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Developmental Disabilities Adult Care Home Training Manual



Care Home Training Modules

All provider applicant, resident managers and caregivers of an adult care home MUST read each module in this training manual, prior to taking the DD Basics Exam. The checklist on the following page must be signed and dated and submitted at the time of your Basics Exam. A certificate for completion of the exam will not be issued unless the accompanying checklist is received.

	Title
Module 1	Introduction to Care for Individuals with Developmental Disabilities
Module 2	Hiring Caregivers in an Adult Care Home
Module 3	Facility Standards
Module 4	Medication Management Best Practices Guidelines
Module 5	Medication Management Fatal Four
Module 6	Documentation
Module 7	Individual Support Plan
Module 8	Working with Challenging Behaviors
Module 9	Abuse Reporting and Investigation
Module 10	Safety

DD Basic Training Module Verification Sheet

I have read the following Adult Care Basic Training Course:

- Module 1 - Introduction to Care for Individuals with Developmental Disabilities
- Module 2 - Hiring Caregivers in an Adult Care Home
- Module 3 - Facility Standards
- Module 4 - Medication Management
- Module 5 - Medication Management Fatal Four
- Module 6 - Documentation
- Module 7 - Individual Support Plan
- Module 8 - Working with Challenging Behaviors
- Module 9 - Abuse Reporting and Investigation
- Module 10 - Safety
- I have reviewed the Multnomah County Administrative Rules**

By signing I verify that I have read and reviewed all of the above:

Print Name

Signature

Date

Module 1

Introduction to Care for Individuals with Intellectual and Developmental Disabilities (I/DD)



What is a Developmental Disability and an Intellectual Disability?

An Development Disability (or DD) is:

- a condition a person is born with or obtains prior to age 22, such as cerebral palsy, autism, or epilepsy, and
- considered to be lifelong and causes significant delays in at least 2 areas of everyday functioning, such as communicating, grooming, dressing, safety and social skills, and
- diagnosed by a qualified doctor.

An Intellectual Disability (or "ID") is:

- a term that in the past was described as "mental retardation," and
- when someone has significantly below average intellectual and adaptive skills as measured by a standardized test administered by a qualified psychologist, and
- diagnosed for a person with consistent IQ results of 75 or below with significant impairment in adaptive behavior, and
- when the onset of the impairment occurs prior to age 18, and
- diagnosed only when it is considered to be lifelong.

How will I support in adult with an I/DD ?

- much like everyone else, have basic desires for friendship, social interaction, leisure activities, and satisfying work!
- differ from one another in their varying levels and types of supports needed to perform daily living activities, handle money, read, express emotions, communicate their choices, and interact with the world;
- all must be determined eligible for services through a county developmental disabilities (DD) program to be placed in your home;
- all have a DD Case Manager and an Individual Support Plan (ISP) Team.

Professional Expectations of Providers

- **Understand the Multnomah County Administrative Rules**
- **Assure that caregivers and resident managers meet qualifications**
- **Meet training requirements for all caregivers**
- **Provide oversight and supervision of caregivers**
- **Maintain accurate documentation**
- **Assure household meets Facility Standards**
- **Maintain license to operate the ACH-DD**
- **Communicate effectively and professionally with others**

A License is Required

Any home that meets the definition of an adult care home in Multnomah County must apply for and obtain a license from the Adult Care Home Program.

Multnomah County Administrative Rules (MCARs)

Are the rules that govern the licensing of all adult care homes in Multnomah County. MCAR 023-110-100 through 023-110-600 are specific to homes that serve residents with Developmental Disabilities.

The Oregon Administrative Rules (OARs), sometimes referred in MCARs, and are an additional set of standards and practices that ensure that services in Oregon are in compliance with federal and local requirements.

Providers are expected to adhere to the requirements in the MCARs. Non-compliance with these requirements can result in licensing action, including civil penalties, non-renewal or revocation of a license.

MCARs are based on Oregon Administrative Rules which are based on Oregon Revised Statutes (law), federal Medicaid waiver requirements, and program standards.

Rules are occasionally revised to maintain compliance with new or revised statutes, as well as federal and local requirements. This is an open process and involves a rule advisory committee consisting of community stakeholders and advocates. Public comment is solicited prior to any final rule revision.



Module 2:

Hiring Caregivers in an Adult Care Home



There are Three Ways to Hire

- Hire from an Caregiver Agency
- Hire an Independent Contractor
- Hire an Employee

When you hire from an agency they provide staff to work in your home. Personnel may be acquired through a home health care agency, nursing service or temporary employment service.

When hiring an independent contractor you need to be aware of the difference between an independent contractor and an employee.

Independent Contractor Vs Employee

An Independent Contractor is somebody who has professional skills, who are in business for themselves, and who you have little control over. Examples are nurses, behavior support specialists, physical or occupational therapists, and dieticians.

Independent Contractor

- Do not need to be trained
- Do not need to be supervised
- Already have the needed skills
- Set their own hours
- Can use own equipment / supplies
- Can hire someone else to do the needed work
- Have multiple customers

When Hiring an Employee consider:

- Paperwork and record keeping requirements
- Minimum wage requirements
- Employment laws and regulations

If you are looking for someone to come into your home and provide care on a regular basis, they are not an independent contractor.

Confusing an Independent Contractor with an employee can have implications with taxes, unemployment, or a worker's compensation claim.

You may want to seek advice or consult with a professional to assure that you are correctly employing caregivers in your home.

Resources for Employers

**The Oregon Corporation
Division Oregon
Business Guide
503-986-2200
www.filingoregon.com**

**The Oregon Bureau
of Labor "Wage and
Hour Handbook"
503-731-4200 ext 4
www.boli.state.or.us**

**State of Oregon
www.oregon.gov**

Then go to selected state agency

Qualifications for Providers, Resident Managers and Caregivers

All Operator and Resident Managers must

- Be at least 21 years of age
- Live in the licensed Adult Care Home
- Have an approved background check
- Be literate and capable of understanding written and oral orders
- Have good communication skills
- Have a valid Oregon Driver's license if transporting individuals
- Have no founded allegations of child abuse
- Have completed the Adult Care Home Qualifying Test
- Have First Aid, CPRs and all another training as required by the ACH classification.
- Possess good physical and mental health, good judgment and character.
- Have a clear understanding and knowledge of ISP's and have the ability to provide individualized care

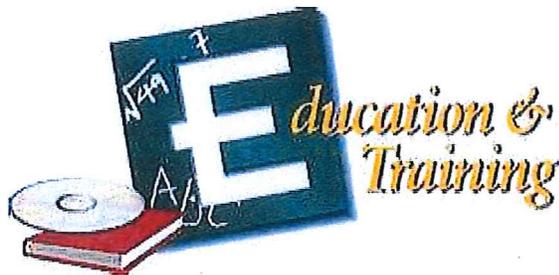
All Caregivers must

- Be at least 18 years of age
- Have an approved background check
- Know all fire and safety emergency procedures
- Be literate and capable of understanding written and oral orders
- Have good communication skills
- Have a valid Oregon Driver's license if transporting individuals
- Possess good physical and mental health, good judgment and character.
- Have a clear understanding and knowledge of ISP's and have the ability to provide individualized care
- Able to meet resident manager qualifications if left in charge for 30 days or longer.
- Have completed the Basic training and meet all training requirements of the licensing classification.

Training Requirements

- All providers, resident managers, and caregivers must read the department's basic training course that includes the completion of the training manual, taking and passing an examination on that course work and necessary skill prior to becoming a licensed operator or resident manager.
- Operators, caregivers and resident manager applicants must have current first aid and CPR certification by a recognized training agency.
- All Operators, caregivers and resident manager applicants of 2B (behavioral) homes must have completed Oregon Intervention Systems (OIS) training by a state approved OIS trainer.
- The Department requires at least 12 hours of Department approved annual training for the provider, resident manager and caregivers.

As the licensed provider you are responsible for the training and supervision of caregivers, and the support they provide in the ACH-DD.



Module 3: Facility Standards



Clean House Clean Spirit

Facility Standards

MCARS 023-100-100

- Must be in good general condition (clean furnishings and building, adequate lighting, up to date documentation such as water well and chimney inspection, building permits).
- Must be sanitary having a good septic system, control of insects and rodents, and proper food storage.
- Bathrooms are clean and free of objectionable odors, and assure privacy, in good repair, with accommodations as required such as grab bars, and have adequate supplies.
- Bedrooms must be furnished, have adequate lighting and ventilation, be occupied by no more than two persons receiving services, and be on ground level for individuals or have a second secondary exterior exit.
- Telephone must be accessible with emergency numbers posted by the phone, including the number of the Community Development Disabilities Program
- Stairways must have adequate lighting and have handrails
- Heating systems must be in working order
- Doorways must be wide enough to support individuals in wheelchairs or walkers if used by individuals
- Must not utilize extension cords in place of permanent wiring.
- Must have single action hardware for all doors used for exit purposes.
- Must have operational smoke alarms, and portable fire extinguisher.
- Homes with accessibility ramps must meet OAR requirements.
- Must comply with the Indoor Clean Air Act
- Medical marijuana cannot be grown in or on the AFH-DD property.

Module 4: Medication Management Best Practice Guidelines



Medication Management

Medication administration is a major part of medication management and is one of the responsibilities of a caregiver. Medication management also includes but is not limited to:

- Monitoring the individual and letting the doctor know if the medication is working or not working, or to observe side effects.
- Preparing, storing and disposing of medications.
- Maintaining complete and accurate records such as copies of *signed* physician's orders, medication administration records, drug disposal records, balancing test and other medical reports, including documentation of delegation if required for individuals.



Medication Administration

Six Rights

“**SIX RIGHTS**” of medication administration is one of the “**Best Practice Guidelines**” intended to assure the health and safety of the individual.

- **RIGHT MEDICATION**
- **RIGHT DOSE**
- **RIGHT ROUTE / METHOD** (oral, topical)
- **RIGHT TIME** (one hour before or after the scheduled time)
- **RIGHT PERSON**
- **RIGHT DOCUMENTATION**

You will need to follow these guidelines so that when you give medication you do not make a mistake. When mistakes are made, serious, even life threatening consequences can occur. Should a mistake happen you will need to have direction from a medical professional on what actions to take. This usually means calling the physician for orders.

The “**RIGHT DOCUMENTATION**” is important so that anyone can tell that the medication was given. Medication errors have been made because someone forgot to document and additional doses of medication have been given. Documentation also reflects that the physician’s order has been followed. **Remember if it’s not documented it’s considered to have not been done.**

Medication Administration

Five Always

- **ALWAYS** have a signed physician's order for every medication or treatment.
- **ALWAYS** wash your hands before administering medication.
- **ALWAYS** pour medication from the container into a medication cup or another container, NOT in your hand. Pour liquid medication directly into calibrated medicine cup / spoon.
- **ALWAYS** identify and stay with the person until the medication is swallowed.
- **ALWAYS** keep the medication storage area locked, clean and orderly.

The “**FIVE ALWAYS**” is one of the other “**Best Practice Guidelines**” intended to assure the health and safety of the individual.

- Signed physicians orders are required for both prescription and over the counter medications, except for over the counter topical medications that are applied to the skin.
- Don't substitute one medication for another unless it's the generic version of the medication ordered (no aspirin for Tylenol).
- Over the counter topical medication used without an order must be documented on the medication administration record (MAR) and must be given per the manufacturers' directions including seeking medical attention as stated in the directions.
- Hand washing and not pouring medication into your hand before administration prevents the spread of germs.
- A clean orderly medication storage area reduces the risk of medication errors. To prevent contamination of medications, store oral medications or those that are to be placed in the eyes separate from topical medications.

Medication Administration

Five Nevers

- **NEVER** leave medication with the individual or on the table.
- **NEVER** give medication prescribed for one individual to another.
- **NEVER** give a medication that was prepared by another person (caregiver).
- **NEVER** use medication that is outdated or from an illegible or unlabeled container.
- **NEVER** give a medication that you have questions about until you have resolved the problem (you can check with the pharmacist or prescriber)

The “**FIVE NEVERS**” of medication administration is one of the “**Best Practice Guidelines**” intended to assure the health and safety of the individual. A medication error could result if the guidelines are not followed.

- The medication administration record (MAR) is proof that the physician's order was followed, and *it is a legal document*.
- If you document on the MAR that the person took their medication but you did not observe it being swallowed, this could be considered false documentation.
- If you're not the person removing medication from the original container do not administer the medication. Don't give medication someone else has prepared.
- Never be afraid to ask questions. This could save both the individual and you from serious consequences.

Medication Administration

Five Musts

- You **MUST** have the individuals Medication Administration Record (MAR) present when giving medications.
- You **MUST** read the label and compare it with the MAR before giving the medication.
- You **MUST** ensure the person is in a good position for swallowing medication.
- You **MUST** record the administration of the medication immediately on the individuals MAR.
- You **MUST** know why you are giving the medication, its actions and possible allergic or side effects.

The “**FIVE MUSTS**” is one of the “**Best Practice Guidelines**” intended to assure the health and safety of the individual.

- Look at the MAR as you give medications, don't depend on your memory. (The order, the MAR and the label should match).
- Good position for swallowing means sitting upright and not tipping the head back, to prevent aspiration.
- Offer something to drink with the medications.
- Document immediately after the medication has been taken, don't wait until the end of the day or shift.
- Inform the physician of any side effects of the medication or its effectiveness in addressing the individual's medical needs. Information regarding side effect and general information about medications can be acquired by speaking to the pharmacist or physician, or using the pharmacy drug information or a drug reference book.
- Medication labels may include special administration needs such as to take with or without water, to assure effective use of the medication and to reduce side effects.

Medication Administration Records

Preparing the MAR

- Record the person's name, the current month and year, and any allergies or history of adverse medication reactions. (if no known allergies write "none")
- Record the name of the medication, the dosage, the number of capsules / tablets, or the amount of liquid, the number of times per day it is to be given, the specific time the medication is to be given and the route / method by which it is to be given.
- Record the same information on the record from the manufacturer's label for over the counter topical medications.
- Record your full signature along with your initials.

Documenting on the MAR

When a medication is given:

- Immediately initial the square for the correct date, time and medication.
- Always check to make sure your full signature is on the MAR

When a Medication is *not* given:

- Initial the box for the correct medication, date and time.
- Circle your initials
- Write an explanation as to why the medication was not given on the back of the MAR.

When a medication is discontinued:

- Write in large letters "DISCONTINUE" or the abbreviation "DISC or DC", followed by the date, time and your initials.
- Remove the medication from the cabinet and properly dispose of it. You will need to keep a record of the disposal. (*Follow the above directions if the dosage of a medication changes. You should write the new order in a new space on the MAR.*)

When a medication is time limited:

Time limited medication should be recorded on the MAR like all other medications with the following additions:

- The date and time the medication is to start
- The number of days or doses it is to be given
- The date and time the medication is to be stopped and your initials.
- Line out the days the medication is NOT to be given
-

Keep in mind that the pharmacy will only dispense the number of pills and tablets ordered. Liquids and creams are not as exact, use according to orders and dispose of any remaining, after the ordered days or doses are finished.

When a person is not at home:

- Initial the box or square on the MAR and circle your initial and write an explanation on the back of the MAR, as you would if a medication is not given.

Or

- Use an abbreviation or code to indicate where the person was during that scheduled medication time with a definition of the abbreviation or code in the signature block. HV = home visit, VOC = voc, etc.

PRN or “as needed” medication:

- Check to be sure there is a current signed order for the PRN medication, except over the counter topical medications. *PRN psychotropic medications are not allowed without a variance. Psychotropic medications alter mood, thought or behavior and include psychoactive medications, anti-depressants and sleep aids).*
- Administer the medication and document the reason the medication was given.
- Later, document on the back of the MAR the effectiveness of the medication. Inform the physician if the medication is not effective for the individual.

Documenting on the MARs continues...

When medication are to be administered at school / work or community inclusion:

- If possible work with the individuals' physician to avoid medication administration during school / work hours.
- Work with the pharmacy to obtain a separate container of the medication to be administered to the person during school / work hours.
- Communicate with the school / work regarding the medication.
- Deliver or make arrangements so they have the med and a copy of the signed physician's order. It is best to have a designated staff identified at the school / work site.
- Use an abbreviation or code with a definition for medications administered at school / work / community inclusion.

When medication is to be given at school / work / community inclusion, it is necessary for you to work together to ensure the health and safety of the individual. Remember they have regulations that they have to follow also. Keep in mind that you will need to:

- Get them a copy of the signed physician's order and the medication to be administered.
- Tell them what the medication is for (the reason it was ordered) and any monitoring the physician wants.
- Tell them how long it is to be taken (which must be in a signed physician's order)
- Let them know when an order has changed.

Having a record of communications, such as a log or communication book, between the AFH-DD and other agency, demonstrates everyone is informed of the health and safety needs of the individual, as conversations are hard to remember days or weeks later.

If a medication is not given at school / work / community inclusion, the party responsible for administration during that time is responsible to communicate this to the AFH-DD provider.

Self-Administration of Medication

When the ISP team determines that self-administration is best for the individual they must develop a plan for individuals to:

- Train individuals to assure consistency in administration across location (school / work / home).
- Describe provisions for periodic monitoring and review of the person's ability to continue self-administration (at *least* annually)
- Consider provisions for retraining when the medication, dose, or time of administration changes.

Individuals must keep their medications in a locked area inaccessible to others.

Self-administration of medication is one way an individual can maintain some independence and control in their life. There are risks if medications are not taken as ordered, so it is up to the ISP team to look at and weigh these risks as well as provide for ongoing monitoring and review.

Periodic monitoring is "Good Practice." The team will need to decide what supports the individual needs, whether the individual will maintain their own MAR and what monitoring should happen (such as counting pills). Documentation should include:

- Supports specified in the plan were provided;
- Monitoring and reviews happened as detailed in the plan; and
- Retraining happened as needed / specified in the plan (such as changes in administration, or person is making medication errors).

Self-administered medications must be stored as recommended by the manufacturer.

Medication Procurement and Storage

- Medication, including refrigerated meds, shall be kept in a secured locked container.
- Medications need to be stored as indicated by the manufacturer.
- Persons who self-administer medications must ensure that medications are not available to other individuals and stored according to the

manufacturer's directions.

- Best practice is to store oral and external meds separately
- Keep med storage area clean and orderly

“Procurement” is another way of saying how medications are obtained. Prescriptions should come from a single pharmacy to reduce the risk of adverse effects or medication reactions. Pharmacies keep profiles on the person's filled prescriptions, and have systems that alert them to potential problems. If a medication needs to be filled through another pharmacy then the reason must be documented in the person's record, since safeguards can't be followed.

Medications must be labeled by the dispensing pharmacy, manufacturer or prescribing physician. Remember the MAR needs to match the order and the medication label.

“Storage” of medications requires that they be kept in a locked container and stored as indicated by the manufacturer. Keep in mind some medications require refrigeration, and need to be kept in a locked container. Some medications cannot be kept in areas where temperature or humidity is high. This may require avoiding places like the bathroom, next to stoves or in vehicles.

The provider may wish to keep their own medications in a separate locked area.

Medication Disposal

- All unused, discontinued, outdated, recalled and contaminated meds must be disposed of in a manner that prevents illegal diversion of these substances.
- The same applies for drugs in containers with worn, illegible or missing labels.
- A written record of the drug disposal must be maintained as required in OAR.

Expired medications are not only unsafe to ingest, but they can also be dangerous when not disposed of properly. When expired, unused or discontinued medications are flushed down the toilet, they end up in the city's water treatment. Often the plant does not have the capacity to thoroughly clean out this pollution and the medications are released into the water system.

If you need to dispose of any medications, crush all pills and mix with cat litter, sawdust or used coffee grounds and dispose into a plastic bag and secure tightly. For liquid medications, fill a plastic bag with an absorbent material such as cat litter or sawdust, then pour the liquid in and tie the bag shut. Wrap the plastic bag in another bag and put into your garbage on the day of collection.

Safe Syringe Disposal

Oregon law (ORS 459.386 to 459.405) prohibits the storage and disposal of syringes in normal trash, yard waste or recycling. All users of syringes must place them in an approved leak proof, rigid, puncture resistant red container that is closed to prevent loss of contents when transported and disposed. Individuals in violation are subject to a civil penalty of up to \$500 per day.

- Call your local garbage collection service to receive an approved red plastic container for SAFE disposal. The container will be delivered to your residence for a nominal fee.
- Some pharmacies may also provide disposal containers
- **LANCET NEEDLES USED FOR BLOOD GLUCOSE TESTING MUST BE DISPOSED OF AS DESCRIBED ABOVE.**

Medication Terminology and Abbreviations

Words, terms or symbols that make up the language of medicine are referred to as medical terminology. Abbreviations are symbols or letters and are used in place of writing a word, or a group of words. It is your responsibility to clarify terms or abbreviations.

During the course of your day you may see words, terms, symbols and abbreviations you need to know to carry out orders and instructions. In order to do your job effectively you must become familiar with some common ones seen in physician's orders. The meaning of a medical term may be found:

- In a medical dictionary (does not explain diagnosis)
- In the "Common Used medical Abbreviations" list in this manual, or
- By asking a medical professional to clarify a medical term you are not familiar with

Medical terms and abbreviations can be used to document care you have provided and response to that care. Only use standardized medical terms, words symbols or abbreviations.

Remember it is **always** your responsibility to clarify any orders or documentation you do not understand.

Commonly Used Medical Abbreviations

Abbreviation	Meaning
o.s	Left eye
o.d.	Right eye
o.u.	Both eyes
os	Mouth
a.d	Right ear
a.s	Left ear
a.u.	Both ears
p	after
pc	After meals
AC or a.c	Before meals
po	By mouth
pr	Per rectum
p.r.n. / PRN	As needed
Q or q	Every
q.o.d	Every other day
q.i.d	4 times daily
b.i.d	Twice daily
s	Without
SL	Under the tongue
stat	Immediately
Tab	Tablet
t.i.d	3 times daily
X	Times
Cap.	Capsule
cc	Cubic centimeter
gtts	drops
gr.	grain
HS or hs	Bedtime
ml.	Milliliter
Mg.	Milligram
@	At
-	Before
a	With
C	With

Medication Administration Worksheets

Staff Name: _____ Date: _____

Scenario #1:

It is January 4, 2015. Read the two medication orders below and document as if you gave Sally her 7 AM medications.

**** As you practice remember to sign and initial in the staff signature box on this MAR and ALL the following MAR's.**

MEDICATION ADMINISTRATION RECORD

ALLERGY: None Known

NAME: Sally Smith		MONTH: January YEAR: 2012																														
MEDICATION & DOSAGE	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
DRUG: Tegretol 200mg DOSE: 1 tab 3 x daily ROUTE: orally	7 AM	W	W	w																												
	1 PM	W	W	w																												
	9 PM	J	J	J																												
		s	s	s																												
DRUG: Colace 100mg DOSE: 1 cap daily ROUTE: orally	7 AM	W	W	w																												
		w	w	w																												

SIGNATURE	INITIALS	SIGNATURE	INITIALS
William Wonka	Ww		
Joe Shmoe	JS		

PRN MEDICATION RECORD (BACK OF MAR)

DATE/TIME	MEDICATION	REASON GIVEN	INITIAL	RESULTS	INITIAL

Scenario #2:

Joe went to see his psychiatrist on January 6, 2015 at 2PM. While there, the doctor wrote an order to "Discontinue Zoloft, effective today"/ Document that order on the MAR below.

MEDICATION ADMINISTRATION RECORD

ALLERGY: Penicillin

NAME: Joe Hernandez

MONTH: January

YEAR: 2015

MEDICATION & DOSAGE	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
DRUG: Zoloft 50mg																																	
DOSE: 1 tab daily	9 PM	J s	J s	J s	J s	J s																											
ROUTE: orally																																	
DRUG: Dilantin 100mg	7 Am	W w	W w	w w	W w	W w	W w																										
DOSE: 1 cap 2x / daily	8 PM	J s	J s	J s	J s	J s																											
ROUTE: orally																																	

SIGNATURE	INITIALS	SIGNATURE	INITIALS
<i>William Wong</i>	<i>Ww</i>		
Joe Shmoe	JS		

PRN MEDICATION RECORD (BACK OF MAR)

DATE/TIME	MEDICATION	REASON GIVEN	INITIAL	RESULTS	INITIAL

Scenario #3:

Today is January 7, 2015. At 2 PM Bart went to his doctor complaining of stomach pain. The doctor wrote the following order: "Tagamet 200 mg po, tab 1 bid. (8 AM & 8 PM) Begin tonight".

Document this order on Bart's MAR.

MEDICATION ADMINISTRATION RECORD

ALLERGY: Sulfa

NAME: Bart Wilson		MONTH: January																														
		YEAR: 2015																														
MEDICATION & DOSAGE	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
DRUG: Multivitamin	7 AM	W	W	W	W	W	W	W																								
DOSE: 1 tab daily																																
ROUTE: orally																																
DRUG:																																
DOSE:																																
ROUTE:																																

SIGNATURE	INITIALS	SIGNATURE	INITIALS
<i>William Wonka</i>	Ww		
Joe Shmoe	JS		

PRN MEDICATION RECORD (BACK OF MAR)

DATE/TIME	MEDICATION	REASON GIVEN	INITIAL	RESULTS	INITIAL

Scenario #4:

On January 3, 2015, Joan complained of ear pain and she appeared to have a cold. The doctor examined her and ordered "Amoxicillin 250 mg., p.o. 1 cap tid (8 AM, 12 PM, 8 PM) for 10 days", to start her that evening before Joan went to bed. Add this order to Joan's MAR.

MEDICATION ADMINISTRATION RECORD

ALLERGY: Penicillin

NAME: Joan Johnson		MONTH: January																															
		YEAR: 2015																															
MEDICATION & DOSAGE	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
DRUG: Tinactin 1% powder	8 PM	J s	J s																														
DOSE: Apply to both feet and between toes nightly after bath																																	
ROUTE: topically																																	
DRUG:																																	
DOSE:																																	
ROUTE:																																	

SIGNATURE	INITIALS	SIGNATURE	INITIALS
<i>William Wonka</i>	<i>Ww</i>		
Joe Shmoe	JS		

PRN MEDICATION RECORD (BACK OF MAR)

DATE/TIME	MEDICATION	REASON GIVEN	INITIAL	RESULTS	INITIAL

Scenario #5:

Alice works 9 AM to 2 PM , Monday through Friday. Indicate that Alice was given her medication at her place of employment on Thursday January 3rd.

MEDICATION ADMINISTRATION RECORD

ALLERGY: None Known

NAME: Alice Anderson		MONTH: January																														
		YEAR: 2015																														
MEDICATION & DOSAGE	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
DRUG: Tegretol 200mg DOSE: 1 tab 4x daily ROUTE: orally	7 AM	w	w	w																												
	1 PM	w	w																													
	5 PM	J	J																													
	9 PM	s	s																													
DRUG:																																
DOSE:																																
ROUTE:																																

SIGNATURE	INITIALS	SIGNATURE	INITIALS
<i>William Wonga</i>	<i>Ww</i>		
Joe Shmoe	JS		

PRN MEDICATION RECORD (BACK OF MAR)

DATE/TIME	MEDICATION	REASON GIVEN	INITIAL	RESULTS	INITIAL

Scenario #6:

Sally went home with her family on January 6, 2015 at 5 PM. She planned to spend the night and return to the group home at 8AM the next morning. Indicate how you would document this on the MAR.

MEDICATION ADMINISTRATION RECORD

ALLERGY: None known

NAME: Sally Smith		MONTH: January																															
		YEAR: 2015																															
MEDICATION & DOSAGE	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
DRUG: Tenex 2mg																																	
DOSE: 1 tab Daily at bedtime	hs	J s	J s	J s	J s	J s																											
ROUTE: orally																																	
DRUG: Colace 100mg	3 PM	W w	W w	w	W w	W w	W w																										
DOSE: 1 cap 2x / daily																																	
ROUTE: orally																																	

SIGNATURE	INITIALS	SIGNATURE	INITIALS
<i>William Wonga</i>	<i>Ww</i>		
Joe Shmoe	JS		

PRN MEDICATION RECORD (BACK OF MAR)

DATE/TIME	MEDICATION	REASON GIVEN	INITIAL	RESULTS	INITIAL

Scenario #7:

On January 8th the caregiver noted that Bart had not had a bowel movement (BM) in the past 3 days. Document on his MAR that you gave him the Dulcolax Suppository at 7 PM that night, and that one hour later he had a large BM.

MEDICATION ADMINISTRATION RECORD

ALLERGY: Sulfa

NAME: Bart Wilson		MONTH: January																														
		YEAR: 2015																														
MEDICATION & DOSAGE	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
DRUG: Multivitamin	7 AM	W w	W w	W w	W w	W w	W w	W w																								
DOSE: 1 tab Daily																																
ROUTE: orally																																
DRUG: Dulcolax Suppository 10 mg																																
DOSE: Give 1 suppository if no BM in three days																																
ROUTE: rectally																																

SIGNATURE	INITIALS	SIGNATURE	INITIALS
<i>William Wonka</i>	<i>Ww</i>		
Joe Shmoe	JS		

PRN MEDICATION RECORD (BACK OF MAR)

DATE/TIME	MEDICATION	REASON GIVEN	INITIAL	RESULTS	INITIAL

MAR Worksheet Answer Keys

Scenario # 1 answer key:

ALLERGY: None Known

NAME: Sally Smith		MONTH: January																														
		YEAR: 2015																														
MEDICATION & DOSAGE	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
DRUG: Tegretol 200mg DOSE: 1 tab 3 x daily ROUTE: orally	7 AM	W	W	W	Y																											
	1 PM	W	W	W																												
	9 PM	J	J	J																												
		S	S	S																												
DRUG: Colace 100mg DOSE: 1 cap daily ROUTE: orally	7 AM	W	W	W																												

SIGNATURE	INITIALS	SIGNATURE	INITIALS
<i>William Wonka</i>	<i>Ww</i>		
Joe Shmoe	JS		
YOUR SIGNATURE	YS		

PRN MEDICATION RECORD (BACK OF MAR)

DATE/TIME	MEDICATION	REASON GIVEN	INITIAL	RESULTS	INITIAL

Scenario #2 answer key:

MEDICATION ADMINISTRATION RECORD

ALLERGY: Penicillin

NAME: Joe Hernandez		MONTH: January																															
		YEAR: 2015																															
MEDICATION & DOSAGE	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
DRUG: Zoloft 50mg																																	
DOSE: 1 tab daily	9 PM	J s	J s	J s	J s	J s																											
ROUTE: orally							Discontinue 1-6-07 YS																										
DRUG: Dilantin 100mg	7 Am	W w	W w	w w	W w	W w	W w																										
DOSE: 1 cap 2x / daily	8 PM	J s	J s	J s	J s	J s																											
ROUTE: orally																																	

SIGNATURE	INITIALS	SIGNATURE	INITIALS
<i>William Wong</i>	<i>Ww</i>		
Joe Shmoe	JS		
YOUR SIGNATURE	YS		

PRN MEDICATION RECORD (BACK OF MAR)

DATE/TIME	MEDICATION	REASON GIVEN	INITIAL	RESULTS	INITIAL

Scenario #3 answer key:

MEDICATION ADMINISTRATION RECORD

ALLERGY: Sulfa

NAME: Bart Wilson		MONTH: January YEAR: 2015																													
MEDICATION & DOSAGE	TIME	1	2	3	4	5	6	7	8	9	0	1	1	1	1	1	1	1	1	1	2	2	2	2	2	2	2	2	2	3	3
DRUG: Multivitamin	7 AM	W w	W w	W w	W w	W w	W w	W w																							
DOSE: 1 tab daily																															
ROUTE: orally																															
DRUG: Tagamet	8 AM	_____																													
DOSE: 200 mg tab 2 x daily	8 PM	_____ YS																													
ROUTE: p.o.																															

SIGNATURE	INITIALS	SIGNATURE	INITIALS
<i>William Wong</i>	WW		
Joe Shmoe	JS		

PRN MEDICATION RECORD (BACK OF MAR)

DATE/TIME	MEDICATION	REASON GIVEN	INITIAL	RESULTS	INITIAL

Scenario #4 answer key:

MEDICATION ADMINISTRATION RECORD

ALLERGY: Penicillin

NAME: Joan Johnson		MONTH: January																														
		YEAR: 2015																														
MEDICATION & DOSAGE	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
DRUG: Tinactin 1% powder	8 PM	J	J																													
DOSE: Apply to both feet and between toes nightly after bath																																
ROUTE: topically																																
DRUG: Amoxicillin	8 AM	Stop after 12 PM dose on 1-13-12 YS																														
DOSE: 250mg cap tid for 10 days	12 P																															
ROUTE: po	8 PM			Y																												

SIGNATURE	INITIALS	SIGNATURE	INITIALS
<i>William Wonga</i>	WW		
Joe Shmoe	JS		
YOUR SIGNATURE	YS		

PRN MEDICATION RECORD (BACK OF MAR)

DATE/TIME	MEDICATION	REASON GIVEN	INITIAL	RESULTS	INITIAL

Scenario #5 answer key:

MEDICATION ADMINISTRATION RECORD

ALLERGY: None Known

NAME: Alice Anderson		MONTH: January																														
		YEAR: 2015																														
MEDICATION & DOSAGE	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
DRUG: Tegretol 200mg DOSE: 1 tab 4x daily ROUTE: orally	7 AM	w	w	w																												
	1 PM	w	w	w																												
	5 PM	J	J																													
	9 PM	J	J																													
DRUG:																																
DOSE:																																
ROUTE:																																

SIGNATURE	INITIALS	SIGNATURE	INITIALS
<i>William Wong</i>	WW		
Joe Shmoe	JS		
YOUR SIGNATURE	YS		
WORK	w		

PRN MEDICATION RECORD (BACK OF MAR)

DATE/TIME	MEDICATION	REASON GIVEN	INITIAL	RESULTS	INITIAL

Scenario #6 answer key:

MEDICATION ADMINISTRATION RECORD

ALLERGY: None known

NAME: Sally Smith		MONTH: January																																
		YEAR: 2015																																
MEDICATION & DOSAGE	TIME	1	2	3	4	5	6	7	8	9	0	1	1	1	1	1	1	1	1	1	2	2	2	2	2	2	2	2	2	3	3			
DRUG: Tenex 2mg																																		
DOSE: 1 tab Daily at bedtime	hs	J s	J s	J s	J s	J s	H																											
ROUTE: orally																																		
DRUG: Coace 100mg	3 PM	W w	W w	W w	W w	W w	W w																											
DOSE: 1 cap 2x / daily																																		
ROUTE: orally																																		

SIGNATURE	INITIALS	SIGNATURE	INITIALS
<i>William Wonka</i>	WW		
Joe Shmoe	JS		
YOUR SIGNATURE	YS		
HOME	H		

PRN MEDICATION RECORD (BACK OF MAR)

DATE/TIME	MEDICATION	REASON GIVEN	INITIAL	RESULTS	INITIAL

Scenario #7 answer key:

MEDICATION ADMINISTRATION RECORD

ALLERGY: Sulfa

NAME: Bart Wilson		MONTH: January																														
		YEAR: 2015																														
MEDICATION & DOSAGE	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
DRUG: Multivitamin	7 AM	w	w	w	w	w	w	w																								
DOSE: 1 tab Daily																																
ROUTE: orally																																
DRUG: Dulcolax Suppository 10 mg									Y	S																						
DOSE: Give 1 suppository if no BM in three days																																
ROUTE: rectally																																

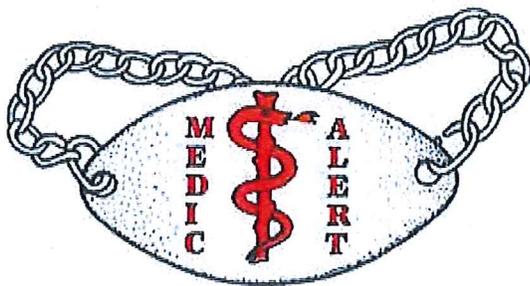
SIGNATURE	INITIALS	SIGNATURE	INITIALS
<i>William Wonka</i>	WW		
Joe Shmoe	JS		
YOUR SIGNATURE	YS		

PRN MEDICATION RECORD (BACK OF MAR)

DATE/TIME	MEDICATION	REASON GIVEN	INITIAL	RESULTS	INITIAL
1/8/12 7 PM	Dulcolax	No BM in past 3 days	YS	BW had a large BM at 8PM	YS

Module 5

Medication Management Fatal Four



Fatal Four

- **Aspiration**
- **Dehydration**
- **Constipation**
- **Seizure**



Aspiration

ASPIRATION along with constipation, dehydration and seizures has been linked to deaths of individuals with developmental disabilities that could have been prevented. That is why it is referred to as one of the “**Fatal Four**”. Caregivers play a vital role in the lives of the people they care for and knowing how to prevent aspiration, or recognizing and seeking treatment for it, is a part of that role.

This training module will assist caregivers to:

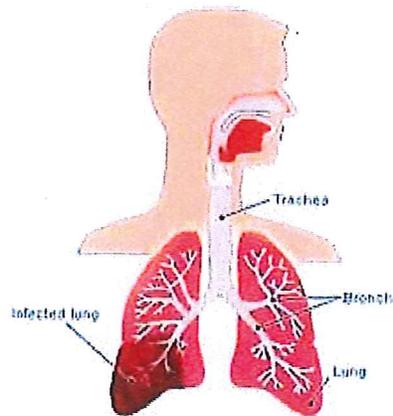
- Understand what **aspiration** is and what causes it
- Learn and put into practice, ways to prevent aspiration.
- Learn what is meant by “**risk identifiers**” and how these increase the chances an individual may aspirate
- Learn what to do when an individual may have, or has aspirated.

ASPIRATION is the process by which either oral or stomach contents enter the airway.

ASPIRATION can happen

- when food, fluid, saliva, medication, or other foreign objects being inhaled into the trachea (windpipe) or lungs.
- When an item is either on the way down or on the way up from the stomach (reflux).
- When individuals are eating meals, snacks, taking medications, or brushing their teeth.
- after or between meals, especially when the person is lying down, asleep, or during a seizure.

Aspiration Anatomy



- Gastrointestinal (mouth, throat, esophagus, stomach intestine).
- Respiratory

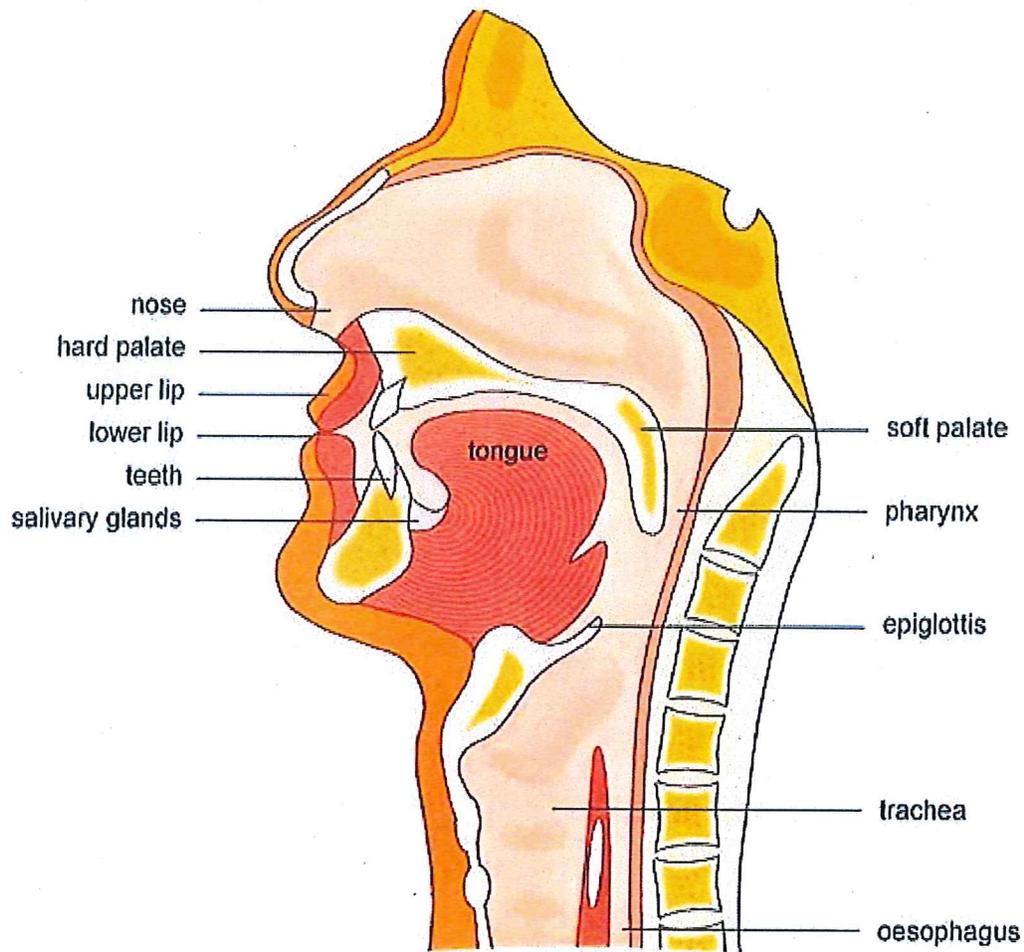
Aspiration occurs when items such as food and fluids, meant for the gastrointestinal system (stomach), are taken into the respiratory systems (lungs).

The Normal Swallow

In the mouth, the lips, teeth and tongue help prepare the bolus (food mass) for further stages of swallowing.

Access between the nasal cavity and mouth closes as the bolus moves into the pharynx (throat).

The picture on the next page shows some of the body structures that are involved in the normal swallowing process. When there are problems with any part of this process it puts the person at risk of aspirating.



The Swallowing Process

- Food is chewed and mixed with saliva
- Rolled into a mass called a **bolus**
- Pushed to the back of the throat (pharynx) by the tongue
- As food reaches the pharynx it stimulates receptors around this area, which triggers the swallowing reflex.

During the swallowing process there is a structure, known as the **epiglottis**, which closes off the **trachea** (wind pipe) preventing the swallowed item going into the lungs. Aspiration occurs when entry to the lungs are not closed off.

If the swallowing process is not working as it should, it puts the person at higher risk of aspirating.

A number of actions take place during the normal process of swallowing:

- The action of several body structures in the area cause the epiglottis to lower. The result is that the epiglottis closes off the opening to the lungs (trachea) so that aspiration does not occur.
- The food (bolus) gets into the back of the throat, into the stomach, and through the rest of the digestive tract by an action known as peristalsis (a wave action moving contents onward).



How Individuals With Disabilities May Be At Risk For Aspiration

Physical Conditions:

- Periodontal Disease
 - Mouth tenderness can lead to swallowing before food is properly chewed
- Neuromuscular conditions
 - Cerebral Palsy
 - Muscular Dystrophy
 - Affect ability to swallow
- Deformities of neck, spine, or trunk
 - Scoliosis
 - Kyphosis
 - Strictures (narrowed area)
 - Can affect the ability of food to be propelled through the digestive system
- Neurological conditions
 - Epilepsy
 - Stroke
- Increased incidence of GER (gastrointestinal reflux)
 - Contents can come back up and into the lungs

Contributing Risk Factors

The following can increase the risk of aspiration in individuals with disabilities:

- **Decreased Alertness** can be from illness, side effects of medications, or after a seizure, or stroke.
- **Feeding by others**, either orally or by G-tube or J-tube.
 - Risk of poor technique (too fast, too much)
 - Poor positioning (not seated upright)
 - Possibility of reflux

Aspiration Risk Identifiers

There are some things that put a person at **risk of aspiration**. These are called “**Risk Identifiers**”. The questions on the following page will help you recognize if someone you are working with is at risk of aspiration. When you answer “**yes**” to one of the questions, a plan is needed to reduce the risk of aspiration.

Keep in mind the following:

- People who are **fed by another** do not have control over how much food or fluids go into their mouth, and may not be able to tell you when they are ready for the next bite or drink.
- Coughing or choking while eating can be the result of a physical or behavioral problem. It’s not considered a risk if the coughing or choking is rare, such as once a year ago, it has to be happening consistently.
- Drooling can be an indication the person’s ability to swallow is compromised.
- If a person regularly refuses to eat or drink, swallowing may be uncomfortable for them. This **doesn’t include** someone who drinks at certain times, likes only a particular food or beverage, refuses some meals but not others. It **DOES include** individuals who eat or drink only for certain caregivers, drink only liquids that are thick or thin, or has unexplained weight loss.
- Chronic chest congestion, wet sounds you notice when the person is breathing, especially around mealtimes, coughing or “gurgling” in the back of the throat, could mean food or fluids are going into the airway or lungs.
- Wheezing can be an indicator of food or fluid entering the airway.
- Individuals who eat or drink rapidly or stuff food could choke and aspirate. Individuals may seek out food also putting them at risk.
- Excessive eating or drinking can lead to vomiting and aspiration.

Aspiration Risk Assessment Questions To Ask

- Does somebody else put food or fluid in the person's mouth?
- Does the person cough or choke while eating or drinking?
- Does food or fluid fall out of the persons mouth, including those who drool?
- Does the person regularly refuse liquids?
- Does the person regularly refuse food?
- Does the person have chronic chest congestion, frequent pneumonia, rattling when breathing, persistent cough, or does the person chronically use cough / asthma medication?
- Does the person eat or drink to rapidly?
- Does the person stuff food into their mouth?
- Does the person have extreme food or liquid seeking behaviors that may cause injury?
- Has the person been diagnosed with GER / GERD?
- Does the person complain of chest pain or heartburn?
- Does the person have small frequent vomiting, or unusual burping?

Aspiration Prevention

As a caregiver you want to know how to prevent aspiration and keep the individual safe.

If you suspect aspiration based on the risk identifiers discuss with the individual's physician. Describe why you think the person is at risk including the person's physical responses, so the physician can determine if a specialist should see the individual such as a speech and language pathologist or occupational therapist.

If required a protocol must be developed and kept current. All caregivers must be trained and follow the written **aspiration protocol** to assure the health and safety of the individual.

Examples seen in aspiration protocols:

- Temperature restrictions for food and fluids.
- Thickening of fluids (nectar, honey or pudding consistency), or altering food texture ("mechanical soft" or "pureed").
- Medications to decrease reflux
- Feeding guidelines
 - Correct posture / positioning
 - Adaptive equipment (cups, plates, spoons, chairs with arms)
 - Special instructions such as approaches when feeding the person
 - Ways to recognize or prevent fatigue
 - Remaining upright after meals
 - Elevating the head of the bed

Aspiration Intervention

What To Do If Aspiration Occurs

- **STOP** eating / drinking / feeding
- **KEEP** the individual upright and encourage coughing
- **NOTIFY** the physician

Once the person has stopped eating / drinking **WAIT UNTIL** they look like they have recovered. They may resume eating, drinking when:

- Breathing appears to be normal
- Color has returned to normal and individual appears relaxed
- Coughing/ gagging has stopped and eyes no longer watering; or
- They can verbally tell you they are OK in a normal tone of voice.

If there are feeding instructions that tell you what to do, you must follow them.

It is recommended that once aspiration has occurred that you check the individual's temperature immediately following recovery and at regular intervals for the next 24-48 hours, or as directed by the protocol, or medical professional. When something is aspirated into the lungs a person's temperature can rise quickly. Report the temperature to the physician.

Keep the person upright and encourage coughing. A person may be tired or not want to continue eating after the event.

When To Call 911

- The individual is **BLUE** and **NOT BREATHING**
- The individual is working **REALLY HARD TO BREATHE** and may be **WHEEZING**
- The individual **APPEARS GRAVELY ILL** and you are concerned about their immediate health and safety.

Dehydration

Dehydration along with aspiration, constipation and seizures has been linked to the deaths of individuals with developmental disabilities that could have been prevented. These four conditions are often referred to as the “**fatal four**”.

Caregivers play a vital role in the lives of the people they care for. Knowing how to prevent dehydration, or recognizing and seeking treatment for it, is part of that role.

This training module will help caregivers to:

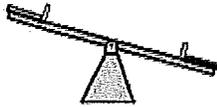
- Understand what “**dehydration**” is and what causes it.
- Learn what “**risk identifiers**” are and how these increase the chances an individual may become dehydrated.
- Learn what you need to do when someone becomes dehydrated.
- Learn and practice ways to prevent dehydration

Dehydration is an excess loss of body fluid, or when fluid output exceeds intake.

Think of dehydration like a balance beam.

INTAKE

- Fluids in food
- Fluids (oral, IV, tube)



OUTPUT

- Routine: Urine, perspiration, respiration, bowel movement
- Infrequent: Diarrhea, vomiting, blood loss, wound drainage

Most body systems and organ functions are affected by dehydration.

- **Circulatory**
 - When blood volume is decreased the heart rate can go up with no exertion while blood pressure goes down.
- **Kidney**
 - Known as the body's recycling center because they save or eliminate fluids and electrolytes (sodium and potassium) from the body.
 - Without adequate fluids can't work properly
- **Skin**
 - Provides a barrier for protection against injury and infection.
 - Requires fluids to remain healthy
 - Dry skin can crack resulting in infection
- **Neurological**
 - Controls thoughts and actions
 - **By the time a person experiences thirst they may have lost fluids that equal up to 1-2% of their body weight.**
- **Gastrointestinal**
 - Includes the bowels
 - Reduced fluids can lead to constipation

Fluid Balance



Preventing dehydration is the goal, so always be on the look out for things that could cause fluid loss such as exercise, illness and hot weather.

How Individuals With Disabilities May Be At Risk For Dehydration?

Common factors that can cause a person with developmental disabilities to be at risk of dehydration:

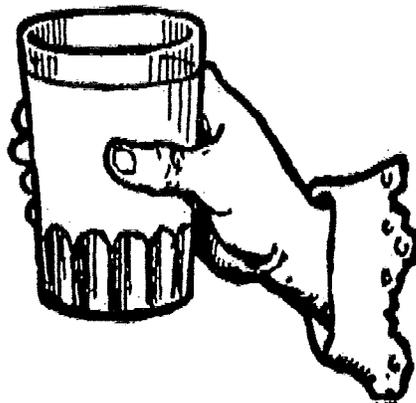
- **Non-verbal**
 - Can't ask for a drink when they are thirsty or tell you when they need to come out of the sun or are overheated.
- **Mobility Issues**
 - Can prevent an individual from accessing fluids or moving out of the heat into a cooler location.
- **Upper body strength / Coordination**
 - Person may not be able to get the glass up to their mouth for drinking, and may spill more fluid than they are able to consume.
- **Oral motor dysfunction**
 - Can cause a person to be fearful because they have learned when they eat or drink they cough or hurt (due to aspiration).
- **Impaired response to thirst impulse**
 - Person does not recognize when they are thirsty so they don't drink when they need to.
- **Any type of stoma**
 - Such as a colostomy, can cause loss of fluids, which need to be replaced.

Symptoms of Dehydration

- Extreme thirst
- Dry sticky mucous
- Decreased urination, dark color, concentrated smell
- No recorded urination for 1 or more 8 hour period per day
- Change in level of alertness, awareness, or functioning, personality, or routine daily activities of the individual
- Dry skin, poor elasticity, or skin turgor
- Heart rate higher than normal without exertion
- Blood pressure lower than normal
- Problems with constipation
- Signs of medication toxicity

IF YOU SEE ANY OF THE ABOVE POTENTIAL DEHYDRATION SYMPTOMS:

- Try to get the person to take more fluids
- Closely monitor the individual and keep a record of what actions you have taken to address your concerns. Document Intake (fluids consumed) and output (number of times a person voids) to report to the physician.
- **REPORT TO THE PHYSICIAN.** Describe what you have seen, when you first noticed it, what you have done about it, and all information you have collected (intake, output, etc)



Dehydration Risk Identifiers

There are things that may put an individual at **risk of dehydration**. We call these "**Risk Identifiers**". If you answer "**yes**" to any of the following questions, a plan or protocol needs to be developed to reduce the risk of dehydration.

Keep in mind the following:

- A person who is dependent on another to access fluids is at risk for dehydration.
- A rare coughing or choking event does not make the person at risk, but they are if this happens most of the time.
- Any individual who drools is losing fluids that need to be replaced.

Dehydration Risk Assessment Questions

- Does the person need, or routinely use assistance to get something to drink or receive fluids?
- Does someone else feed the person?
- Does the person cough or choke while eating or drinking?
- Does food or fluid fall out of the person's mouth?
- Does the person regularly refuse liquids and/or food?

Dehydration Prevention

Routinely Offer Fluids

- 8-10 glasses daily

Provide Extra Fluids if

- Vomiting or diarrhea has occurred
- Fever is present
- Environment is hot
- Individual is ill
- **Check with the doctor before giving additional fluids if the individual has heart or kidney disease.**

Dehydration can occur in a matter of hours or days depending on the circumstances.

The average sized person should drink 8-10, 8 ounce glasses of fluid per day, or 64-80 ounces (1920-2400cc). Fluids that turn into liquid form at room temperature count.

1 cup = 8 ounces or 240cc

People who are overweight may need to drink more than the recommended amount and people who weigh less may drink less.

Individuals, who are **very active work hard, have a fever or perspire**, may need more fluids.

Water makes up 50-60% of an adults weight. Fluid loss = weight loss.

Individuals with **kidney** or **cardiac** disease must seek physician's advice about fluid intake. The physician may want to set limitation for them because their medical condition may be affected by an excess of fluids.

Creative Ways To Increase Fluid Intake

Below is a list of ideas to try and increase an individuals fluid intake. Keep in mind any special dietary consideration such as limitations on sugar or texture modifications when employing these strategies, especially if they are going to be used for a long period of time.

If you are concerned an individual is not getting enough fluids then start tracking (documenting) their intake, so that you can report to the physician how much the person has actually consumed.

- Fruits
- Fruit juice
- Fruit slushies
- Flavored water
- Iced herbal tea
- Popsicles
- Crystal Light
- Decaf coffee (regular or flavored)
- Soups
- Puddings
- Ice Cream
- Yogurt

Use fun cups, silly straws, theme glasses that may encourage a person to consume liquid

Dehydration Professional Interventions

Sometimes all efforts to assure adequate fluid intake are not enough and professional intervention is needed. The physician will direct these actions, which can include:

- Consulting with a dietician to
 - Provide ideas about ways of preparing food
 - Assess eating and drinking habits to identify problems and make recommendations
- Order lab work
 - To determine if person is dehydrated
 - Determine effects on the body such as medication levels
- IV Fluids
 - May be required if an individual is significantly dehydrated.

If you know the person has had an episode of dehydration in the past and required IV fluids, try to find out the circumstances leading to that event, This information can be used to develop the protocol and prevent future need for IV fluids.

Call 911 if:

- The person **appears gray or gravely ill**
- You are concerned about the individual's **immediate health and safety.**

Dehydration can adversely affect an individual and potentially cause confusion, weakness, constipation, medication toxicity, seizures and IN EXTREME CASES COMA AND DEATH.

Constipation

Constipation along with aspiration, dehydration and seizures has been linked to deaths of individuals with developmental disabilities that could have been prevented. That is why it is referred to as one of the **“Fatal Four”**. Caregivers play a vital role in the lives of the people they care for and knowing how to prevent constipation, or recognize it and seek treatment is part of the caregivers’ role.

This training module will assist caregivers to:

- Understand what **“constipation”** is and what causes it.
- Learn and put into practice prevention measures to reduce the risk of constipation
- Learn what is meant by **“risk identifiers”** and how these increase the chances that an individual may become constipated.
- Learn what actions need to occur when a person becomes constipated to maintain health and safety

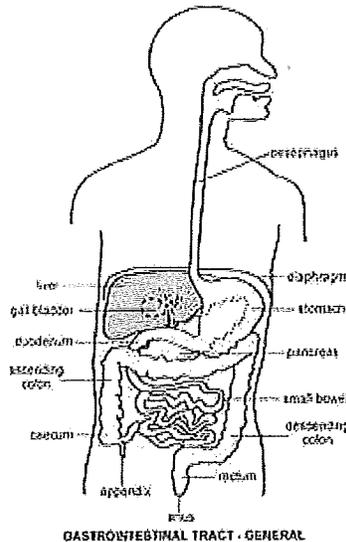
Constipation Is:

- Hardness of bowel movement (BM)
- Difficulty in the passage of stool, or
- Infrequency of passing stool

The most important thing to know is that each individual has their own normal bowel movement cycle. What is **normal for one person may not be normal for another**.

Because normal frequency, patterns, routines and toilet habits vary from person to person, you need to know what is “normal” for the individual. A **variation from the normal** for an individual may indicate a problem that needs further investigation or action to keep the person safe.

Constipation Anatomy



Think of the intestines (small intestine and colon) as a tube. There is an opening at the top which gets food and fluid from the stomach, and an opening at the bottom (rectum).

Normal Digestive Process

- Food is chewed in the mouth, which breaks it down into small pieces, mixed with secretions (saliva), and then swallowed.
- From the mouth food moves into the stomach where it is churned and mixed with digestive enzymes.
- Food then moves into the small intestine, where nutrients are absorbed.
- From the small intestine the food moves into the large intestine (colon) where water and some electrolytes are reabsorbed.
- In the colon the filling and stretching, by voluntary and involuntary muscles, triggers the release of the bowel movement (BM).

NOTE: The GI tract from the mouth to the rectum is one muscle. Individuals with low muscle tone, such as individuals with Down's Syndrome or Prader-Willi Syndrome, may have constipation issues.

How Individuals With Developmental Disabilities May be at Risk for Constipation

- Low or absent muscle tone
 - The GI tract is one long muscle from the mouth to the rectum
- Swallowing or chewing problems
 - Can contribute to poor fluid intake
 - May need a mechanically altered diet, which is usually low in foods containing fiber, like raw vegetables
- Non-mobile / Non-ambulatory
 - May not get help from other muscles in the body that aid in normal digestive process, as seen in such conditions as Cerebral palsy or Spastic Quadriplegia.
- Medication side effects
 - Constipation is a potential side effect of medications such as psychotropic and pain medications.
- Behaviors / Habits (pica)
 - Individuals may be unable or unwilling to have a BM because of a previous traumatic event or pain.
 - Privacy issues or limited opportunities for toileting
 - Pica is a condition in which a person craves and compulsively seeks out non food items to ingest (pennies, cigarette butts, rocks, etc).

Pica is a behavior that may cause bowel obstruction, perforation or death. Caregiver support is crucial!

Constipation “Risk Identifiers”

Individuals taking medication for constipation (except fiber) are considered to have a constipation problem. If the medication is working you may not observe constipation problems, but it does not mean the individual is not at risk.

Be watchful if:

- Individual has not had a BM for more than 2 DAYS (remember it may be different for some individuals)
- The abdomen is firm to touch, the stomach looks distended or bloated, or the individual complains of abdominal pain.
- Vomiting without any fever / flu symptoms
- Vomit that smells like BM (**this is a serious medical condition and immediate medical attention is required**).
- Stool is runny or liquid after several days of small hard BM or no BM.
- Routines change
 - Trips to the toilet increase
 - Staying in the bathroom for a long time
 - Rectal digging or scratching
 - Unusual verbalizations
 - Changes in routine activities or
 - Decreased appetite or intake
- Complaints of, or observed
 - Hard, small or painful BM
 - Especially if problem lasts more than a day or two, or the last two BMs have been hard or small



Constipation Indicators

A person may be at risk of constipation if within the past year they have had trouble with moving the bowels, complained of pain during bowel movement or had a BM that is hard and small.

Individuals are considered to have a constipation problem when

- The individual routinely takes bowel medications.
- The person required a suppository or enema for constipation in the past year.

Be watchful if:

- A routine bowel medication is discontinued
- A new medication is started, especially those with constipation as a common side effect.
- Pain medications are started, such as after a surgery, even if the person has no history of constipation.
- New medications for constipation are introduced (may cause loose stool)

FIBER alone does not mean that a support intervention / protocol addressing constipation is not needed.

Remember fiber products (Metamucil) **NEED LOTS OF WATER TO WORK.** Check the manufacturer's directions.

Fiber

Food sources of fiber include whole wheat, bran, fresh or dried fruits, and vegetables



Lifestyle Prevention for Constipation

- **Dietary Fiber**
 - Can be added to the diet, but has to be consistent with diet orders such as calorie count or texture modifications
 - Fiber sources include:
 - Bran or cereals and muffins made with bran
 - Fruits, especially figs, prunes, dates and apricots
 - Vegetables, especially if they are raw
- **Fluids**
 - Increased intake especially in warm weather to replace fluids lost by sweating.
 - Fluids high in caffeine have a diuretic effect, causing increased urine output and need to replace fluids
 - If you are thirsty others may be too
- **Exercise / movement**
 - Helps to stimulate the bowels
 - Needs to fit the ability of the individual, for example: walking, use of weights, wheel chair exercises or range of motion.
- **Positioning**
 - Important as gravity helps push things through the bowel
 - Individuals who cannot turn or reposition themselves require a caregiver to do this and may require the following for health and safety:
 - Turning schedules
 - Sidelyers
 - Wedge
- **Toileting**
 - Routine may be needed
 - Avoid rushing
 - Allow for privacy, but keep in mind safety issues

Treatments for Constipation

All treatments require signed physician's orders!

TREATMENT METHOD	EXAMPLES
Fiber	Metamucil, Citrucel, Fiber Con tabs, Prune pudding. Fruit – Eze
Stool Softeners	DSS (docusate), Colace
Lubricants	Mineral Oil
Stimulants	Milk of Magnesia (MOM), Bisacodyl
Osmotics	Lactulose, "Colyte / Go – Lytely"
Suppositories	Glycerine, Bisacodyl
Enemas	Fleets, Tap Water, Soap Suds, Oil Retention
Digital Stimulation	

May require hospitalization for X-ray and disimpaction.

When to call 911

Calling 911 is not something usually thought of regarding constipation. However, constipation can progress into an emergency situation. Blockage of the bowel where nothing passes through (impaction) is one situation, but there are others, all which can be **life threatening**.

Call if:

- The person **appears gravely ill** or you are concerned about their **immediate health and safety**
- Is vomiting material that **smells like BM**
- Has a very hard, protruding abdomen
- Has severe abdominal pain

Be aware that it is **ALWAYS** better to err on the side of caution.

Constipation

Life Threatening Scenarios

Constipation can progress and be life threatening as it can result in:

- **Obstruction** – a blockage in the intestines that doesn't allow the passage of food or fluids. If the bowel is blocked long enough, and the person continues to eat and drink, the blockage will continue to expand until something tears, called a "perforation".
- **Perforation**- a tear in the intestinal lining, allowing contents to leak out into the abdominal cavity. This results in infection or sepsis.
- **Sepsis** – infection that spreads into the blood stream.
- **Peritonitis** – an infection of the membrane lining the abdominal cavity. This is a very serious condition, which could result in **death**.

Constipation

Obstruction → Perforation



→ Sepsis

→ Peritonitis

→ Surgery

→ Death Obstruction



Vomiting → Aspiration



→ Hospital-Pneumonia



→ Death

When the intestines become blocked (obstruction) the food and fluids ingested can't move through the GI tract. Without tearing the only way out is to come back up (vomiting). When vomiting happens to a person who is constipated, there is a risk of aspiration, which can lead to infection (pneumonia) requiring hospitalization or even death.

With chronic constipation an individual can have chronic distention of the colon resulting in:

- **Atonic Bowel**
 - Relaxed bowel that lacks normal muscle tone

OR

- **Mega Colon**
 - Extremely dilated colon

With these chronic problems the colon doesn't work as it should. Food and fluids pass through the intestines slowly, making the fecal mass large and hard.

Individuals with conditions in the diagram below may have extremely large and hard or very infrequent BMs. Individuals with these problems:

- Usually take many different medications; and
- Need careful monitoring to quickly address problems which can become life threatening
- Require written protocols that are kept up to date

Call 911 if the person appears gravely ill or you are concerned about their health and safety.

Seizures

Seizure along with aspiration, constipation and dehydration has been linked to deaths in individuals with developmental disabilities that could have been prevented. Seizures are referred to as one of the “**fatal four**”. Caregivers play an important role in the lives of the people they care for. Knowing how to recognize seizure and when to seek treatment is part of that role.

This training module will assist caregivers to:

- Define seizures and epilepsy
- Identify risk factors for individuals who have a diagnosis of epilepsy or seizure disorder
- Identify seizures that may pose an immediate danger to an individual.
- Identify steps that can be taken to support a person with a diagnosis of epilepsy or seizure disorder.
- Identify what to do if an individual has a seizure.
- Identify when a seizure could be life threatening

A Seizure is a sudden, excessive and disorderly electrical discharge in an apparently healthy brain.

- May be caused by conditions such as medications , electrolyte imbalance or fever.
- Individuals have a 10% chance of having a seizure at some point during our lifetime.

Epilepsy is a sudden, recurrent, unprovoked seizures that occur in a brain that has an injury.

- **Seizure Disorder** is another name for **Epilepsy**
- In about 50% of individuals with **Epilepsy**, the brain insult or injury cannot be identified.
- Seizure anatomy involves the brain.

How Individuals With Developmental Disabilities May be at Risk for Seizures

- **Prenatal injuries**
 - Injury to the brain that occurs before birth
 - Trauma, lack of oxygen, brain infections
- **Postnatal injuries**
 - Injuries to the brain occurring after birth
 - Traumatic head injuries, strokes, brain tumors, brain infections
- **Traumatic Head / Brain Injuries**
 - be caused by falls, motor vehicle accidents, abuse, sports injuries, etc.
- **Strokes**
 - Interrupted blood flow to the brain that could be the result of blood clots or a blood vessel breaking causing bleeding into the brain known as a **hemorrhage**.
- **Infections which affect the brain**
 - **Meningitis** – inflammation of the membranes of the brain or spinal cord.
 - **Encephalitis** – inflammation of the brain.

Seizure Types

Seizures that pose an immediate danger:

- **Seizures** where the person loses muscle tone and may fall
- **Seizures** where the person loses consciousness and may aspirate
- **Seizures** where the person loses awareness of their surroundings and may walk, run or climb into unsafe areas.

Some seizure types do not pose an immediate risk.

Seizures in which muscle tone and consciousness are lost:

- **Generalized tonic clonic seizures** - also known as grand mal seizures
- **Tonic seizures** -characterized by tension / contraction / relaxation of muscles
- **Clonic seizures** – characterized by alternate contraction / relaxation of muscles
- **Atonic seizures** – also known as drop seizures
- **Myoclonic seizures** – characterized by jerking, may be so brief that muscle tone and consciousness are preserved

Seizures where awareness of surroundings is lost:

- **Complex partial seizures**

Seizures where the risk of falling or aspirating is low:

- **Absence** – (petit mal)
- **Atypical absence**
- **Simple partial seizure**

Epilepsy Risk Identifiers

There are some things that put a person who has seizures at a risk known as “**risk identifiers**”. If any of the below describes the person you are providing support for a protocol is needed to reduce risks when a seizure occurs. Keep the plan up to date, which means making changes to it as the needs of the person change. Keep the protocol in place as long as the person has seizure risk identifiers.

Identifiers

- Individual has a diagnosis of seizures, seizure disorder or epilepsy
- Individual takes medications for seizures or epilepsy
- Individual has had a seizure in the past 5 year

Keep in mind:

- Seizure that was a one-time event would not need a protocol.
- Medications used to treat seizures (anti-epileptics) may be used to treat other disorders such as bipolar mood disorder or nerve pain (neuropathies). This is why it is important to know why a medication is being taken.
- A person may have had a seizure or seizures but does not have a diagnosis of epilepsy or seizure disorder.

Epilepsy Red Flags

When any of the following “**Red Flags**” happen you must closely monitor the individual and inform the physician or health care professional of these changes:

- Seizures **increase in number** – more happening in the day, week or month.
- Seizures **increase in intensity** – more serious or last longer
- **Repeated minor injuries and suspected aspirations** as a result of seizure activity
- **Illness with vomiting – dehydration**
- **Not taking medication**- a pattern of medication refusal can lead to low levels of medication in the blood and result in increased seizure activity.

Seizure activity can change over time, and any changes must be reported to the physician.

Record all seizures and review the documentation to note changes over time, and provide the information to the physician. Complete accurate record keeping is needed as health care professionals base their interventions and treatments on information they receive from the person, family or caregiver’s that accompany the individual.

A time to be extra vigilant is when the physician is changing medications.

There is a period during the adjustment time when levels may be low resulting in increased seizure activity, requiring close monitoring.

Look for safety issues or need for safety precautions the individual has such as a need for aspiration protocols.

When a person becomes ill they may not be able to take their medications or may vomit after medications are given, which can lead to a drop in the anti-epileptic drug (AED) blood levels. If the individual is able to take their medications, but are not taking fluids they could become dehydrated and AED blood levels rise possibly to the point of toxicity.

Day to Day Safety Seizures and ISP Team Discussion

The ISP team needs to look at and discuss potential issues and risks the individual with seizure activity may have. The team must consider what may be altered (such as the environment) to assure the person is safe. The type and frequency of the seizure activity must also be considered.

Environmental Considerations must include but are not limited to: **home, community, and employment settings**

Examples may include:

- Obtaining or wearing a medical alert bracelet or pendant;
- Padding or replacing hard flooring such as cement or wood;
- Eliminating, limiting or assisting in the use of stairs;
- Placement of the bed, mattress and possible need for bedrails or padding on or around the bed, bedrail or wall;
- Replacing or padding furniture, counter tops, cabinets, etc. that may cause injury due to sharp edges / corners or glass tops;
- The need for safety devices such as helmets, knee pads, commodes with arm supports, grab bars in the shower or bathtub; and
- Consideration of the individual's ability to operate things such as power tools or equipment, or kitchen appliances;

ISP Team Considerations

Water Safety

ISP team discussions around water safety need to be respectful of the individual's privacy and wishes, while considering the risks involved, especially for those individuals with active seizures.

Water safety Considerations can include:

- Shower vs. bath
 - Drains in tubs need to be working properly as standing water poses both a fall and drowning risk
- Supervision while bathing / showering
 - Caregiver in the room 1:1, standby assistance outside the door?
- Accommodations for bathing
 - Grab bars, shower chair, hand held shower nozzles
- Devices used in the bathroom, such as razors and hair dryers
- Flotation devices and / or 1:1 supervision when swimming
 - Flotation devices must fit right and be in good repair

Use of a tub or hot tub when unattended is not safe, with rare exceptions!



ISP Team Considerations

Transportation Safety

When individuals are out in the community, using a wheelchair, bike or other transportation, there are some issues that need to be considered and addressed.

Common transportation safety considerations:

Wheelchair Safety:

- Use of safety belt
- Secured in transportation vehicle
- Helmet needed
- Type of equipment (electric vs. manual)
- Level of supervision required

A wheelchair may be needed at times for individuals who are not steady following a seizure.

Bicycle Safety

- Helmet use
- Knee and elbow pads
- Three wheeled bike
- Carrying identification and emergency information
- Safe locations for riding
 - Out of busy traffic areas, on paths or side roads
 - Caregiver support needed

Vehicle Safety

- Caregiver support during transport
- Actions if a seizure occurs during transport
- Carrying emergency information
- Safety belts / tie downs

Public transportation systems (bus, MAX, taxi) may have their own policies to guide actions should a seizure event occur during transport.

ISP Team Considerations

General Safety

Considerations for food preparation and meals:

- Utilization of appliances and equipment
 - Knives, blenders and small appliances
 - Microwaves and stoves
 - Gas vs. electric – gas should be avoided as a person could fall or lean into the flames
 - Front burner vs. back burner
- Use of glassware vs. plastic for plates, glasses etc.
- Use of rubber gloves for dishwashing to prevent accidental injury
- Dining chairs with arms to prevent falling

Smoking Considerations

- Level of supervision required
- Safety in outdoor smoking location
- Use of smoking aprons or other covering for clothes to prevent accidental burning

Intervention During a Seizure

All caregivers must know the person's seizure protocol, which should include the length of a typical seizure, when to seek medical attention, and what to do if a person becomes combative or disoriented after a seizure.

Remember to:

- Stay calm
- Stay with the person and gently guide away from, or prevent access, to dangers
- Move injurious objects away from the person
 - If in water, keep head above water
- Pad under head, arms and legs
- DO NOT RESTRAIN!
- DO NOT PUT ANYTHING IN THE MOUTH!
- Provide for privacy and dignity
 - Extra clean dry clothing may be needed when in the community in the event of incontinence.
 - Do not rush the individual after a seizure, they can be extremely tired after an event.
- Reassure and support the person and others who may be nearby. If in public you may have to explain to bystanders that it's a normal occurrence and the person will be fine or ask for help if needed.
- Time the length of the seizure and document

After a Seizure Has Occurred

- Turn the person on their side when they are relaxed.
- Loosen clothing and check for injuries
- Reassure and support the person
 - Confusion, drowsiness, irritability or depression may occur after a seizure
 - A person may have the ability to hear before speaking after a seizure
- DO NOT offer food or fluids right after a seizure, make sure the individual is alert and able to safely swallow.
- Document the event including the length of the seizure activity, and any injuries that occurred
- Allow sufficient recovery time before returning to normal activities

When to Call 911

- When a seizure lasts for **more than five minutes**, unless the seizure protocol states otherwise.
- **Two or more** seizures occur without full recovery of consciousness between seizures
- When **breathing does not resume** after a seizure, proceed with rescue breathing
- When it is the **first seizure** for an individual
- When the person may have taken water into their lungs

Remember you need to be familiar with and know the emergency directions contained within an individual's seizure protocol.

- Be concerned if a person, who has not had seizures for years or since childhood, suddenly has one.
- They individual may fall and be injured. Injuries can be minor such as scrapes and bruises, or more severe, resulting in broken bones, brain damage or even death
- Aspiration may occur which may damage the lungs, brain or result in death. n individual may require an aspiration protocol.

Epilepsy: Life Threatening Outcomes

When seizure activity does not stop it can lead the following life threatening outcomes:

- Lack of oxygen
- Falls resulting in injury or brain damage
- Aspiration, which may also result in pneumonia
- Acidosis
- High fever
- Cardiac Arrest

Even if the individual survives, there may be significant injury and brain or lung damage may occur.



Protocols

A protocol may be needed for a specific health issue such as aspiration, constipation, dehydration or seizures. It is recommended that you DO NOT have the physician write these protocols because this method would require the physician's order to change or update the protocol. You can ask the physician and others to gather information for the ISP team or contract RN to complete the protocol.

Protocols are written instructions for caregivers to follow when individuals have specific, chronic, or frequent problems from a condition that may or may not have a predictable outcome. Protocols are usually written regarding a medical condition that requires caregiver monitoring or intervention, such as seizures or constipation. Protocols give guidance to the caregiver regarding signs and symptoms to look for, when and how to intervene, emergency procedures, including when to contact the physician or 911.

Protocols are sometimes confused with procedures. Procedures are task oriented. They provide step-by-step instructions on how to do a task. For example: "How to Administer Gastronomy Feeding", "How to Assist a Person with Dysphagia when Eating". Protocols are problem oriented, and explain what to do about a problem. Protocols contain a description of the problem, when and how to intervene.

Protocols need to be specific to the setting AND the individual. For instance, if three people in the same home have seizure protocols, they would all read differently based on the individual's type of seizure activity and supports needed. There may be similarities such as basic safety guidelines and documentation requirements. Protocols need to be specific to the setting. The protocol for an individual at home will read slightly different than the protocol developed for the vocational setting.

Protocols must identify who wrote them. If a nurse (contract RN or other) is involved in the individual's care, they would typically author all protocols involving medical conditions. Occasionally, a physician will write directions on how to address a specific health issue, which are to be included in the protocol, as they are usually inadequate for a complete protocol. If the person does not require a nurse, someone who is knowledgeable about the condition and the person, usually the provider with ISP team assistance, would write the protocol.

Protocols need to be dated and reviewed periodically. An individual's condition can change, and the protocol should be reviewed to be updated or discontinued if no longer needed. When medical orders are changed, such as medications or interventions, the protocol must be updated to include the modified orders. Any changes made to the protocol need to be initialed and dated by the person making the change.

General Protocol Outline

- **Title:** The name of the risk listed or an identifier on the document such as "Aspiration Protocol".
- **Name:** of the person the protocol supports, such as "Seizure Protocol for John Adams"
- **Description:** of the problem, issue and risk
- **Prevention:** specific steps to prevent the problem from happening or from getting worse
- **Signs and Symptoms** what staff would see if the problem occurs
- **Intervention or Direction** for staff to follow if the problem occurs or gets worse
- **911 Section** to indicate when staff **must call 911.**
- **Author** indicating who wrote the protocol to include the author's signature and date the protocol was developed.

Module 6: Documentation



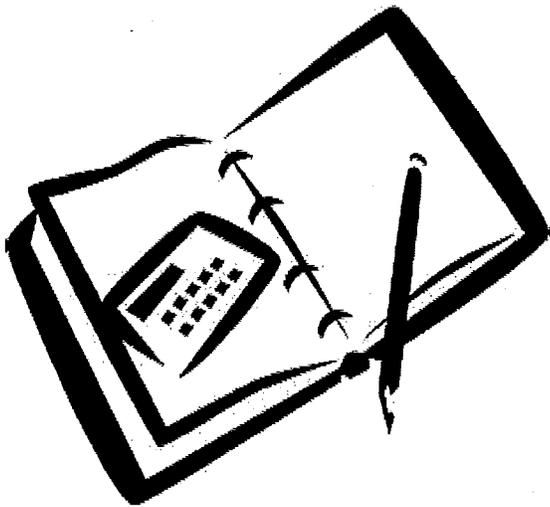
Documentation

MCAR 023-080-100 thru 023 81-100 and 023-110-400

- **Individual Records**
 - Individual Summary Sheet
 - Emergency Information
- **Individual Account Records**
 - Financial records
- **Individual's personal Property Record**
- **Medication Administration Records**
- **Individual Support Plan (ISP)**, and supporting documentation such as protocols, nursing care plans, behavior support plans, mental health treatment plans, and court orders
- **House Rules**
- **Incident Reports**
- **Individuals Bill of Rights**
- **Monthly Progress Notes**
- **Personnel Information**
 - Training documentation
 - Application
 - Criminal Background Check
 - Mandatory reporting
- **General Information and Correspondence**

Best Practices

- **Always** make entries promptly
- **Always** use blue or black ink
- **Always** correct errors with a single line through the entry and your initials
- **Never** use white out or scribble over errors
- **Always** include signatures with entries



Individual Records

The individual record for each individual admitted to the adult care home will be developed, kept current and available to all caregiver's.

The individual summary sheet developed for each individual in the home must include:

- Name, current and previous address, date of birth, gender, marital status, religious preference, preferred hospital, Medicaid prime number and private insurance number if applicable, and guardianship status
 - If a guardian is appointed the name address and phone number of the guardian.
- The name address and phone number of the following are to be included: legal representative, family member, advocate or significant person, the primary health provider, dentist, day program or employer, service coordinator and other agency representatives, such as psychiatrist or vocational rehabilitation counselor.

Please remember:

Individuals' records must be available at the adult care home to representatives of the ACHP or DHS conducting inspections or investigations.

Individual records must be kept for a period of at least 3 years. If an individual moves, their records get transferred with them. Financial records must be kept for 7 years.

Resident Account Record

For individuals not yet capable of managing their own money, as determined by the ISP team or guardian, the providers must prepare and maintain a separate and accurate written record for each individual of all money received or disbursed on behalf of or by the individual.

The Record Must Include:

- The date, amount and source of the income received (such as SSI disbursement or wages)
 - The amount and purpose of funds distributed (such as \$10 for haircut)
 - The signature of the provider making each entry
-
- Purchases of \$5 or more made on behalf of an individual must be documented by sales receipt, unless a smaller amount is otherwise specified by the ISP team.
 - Personal Incidental Funds (PIF) for individuals are to be used at the discretion of the individual for such things as clothing, video games, and snacks (not part of daily diet) and addressed in the ISP.
 - Each Resident Account Record must include the disposition of the room and board fee that the individual pays to the provider at the beginning of each month. The record must show that part of the fee was used for the individual's rent and room and board expense, which is used for the provision of meals, laundry and housekeeping for the individual.
 - The provider **MUST REIMBURSE** to the individual any funds that are missing due to theft or mismanagement on the part of the provider, resident manager, or any caregiver of the foster home, or for any funds that are within the custody of the provider that are missing. Such reimbursement must be made within 10 working days of the verification that funds are missing.

Sample Individual Financial Record

Persons name: John Jones **Year:** 2015

Date	Income Source	Amount	Expenditure	Amount	Receipt#	Balance	Initial
2/05/15	SSI	\$507.40	Room and Board	\$407.70	#1	\$99.70	JJ
2/10/15	Wages	\$72.00				\$171.70	JJ
2/12/15			Haircut	\$12.00	#2	\$159.70	PD
2/12/15			Lunch at Arby's	\$5.27	#3	\$154.43	PD
2/15/15			Movie Theater	\$7.00	#4	\$147.43	JJ
2/15/15			Theater snack and drink	\$7.00	#5	\$140.43	JJ
2/18/15			To work site for daily \$1 purchases	\$25.00	#6	\$122.43	JJ
2/22/15			CD and pajama's at Walmart	\$16.00	#7	\$106.43	PD
2/25/15			Purchase gift and card for Mom's birthday	\$20.00	#8	\$86.43	PD
2/25/15	Change from purchase \$4.12					\$90.55	
2/26/15			To savings for trip planning	\$20.00	#9	\$70.55	JJ
3/05/15	SSI	\$507.40	Room and Board	\$407.70		\$170.25	JJ
3/06/15	Wages	\$94.00				\$264.25	JJ

Signature Key

Name	Initial	Name	Initial
<i>Jenny Jones</i>	JJ	<i>Phil Donahue</i>	PD

- Keep each person's record separate
- Keep records private
- Individual's funds are used only for that individuals benefit
- **NEVER** borrow or loan money
- **NEVER** comingle an individual's funds with another individual or with the provider's funds
- Update the personal property record as appropriate
- Financial records must be kept for seven years

Individual Personal Property Record

The provider must prepare and maintain an accurate individual written record of personal property that has significant or monetary value to the individual as determined by a documented ISP team or guardian decision. The record **MUST** include:

- The descriptions and identifying (serial) number of the item if applicable
- Date the item was included in the record
- Date and reason why an item was removed from the record (such as broken CD player)
- Signature of the providers making each entry
- A signed and dated annual review of the record for accuracy



Sample Personal Property Record

Persons Name: Jane Smith	Date of Birth: 7/29/92
Entry date: 2/8/15	Exit Date:

Date added	Item	ID#	Signature	Date removed	Reason	Signature
2/08/15	7 shirts		Sally May			
2/08/15	8 pair of jeans		Sally May			
2/08/15	2 dresses		Sally May			
2/08/15	1 pair sneakers	White Nike, size 7	Sally May			
2/08/15	Canon SD750 digital camera	DVG2343 -R	Sally May			
2/08/15	1 Blue Coat	Denim size 8	Sally May	2/21/15	Outgrown discarded	Sally May
2/08/15	1 Photo Album	Red leather cover	Sally May			
2/08/15	1 Oak Bed w/ Headboard, mattress set	Twin,	Sally May			
2/08/15	Underwear and socks	20 each	Sally May			
2/21/15	1 beige winter coat	Size 12, Columbia	Sally May			
2/25/15	Nintendo DS	NGS5467	Sally May			
2/25/15	Super Mario NDS game	NGS 502	Sally May			

Individual Support Plan (ISP)

A health and safety transition plan must be developed at the time of admission for the first 60 days of service and a complete ISP must be developed by the end of 60 days of admission. The ISP must be updated annually or more frequently whenever the individuals support needs change.

A completed ISP must be documented on the Department mandated Foster Care ISP form that includes the following:

- What is most important to the person
- What works and does not work
- The type and frequency of supports to be provided
- The person responsible for carrying out the plan
- A copy of the employment or ATE provider's plan must be integrated or attached to the foster home ISP for persons also supported in an employment or other department funded day service.

The ISP must include at least 6 hours of activities each week that are of interest to the individual, not including television or movies made available by the provider. Activities available in the community and made available or offered by the provider or the CDDP may include:

- Habilitation services
- Rehabilitation services
- Educational services
- Vocational services
- Recreational and leisure activities
- Other services or activities required to meet and individuals need as defined in the ISP.

“Nothing About Me Without Me”

House Rules

A copy of the written house rules must be provided to and discussed with each individual receiving services in the adult care home. The provider must document when the house rules were provided to and discussed with the individual. House rules must be reviewed upon entry and annually for all individuals in care.

House rules must be in compliance with the Resident's Bill of Rights.

House rules must include:

- Any restrictions on the use of alcohol, tobacco in compliance with the Indoor Clean Air Act, medical marijuana, pets, visiting hours, dietary restrictions and religious preferences in the household.
- Not be in conflict with the atmosphere of the home, or the Multnomah County Administrative Rules for ACH-DD.
- Include rules specific to the notification of substantiated abuse occurring in the ACH-DD.

House rules must be available to be seen and read by individuals and visitors.



Unusual Incidents

A written report of all unusual incidents relating to an individual must be sent to the CDDP within 5 working days of the incident. The report will include:

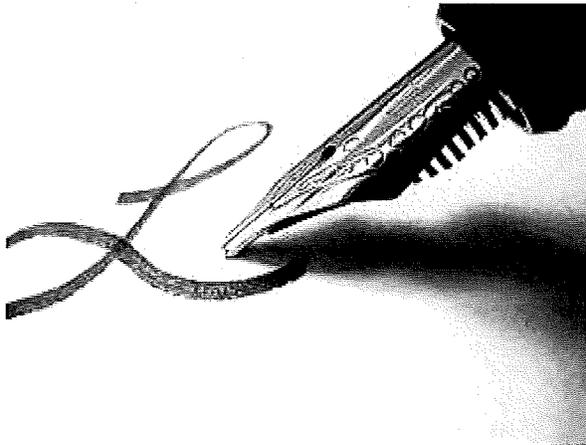
- How and when the incident occurred
- Who was involved in the incident
- What action was taken during the incident\
- The outcome to the individual
- What action is being taken to prevent a re-occurrence of the incident.

General Information

The provider will maintain any other information or correspondence pertaining to the individual.

Weekly Progress Notes

The provider will maintain, at minimum, weekly progress notes for each individual residing in the home, regarding the success of the ISP, and medical , behavioral or safety issues, or any other events that are significant to the individual.



Individual Bill of Rights

The provider and all caregivers will abide by the Residents' Bill of Rights, which shall be posted in a location that is accessible to the individual, guardians or legal representatives.

RESIDENTS' BILL OF RIGHTS MCAR 023-030-100

- (a) Be treated as an adult with respect and dignity.
- (b) Live in a safe, secure, homelike environment.
- (c) Be informed of all resident rights and house rules.
- (d) Be encouraged and assisted to exercise rights as a citizen, including the right to vote and to act on his or her own behalf
- (e) Be given information about his or her medical condition.
- (f) Consent to or refuse treatment, medication or training.
- (g) Have all medical and personal information kept confidential.
- (h) Receive appropriate care and services from the Adult Care Home and access to prompt medical care as needed.
- (i) Be free from mental or physical abuse, neglect, abandonment, punishment, harm or sexual exploitation.
- (j) Be free to make suggestions or complaints without fear of retaliation.
- (k) Be free from financial exploitation, including charges for application fees or non-refundable deposits and solicitation, acceptance or receipt of money or property by an Operator, Resident Manager or caregiver other than the amount agreed to for care and services.
- (l) Be free from physical or chemical restraints except as ordered by a physician or qualified practitioner. Restraints are used only for medical reasons, to maximize a resident's physical functioning, and after other alternatives have been tried. Restraints are not used for discipline or convenience.
- (m) Be free from discrimination in regard to race, color, national origin, gender, sexual orientation, or religion.
- (n) Be afforded personal privacy, the opportunity to associate and communicate privately with any person the resident chooses, to send and receive mail unopened, and to use the telephone in private.

- (o) Participate in social, religious, and community activities.
- (p) Make personal decisions about such things as friends, leisure activities, choice of physician, spending personal money, food, personal schedules, and place of residence.
- (q) Be allowed and encouraged to develop talents and learn new skills, relate to other residents in meaningful ways, and the choice to take part in the normal activities and upkeep of the home.
- (r) Keep and use a reasonable amount of personal clothing and other belongings, and have a reasonable amount of private, secure storage space.
- (s) Be free to manage financial affairs unless legally restricted.
- (t) Receive a written agreement regarding the care and services the home shall provide and rates charged, and receive at least 30 calendar days written notice before the home's ownership or rates change.
- (u) Receive at least 30 calendar days written notice from the Operator and an opportunity for a hearing before being involuntarily moved out of the home by an Operator, unless there is an emergency situation.
- (v) Be involuntarily moved out of the home by an Operator only for the following:
 - (1) Medical reasons.
 - (2) The resident's welfare.
 - (3) The welfare of the other residents.
 - (4) Nonpayment.
 - (5) Behavior which poses an immediate threat to self or other.
 - (6) Behavior which substantially interferes with the orderly operation of the home.
 - (7) The care needs of the resident exceed the ability or classification of the Operator.
 - (8) The home is no longer licensed.
- (w) Receive complete privacy when receiving treatment or personal care.
- (x) Receive visitors free from arbitrary and unreasonable restrictions.
- (y) Practice the religion of his/her choice.
- (z) Not be forced to work against his/her/ will, and to be paid for agreed upon work.

RANGE OF MONTHLY RATES FOR PRIVATE PAY RESIDENTS \$

FROM \$ _____ TO: \$ _____

Module 7: The Individual Support Plan



The Individual Support Plan

The ISP addresses the following for an individual:

- Preferred activities
- Contact with family and friends
- Communication
- School, employment / ATE / Community Inclusion
- Finances
- Health and medical care
- Behavior Support
- Activities of Daily Living
- Safety

The ISP team must include:

- The individual
- The Service Coordinator
- The legal guardian if applicable
- The licensed provider

Other participants may also include:

- Family members
- School or vocational representatives
- Other caregivers of the ACH
- Advocates

When an individual is to be admitted into the ACH-DD there must be an ISP team meeting prior to the onset of services also referred to as an **“entry meeting”**. Findings of that meeting must be documented in the individual’s record and include a transition plan if it is determined that the individual will be served in the ACH-DD.

The transition plan must address:

- Health and medical care
- Behavioral supports
- Safety supports

A formal ISP must be developed within 60 days of an individual’s entry into the ACH-DD.

Support Services Plan of Care and Crisis Addendum

For individuals receiving Support Services (Brokerage) under OAR 411-340, and receiving crisis services in an ACH-DD they will have the **Support Service Plan of Care and Crisis Addendum** instead of an ISP.

Individuals who are not enrolled in support services, receiving crisis services in an ACH-DD or less than 90 consecutive days must have a transition plan on admission addressing any critical information related to **health and safety**.

ISP Required 60 Days After Admission

- A formal ISP must be developed by the end of the first 60 days after admission
- The ISP must be documented on the Department mandated foster care ISP form
- The ISP must include the supports needed, including the type and frequency and who is responsible for supporting the individual

A copy of the employment or ATE providers ISP must be integrated or attached to the foster ISP if applicable.

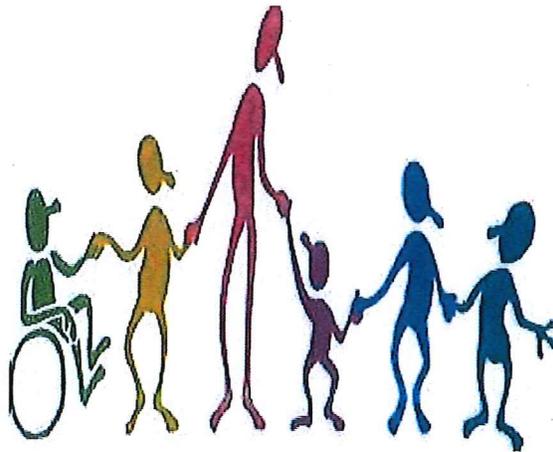
The ISP team members need to sign the plan. If the team cannot reach agreement this should be documented in the ISP. The team shall look at an issue that the individual does not agree with and see if some action can be taken to address the individual's wish.

An individual who does not have a guardian must sign his / her ISP.

The service coordinator must sign the ISP.

Individual Support Plan Annual Requirement

- The ISP must be updated annually and more frequently as needs change.
- The team reviews the support needs, type and frequency of support and the person responsible for carrying out the plan.
- The ISP is considered the Medicaid Plan of Care and is required by Medicaid as well as Oregon Administrative Rule.
- The plan must be signed by the team members
- The plan is not authorized unless signed by the Service Coordinator



Module 8: Working with Challenging Behaviors in ACH-DD



Positive Behavior Support

Embraces **Person Centered Practices** which:

- Are designed around and for the individual
- Honor the person's preferences
- Involves the individual in planning
- Allows for personal choice
- Allows for the individuals lifestyle and preferences
- Supports positive relationships

The focus of Positive Behavior Support is to make challenging behavior ineffective, inefficient and irrelevant while at the same time developing outcomes that are more acceptable and agreeable to the individual and others.

In this module providers and caregivers will better understand the role they play in providing supports to individuals living in their home, including, understanding and accepting responsibility for how they can contribute to a challenging behavior or help decrease it.

The intent for all providers and caregivers is to use Positive Behavior Support strategies before resorting to more intrusive measures.

Effective Positive Behavior Support includes, but is not limited to:

- Implementing Person Centered Practices designed around and for the individual.
- Finding out what a person wants and including the individual as an active participant in all planning efforts as well as every other aspect of their lives
- Incorporating the principles of true choice, positive relationships, and empowerment of the individual to a life of his or her choosing

The emphasis of Positive Behavior Support is to design effective strategies that improve the quality of life of people who may exhibit challenging behavior. Attention is focused on creating environments that improve the quality of life of the people that we serve. The focus is on making challenging behavior ineffective inefficient, and irrelevant. At the same time, interventions, developed with the ISP team, should promote outcomes that are more socially acceptable and agreeable to the individual the family and the support community

Multnomah County Administrative Rules and Oregon Administrative Rule

- **OAR 411-360-0070 Classification.** One classification of AFH-DD is Level 2B homes, which are homes that intend to provide care and support to more than one individual that exhibits behavior, which poses a significant danger to the individual or others.
- **OAR 411-360-0020 Definitions.** Defines **protective physical interventions** (PPI's) and when they are considered abuse.
- **OAR 411-360-0160 Behavior Supports.** Describes the use of protective physical intervention, training and documentation requirements
- **MCAR 023-030-100 (l) and OAR 411-360-0170(9)(o) The Resident's Bill of Rights.** Clarifies when behavior intervention programs can be used, i.e. only if approved in writing in the ISP.



Provider and Caregiver Impact

Many areas about ourselves impact and influence those around us including our:

- Appearance
- Culture
- Moods, motivations, values, attitudes
- Ability to communicate effectively, including tone and body language
- Decision making process
- Ability to offer choices
- Response to conflict or stress
- Ability to show empathy
- Ability to listen to others
- Ability to work with others as a team

It's
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Positive Behavior Support Plans

If the ISP is the Compass...

Then the BSP is the Roadmap of how caregiver's will:

- Develop a good understanding of the individual supported
- Set up or adapt the environment for success
- Recognize triggers or beginning of challenging behaviors (sometimes referred to as "triggers", "antecedents" or "setting events")
- Identify behaviors to be supported
- Describe what to do

A individual's abilities or disabilities do not deprive him or her of their constitutionally given rights. (However, in certain circumstance and with the ISP team's approval, we sometimes restrict a person's rights.)

At the same time, the individual's rights do not deprive us, as caregivers, of our rights. We have the right to be free from verbal and physical abuse, injury and mistreatment. However the reality is that the individuals we support, will at times, act in ways that can make us feel abused. The real challenge is to maintain a positive attitude while managing these feelings of being threatened, mistreated or abused while providing supports that the individuals in our care deserve.

Understanding Diagnosis

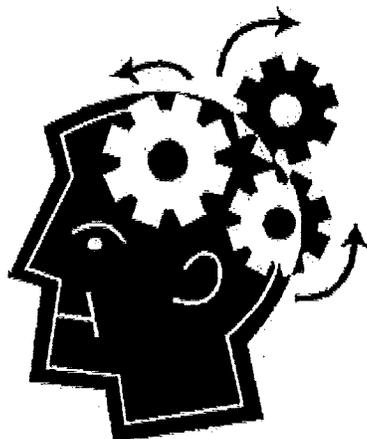
Challenging behaviors can be a direct result of a psychiatric disorder, a neurological disorder or the individual's disability. (Some of the neurological disorders that can affect behavior are Autism, Asperger's Syndrome, Rett's Syndrome, Childhood Disintegrative Disorder, Alzheimer's, ADHD, and Brain Injury).

A Diagnosis can impact an individual's:

- Ability to communicate
- Cognitive Abilities
- Ability to organize and sequence activities and materials
- Rituals and routines they engage in
- Sensory experience
- Perception of experience

Some individuals we support have both developmental disabilities and mental health diagnoses and may receive services that include:

- Medications to treat chemical imbalances in the brain;
- Counseling to assist them in understanding the symptoms of the disorder and how to manage those symptoms; and
- On-going assessment and evaluation by a qualified medical professional



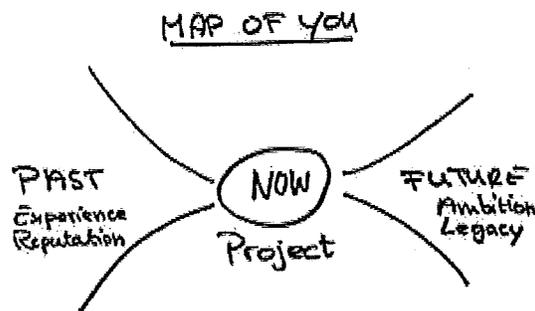
Understanding Life History

Everyone has life experiences that can influence their behavior.

Life History

Everybody has life experiences and these can influence the individual's behavior. Learning about the person's life experience may be helpful in understanding the meaning of the person's challenging behavior. When we understand the meaning of the person's challenging behavior, and we understand what is "triggering" or "setting up" the behavior, we get a better idea of what to do to support the person.

A person's life history may include abuse or neglect. The person may have a history of moving from place to place. There may be anniversaries of special occasions that the person may want to mark such as the anniversary of moving from one adult care home to another, the death of a significant person in that individual's life, etc. These factors certainly can contribute to challenging behavior.



Understanding Developmental and Cognitive Levels and Adaptive Skills

Developmental, Cognitive, or Adaptive Levels:

Typically, individuals develop some impulse control, anger management skills, conflict resolution skills and problem solving skills over time.

A person may learn to cover up the fact that they do not have skills in certain areas. They may become cue (verbal direction) or caregiver dependent and not strive for independence (learned helplessness), and a person may become overwhelmed and frustrated. When we over estimate or under estimate an individual's skills, our expectations may cause challenging behaviors.

It is important to know how an individual adapts to environments. A person may have had to develop behaviors to adapt to an unhealthy environment, which may be considered risky, unhealthy, or challenging behaviors in a different, more stable environment. For example a person may have learned to find and hoard food in an environment where food was scarce. In a new environment, where food is available, the behavior continues and is labeled "hoarding". If we simply stop the person from hoarding, the person may become distraught and possibly combative. However, the person may not be ready to give up these behaviors until replacement behaviors have been established. Behaviors may arise if we threaten to remove the person's adaptive behaviors without providing them time so that they become comfortable and learn to trust us, or we do not provide alternative behaviors for them.

Understanding Health and Medical Issues

Health and Medical Issues:

Many of the individual's we support have underlying and often unresolved medical issues that are at the root of their challenging behavior. When analyzing the meaning of a person's challenging behavior we look at possible medical causes. Often, once we address a medical issue, the challenging behavior may decrease or go away. Some common medical issues to assess are:

- Illness
- Pain (dental or other)

Many of the individuals we support are taking medications, which have **side effects**, which we need to be aware of. For example, a person who is trying to lose weight may be taking a medication that decreases their appetite, which may lead to anxiety or irritability.

Sometimes an individual receives ongoing medical care, which they do not understand or don't cooperate with. The result may be the need for physical intervention, which may be an emergency, or a planned intervention. For example, the person has a monthly blood draw but will not hold still requiring their arm to be held still and a plan for this physical intervention is in place.

Understanding Relationships

Our mission is to assist a person to achieve meaningful relationships by:

- Modeling positive interactions in our relationships
- Helping the individual to develop relationships with others

It is not always easy for us to build relationships with the persons we support. Developmental issues and / or communication difficulties may make it hard to connect with the person. The person may avoid forming close relationships with others based on their past experiences:

- Some persons who are adults now may have been institutionalized at an early age and may have had little or no contact with their families.
- Relationships people have developed are disrupted every time the person moves from one living situation to another.
- Relationships can also be disrupted when a caregiver stops working
- Caregiver's (past or present) actions when enforcing rules or setting limits in order to maintain health and safety, can influence the development of a relationship.

Our mission, then, in assisting a person to achieve meaningful relationships is to:

- Model positive interactions in *our* relationship with that person by interacting respectfully, communicating clearly and
- Help the person develop relationships with people he or she meets in the community.

Understanding Environmental Impacts

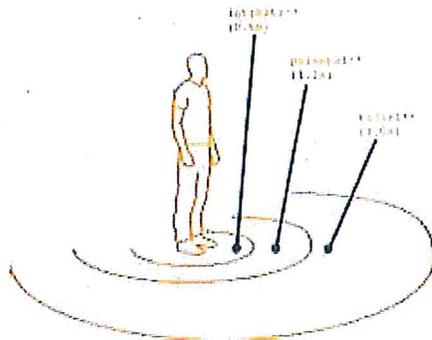
The Environment:

Environmental issues (such as temperature, noise, unstructured or unclear expectations around activities, inconsistency, lack of predictability, and groupings of individuals and their individual habits) may impact behavior. Factors that cause stress are highly individualized. To learn about how to set up environments that work you can:

- Ask the person what they want
- Observe them at home, work and in the community
- Understand a person's developmental, neurological or psychiatric conditions

Personal Space:

Every one of us carries around with us a sort of invisible bubble of personal space. We think of this space inside this bubble as our own, perhaps as an extension of our own bodies. When someone moves so close to us that our bubbles overlap, our space has been compromised, which can impact our behavior. We need to respect each other's personal space.

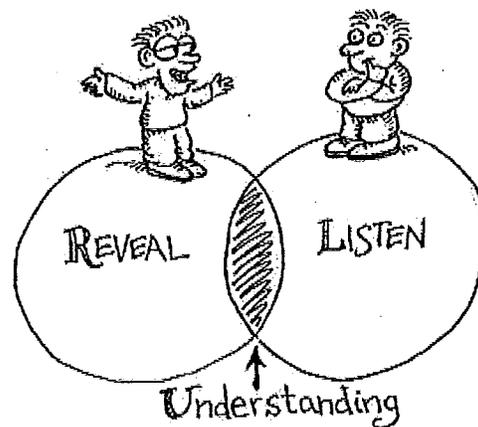


Basic Needs

Human behavior may be viewed as a set of actions that assist in meeting very basic biological and social needs. Fundamental needs include survival needs (water, shelter, food, clothing, human contact), safety and predictability. After fundamental needs are met, an individual can then focus on social and achievement needs. Human behavior can be affected by these basic needs.

Communication

Understanding the importance of communication with the people we support is critical. They need to be heard but often have **expressive skills** that are difficult to understand. They need to be able to listen but often have **receptive skills** that complicate listening. Communication is composed of verbal and non-verbal components. The words we choose convey only part of the message. How we say things may be just as powerful, or more powerful, than what we say.



Intervening Risks and Responsibilities

When we begin discussing challenging behavior, it is appropriate to discuss risks and responsibilities. When we assume responsibility for the support of persons who may have challenging behaviors, we face such risks as:

- Being injured during an incident.
- Contributing to an avoidable injury by either failing to respond or by over-responding with excessive intervention.
- Using unapproved procedures resulting in injury or abuse.

Abusive Techniques

Abusive techniques are clearly outside the parameters of good practice. Abusive techniques are those techniques that humiliate or deliberately cause pain or discomfort to the individual for which intervention is used. **There are NO circumstances under which abusive techniques should be applied!!!**

Abuse of Techniques

Although the techniques may be applied (physically) correctly, abuse may also occur by applying these interventions when unnecessary, before really necessary, or for too long a period of time after an individual is no longer a threat to health and safety, etc. Abuse may also occur when unauthorized restraints or other interventions are applied.

Neglect

Neglect occurs when a caregiver fails to act in a timely manner to decrease the chances of an avoidable injury.

A **protective services** action can be taken when a person makes an allegation of abuse, the individual is injured during a behavior, or our response resulted in injury to a person.

Minimizing Risks

We as caregivers are responsible for trying to minimize the risks

Ways to Minimize Risks:

- Get to know the person, establish a relationship
- Be respectful of the persons feelings and wishes
- Look for problem areas in the environment that cause the person stress, then look for ways to reduce or remove those things
- Keep the CDDP services coordinator informed when there are problems
- Work with the services coordinator and the ISP team, if needed, to develop a Behavior Support Plan, which may include being trained in approved OIS (Oregon Intervention Systems) intervention techniques conducted by a certified trainer.

Reasonable Response

Just enough intervention for protection from injury, and NO more than is absolutely necessary.

When responding to a challenging behavior or incident, caregivers are expected to protect themselves from injury, but are limited to using the most reasonable response.

During a behavioral event the person may become aggressive. The caregiver must evaluate the risk of injury from the acts of aggression and match the intervention to the level of danger involved. A caregiver who fails to respond appropriately may pose more danger to the individual(s) involved and thus constitutes abuse.

When responding in a crisis situation, we need to consider what is the most respectful and dignified way to intervene that also maintains safety in the situation, it is considered respectful to begin eliminating environmental stressors, which can be other individuals, sounds or objects.

Talking to the person (if this assists in calming them) or changing the environment should be tried first to de-escalate a behavioral situation. If those efforts are not working, the caregiver may need to increase the level of response.

This may mean assisting others to safety and / or utilizing emergency protective physical interventions from the Oregon Intervention System (OIS) which includes evasion (getting out of the way and staying out of the way), escape, and covering and deflection (changing the direction of the attack).

The use of a protective physical intervention is not “reasonable” if an individual only threatened, but did not attempt physical contact. In this case communicating verbally and moving possible victims out of range would be considered reasonable. The same would be true if an individual takes a single swing or kick, and does not attempt serious injury.

Protective Physical Interventions

Physical Intervention is NEVER to be used to demonstrate that the caregiver is more powerful, or to require an individual to complete a task.

Use of Protective Physical Interventions (PPI's)

- Only in an emergency
- When someone is in danger of being physically harmed
- Only used until a person is no longer a threat
- If intervention is used more than 3 times in 6 months, it prompts an ISP team meeting

Occasionally, the use of protective physical intervention becomes necessary in order to maintain the safety of the person. *Protective physical intervention* is not only direct physical contact and restraint that limits an individual's movement, but also includes physical blocking of access to a portion of the house that they are usually free to use. Protective physical intervention is only permitted in emergency situations when:

- Any person living in the home is in danger of being physically harmed.
- The individual is a danger to themselves or others, such as objects being picked up or used in a way that is likely to cause tissue damage to themselves or others.
- The individual is attacking the caregiver and the caregiver cannot free themselves or others from the situation unless physical restraint is used, such as biting or pulling hair and refusing to let go.

Remember:

Before choosing a physical intervention, ask yourself: "What is the worst thing that is likely to happen if a protective intervention is not used right now?"

Protective physical intervention or physical positioning is appropriate when:

- The behavior can be safely controlled with intervention
- The intervening caregiver is sufficiently trained and can reasonably expect to achieve safe control.

Communication Matters

- Notify the services coordinator **whenever problematic behavior occurs**.
- Notify the service coordinator **NO LATER THAN the next working day** when a protective intervention is used.
- Notify the services coordinator **IMMEDIATELY** of any protective physical intervention resulting in injury.
- An **incident report MUST BE WRITTEN and forwarded** to the services coordinator within **five working days** of the incident.

Caregivers Must Understand

- The risks and how to manage or minimize those risks
- What intervention techniques should be used in a crisis situation
- How to observe and use supervision levels
- How to identify and utilize the most reasonable response
- How to make good judgment calls that keep people safe
- How internal and external factors influence behavior

Any supports needed to mitigate a person's challenging behaviors must be made by the ISP team and documented in the ISP or in a formal Behavior Support Plan using Person Centered Planning.

Good documentation allows teams to see patterns of behavior, make educated decisions regarding behavior, and evaluate the effectiveness of behavior supports.

Module 9:

Abuse Reporting and Investigation



Abuse Reporting and Investigation

Vulnerable populations protected by mandatory abuse reporting:

- Persons aged 65 and older
- Children
- Adults with Mental Illness
- Adults with Developmental Disabilities
- Adults with Physical Disabilities

Statute and Administrative Rules Governing Abuse

- **ORS 430.731-768**
“Abuse reporting for Adults with Mental Illness or Developmental Disabilities”
- **OAR 407-045-0250-0360 (DD)**
- **OAR 943-045-0250-0360 (MH)**
“Abuse Reporting and Protective Services in Community Programs and Community Facilities”



Definition of Adult:

For the purpose of the above rules an adult is an individual who is:

- 18 years of age or older;
- The alleged abuse victim;
- Is developmentally disabled and / or is

“Currently receiving services from a community program or facility or was previously determined eligible for services as an adult. Received services from a community program or facility or care provider which is licensed or certified by or contracts with the Department”.

- State Operated Community Programs (SOCP)
- Case Management - Service Coordination
- Brokerage Services
- Department funded services such as Group home, foster care, supported living, vocational or ATE services, respite care.

Who Must Report Abuse or Neglect?

Per Multnomah County Administrative rules 023-110-605

Operators, Resident Managers, and caregivers shall report suspected abuse in accordance with MCAR 023-120-100. Operators, Resident Managers, and caregivers shall not, in the act of reporting allegations of abuse or neglect, conduct their own internal investigations with intent to gather details of alleged incidents in order to determine for themselves whether the allegation can be substantiated. Operators, Resident Managers and all caregivers must instead report such allegations to DDS and, if there is concern that a crime has been committed they also must report to the local law enforcement agency immediately. The appropriate agencies will investigate and determine whether an allegation can be substantiated. It is the Operator's responsibility in situations where such allegations have been made to place emphasis on assuring the health and safety of the residents.

ANY public or private official who, while **acting in official capacity** comes in contact with and has reasonable cause to believe that an adult has suffered abuse or, that any individual with whom the official comes in contact while acting in official capacity has abused an adult.

Public or Private Officials

- DHS Staff
- OHA staff
- County Health staff
- CMHP / CDDP staff
- Employees of private agencies contracting with any public body to provide any community services
- Physician's (including interns, chiropractors, naturopaths, etc.)
- Psychologists
- Clergy
- Speech, Physical and Occupational Therapists
- Attorneys
- Nurses, CNAs, CMAs, home health aides, etc.
- Info & referral, crisis, outreach workers
- Licensed clinical social workers (LCSW)
- Peace officers
- Firefighters, Emergency Medical Technicians (EMTs)
- Any public official

Who May be Held responsible for Abuse or Neglect?

- Caregivers
- Providers
- Residential Facilities / agencies
- CDDP / CMHP
- **ANY PERSON** in a **trust relationship** with an adult

Evaluation of a *Trust Relationship*:

- What is the amount and level of contact
- Does the person provide care to the adult?
- Is the contact ongoing and abuse likely to reoccur?

Objective assessment and judgment are needed to determine whether or not a Trust Relationship with an adult exists.

Per Multnomah County Administrative rules 023-120-105

Operators, Resident Managers and caregivers shall exercise all reasonable precautions against conditions that could threaten the health, safety or welfare of adult care home residents. It is prohibited for anyone who lives or works in an adult care home to, abuse, neglect or exploit residents or other occupants. Abuse, neglect or exploitation is a violation of ACHP rules and may subject the offender to civil and/or criminal proceedings. Operators shall be responsible for preventing abusive or neglectful treatment or exploitation of any resident by any occupant in the ACH.

Definitions of Abuse

MCAR 023-120-100 through 023-120-125

Abandonment

“Including desertion or willful forsaking of an adult or the withdrawal or neglect of duties and obligations owed an adult by a caregiver or other person”.

Death of an Adult

“Caused by other than accidental or natural means or occurring in unusual circumstances”

- Screened for neglect, including suicides

Financial Exploitation

“Wrongfully taking the assets, funds or property (including medications) belonging to or intended for the use of an adult.

“Alarming an adult by conveying a threat to wrongfully take or appropriate money or property of the adult if the adult would reasonably believe that the threat conveyed would be carried out”

“Misappropriating, misusing, or transferring without authorization any money from any account held jointly or singly by an adult”.

“Failing to use the income or assets of an adult effectively for the support and maintenance of the adult. Effectively means use of income or assets for the benefit of the adult”.

Involuntary Seclusion

“The involuntary seclusion of an adult for the convenience of a caregiver or to discipline the adult that may include placing restrictions on adult’s freedom of movement by restriction to his or her room or a specific area or restriction from access to ordinarily accessible areas of the facility, residence or program, unless agreed to by the ISP team and included in an approved BSP or in a brokerage plan’s specialized support”.

Exception to involuntary seclusion

“Restriction may be permitted on an emergency or short term basis when an adult’s presence would pose a risk to health or safety”.

Neglect

“Active or passive failure to provide the care, supervision, or services necessary to maintain the physical and mental health of an adult that **may result in physical harm or significant emotional harm to an adult**”.

- “**Services** include but are not limited to the provision of food, clothing, medicine, housing, medical services, assistance with bathing or personal hygiene, or any other services essential to the well-being of an adult”.

“ Failure of a caregiver to make a reasonable effort to protect an adult from abuse”.

“Withholding of services necessary to maintain the health and well-being of an adult which leads to physical harm of an adult”.

Physical Abuse

“ Any physical injury by other than accidental means or that appears to be at variance with the explanation given for the injury”.

“Willful infliction of physical pain or injury”

“Physical abuse is presumed to cause physical injury, including pain, to adults otherwise incapable of expressing pain”.

Sexual Abuse

“An act that constitutes a crime under

- **ORS 163.375** (rape in the first degree)
- **ORS 163.405** (sodomy in the first degree),
- **ORS 163.411** (unlawful sexual penetration in the first degree)

- **ORS 163.415** (sexual abuse in the third degree)
- **ORS 163.425** (sexual abuse in the second degree)
- **ORS 163.456** (public indecency), or
- **ORS 163.467** (private indecency)

“Sexual contact with a nonconsenting adult or with an adult considered incapable of consenting to a sexual act under **ORS 163.315**”.

“Sexual harassment, sexual exploitation or inappropriate exposure to sexually explicit material or language including requests for sexual favors”.

“Sexual harassment or exploitation includes but is not limited to any sexual contact or failure to discourage sexual contact between an employee of a community facility or community program, provider, or other caregiver and an adult”.

Sexual Abuse

“For situations other than those involving an employee, provider, or other caregiver and an adult, sexual harassment or exploitation means unwelcome physical sexual contact and other physical conduct directed toward an adult”.

“Any sexual contact between an employee of a facility or paid caregiver and an adult served by the facility or caregiver”.

- **A caregiver is** an individual or facility that has assumed responsibility for all or a portion of the care of an adult as a result of a contract or agreement”.

“Any sexual contact that is achieved through force, trickery threat or coercion”.

“Any sexual contact between a person with a developmental disability and a relative of the person with the developmental disability other than a spouse or partner.”

- **A relative** means a parent, grandparent, children, brother, sister, uncle, aunt, niece, nephew, half brother, half sister, stepparent or stepchild

Sexual Abuse Exception

“Sexual abuse does not mean consensual contact between an adult and a paid caregiver who is the spouse or partner of the adult”.

Sexual Contact

“ As defined in **ORS 163.305**, ‘sexual contact’ means any touching of the sexual or other intimate parts of the actor for the purpose of arousing or gratifying the sexual desire of either party”

Wrongful Restraint

“A wrongful use of physical or chemical restraint, excluding an act of restraint prescribed by a licensed physician, by an ISP team approved plan, or in connection with a court order”

Wrongful restraint exception

“Does not include physical emergency restraint to prevent immediate injury to an adult who is in danger of physically harming himself or herself or others, provided that only the degree of force reasonably necessary for protection is used for the least amount of time necessary”.

Verbal Abuse

“Includes threatening significant physical or emotional harm to an adult through the use of:

- Derogatory or inappropriate names, insults, verbal assaults, profanity or ridicule;
- Harassment, coercion, punishment, deprivation, threats, implied threats, intimidation, humiliation, mental cruelty, or inappropriate sexual comments”

“A threat to withhold services or supports, including an implied or direct threat of termination of services”.

“Verbal conduct includes but is not limited to the use of oral, written, or gestured communication that is directed to an adult or within their hearing distance, or sight if gestured, regardless of their ability to comprehend”

- In this circumstance the assessment of conduct is based on a reasonable person standard

“The emotional harm that can result from verbal abuse may include but is not limited to anguish, distress, or fear”.

Spiritual Exception

“An adult who in good faith is voluntarily under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner shall for this reason alone not be considered subjected to abuse”.

If any of the abuse occurs, complete an incident report and contact the individuals CDDP service coordinator.

Remember Operator, Resident Manager and caregivers are all considered MANDATORY ABUSE REPORTERS.

- You have the right to immunity if you report in good faith and your report can be anonymous.
- You have the right to be free from retaliation against you for reporting.

If the Office of Investigations and Training (OIT) investigates, then the provider must receive authorization from the Department before conducting any separate (internal) investigation before the formal investigation is complete. All providers are required to report any allegation of abuse to the CDDP representative. The provider and community shall confer about who will notify the guardian (if not the alleged abuser).

Is it Crime or Abuse?

- If you think it's a crime, then you **MUST** call the police / local law enforcement agency.
- Also report the incident to the CDDP
- The investigator will work with the law enforcement agency and / or do an abuse investigation

What Happens During an Abuse Investigation?

- Initial report is made to the CDDP
- Protective Services assessed and provided
- OIT and licensing are notified
- Investigator is assigned
- All relevant evidence is reviewed
- Interviews occur
- A conclusion is reached
- Abuse investigations and Protective Services Report including required actions is written
- Case closed

This is all completed within 45 days from the initial report unless the investigator requests and is granted an extension from OIT.

Protective Services

- Alternate living arrangements
- Physical and mental status evaluation
- Medical services
- Legal services
- Financial services
- Advocacy services
- Counseling
- Victim Assistance Programs
- Other services as necessary

If You Are Interviewed in an Investigation

- The interview is part of **Mandatory Reporting**
- All interviews and evidence will be included in the final report
- Be honest
- Provide as much information as you can
- It is OK to say "I don't know"
- It is OK to ask for a break
- It is preferable not to talk to others about the case (at the least, stick to what you know)
- You may ask the investigator to review the interview with you for accuracy
- Contact the investigator if you have further information
- The investigator may contact you for a follow-up interview

The Final Report

The report is confidential, but some information is disclosed and is redacted:

- The named of the victim and witnesses are removed
- Any clinical or medical records / summaries
- Personal health information

Anyone can request in writing from the CDDP or OIT, a redacted copy of the final report.

Disability Rights Oregon (DRO), licensing agencies, and law enforcement can receive **UNREDACTED** copies.

Confidentiality

- ORS and MCAR allow review of program and facility records
- Releases of information are not necessary
- Review your consent to treatment form

Module 10: Safety



Safety

Fire Evacuation Drills

The provider must conduct **unannounced evacuation drills** when individuals are present, one every **90** days with at least **one drill per year occurring during the hours of sleep**. Drills must occur at **different times of the day**, evening and night with exit routes being varied based on the location of the simulated fire.

Fire Drill Documentation

- Written fire drill documentation is required
- Documentation must be made at the time of the evacuation drill and kept by the provider for at least 2 years following the drill.
- Fire documentation must include:
 - The date and time of the simulated drill
 - The location of the simulated fire and exit route
 - The last names of all individuals and providers present on the premises at the time of the drill
 - The type of evacuation assistance provided to individuals
 - The amount of time required by each individual to evacuate the house to the safe location
 - The signature of the caregiver conducting the drill

The provider must demonstrate the ability to evacuate all individuals from the foster home within 3 minutes. If there are problems in demonstrating this evacuation time, the licensing authority may apply conditions to the license that include reduction of individuals under care , additional staffing, increased fire protection or revocation of the license.

The Support plan and Emergency Preparedness Plan for the individual upon entry into the adult care home must document that, within 24 hours of arrival, each new individual receives an orientation to basic safety and is shown how to respond to a fire alarm, and how to exit from the adult care home in an emergency.

Posting a Floor Plan

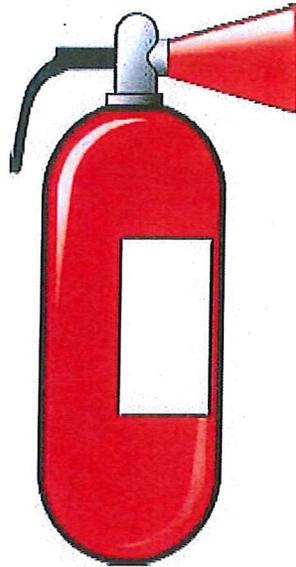
The provider will provide, keep updated, and post a floor plan on each floor containing room sizes, location of each individual's bed, window, exit doors, resident manager or provider's sleeping room. Smoke detectors, fire extinguishers, escape routes and wheelchair ramps. A copy of this plan must be submitted with any initial application and updated to reflect any change.

Flashlights

There must be at least one plug in, rechargeable flashlight available for emergency lighting in a readily accessible area on each floor including the basement.

Fire Extinguishers

Portable fire fighting equipment. At least one 2A-10BC rated fire extinguisher must be in a visible and readily accessible location on each floor, including basements, and must be inspected at least once a year by a qualified worker that is well versed in fire extinguisher maintenance. All recharging and hydrostatic testing must be completed by a qualified agency properly trained and equipped for this purpose and documentation maintained.



Hazardous Material MCAR 023-100-900

- Flammable and combustible liquids and hazardous materials must be safely and properly stored in original, properly labeled containers, or safety containers, and secured to prevent tampering by individuals and vandals.
- Hunting equipment and weapons on the premises of a foster home must be stored in a locked permanent enclosure. The permanent enclosure must be located in an area of the home that is not readily accessible to individuals and all ammunition must be stored in a separate, locked location.
- Smoking regulations will be adopted to allow smoking only in designated outdoor areas per the Oregon Indoor Clean Air Act. Ashtrays of noncombustible material and safe design will be provided in areas where smoking is permitted.
- Cleaning supplies, medical sharps containers, poisons and insecticides must be properly stored in original properly labeled containers in a safe areas away from food, preparation and storage, dining areas and medications.



STORAGE OF FLAMMABLE LIQUIDS, HAZARDOUS SUBSTANCES, AND HUNTING AND SPORTING EQUIPMENT

Flammable and combustible liquids and hazardous materials shall be safely and properly stored in original, properly labeled containers or safety containers and secured in areas to prevent tampering by residents or vandals. Storage of flammable liquids is prohibited in living areas.

Cleaning supplies, poisons, insecticides, etc. shall be stored in original labeled containers, in a safe area that is not accessible to residents. Kitchen cleaning supplies may be kept in a separate enclosed space in the kitchen.

Firearms must be stored, unloaded, in a locked cabinet. The firearms cabinet must be located in an area of the home that is not accessible to residents. Ammunition must be secured in a locked area separate from the firearms. Other hunting and sporting equipment (i.e. knives, swords, arrows, and martial arts weapons) must be stored in a safe and secure manner.