

## Unit X: Self-Administration Assessment Introduction and Tool

### Introduction to Completion of Self-Administration Assessment

The purpose of the Self-Administration Assessment is to ensure that the client is able to **SAFELY self administer tube feedings and medications per G – J Tube**. Every client with DD has the right to self-administer their medications. The county board (CB) and the service provider are responsible for the safety of the individual with developmental disabilities.

#### When it is determined a Self –Medication Assessment is needed:

Consider the client's safety. If on occasion the client cannot safely self administer formula or medications (e.g. ◀ client experiences an episode of mental illness, ◀ client becomes physically ill, ◀ client goes to a new environment and cannot transfer skills to the new environment right away), **certified** staff will need to provide assistance or administer medications / formula to the client during those times. When the client is able, he can self administer formula / medications as indicated in the ISP.

The self administration assessment needs to be completed at a minimum of every 3 years, with a review done annually. A new assessment will be completed in the event of (but not limited to) the following occurrences:

- The needs of the individual changes
- The medication or formula packaging changes (ie. flip top can to screw top can; liquid formula to powder)
- There is a change in the usual medication routine (new location, new provider)

#### Where to complete the assessment

Complete the assessment in the setting(s) where the client takes / receives medications / feedings. This is to determine if the client is able to safely take medications or self administer tube feedings in his own environment.

#### Using the form

Answer each question on the form. Questions are answered with a "Yes" or "No." Follow the instructions on the form to determine where to go following a "Yes" or "No" response.

#### Processing the Assessment results

Once the assessment is completed, the Individual's Service Plan should specify how medication / formula administration will be done. See the form for statements that could be used. Check the appropriate statements to include in the ISP.

#### Other

Remember, clients have the right to do as many steps of the medication / formula administration as they can do either independently or with support, even if they are not assessed to be able to self-administer with or without assistance (5123: 2-6-02 (C)).

#### Medication(s) assessed at this time:

Attach another page if there is not enough space on the form to record meds/ formula or attach a copy of the MAR. Multiple Self-Administration Assessments may be used for an individual.

For example, if a client requires certified staff assistance due to multiple medications at 8am but can self – administer 1 medication at 12N or can self-administer formula, separate Self - Administration forms must be used and should be included in the ISP.

#### Reviewed by (May be other than those completing Self Administration Assessment Form):

- ◆ If the client has a SSA, the SSA should review the results and make the applicable indications on the IP.
- ◆ The delegating nurse should view and sign the assessment.
- ◆ The Med Administration course is a training for DD personnel and does not constitute authorization, or delegation from the RN teaching the course.

If two people do not agree with the assessment, a third party should be consulted. If an agreement cannot be determined, the DODD representative should be consulted.

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# Self - Admin Assessment for Adm Food / Meds per G/J Tube

Name of Individual (Client) \_\_\_\_\_  
 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 tube feeding. The demonstrations must take place during the actual assessment. See reverse side for additional documentation.

1. I know why I receive food / medications per G / J Tube  
 YES  Go to 2. NO  Go to ☹

2. I know the name(s) of my formula / medications  
 YES  Go to 3. NO  Go to ☹

3. I know when to take my formula / medications. I have demonstrated that I take my formula / medication(s) 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. I have demonstrated that I can read the label on the formula / medications and that I can administer the correct amount of formula / medications.  
 YES  Go to 5. NO  Go to ☹

5. I have demonstrated I can regulate the rate of formula administration .  
 YES  Go to 6. NO  Go to ☹ N/A  Go to 6.

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

7. I have demonstrated how to prepare my medications for self administration and have demonstrated ability to correctly self administer medications once they are prepared (crushed and dissolved in water)  
 YES  Go to 8. NO  Go to ☹

8. I know how to store left-over formula and how to dispose of it if it is more than 24 hours old.  
 YES  Go to 9. NO  Go to ☹

9. I know how to trouble shoot clogs and how to properly care for my equipment.  
 YES  Go to 10. NO  Go to ☹

10. I have demonstrated harmful behaviors to self and cannot self administer my formula / medications with or without assistance.  
 YES  Go to ✗ NO  See comment below

If the answer to questions 1-9 were all **yes**, go to ☺

☹

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

*Will Require Staff With Certification 2 in Administration of Food or Medications by G / J Tube*

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 2 to Administer All Medication / Formula*

Identified Behavior / Justification **MUST** be documented

**REMINDER:** DD Personnel **MUST** have a **current** certification 1 as well as a current certification 2 in order to administer medication or formula by G / J Tube.

Self-Administration Assessment continued

Once the assessment is completed, the service plan for the individual should specify how medication 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 medication(s)/ formula without assistance.
- I can self-administer medication(s) / formula with assistance (select one of the following related to the assistance).
  - The individual receives assistance with self-administration of medication(s) / formula through reminders of when to take the medication(s). Specify reminders needed in the client's ISP.
  - The individual receives assistance with self-administration of medication(s) / formula through physically handing the medication container / formula container to client. Provide specific instructions in the client's ISP.
  - The individual is physically impaired and the provider may open the medication container / formula container for the individual to assist with self-administration of medication / formula. Place specific instructions in the ISP.
  - The individual is physically impaired and the provider physically assists them with opening the medication or formula container and preparing the medication or formula for administration. Place specific instructions on the client's ISP

**Other:**

- I need certified staff to administer my medication. Use this if answer to any question leads you to the top box on the right side of this form. If any question, #1-9 is answered "no" use this answer.
- I require certified staff to administer my medications while I am learning to self-medicate. IP Team should consider Skill Development programs as appropriate. Use this answer if the client cannot consistently self-medicate. A specific plan should be written with goals and time frames. See 5123:2-6-02 (C).
- I can self-administer specific medication or task (ie. prepare formula, check placement of feeding tube, etc.)
  - Describe medication and/or task \_\_\_\_\_
  - Ability Level with task \_\_\_\_\_
  - Designate if independence or staff administration of a task/ medication 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 medication/ formula 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 med administration / tube feeding for his / her own safety.

**RESULT:**

- Self Administration with assistance
  - Self Administration
- Medication Administration/ Delegated Nursing (DN)
- I live in a 5 bed or less setting and will receive my medication from staff that have a level one certification for medication
  - (or)
  - I will receive DN services per the state's DN rules

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

Medication / Formula Name	Dose	Route
_____	_____	_____
_____	_____	_____

**Reviewed by:**

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

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