies
✓ Physical Management (PT/OT)	__ TD Screen (DISCUS, AIMS, etc.)
__ Respiratory	✓ *Individual Specific Training
__ *TD Screen, standardized	
*Specify in Reviewer Recommendations Section below	*Specify in Reviewer Recommendations Section below

Reviewer Recommendations (Sign all entries):
Medical specialties: dermatology, urology CS
Health Care Protocols: urinary catheter care CS
Individual specific training: skin care; bowel management. CS

17. The RN REVIEWER performs interviews and record reviews to validate HRST ratings and score computations. Changes to REVIEWER scoring by the RN REVIEWER are completed by drawing a single line through the incorrect information, entering the correct information and initialing the change. All clarifying information about a rating area entered by the RN REVIEWER is written in the COMMENTS SECTION for the appropriate ITEM and initialed. All revisions or additions to *Reviewer Recommendations* are documented using the same method.
18. After completing the in-depth review, the RN REVIEWER completes the RN REVIEW section on page 1 including the name of the RN reviewer, signature title and date of review.

**RN Review
Print Name of Reviewer: Joan Jet
Signature /Title RN Reviewer: Joan Jet, RN
Date of RN Review: 11/11/00

19. Staple pages 1 and 2 to the completed pages of the instrument. File in the appropriate section of the person's record.

CATEGORY I – FUNCTIONAL STATUS

A. Eating

☐ 0. Eats independently. May require simple adaptive equipment (hand splint, special utensil). Able to eat without assistance. Exception: meal preparation (cutting meat).
☐ 1. Requires intermittent physical assistance AND/OR verbal prompts to eat. Has difficulty attending to task and/or needs direct physical help due to motor limitation. With assistance, is able to safely complete meal.
☐ 2. Requires constant verbal and physical help to complete a meal. Has difficulty attending to task or motor limitations which require constant physical AND/OR verbal assistance. With constant physical assistance, is able to safely complete meal.
☐ 3. Requires constant physical assistance and mealtime intervention to eat safely. Unable to obtain adequate calories and fluids without assistance. May have difficulty breathing/swallowing while eating or conditions that impairs ability to eat safely. Interventions are required (specific positioning support, eating devices, pinsensation techniques, modifications in food/fluid consistency). May have enteral (feeding) tube, but maintains some level of oral eating.
☐ 4. Receives all nutrition/hydration through an enteral tube (gastrosiomy, jejunostomy). Unable to swallow safely. All nutrition is given through the tube.

B. Ambulation

☐ 0. Ambulates independently. May use walker or other means of support without problems of safety.
☐ 1. Walks with minimal supervision. Requires some type of support (walker) with support of another in close proximity. The primary issue is safety during ambulation.
☐ 2. Uses wheelchair for primary means of mobility. May not have ability to use his/her lower body. Able to use upper body strength for repositioning. Able to maintain trunk alignment. May not recognize need to reposition on a consistent basis.
☐ 3. Requires assistance to change positions or shift weight in wheelchair. Has limited use of limbs. May need assistance to propel wheelchair.
☐ 4. Disability prevents sitting in an upright position. Requires assistance to change position, shift weight in wheelchair and/or propel wheelchair, but due to degree of musculoskeletal deficits or deformity has limited positioning options.

C. Transfer

☐ 0. Transfers independently. May require verbal prompts, but no physical assistance.
☐ 1. Needs someone to supervise the transfer for safety.
☐ 2. Needs physical assistance of 1 person to transfer or change position.
☐ 3. Needs physical assistance of 2 people to transfer or change position.
☐ 4. Needs lifting equipment/procedures to safely transfer. May need range of specially designed positions. May require specialized equipment due to severe spasticity, history of bone fragility, potential for injury due to size, or due to degree of physical deformity.

D. Toileting

☐ 0. Independently uses toilet. No assistance required or appreciated.
☐ 1. Minimal supervision or adaptation required. May require reminders or some verbal and physical assistance to maintain hygienic practice or manage clothing adjustments. Beyond this, minimal assistance is necessary.
☐ 2. Continent of bladder or bowel, constant attention is needed. Requires physical assistance to complete hygiene tasks (wiping, hand washing) and clothing repositioning. May have occasional accidents.
☐ 3. Incontinent of bowel or bladder. Inability to recognize elimination (loss of sensation, physical inability to manage toileting needs). May require scheduled toileting or use of incontinent briefs.
☐ 4. Indwelling catheter or colostomy. Has either a severely disabling medical condition or has experienced a medical crisis making elimination through the rectum or urinary tract either difficult or impossible. May be temporary or permanent. Caregivers require training related to the underlying condition and skills to manage the catheter, colostomy and/or ileostomy.

E. Days Missed at a Day Program Site due to Illness (In Last 12 Months)

☐ 0. None, or person does not attend due to guardian objections. No clinical restrictions.
☐ 1. Less than 2 days in a month due to clinical issues. Able to actively participate in Day Program, but due to chronic, stable condition or behavioral issues, may be ill or have physician appointments to monitor condition or receive treatment.
☐ 2. 2 to 4 days in a month due to clinical issues. Able to actively participate in Day Program, but due to chronic, stable condition or behavioral issues, may be ill or have physician appointments to monitor condition or receive treatment.
☐ 3. 5 to 10 days in a month due to clinical issues. Able to actively participate in Day Program, but due to chronic unstable or progressively worsening health or behavioral issues, may be ill or have physician appointments to monitor condition or receive treatment.
☐ 4. More than 10 days in a month or does not attend due to intensity of clinical issues. Able to actively participate in Day Program, but due to chronic unstable or progressively worsening health or behavioral issues, may frequently be ill or have physician appointments to monitor condition or receive treatment. Intensity of clinical issues prevents any attendance.

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CATEGORY I – FUNCTIONAL STATUS
COMMENTS

Please identify the section (A, B, etc.) on which you are commenting

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CATEGORY II - BEHAVIORS

F. Self Abuse

- ☐ 0. No self abuse.
- ☐ 1. Minimal self abuse, no skin breakdown. May have redness of skin.
- ☐ 2. Self abuse needing additional observation less than 2 times a month. Demonstrates behaviors that cause minor self-injury, which may require treatment, but less than twice a month.
- ☐ 3. Self abuse needing medical/nursing attention more than 2 times per month. Demonstrates behaviors that cause minor self-injury, which may require treatment, but more than twice a month.
- ☐ 4. Self-injury interferes with program, causes excessive physical harm. Self inflicted injury to the extent that he/she is not able to attend programming.

G. Aggression Toward Others and Property

- ☐ 0. No aggression.
- ☐ 1. Less than 5 incidents per month of minor aggression (verbal or physical) but no injuries.
- ☐ 2. More than 5 incidents per month of aggression without injury to others or property.
- ☐ 3. Less than 5 episodes of aggression per month with minor injuries to others (injuries not needing medical attention) or property.
- ☐ 4. Episodes of aggression require increased staffing ratios or restrictive interventions.

H. Use of Physical Restraints: Restraints Defined as Restriction of Movement. These procedures are highly controlled and in most cases PROHIBITED.

- ☐ 0. Has never been restrained
- ☐ 1. Has been restrained less than once per month in past 12 months. May include restraints used to facilitate some type of urgent medical procedure or care that without using restraint would have been impossible. This instance would be rare, requiring a physician's approval. Less restrictive options would have been explored and ruled out.
- ☐ 2. Has been restrained more than once per month in past 12 months. May include restraints used to facilitate some type of urgent medical procedure or care that without using restraint would have been impossible. This instance would be rare, requiring a physician's approval. Less restrictive options would have been explored and ruled out.
- ☐ 3. Use of devices or physical restraint procedures more than 5 times per month or wears some sort of device (fencing mask, helmet) on a regular basis (at least once per day). Generally has behavioral issues (hitting, throwing objects, biting, head-banging, etc.) that cause injury to self and others. May wear protective devices.
- ☐ 4. Individual injury requiring medical attention during application of restraints or use of some sort of device twelve hours a day (fencing mask, helmet). Generally has significant behavioral issues (severe and continuous tissue damage, use of physical/mechanical restraint).

I. Use of Emergency Drugs: The use of any drug to restrict function or movement.

- ☐ 0. Has not received drugs given in an emergency to control behavior in the past 12 months. May have behavior issues, but coping skills are sufficient to calm down without the necessity of drug/medication administration.
- ☐ 1. Received medication before any medical or dental procedure. Anxiety/pain threshold has resulted in use of drugs prior to medical or dental procedure.
- ☐ 2. Has received emergency drugs to control behavior 1 time in last 12 months.
- ☐ 3. Has received emergency drugs to control behavior 2-3 times in last 12 months.
- ☐ 4. Has needed emergency drugs to control behavior 4 or more times in last 12 months.

J. Use of Psychotropic Medications ***(Before rating this item consult the list of psychotropic drugs and tardive dyskinesia definition on the back of this page.)***

- ☐ 0. Receives no medication to control behavior or psychiatric disorder.
- ☐ 1. Receives 1 medication not associated with or known to cause Tardive Dyskinesia (TD) to control behavior or psychiatric disorder.
- ☐ 2. Receives 2 medications not associated with or known to cause TD to control behavior which are unchanged in the past year. May or may not be taking a "traditional" psychotropic drug, but is taking medication (e.g., Benadryl, Inderol, Tegretol) for identified behavior.
- ☐ 3. Receives more than 2 behavioral medications not associated with or known to cause TD OR behavior medications have been changed in the past year. On 2 or more medications to control behaviors OR receives 2 medications to control behavior with at least one change in past year.
- ☐ 4. Receives one or more medications associated with or known to cause TD. OR currently on a reduction/discontinuation of medication associated with TD (in the previous 30-90 days). OR anyone on metoclopramide (Reglan), regardless of the reason.

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CATEGORY III – PHYSIOLOGICAL

K. Gastrointestinal (GI) Conditions (includes vomiting, reflux, heartburn or ulcer) ***(Before rating this item consult the list of GI drugs and gastroesophageal reflux definition on the back of this page.)***

☐ 0. None. No history or current status of any GI concerns.
☐ 1. Occasional episodes of GI symptoms in absence of acute illness. Health is very stabilized, only has an occasional episode of GI symptoms (2 or less per month). GI distress occurs with no apparent explanation.
☐ 2. More than 3 episodes of GI symptoms per month. Health is stable with occasional episodes of GI symptoms, but symptoms occur 3 - 6 times a month. A documented pattern of incidents may be developing. These episodes are more likely associated with a disorder of the stomach or GI tract instead of following an acute illness like the flu.
☐ 3. More than 6 episodes of GI symptoms per month, OR coughing within 1-3 hours after meals or during the night, OR "hand-mouthing" where person attempts to stick hand down throat (mostly at night or around mealtimes), OR has a history of GI bleeding, OR a current diagnosis of gastroesophageal reflux (GER).
☐ 4. GI condition requiring hospital admission in past 12 months (A GI condition requiring hospitalization could include GI bleeding, vomiting, persistent dehydration, reflux-causing aspiration, intestinal infections, parasites, impaction and/or obstruction) OR receives more than one medication for GER.

L. Seizures

☐ 0. No seizure in lifetime or by history only.
☐ 1. No seizure in last 2 years. Has a history of seizure activity, but has been seizure-free for past 2 years. May or may not be on anticonvulsant medication.
☐ 2. Less than 1 seizure per month which DOES NOT interfere with functional activity.
☐ 3. Major seizure activity that DOES interfere with functional activities. Generalized seizures more than once a month, OR seizure activity (any classification) more than once a month which interferes with functional activities (work, school, recreation).
☐ 4. Has required hospital admission for seizures in past the 12 months. Any classification of seizure requiring a hospital ADMISSION (not just ER visit) to manage problems related to excessive seizure activity.

M. Anticonvulsant Medication Use (if prescribed for behavioral concerns, rate under item J) ***(Before rating this item consult the list of anticonvulsant drugs on the back of this page.)***

☐ 0. None. Not on an anticonvulsant.
☐ 1. Use of SINGLE anticonvulsant which has NOT CHANGED in the past year.
☐ 2. Use of 2 anticonvulsant medications which have NOT CHANGED in the past year.
☐ 3. Use of 3 or more medications, OR any change in anticonvulsant type or dosage in past 12 months, OR receiving felbamate (Felbatol) or valproic acid (Depakene or Depakote) in combination with any other anticonvulsant medication.
☐ 4. ER visit, OR hospitalization due to anticonvulsant toxicity in past 12 months.

N. Skin Breakdown

☐ 0. None. Skin breakdown is not a problem.
☐ 1. Red or dusky color of skin. Skin is reddened or has signs of poor circulation, especially in the area of the buttock, elbow, heel and/or hip.
☐ 2. Either currently has, or has had, broken skin in last 12 months, OR has a history of areas of broken skin. Areas of susceptible skin breakdown include the buttock, elbow, heel, hips or possible pressure areas identified by bony protrusions, especially if there are musculoskeletal deformities.
☐ 3. Within the past 12 months a pressure sore has developed which required more than 3 months to heal, OR has a condition directly associated with skin vulnerability (examples include spina bifida, spinal cord injury, nutritional compromise, diabetes mellitus).
☐ 4. The skin condition required recurrent medical treatment or hospitalization in past 12 months.

O. Bowel Function ***(Before rating this item consult the list of bowel drugs on the back of this page.)***

☐ 0. No bowel elimination problems. No problems with intestinal tract. No history or present condition of constipation or diarrhea.
☐ 1. Bowel elimination is easy to manage with diet. May receive a diet modification or fiber supplement.
☐ 2. Bowel elimination is easy to manage with diet and routine supplements. Has slight problems with constipation requiring intermittent or routine stool softener.
☐ 3. Daily management of bowel elimination requires on-going observation and preventative measures including enemas AND/OR manual impaction assessment. Has recurrent problem with constipation requiring 3-6 suppositories per month, OR one or more enemas. Experiences episodes of intermittent diarrhea, OR requires more than 1 medication to prevent constipation. May require manual assessment for impaction.
☐ 4. Any hospitalization in past 12 months required to treat an impaction or bowel obstruction. Has required a physician office visit or has been hospitalized to treat constipation, OR history of any hospitalizations for a bowel obstruction.

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CATEGORY III – PHYSIOLOGICAL
(continued)

P. Nutrition

☐ 0. Within ideal body weight range and is able to maintain weight. Requires no diet modifications, prescribed nutritional supplements or intervention to maintain health.
☐ 1. Is slightly above or below ideal body weight range. May require extra calories or some dietary restrictions. Health generally stable, though weight not within ideal range. May require additional calories through supplemental products or snacks, OR may require dietary restrictions (single servings at mealtime, low fat and low calorie foods).
☐ 2. Is well managed on a prescribed diet (Low Sodium, Low Fat/Cholesterol, calorie controlled, etc.). Within desired weight range, but has a diet prescription for health maintenance or health concerns which have been under control for the past 12 months.
☐ 3. Is on a prescribed diet with a history of weight instability OR nutritional risk which requires nutrition status monitoring within past 12 months. Has displayed unstable nutritional status episodes or trends in past 12 months which have produced health issues requiring intervention to maintain health. Risk factors to monitor are:
- inability to reach or maintain desired body weight
- unplanned changes/trends in body weight
- a chronic medical condition which affects nutritional status (diabetes mellitus, anemia, renal or hepatic disease, GI disorder, impaction, decubitus ulcer, etc.)
- fluid intake levels specific to nutrition
- difficulty consuming adequate intake, poor appetite or frequent meal refusals
- food allergies or intolerance which limits intake of major food groups

☐ 4. Nutritional status unstable. High nutritional risk with an unstable nutritional status. Requires intensive nutritional intervention to address any of the following conditions:
- unplanned weight loss >10% of usual weight in past 12 months
- morbid obesity (body weight 100 pounds greater than, or twice the desired weight range)
- hospitalization and/or treatment in past 12 months for recurrent aspiration pneumonia, choking episodes, GI bleeding, unresolved diarrhea, vomiting or unresolved decubitus ulcer
- inability to consume an adequate diet due to chewing or swallowing disorder
- gastrostomy or jejunostomy tube placement, OR complications with existing enteral tube in the last 12 months

Q. Treatments (if any apply, score is 4 - please check all that pertain)

☐ Tracheotomy that requires suction.
☐ Ventilator dependent.
☐ Nebulizer treatments. Receives medications such as Ventolin or Theophylline, by oxygen mist nebulizer.
☐ Deep suction. Requires deep suction which means entering a suction catheter 6" or more into or below the voice box either via tracheotomy, oral or nasal routes.
☐ Diabetic requiring insulin. Requires complex medication calculations.
☐ Has a condition that requires hands-on treatment by a professional nurse that CANNOT be taught and delegated to a non-licensed person. Has a chronic condition that requires professional nursing assessment and evaluation, including but not limited to:
- medication therapy requiring intramuscular or intravenous injections or hemaport irrigations
- catheterization requiring sterile technique
- physician ordered treatments that CANNOT be delegated to a non-licensed person
- sterile dressing/wound treatments routinely performed only in clinical settings or by licensed practitioners
- individuals in acute and/or end stages of liver, lung or kidney disease
- terminal illness (cancer) or persons with progressive neurological disorders (San Phillipo Syndrome, Multiple Sclerosis, Huntingtons Chorea) when multiple systems problems begin occurring which require regular licensed intervention.

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CATEGORY IV - SAFETY

R. Injuries

- ☐ 0. No injury or minor bruises requiring no medical intervention.
- ☐ 1. Bruises or cuts less than 1 to 2 times per year requiring nursing/medical attention.
- ☐ 2. Bruises or cuts requiring nursing attention or first aid occurring 3 or more times a year. Can be due to safety problems, self abuse, etc., but must occur more than 3 times in the past 12 months.
- ☐ 3. Injury requiring medical attention in the past year. Sustained an injury which has required medical intervention or emergency room treatment (sutures, casting a fracture).
- ☐ 4. Major injuries requiring hospital admission. Has documented evidence of fracture or other major trauma which has required hospital admission.

S. Falls

- ☐ 0. No falls.
- ☐ 1. 1 - 3 falls per year.
- ☐ 2. 4 - 6 falls per year. OR wears a protective helmet to protect from injuries due to falls.
- ☐ 3. More than 6 falls per year.
- ☐ 4. Any fall which results in fracture OR hospital admission due to injuries.

CATEGORY V- FREQUENCY OF SERVICE

T. Professional Health Care Services

- ☐ 0. No visits other than annual and/or quarterly health assessment.
- ☐ 1. Required 2 visits per quarter on an average over one year period to health care provider(s).
- ☐ 2. Required 1 – 2 visits per month on average to health provider(s) OR required daily nursing services greater than 14 days continuously in past 12 months.
- ☐ 3. Required 3 visits per month on average to health care providers.
- ☐ 4. Required 3 visits per month to health care providers plus emergency appointments.

U. Emergency Room Visits

- ☐ 0. No Emergency Room visits.
- ☐ 1. Emergency Room visit due to physician absence or non-emergency situation.
- ☐ 2. One Emergency Room visit in last year for acute illness or injury.
- ☐ 3. More than one Emergency Room visit for acute illness or injury in last year.
- ☐ 4. Any Emergency Room visits in the last year for acute illness or injury that resulted in hospital admission.

V. Hospital Admission

- ☐ 0. No hospital admissions.
- ☐ 1. Hospital admission for scheduled surgery or procedure.
- ☐ 2. Hospital admissions for acute illness.
- ☐ 3. 2 or more hospital admissions for acute illness in the past 12 months.
- ☐ 4. Transfer to ICU during hospitalization in past 12 months.

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