

# Self - Administration Assessment for Subcutaneous Insulin Injection

Name of Individual: \_\_\_\_\_

Signature & Title of Persons **Observing** Assessment (2 required). One of the observers **MUST** be a licensed nurse:

Nurse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Other Observer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Persons conducting assessment will need to have ALL necessary information regarding the individual's current medications and physician's orders for glucometer checks. The demonstrations must take place during the actual assessment. See reverse side for additional documentation.

1. I know why I take insulin.  
 YES  Go to 2. NO  Go to

2. I know how many units of insulin I should take, including how many units to take if I am on a sliding scale.)  
 YES  Go to 3. NO  Go to

3. I know when to take my insulin. I have demonstrated that I take my insulin at the right time every day by using the clock or my routine (after the news, before lunch, etc).  
 YES  Go to 4. NO  Go to

4. If the insulin is from a vial, I have demonstrated that I can read the label on the vial and the numbers on the syringe. I have demonstrated that I draw up the correct dosage into the syringe. I will not take insulin from the wrong vial.  
 YES  Go to 5 NO  Go to  N/A

5. If the insulin is from a pre-filled insulin pen, I have demonstrated that I can dial the correct dose.  
 YES  Go to 6 NO  Go to  N/A

6. I know who to tell when I have 4-7 days of insulin left so I never run out.  
 YES  Go to 7. NO  Go to

7. I know the places on my body where I can inject the insulin and I know how to rotate sites. I have demonstrated that I can safely and properly inject myself with insulin.  
 YES  Go to 8. NO  Go to

8. I keep my insulin in the correct place and properly dispose of used syringes.  
 YES  Go to 9. NO  Go to

9. I have demonstrated harmful behaviors to self and cannot self administer my glucometer check with or without assistance.  
 YES  Go to  NO  see comment below

**Unable to Self Administer With or Without Assistance**

*Will Require Staff With Certification 1 and current Certification 3 in Subcutaneous Insulin Injection to give insulin under Nursing Delegation*

Continue to next assessment question.  
Complete this form in its entirety.

**Self Administer With Assistance**

*Service Plan to Include:  
Time Reminder*

**Continue To Next Step**

**Self - Administer Without Assistance**

**Unable to Self Administer With or Without Assistance**

*Will Require Staff With Certification 1 and current Certification 3 in Subcutaneous Insulin Injection to give insulin under Nursing Delegation*

Identified Behavior/Justification MUST be documented

If the answer to questions 1-8 were all Yes Go to

Continue to next page →

Once the assessment is completed, the service plan for the individual should specify how insulin administration will be done. Any of the following statements could be used in the service plan, depending on what is correct for each specific person.

- I can self-administer insulin without assistance.
- I can self-administer insulin with assistance (select one of the following related to the assistance).
  - The individual receives assistance with self-administration of insulin through reminders of when to administer the insulin. Specify reminders needed in the client's ISP.
  - The individual receives assistance with insulin administration through physically handing prefilled Insulin Syringe / Pen to client. Provide specific instructions in the client's ISP.

**Other:**

- I need certified staff to administer my insulin. Use this if answer to any question leads you to the top box on the right side of this form. If any question, #1-2, 4-6 is answered "no" use this answer.
- I require certified staff to administer my insulin while I am learning to self inject. IP Team should consider Skill Development programs as appropriate. Use this answer if the client cannot consistently self-inject. A specific plan should be written with goals and time frames. See 5123:2-6-02 (C).
- I can self-administer insulin.
  - Describe insulin \_\_\_\_\_
  - Ability Level with task \_\_\_\_\_
  - Designate if independence or staff administration of insulin is applicable to a specific location or time of day (ie. Work setting) \_\_\_\_\_
- I have demonstrated unsafe behaviors and am therefore unable to self-administer insulin with or without assistance. Identify behavior / justification.

If the client has a history of unreliability or noncompliance the person doing the assessment may indicate that the client requires insulin administration for his / her own safety.

**RESULT:**

- Self Administration with assistance
- Self Administration

Insulin Administration / Delegated Nursing (DN)

- I live in a 5 bed or less setting and will receive my medication from staff that have a level 3 certification for insulin administration
- (or)**
- I will receive DN services per the state DN rules

**Insulin(s) assessed at this time:** (Attach another page if more space needed – or copy of MAR)

| Insulin Name | Dose  | Route |
|--------------|-------|-------|
| _____        | _____ | _____ |
| _____        | _____ | _____ |

**Reviewed by:**

SERVICE SUPPORT ADMINISTRATOR (signature & date): \_\_\_\_\_

NURSE (signature & date): \_\_\_\_\_

# Self - Assessment for Using a Glucometer

(p1 of 2)

Name of Individual(Client) : \_\_\_\_\_

Signature & Title of Persons **Observing** Assessment (2 required):

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Persons conducting assessment will need to have ALL necessary information regarding the individual's current medications and physician's orders for glucometer checks. In addition, the persons doing the assessment must know how to properly use and maintain the type of glucometer being used by the individual. See reverse side for additional documentation.

1. I can check my glucometer to make sure it is working correctly. I know what to do if it is not working correctly.  
YES  Go to 2. NO  Go to ☉

2. I know how to check the code on my test strip with the code on the glucometer. I know what to do if the codes do not match.  
YES  or NA  Go to 3. NO  Go to ☉

3. I know how to clean my glucometer and lancet pen.  
YES  Go to 4. NO  Go to ▼

4. I can use the lancet and / or pen correctly.  
YES  Go to 5. NO  Go to ▼

5. I have demonstrated that I can correctly place the blood sample on the test strip and successfully complete the glucometer check.  
YES  Go to 6. NO  Go to ☉

6. I know what to do if the number is too high or too low.  
YES  Go to 7. NO  Go to ☉

7. I know who to tell when I have 4-7 days of test strips left so I never run out. YES  Go to 8. NO  Go to ☉

8. I know to wash my hands and change the finger I use for the finger stick. YES  Go to 9. NO  Go to ☉

9. I have demonstrated that I do my glucometer check at the right time every day by using the clock or my routine (after the news, before lunch, before taking insulin, etc).  
YES  Go to 10. NO  Go to ▼

10. I can get the glucometer supplies to and from storage, out of the container, and properly dispose of used needles.  
YES  Go to 11. NO  Go to ▼

11. I have demonstrated harmful behaviors to self and am unable to self-administer my glucometer check with or without assistance.  
YES  Go to ✕ NO  Go to ☿

If answers to questions 1-10 are all yes, then go to ☿

49

☉  
**Unable to Use Glucometer With or Without Assistance**

**Will Require Medication Administration Certified Staff to Do All Glucometer Checks as Ordered**

Continue to next assessment question.  
Complete this form in its entirety.

▼  
**Able to Use Glucometer With Assistance**

**Service Plan to include all that apply:**

- Time Reminder
- Physical Assistance with any of the following:
  - ◀ Use of pen and lancet
  - ◀ Cleaning the glucometer
  - ◀ Checking with test solutions
  - ◀ Set-up and storage of equipment

**Continue To Next Step**

☿  
**Able to do own Blood glucose monitoring Without Assistance**

✕  
**Unable to perform Blood Glucose Monitoring With or Without Assistance**

**Will Require MRDD Staff with Certification 1 to Perform Blood Glucose Monitoring**

Identified Behavior/Justification  
MUST be documented

Continue on next page →

Once the assessment is completed, the service plan for the individual should specify how Blood Glucose Monitoring (BGM) will be done. Any of the following statements could be used in the service plan, depending on what is correct for each specific person.

- I can perform my own blood glucose monitoring (BGM) without assistance.
- I can perform BGM with assistance (select one of the following related to the assistance).
  - The individual receives assistance with BGM through reminders of when to perform BGM. Specify reminders needed in the client's ISP.
  - The individual receives assistance with BGM through physically handing the equipment needed to the client. Provide specific instructions in the client's ISP.

**Other:**

- I need certified staff to do my blood sugar testing. Use this if answer to any question leads you to the top box on the right side of this form. If any question, #1-10 is answered "no" use this answer.
- I require certified staff to do my blood sugar checks while I am learning how to do them. IP Team should consider Skill Development programs as appropriate. Use this answer if the client cannot consistently do own BGM. A specific plan should be written with goals and time frames. See 5123:2-6-02 (C).
- I can do my own BGM.
  - Describe BGM procedure \_\_\_\_\_
  - Ability Level with task \_\_\_\_\_
  - Designate if independence or staff performance of BGM is applicable to a specific location or time of day (ie. Work setting) \_\_\_\_\_
- I have demonstrated unsafe behaviors and am therefore unable to do my own BGM with or without assistance. Identify behavior / justification.

If the client has a history of unreliability or noncompliance the person doing the assessment may indicate that the client requires someone to do his / her BGM to assure safety.

**RESULT:**

- Self BGM with assistance
- Self BGM – no assistance needed.

**BGM / Delegated Nursing (DN)**

- I live in a 5 bed or less setting and will receive my BGM from staff that have been trained to do BGM.
- (or)**
- I will receive DN services per the state DN rules

**Schedule for BGM** (Attach another page if more space needed – or copy of MAR)

**Schedule and Manner for BGM**

(Time) \_\_\_\_\_ Manner \_\_\_\_\_ Site \_\_\_\_\_

(Time) \_\_\_\_\_ (Manner) \_\_\_\_\_ Site \_\_\_\_\_

**Reviewed by:**

SERVICE SUPPORT ADMINISTRATOR (signature & date): \_\_\_\_\_

NURSE (signature & date): \_\_\_\_\_