



Illinois Department of Human Services
Division of Developmental Disabilities

MEDICATION ADMINISTRATION IN THE COMMUNITY COURSE PREREQUISITE INFORMATION

Nurse-Trainer Webinars

- To complete the Nurse-Trainer course by GoToMeeting Webinar you will have to pre-register for Live 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 - 9:30 am – 11:30 am
- Webinar 2 – 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>.

Course Credit

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

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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

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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 by completing Request/Approval for RN Nurse-Trainer Status form
- ◉ Complete the open book internet based test administered by the Division of Developmental Disabilities with a score of 90% or better.

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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

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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

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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.

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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.

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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.

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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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Section 4

Sample Nursing Assessment Form

Training Program
for
Authorized Non-licensed Direct Care Staff

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**NURSING ASSESSMENT
Sample**

Page 1 of 20

INDIVIDUAL				D.O.B.	GENDER	I.D.#
Reason for Assessment:	Initial	Annual	Other:			

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

- Diagnostics
- Current diet and dietary restrictions
- Current medications and effectiveness
- 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, date/duration, and general treatment): None

Hospitalizations (number, duration, diagnosis, status of condition causing hospitalization): None

Major illnesses (type, frequency of each type, date/duration, and general treatment): None

Episodes (type, frequency of each type, date/duration, and general treatment): None

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Individual's Name	_____
Date of Birth	____/____/____
Sex	_____
DOB ID#	_____
Last Name	_____
Date	____/____/____



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

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.

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.

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 agency error policies and 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

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.

Script

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.



Section 6

Appendix A - SKILL STANDARD A

TEACHING MATERIALS

Medical Abbreviations
Weights, Measures, and Conversions
Games
Medication Worksheet & Agency Policies
Medication Table of Contents
Medication Tables

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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 your 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

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Illinois Department of Human Services
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Section 7
Appendix B - SKILL STANDARD B
TEACHING MATERIALS

BODY SYSTEMS

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Section 8
Appendix C - SKILL STANDARD C
TEACHING MATERIALS
Considerations for Medication
Vehicle Selection
Administration of Medication
Check Lists

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Training Program Medication Administration Module
Skill Standard C Teaching Materials

Considerations in Selection of a Vehicle for Medication Administration

	Vehicle	Options
Texture	Too coarse	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)

Training Program Medication Administration Module
Skill Standard C Teaching Materials

Administration of Oral Medications Practice

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

Scoring Key: ✓ = Successful completion X = 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 cups, 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 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.

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Training Program Medication Administration Module
Skill Standard C Teaching Materials

- () 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.

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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**

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Section 10

Appendix E

Testing MATERIALS

**Initial Authorization Medication Test
Test Question Bank
Competency Based Training Assessment
(CBTA) for Medication Administration**

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Training Program
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**Medication Administration Module
Skill Standard E Testing Materials**

Training Program

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 _____ (Agency/Provider Name) Policies and Procedures.

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

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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E 1

**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: _____, 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 syringes/pipette, 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.

TASK	INDIVIDUALS															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Appropriately obtains individual 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/label on MAR																
Washes hands, checks pulse, blood pressure, temperature, etc.																
Checks individual's hands before pouring medications for each individual																
Checks for correct drug administration by stating aloud (or mumbling) 7 rights of Medication Administration																
(1) when removing specific drug container from box/bottle																
(2) before pouring/drawing up the accurate dose																
(3) before returning drug container to box/bottle																
Records correct medication, dose, date, time, route & quantity																
Assists individual to receive/or take medication as necessary																
Checks individual to make consumption/record application of medication(s)																
Follows OTC/Herbal/Supplement Program to measure and record administration																
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)

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



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
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Section 12

NURSING SERVICES PACKET COMPLETION

Self-Administration of Medication Assessment Form

Physical Status Review/Health Risk Screening Tool

Training Program
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**COMPLETION OF THE
NURSING SERVICE
PACKET**

*Division of Developmental
Disabilities*

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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. These programs are as follows:

- Community Integrated Living Arrangement (CILA) (60D)
- Purchase of Service (POS) CILA (61D)
- Hourly CILA (65D)
- 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.

Nursing Services Packets (NSP) for Adult Residential Supports

May 4, 2005 Page 2

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 individual's 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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CLIENT NAME: _____ DATE: _____

HOW		MANNER
W) In writing/reading	S) By signing	D) Directs performance of 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, thickener, 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.

43

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____

44

Physical Status Review

“Health Risk Screening Tool”

45

HEALTH RISK SCREENING TOOL

Complete a HIRST 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: _____
 HSCase Manager: _____ Provider Agency: _____
 Information Sources (e.g., name and relationship, health record, etc.): _____

Computation of Category Scores	Identification of a Health Care Level																																																																																		
<p style="text-align: center;"><small>To be completed by Reviewer.</small></p> <p style="text-align: center;"><small>Enter ratings for each item and compute Category Score.</small></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Category and Item</th> <th style="text-align: right; border-bottom: 1px solid black;">Item Score</th> </tr> </thead> <tbody> <tr> <td colspan="2">I. FUNCTIONAL STATUS</td> </tr> <tr> <td>A. Eating</td> <td style="text-align: right;">+ _____</td> </tr> <tr> <td>B. Ambulation</td> <td style="text-align: right;">+ _____</td> </tr> <tr> <td>C. Transfer</td> <td style="text-align: right;">+ _____</td> </tr> <tr> <td>D. Toileting</td> <td style="text-align: right;">+ _____</td> </tr> <tr> <td>E. Day Program</td> <td style="text-align: right;">+ _____</td> </tr> <tr> <td>FUNC. STATUS CATEGORY SCORE</td> <td style="text-align: right;">= _____</td> </tr> <tr> <td colspan="2">II. 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If item "Q" is scored "YES", raise to Level 5.</p> <p>**Level 5: Total score 54 – 68. If item "Q" is scored "YES", raise to Level 6.</p> <p>**Level 6: Total 69 or greater. If item "Q" is scored "NO", raise to Level 5. To score at Level 6, item "Q" must be scored "YES".</p> <p>**Levels 3 through 6 require in-depth RN Review of the HIRST.</p> <p style="text-align: center;">TURN TO PAGE 2 AND COMPLETE EVALUATION AND TRAINING RECOMMENDATIONS.</p> <p style="text-align: center;">**RN Review</p> <p>Print Name of RN Reviewer: _____ Signature/Title RN Reviewer: _____ Date of RN Review: _____</p>	FUNCTIONAL STATUS CATEGORY SCORE	= _____	BEHAVIORS CATEGORY SCORE	= _____	PHYSIOLOGICAL CATEGORY SCORE	= _____	SAFETY CATEGORY SCORE	= _____	FREQ. OF SERVICES CATEGORY SCORE	= _____	TOTAL SCORE	= _____
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-1-

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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	+ 1
P. Nutrition	+ 1
Q. Treatments	+ 0
PHYSIOL. CATEGORY SCORE	= 11 x 2 = 22
<small>(Note: This category score is weighted. Multiply the sum of the item scores by 2.)</small>	

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)

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 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.	

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:
<input type="checkbox"/> Baseline data collection <input type="checkbox"/> Behavior <input type="checkbox"/> Dental <input type="checkbox"/> Medical <input checked="" type="checkbox"/> *Medical specialty (psychiatry, neurology, etc.) <input checked="" type="checkbox"/> *Nursing <input checked="" type="checkbox"/> *Nutritional/Clinical Dietitian <input type="checkbox"/> Oral Motor (OT/Speech) <input type="checkbox"/> Personal Support Team <input type="checkbox"/> Pharmacological <input checked="" type="checkbox"/> *Physical Management (PT/OT) <input type="checkbox"/> Supportive <input type="checkbox"/> *TD Screen, standardized <input type="checkbox"/> *Specify in Reviewer Recommendations Section below	<input type="checkbox"/> Behavioral Interventions <input type="checkbox"/> Emergency First Aid/CPR <input type="checkbox"/> Health Care Protocols <input checked="" type="checkbox"/> *Medicine Management - Basic (includes: preparation, adaptive equipment, food texture and positions) <input type="checkbox"/> *Medicine Management - Advanced (includes: assistive techniques, emergency intervention, oral motor technique and troubleshooting medicine problems) <input checked="" type="checkbox"/> *Medication Administration <input checked="" type="checkbox"/> *Physical Management - Basic (includes: body mechanic lifting and transfers) <input type="checkbox"/> *Physical Management - Advanced (includes: therapeutic positioning and specialized transfer) <input checked="" type="checkbox"/> *Seizure Recognition and Management <input checked="" type="checkbox"/> *Signs/Symptoms/Emergency <input type="checkbox"/> TD Screen (DISCUS, ADMS, etc.) <input checked="" type="checkbox"/> *Individual Specific Training <input type="checkbox"/> *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: <u>Joan Jet</u> Signature/Title RN Reviewer: <u>Joan Jet, RN</u> Date of RN Review: <u>11/11/00</u>
--

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 device, presentation 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 (gastrostomy, 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 enhance 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/procedure 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 hygiene 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 (e.g., 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. Incontinent of rectum 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 surgical absences. 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 clinically 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.

CATEGORY I – FUNCTIONAL STATUS
COMMENTS

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

Blank lines for handwritten comments.

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 requires 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 requires 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 staff/na 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 (coping mats, held on a spinal axis for least once per day). Generally has behavioral issues (biting, throwing objects, biting, head-banging, etc.) that cause injury to self and others. May wear protective devices.
 - 4. Individual injury requires medical attention during application of restraints or use of some sort of device (verbal abuse, a div (finger, nose, hand)). Generally has significant behavioral issues (verbal and continuous tissue damage, use of physical/mechanical restraints).
- 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, Inhaled, Regenerol) for identified behavior.
 - 3. Receives more than 2 behavioral medications not associated with or known to cause TD OR behavior medications that have changed in the past year. OR 2 or more medications to control behavior 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/continuation of medication associated with TD (in the previous 30-90 days), OR avoxt on metoclopramide (Reglan), regardless of the reason.

CATEGORY III – PHYSIOLOGICAL

- K. Gastrointestinal (GI) Conditions** (Includes vomiting, reflux, heartburn or ulcers) *(Before rating this item consult the list of GI drugs and gastroesophageal reflux definitions 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 stable/and, 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 "acid regurgitation" where person attempts to stick hand down throat (especially 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 no 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 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 Phenytoin (Dilantin) or valproic acid (Depakene or Divalproex) 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 prominences, 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. Daily management of bowel elimination requires on-toilets observation and preventative measures including enemas AND/OR manual impaction management. Has recurrent problem with constipation requiring 3-6 suppositories per month, OR one or more enemas. Experiences episodes of incontinence diarrhea, OR requires more than 1 medication to prevent constipation. May require manual assessment for impaction.
 - 3. 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.

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 mealtimes, 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:
 - emphysematous 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 tracheostomy, oral or nasal routes.
 - Diabetic requiring insulin. Requires complex medication calculations.
 - Has a condition that requires hand-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 heparin 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 Filippo Syndrome, Multiple Sclerosis, Huntington's Chorea) when multiple systems problems begin occurring which require regular licensed intervention.

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 2 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.