COMMUNITY MENTAL HEALTH SERVICES OF MUSKEGON COUNTY

Practice Guideline

No. 12-007

Prepared by:

Effective Date: August 1, 2005
Revised: June 5, 2013

Cyndi Blair
Medical Services Manager

Subject: Nursing Guidelines

Approved by:

_____
Julia Rupp, Executive Director

I. PRACTICE GUIDELINE:

Nursing Guidelines

II. PURPOSE:

To provide education and direction to individuals in order to promote consistent skills for healthy living.

III. APPLICATION:

This practice guideline applies to all CMH employees, contracted providers, consumers, and caregivers (family members, AFC home operators, etc).

IV. PROTOCOL/GUIDELINE:

The Nursing Guidelines are attached.

COMMUNITY MENTAL HEALTH SERVICES OF MUSKEGON COUNTY

NURSING GUIDELINES

Community Mental Health Services Of Muskegon County
Nursing Guidelines
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Community Mental Health Services of Muskegon County

Nursing Consultation Guidelines

Purpose

To provide nursing consultation guidelines and examples of situations they are authorized to resolve.

Application

These guidelines apply to all CMH staff and contracted staff/providers working within the CMH network requiring consultation with the CMH nurse.

Definition

"PRN per protocol": Applies only to a medication prescribed by a CMH prescriber when the order is written for "prn use per protocol". "PRN" refers to as needed. "Protocol" is a specific plan written for staff to refer to for specific criteria to be considered prior to administration of the "prn" medication. When it has been determined there is need for a behavioral plan, the protocol for the administration of the PRN behavioral medication will be included. When it has been determined there is no need for a behavioral plan, a protocol with instructions for the administration of the PRN behavioral medication is written by the nurse as part of the health care plan. This applies to a unique population of clients served at CMH to give guidance to CMH staff and contracted staff for specific behavioral issues.

Procedure

1. Consultation with CMH nursing staff is always allowed and encouraged if in doubt about any medication or medical condition.
2. Consultation should occur with the assigned home nurse during CMH regular business hours whenever possible. If nurse not available, may leave voice message on desk phone.
3. All after hour telephone calls to the on-call nurses, should be approved by a Residential Corporation home supervisor/designee for clients residing in a specialized residential setting.
4. Care Plans will be in place in the home for every client's known health/medical related problems for the home supervisor/staff to follow when specialized nursing has been authorized.
5. On-call nursing staff can be consulted to determine if an emergency room visit is warranted in the case of injury or illness. The on call nurse will determine if the client needs to be transported to the Emergency Room for medical intervention. The home supervisor will notify/communicate with the guardian regarding the client's Emergency Room visit prior to treatment and to report findings and treatment after the visit.
   If after "on-call" hours, the home supervisor will use his/her best judgment to determine whether client needs seek immediate medical attention.

6. Consultations must be documented in the client's record on a progress note, or Incident Report if appropriate, written by the person who initiated the consultation. The note must include the reason for the call, the information received from the nurse, and the subsequent action taken by the caller.
7. The nurse must document the call within the first business day after receiving the call.
8. A nursing consultation should occur and be documented in the following situations:
   A. Medical Issues: (if after on-call hours, client must be brought for immediate medical attention)
      1. A client reports, or staff observe, a medical issue that, left untreated could endanger the client if left until the nurse is available during regular working hours, and staff are unsure what action to take.
      2. The client's health care plan stipulates it in the Plan of Action such as for continued seizure activity after medication administered.
      3. The client has an elevated temperature greater than 100 degrees axillary for more than 24 hours if not relieved with medications.
      4. The client has cold symptoms, vomiting, and/or fatigue for more than 24 hours.
      5. The client is noted with any rectal, vaginal (other than menses), or penile bleeding.
      6. The client is noted to be vomiting red blood, coffee ground, or vomitus contains medications.
      7. The client is noted with swelling of the genital area.
      8. The client is noted with a rash especially after starting a new medication.
      9. The client may be having a possible medication reaction.
      10. The client is noted with any respiratory problems including shortness of breath, cyanosis, congestion, or persistent cough not relieved with medication.
   B. Trauma Issues:
      1. The client has received an injury to the head. (Remember: if "serious head injury symptoms" – Page 2 of head injury protocol are present, call 911)
      2. The client is noted with a bruise that includes swelling to the area.
      3. The client is noted with any new swelling of the limbs.
      4. The client is noted to be favoring or limiting the use of his/her limbs; possible fracture.
9. The home nurse will discuss the medical/medication/illness/injuries occurring during the weekend with the home supervisor/staff every Monday morning.
10. Pharmacy Issues: (Notify nurse during on-call hours. After on-call hours, leave a voice message for on-call nurse)
      1. A prescribed medication was not administered within one half hour before or one half hour after the designated time and now staff wants to administer the dose or the resident requests taking the dose.
      2. The staff has contacted the pharmacy and cannot obtain an adequate supply of medication and this will result in the client going without medication.
      3. Staff administering the medication needs clarification on the correct dose, strength, dispensing time or name of medication.
      4. The client has missed a dosage of medication due to vomiting or refusal.

#2

Community Mental Health Services of Muskegon County

Protocol

Prepared by:
Maureen Reilly, ICP

Effective: February 2004
Revised: May 2013
Subject: Consumer Attendance at Day Programs Re: Illness

Purpose

To prevent the spread of infection and to promote consumer comfort.

Procedure:

I. Consumers should remain home when one or more of the following symptoms are present. (This list is not all-inclusive nor absolute. Consultation with a nurse may be necessary for final determination.)

II.

* a. Fever
* b. Diarrhea (frequent, watery stools)
* c. Vomiting
d. New onset of unexplained rash
e. Cramps, stomach ache, or other pain that persists
f. Heavy, hacking cough
g. Post surgical recovery/medical procedure sedation
* h. Persistent redness/discharge from eyes
* i. Prescribed antibiotics – first 24 hours

- A consumer should remain home if they have any symptoms or conditions that would interfere with their customary participation in programs.
- If the consumer arrives at Day Program with these symptoms or develops them while there, the group home/supports coordinator will be contacted by the site supervisor/designee about the need for the consumer to be transported home.

* If starred conditions apply, consumer needs to remain home for 24 hours.

III. Consumers who have a communicable disease (i.e. lice, scabies, MRSA) should not attend day program until they are no longer contagious. Determination of this should be made by a physician or nurse.

IV. If a communicable disease in sufficient numbers exist in a Day Program, the homes will be notified after consultation with the CMH Infection Control Practitioner.

Community Mental Health Services Of Muskegon County
Nursing Guidelines

LOOSE STOOLS OR DIARRHEA

If two or more loose stools occur within a two hour period:

Check temperature initially and at least every 4 hours while condition persists.

1. Clear to full liquid diet for 4-6 hours.
   Laxatives should be held for 24 hours after last stool.
2. Small amounts of soft foods may be used with medications.
3. If liquid diet is tolerated without further loose stools, progress to a BRATT diet. (Bananas, Rice,
   Applesauce, Toast or Tea – in any combination.)
4. Progress to scheduled menu meal at the next scheduled meal time. Avoid spicy or difficult to
   digest foods.

Call RN or nurse on call if loose stools persist or progress to diarrhea (watery stools), or if stool is red, or black, or if temperature is over 100.

If after on-call hours, leave a voice message for RN. If active bleeding, black tarry stools or excessive watery stools – more than five in an 8-hour shift, client should be taken to ER for medical evaluation (of if client becomes listless).

VOMITING

If vomiting occurs, check temperature. If taking oral temp, wait 5 minutes after vomiting occurs. Give nothing by mouth for 2-4 hours. If axillary temp, be sure to add 1 degree; if rectal, subtract 1 degree.

After 2-4 hours, offer clear liquids. Progress to BRATT diet, bland diet, and then normal menu.

If vomiting recurs, repeat the cycle.

Check temperature at least every 4 hours while condition persists.

Call RN or nurse on call immediately if temperature over 100, vomiting persists beyond 4 hours, a medication time is involved, or if emesis contains blood or coffee ground material, or medication during on-call hours.

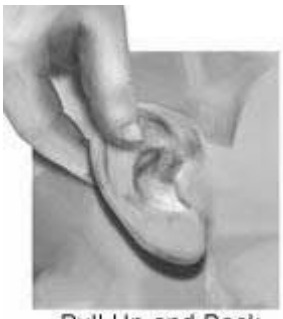
After on-call hours, if temperature is above 101 degrees and doesn't respond to Tylenol, vomiting beyond 4 hours, or vomiting blood or coffee ground emesis – go to ER.

#4

Community Mental Health Services Of Muskegon County
Nursing Guidelines

Instilling Ear Drops

1. Wash hands.
2. Turn the affected ear up toward the ceiling, best accomplished by lying down.
3. For Adults: Hold the upper, outer ear and gently pull upward and backwards.
   For Children: Hold the lower, outer ear and gently pull down and backwards.
4. Place prescribed amount of solution into that ear canal.
5. Pump on the nipple (tragus) for 15 seconds. This is the single most important step.
6. Wait for 3 minutes with that same ear toward the ceiling.
7. Now turn that same ear down toward the floor. Allow 3 minutes for drainage.
8. Wipe off the spillage of drops with a dry cloth.
9. Repeat this procedure on the opposite ear, if necessary.
10. Go about your business; do not use cotton in your ear unless prescribed by the physician.
11. Repeat procedure for each administration.



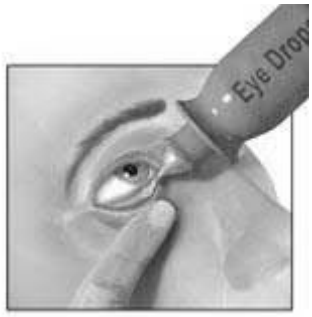
Pull Up and Back

Community Mental Health Services Of Muskegon County
Nursing Guidelines

Instilling Eye Drops

1. Shake well before using.
2. Wash hands.
3. Tilt head backward or lie down and gaze upward.
4. Gently grasp lower eyelid below eyelashes and pull the eyelid away from the eye to form a pouch.
5. Place dropper directly over the eye. Avoid contact of the dropper with the eye, finger or any surface.
6. Look upward just before applying a drop.
7. After releasing the drop or prescribed amount, look downward for several seconds.
8. Release the lid slowly.
9. Close eyes gently for 1-2 minutes. Closing the eyes tightly may cause the drug to spill out of the eye.
10. Apply gentle pressure with fingers to the bridge of the nose (inside corner of eye). This prevents drainage of solution from the intended area.
11. Pat excess, Do Not Rub the eye. Minimize blinking.
12. Do not rinse the dropper.
13. Do not use eye drops that have changed color.
14. If more than one type of eye drop is to be used, wait at least 5 minutes before using the second agent.
15. When the instillation of eye drops is difficult (children, adults with particularly strong blink reflex), the close-eye method may be used. This involves lying down, placing the prescribed number of drops on the eyelid in the inner corner of the eye, then opening the eye so that drops will fall into the eye by gravity.

Gels/Ointments: Use solutions before ointments. Ointments prevent entry of subsequent drops. Apply ointment as above, placing the line of ointment in the pocket formed by the lower lid.



Using Eyedrops Correctly

Community Mental Health Services Of Muskegon County
Nursing Guidelines

FOOD SAFETY

Separate, don't cross-contaminate. Always thoroughly wash cutting boards, utensils and dishes in between uses for raw animal foods (meat, poultry, fish, pork, and eggs) and fresh produce or other foods that will not be cooked before serving. Another option is to use separate cutting boards, utensils and dishes for raw animal foods and other fresh foods.

- Cut your losses with old cutting boards. Discard any cutting boards with deep grooves, cuts or cracks. These crevices make good hiding places for bacteria.

- Follow the thaw law. Only thaw frozen foods in the microwave or refrigerator. Do not thaw on the kitchen counter; room temperature puts food at risk for bacterial growth.

- To marinate, refrigerate and separate. Do not marinate raw animal foods at room temperature (put them in the refrigerator), nor reapply marinade to foods after they are cooked.

- Use your noggin with eggnog. Only drink pasteurized or boiled homemade eggnog. Drinking raw eggnog may cause food borne illness.

- Consider the cider. Unpasteurized apple cider should be heated to 160 degrees or boiled before drinking to avoid risk of E. coli contamination. Cider that is labeled pasteurized is safe.

When cooking food:

- If hamburger is not well done, have none. Always cook ground beef to an internal temperature of 160 degrees or until its juices run clear. Hamburgers should have no pink on the inside.

- Don't foul up the foul. Cook poultry to an internal temperature of 180 degrees in the thigh or 170 degrees in the breasts, and ground chicken or turkey to 165 degrees or until its juices run clear. Poultry dressing or stuffing should be cooked to 165 degrees.

- Cook eggs-cellently. Always cook eggs until they are firm, not runny. Egg dishes should be cooked to 160 degrees before eating. Keep eggs refrigerated until ready to cook.

- Any recipe that calls for raw eggs should have cooking instructions or a warning that eating uncooked dishes with raw eggs may cause food borne illness. In other words, it's not a good idea to sample holiday cookie dough!

- Don't cook ham under 160 degrees. Always cook pork thoroughly until at least 160 degrees or its juices run clear.

- If it doesn't flake, it's fishy. Fish should flake with a fork when it is properly cooked.

- Leftovers should be feeling hot, hot, hot! Heat leftovers to 165 degrees or until steaming hot.

- Wrap before a zap. When using the microwave, put food in a microwave-safe container and cover with a microwave-safe lid or plastic wrap so steam can aid thorough cooking. Vent the wrap or lid and do not let it touch the food.

- Rotate the plate. Stir and rotate food in the microwave and follow recommended standing times to ensure even heating. If there is no turntable in the microwave, rotate the dish once or twice during cooking.

Source: Institute of Food Technologists
5/24/01

Community Mental Health Services Of Muskegon County
Nursing Guidelines

Head Injury = Any injury to the head, including lacerations and bruises to the head, scalp or face or any fall that was not witnessed.
If a person experiences a head injury, check level of consciousness (see back of page), amount of bleeding, overall condition. If the person loses consciousness, or if it is a serious emergency, 911 should be called first.

If there is a laceration, attempt to stop bleeding with direct pressure. If there is heavy visible bleeding or spurting blood that does not slow significantly with direct pressure for 30 seconds or less, **call 911,** this is a serious emergency and the person should be transported to the emergency room by ambulance.

A wound that is deep enough to gape open even though the bleeding stops, should be evaluated for sutures at the doctor's office, the med stop, or the emergency room.

If there is noticeable swelling, apply ice.

Check Vital Signs: Blood pressure, Pulse, Respirations

Call on-call nurse for all head injuries (see definition above) within ½ hour of injury.

If after on-call hours, leave a voice message for the home nurse. If symptoms listed on next page are present, call 911.

Treatment protocol: (may be modified by R.N. or Physician based on consumer needs)

- Close observation every 15 minutes for one hour, then every hour for 8 hours, then every 4 hours for the next 16 hours. Observations should be documented in progress notes.
- If client is leaving the place the injury occurred, a responsible care giver (such as: school staff, family, home staff, etc.), should be informed of the head injury.
- Check blood pressure, respirations, and pulse. Initially every hour for four hours, and then every two hours for the following eight hours after the injury.
- Provide quiet environment and rest.
- Keep head and shoulders elevated.
- Tylenol as ordered. No aspirin.
- Apply ice pack 20 minutes on the site, 20 minutes off, as tolerated by the client, during wake hours for the first 24 hours to reduce swelling and relieve discomfort.

Serious Head Injury Symptoms

Observe for and call 911:

1. Change in consciousness or increased confusion.
2. Any change in normal behavior or appearance.
3. Severe and persistent headache.
4. Tingling, numbness in extremities.
5. Loss of movement in any body part.
6. Unusual bump or depression in head.
7. Blood or fluid from ears or nose. (Do not plug nose or ears.)
8. Onset or increase in seizures.
9. Impaired breathing.
10. Vision or speech disturbance.
11. Unsteady gait.
12. Bruising around eyes or behind ears.
13. Abnormality of pupils or eyes.
14. Nausea or vomiting.

COMMUNITY MENTAL HEALTH SERVICES OF MUSKEGON COUNTY
Nursing Guidelines

GUIDELINES FOR MINOR CUTS, ABRASIONS, AND HUMAN/ANIMAL BITES

Most minor cuts and abrasions can be treated at home.
If injury is the result of a bite, a nurse must be notified immediately during on-call hours.
If after on-call hours, contact the home supervisor for guidance immediately.

PROCEED TO EMERGENCY CARE IF ANY OF THE FOLLOWING OCCUR:

- Blood is spurting from the wound
- The consumer has lost more that ½ of a cup of blood
- The injury is deep, exposing muscle or bone
- A cut that is longer than an inch
- Bleeding does not stop after 20 minutes of pressure

If none of the above conditions apply, follow the guidelines below for minor cuts and abrasions:

- Use a sterile gauze or a clean cloth to cover the wound. Apply pressure to the wound if necessary to stop the bleeding.
- Clean the wound with soap and water. It is o.k. if it gets in the wound, but it may hurt a bit.
- Following the consumer's health care plan or physician's order, apply specified cream/ointment on the clean, dry wound.
- Cover the wound completely with a gauze dressing or regular bandage.
- The dressing should be changed daily, or whenever it appears soiled.
- An ice pack may be applied, (20 minutes on the site, 20 minutes off, as tolerated by the client, during wake hours for the first 24 hours), to relieve initial pain if necessary.
- Notify the nurse of the injury and document it in the staff progress notes and fill out an incident report. If after on-call hours, leave the home nurse a voice message.
- If the consumer develops increased redness, continued drainage, increase in swelling, a fever or streaking redness, notify the nurse immediately. These are signs of infection that need to be addressed immediately. If after on-call hours, client must be taken to the ER for immediate medical attention.

Community Mental Health Services Of Muskegon County
Nursing Guidelines

NOSEBLEEDS

Nosebleeds are a common and disturbing nuisance in our particular climate. The peak time for nosebleeds occurs between September and April every year when we turn on the heat, and thus, make our homes dry. That dryness of the nasal cavity lining promotes itching and rubbing of the nose, which then leads to broken blood vessels in the front of the nose (on the inside of the front of the nose). Some people have allergies and itchy noses year-round; and bloody noses year-round.

This itching and rubbing of the nose may occur during the day (creating a small amount of blood which dries to a clot) while the bleeding can occur at night, at the time that the clot is rubbed off while turning in bed. The clot may be loosened while showering or stooping to tie shoelaces. The bleeding cannot "spontaneously" occur without breakage of the wall of the blood vessels in the nose. That breakage is usually caused by a finger or the side of the hand (or even a balled up fist), or in some adults by markedly elevated blood pressures.

MANAGEMENT

1. Gently blow your nose. This will dislodge clots which may be holding your blood vessel open.
2. Flex the neck (put your chin on your chest)
3. Firmly pinch the soft, fleshy tip of the nose and hold it for 5 minutes (by the clock).
4. Release the tip and observe for 2 seconds to see if bleeding recurs.
5. If bleeding resumes, repeat Step 3.
6. Release again and, if bleeding resumes, hold onto the nasal tip and go immediately to the hospital for treatment.
7. If, while pinching the nasal tip, bleeding continues and fills the back of the mouth or blood runs out of the mouth, go immediately to the hospital for treatment; likely, nasal packing will occur.

Community Mental Health Services Of Muskegon County
Nursing Guidelines

Charting Guidelines

1. Print or write clearly.
    - *Use correct spelling and punctuation*
    - *Clearly state what you mean – use quotes, avoid opinions*

2. Always use ink
    - *Always use black*
    - *Sign entries with first and last name and title*
    - *Do not leave blank lines or spaces*

3. Document time and date.
    - *General end of shift charting –Chart a block of time, i.e. 7am to 3pm.*
    - *Specific incident charting-Chart the time you are doing the charting and the actual time the incident occurred.*

4. Flow charting
    - *Used to record unusual or significant events happening over a period of time*
    - *The exact time of each entry is used as a record of the sequence of events.*
    - *An entry is made as often as situation dictates (If vital signs are to be taken every 15 minutes, entries will be made, as directed, until situation is stable.)*

5. Be brief, specific, objective.
    - *Use specific words to make a clear statement*
    - *Use complete sentences*
    - *Avoid slang*
    - *Avoid abbreviations, unless on approved list of abbreviations*
    - *Avoid opinions.*

6. Chart as soon after an incident happens as possible
    - *Important details are not forgotten if you chart immediately*

When you chart an incident, chart what you did about it and whom you reported it to.

- *(Example: if you write that a client complained of a headache, chart what you did to help the client relieve his headache, such as administered PRN Tylenol. Record whether you notified anyone, and if the PRN was effective in relieving the headache.)*

7. Record any accident or unusual incident.
    - *Complete an Incident Report*
    - *Document in the progress notes expanding on the incident or accident*
    - *Document what first aid or medical advice was given, and how tolerated*
    - *Document any unusual incident reported to you by day program, family, etc.*

8. Avoid "basket terms" and generalizations
    - *Describe what you see and hear*
    - *Avoid statements such as "Looks Depressed"*
    - *Use descriptions such as, moving slowly, mumbling under breath, head hanging down*

9. Use "non-judgmental" charting
    - *Write what happened in objective terms*
    - *Write what the client actually said or did*
    - *Be descriptive and use quotes*

10. Never erase, scribble over or use white-out
    - *If a correction must be made, cross out word or phrase with one line, write error above it and your initials, then proceed with charting.*

11. Document follow-up.
    - *If client has been experiencing a problem, i.e., has been ill-be sure to address this in your charting*

- *When a client starts a new medication,*

1. *Chart effectiveness*
2. *Chart any unusual response or possible side effects you may see*
3. *Chart who you reported to*

12. Medical appointments
    - *Chart why client went to the Doctor*
    - *Chart what medication or treatment the doctor prescribed*
    - *Chart any comments made by the doctor that you feel may be important*
    - *Chart if prescription was taken or faxed to the pharmacy*
    - *Notify assigned CMH nurse of new physician orders*
    - *Document that you notified the RN*
    - *Record any other medical appointments, lab visits, and dental or podiatrist appointments, wheelchair clinic, brace clinic, etc.*

13. When referring to another person in your charting:
    - *If a client, use first name and case number*
    - *If not another client, use full name and title.*

SPECIFIC EXAMPLES:

Include clear information in your charting and when writing an Incident Report: what you observed, what you did about the problem, who you reported it to, and any other pertinent information.

Wounds/Infections/skin breakdown:

Do you note drainage from the wound? What color? How much? Is there redness, swelling, or anything else unusual? Did you treat the wound with cleansing, a PRN ointment, a dressing, or any other treatment you were instructed to do when you reported it to the RN? Do you know how the injury happened?

Rashes:

Is the rash flat or raised? Is it all-over or scattered? Blotchy? Do you think the client came in contact with a substance that may have caused the rash? Did you treat the rash with a PRN treatment per a health care plan or as ordered? (See med sheets) Who did you notify about the rash? Was it reported to the RN?

Falls:
Do you know how the fall happened? Did you witness the fall?
Describe the fall: how the client landed, whether they struck a body part on an object, such as a table. Does it involve a head injury? Is there loss of consciousness? Do a body check immediately for any evidence of injury and document what you find. Take vital signs so that when you notify the RN, you can report these. Document what you did.

Remember that an injury may not be evident until later - chart who you reported it to for follow-up if you are leaving your shift. Is the client favoring any limbs? Is there complaint of pain or discomfort, or behavior changes that would make you suspect pain or discomfort such as facial grimacing or crying out? Is there swelling, warm to touch, unusual movement or redness of any area?

If the fall involves a head injury, or the fall was unwitnessed, refer to head injury guidelines.

Vomiting:
How soon after medications were administered? Do you see any intact meds in the vomitus? What color is the vomitus? Texture? How soon after a meal? Are there any other symptoms? Take the clients temperature and be ready to report this when you report the vomiting. Document any instructions given. Did you follow the vomiting protocol?

Diarrhea:
What color? How much or how many loose or watery stools? If black and tarry or contains red blood, did you report it to the RN immediately? Unusual odor? Did you check the client's temperature? Are you holding any stool softeners/laxatives for the day?

Coughing/cold symptoms:
Is the cough productive or non-productive? Does it sound loose, dry, hacking, barking, or wheezing? What color is the sputum or nasal discharge? Is the client having any unusual respirations? Noisy or fast? Did you check vital signs or temperature? Do you note any other symptoms? Did you give a PRN med? Did you report the symptoms to the RN?

Seizures:

Did you document all observed seizures on the seizure record? Did you also document any that were reported to you by family members or others if client was on Leave Of Absence from the home or on an outing with others (record that they were reported to you, that you did not observe the seizure) in notes as well as on seizure record? Did you follow a Health Care Plan or seizure protocol for PRN medication such as Diastat? Did you report the seizure (s) to anyone? Did you check the client over for any injuries? Was there anything unusual about the seizure activity?

If the client has no history of having seizures, call 911.

#11

COMMUNITY MENTAL HEALTH SERVICES OF MUSKEGON COUNTY

Nursing Guidelines

PHYSICIAN APPOINTMENT INSTRUCTIONS

1. **KNOW WHAT YOU ARE TAKING THE CLIENT TO THE DOCTOR FOR. If you don't know, call your supervisor or nurse to find out.**
2. **ARRIVE AT THE DOCTOR"S OFFICE AT LEAST 10 MINUTES EARLY!**
3. **BRING WITH YOU:**
    - **Physician's Appointment/Communication Form**
    - **List of allergies**
    - **Current medication administration record, so you can show what medications the client is currently taking**
    - **Any other pertinent information (Current lab reports, seizure records, blood sugar records, etc)**
    - **Medicaid/Medicare/private insurance cards**
4. **IF THE DOCTOR ORDERS A NEW MEDICATION, LAB, OR PROCEDURE:**
    - Remember-you can't take a verbal order- **make sure the doctor writes the order on a physician's order form-either our physician's orders, or his order pad. If it is late in the day, and the doctor is ordering something he wants the client to start on today, you may have to get it filled at a local pharmacy- the order must be on a regular physician script pad from the doctor's office.**
    - **Ask the doctor to write on the progress notes or the Appointment/ Communication form.**
    - **If there is a new prescription, NOTIFY THE HOME RN, OR, IF UNAVAILABLE, THE ON-CALL RN during on-call hours. After hours, leave message for on-call nurse.**
    - **Take the prescription to a local pharmacy to have filled (if on a regular prescription), or fax the order to St Mary's Pharmacy 1-800-541-3972. (If St Mary's is the pharmacy you use.)**
    - **You may be asked to write the order on the Medication Administration Record from the pharmacist's label on the bottle. Don't try to figure out what the doctor wrote—you may not be able to interpret it correctly. Leave a note for other staff.**

- **Read the teaching sheet delivered with the medication from the pharmacy. Check med sheet/blue chart for listed allergies. Notify RN if you have a question or see a med has been ordered that the client is allergic to. Monitor for possible side effects. Notify RN if you see any of the listed side effects, or note anything unusual after starting a new medication.**
- **Monitor temperature, vital signs, as instructed. Anyone starting a new antibiotic will need their temperature checked once a shift while on the antibiotic.**

#12

COMMUNITY MENTAL HEALTH SERVICES OF MUSKEGON COUNTY
Physician's Appointment / Communication Form

Date _____ Name _____ Case No. _____
Date of Birth _____

☐ Nursing – 376 E. Apple Ave., 724-3699, Fax 724-3327
☐ Brinks Hall, 155 E. Apple Ave., 724-6040, Fax 724-6042
☐ Indian Bay Residence, 8770 Indian Bay Road, 894-6400, Fax 893-3021

Appointment Date _____ Time _____ Physician _____
Location _____
Current Medications: ☐ See Attached Medication Sheet

_____
_____
_____

Reason for Appointment / Communication / RN Comments:

_____
_____
_____
_____
_____
_____
_____
_____

Staff / RN Signature Date

Findings / Plan / Restrictions: (Please document findings below)

_____
_____
_____
_____
_____
_____
_____

Follow up Appointment? _____ Keep home from school/work? ☐Y ☐N ☐N/A

Physician Signature Date

C204 (Rev. 09/22/10)
(Treatment Activity/Other)

Community Mental Health Services Of Muskegon County
Nursing Guidelines

RAZOR USE

- Never attempt to shave a client when they are agitated.
- All razors must be kept locked away out of the reach of clients
- All used, disposable razors must be disposed of according to licensing guidelines. If a Sharps Container is available, place the used razor in the container and this container must be kept locked away and out of the reach of clients.
- Do not share razors. Each client must have their own.

Community Mental Health Services of Muskegon County **#14**
Procedure

No. 06-018

Effective: August 1, 2005
Revised: May 4, 2011

Prepared by:

Cynthia Blair, RNBC
Senior Nurse

Subject: Responding to Medical Emergencies/ Unusual Medical Events

John North, Executive Director

I. PURPOSE

To establish clear guidelines that will enable CMH and contract staff to respond promptly and effectively to medical emergencies and unusual medical events that may occur in CMH facilities or under contract with CMH.

II. APPLICATION

All CMH staff and contracted providers

III. DEFINITIONS

Medical Emergency: A potentially life threatening injury or illness

Unusual Medical Event: Any incident that could or does result in the need for medical treatment, including those related to the use of medication.

Residential Facility: A residential facility run or contracted by CMH that has an on-call nurse available.

Day Program Facilities: CMH operated facilities providing skill building activities for individuals with Developmental Disabilities.

CMH Outpatient Service Sites: CMH operated facilities providing out patient services. These sites include: Assertive Community Treatment, Clubhouse, John Halmond Center, County Mental Health Center, and Youth Services.

Health Care Professional: Physician, Physician Assistant, Nurse, or Nurse Practitioner.

Potential Poison: Anything that a person eats, breathes, or touches, that could cause illness or death.

STAT: A universal term that is taught to Health Care Professionals that a medical situation that requires immediate attention has been identified.

IV. PROCEDURE

A. Medical Emergencies:

1. The first person on the scene will:

   a. Survey the area to determine if it is safe and then check the victim. Immediately call 911 or designate a bystander to do so. ***Do Not call 911 if the event is a drill and not an actual event***.

   b. If possible, designate someone to meet the First Responders to direct them to the location of the ill or injured person.

   c. Perform First Aid if needed and trained in it, otherwise attempt to find someone who can. If a healthcare professional is available, summon them. Use Universal Precautions at all times.

   d. Stay with the individual and reassure them as much as possible. Do not move them unless the location becomes unsafe.

B. Unusual Medical Events:

1. Determine if any treatment is needed and, if possible, provide treatment within the scope of one's training.

2. Instruct the individual/caregiver to monitor for signs and symptoms related to the illness/injury.

C. Documentation and Reporting:

1. Notify your supervisor.

2. Document actions on the appropriate forms (Progress Notes, Incident Report Form, Muskegon County General Accident Form)

D. Residential Facilities

1. In the case of a medical emergency concerning an individual who resides in a CMH residential facility, staff will also notify the CMH primary worker, nurse and appropriate supervisor.

2. In the case of an unusual medical event concerning an individual who resides in a CMH residential facility, the staff will immediately inform the CMH nurse/on-call nurse and appropriate supervisor. The nurse will take appropriate action per procedure. Residential staff will also notify the CMH primary worker.

3. In the case of an unusual medical event/medical emergency occurring in a residential home, the home supervisor or the primary worker will notify the individual's legal representative.

E. Day Program Sites

1. In the case of a medical emergency concerning an individual receiving CMH services, Skill Building Day Program staff will notify the CMH support coordinator, nurse, and primary caregiver.

2. In the case of an unusual medical event concerning an individual receiving CMH services, the Skill Building Day Program Staff will immediately inform the CMH nurse/on-call nurse. The nurse will take appropriate action per procedure. Skill Building Day Program Staff will also notify the CMH support coordinator and primary caregiver.

3. In the case of an unusual medical event/medical emergency occurring at a Skill Building Day Program site, the program staff or primary worker will notify the legal representative of the individual receiving services.

F. CMH Outpatient Service Sites:

1. In the case of a medical emergency, the Healthcare Professional will notify appropriate staff and/or significant persons involved (i.e., parent, spouse, family, friend).

2. In the case of an unusual medical event, staff will notify a CMH nurse on site or page the on-call nurse and leave a message if between 11:00 p.m and 7:00 a.m. The nurse will take appropriate action per procedure. The nurse will notify the appropriate worker and/or significant others (i.e. parent, spouse, family, friend).

G. If CMH staff or Contracted Providers are in a situation where they have to make a judgment call, they are urged to error on the side of caution until the event is completely investigated and/ or resolved.

H. Nursing Guidelines

1. In the case of Medical Emergencies the CMH nurse shall:

a. Assess and determine necessary treatment.

b. Provide necessary treatment within the scope of their training.

c. Provide emergency medical services pertinent information when they arrive on the scene.

d. Document actions taken on all appropriate forms (Nursing Progress Notes, Incident Report, Accident Report, etc.).

2. In the case of Unusual Medical Events the CMH nurse shall:

   a. Assess and determine necessary treatment.

   b. Provide necessary treatment within the scope of their training.

   c. Instruct individual/care giver to monitor for signs/symptoms related to the suspected injury/illness.

   d. Coordinate care with appropriate medical services as deemed necessary.

   e. Document actions taken on all appropriate forms (Nursing Progress notes, Incident Report, Accident Report, etc.).

   f. The nurse will attempt to notify the legal representative of the individual receiving services if the medical situation is emergent.

3. Nursing Consultation Guidelines as attached.

I. Poison Control

1. CMH staff will follow the Emergency Action Guidelines for Poisoning as follows:

   a. Inhaled Poison:
   Immediately get the person to fresh air. Avoid breathing fumes. Open doors and windows wide. If victim is not breathing, start artificial respiration.

   b. Poison on the Skin:
   Remove contaminated clothing and flood skin with water for 10 minutes. Then wash gently with soap and water and rinse.

   c. Poison in the Eye:
   Flood the eye with lukewarm (not hot) water poured from a large glass 2 or 3 inches from the eye. Repeat for 15 minutes. Have patient blink as much as possible while flooding the eye. Do not force the eyelid open.

   d. Swallowed Poison:

   - **Medicine:** Do not give anything by mouth until calling the Regional Poison Center for advice.

   - **Chemical or Household Products:** Unless patient is unconscious , having convulsions, or cannot swallow—give milk or water immediately—then call for professional advice. about whether you should make the patient vomit or not.

2. After emergency actions, call **Regional Poison Center** at **(800) 222-1222.** ***Do Not Call if the event is a drill and not an actual event.***

3. When you call the Poison center, have the following information ready:

   - Age and weight of the poisoning victim.
   - Name of the poison product, and amount involved in the exposure.
   - Time the exposure happened.
   - Any symptoms occurring right now.
   - Any first-aid measures you have already given the victim.
   - Your name and telephone number.

4. Regional Poison Center phone number and Poison Safety Guide information will be readily available to CMH staff and contracted providers via the CMH Intranet and posted in nurses' offices and medication administration rooms.

5. Regional Poison Center phone number and Poison Safety Guide information will be readily available to all CMH recipients in all CMH sites' waiting rooms.

V. REFERENCES:

Devos Children's Hospital Poison Safety Guide

VI. APPENDIX:

Appendix A: Nursing Consultation Guidelines

Community Mental Health Services of Muskegon County
January 12, 2009 (Revised)
Nursing Consultation Guidelines
Appendix A

Purpose

To provide nursing consultation guidelines and examples of situations they are authorized to resolve.

Application

These guidelines apply to all CMH staff and contracted staff/providers working within the CMH network requiring consultation with the CMH nurse.

Definition

"PRN per protocol" : applies only to a medication prescribed by a CMH prescriber when the order is written for "prn use per protocol". "PRN" refers to as needed. "Protocol" is a specific plan written by a psychologist for staff to refer to for specific criteria to be considered prior to administration of the "prn" medication. When it has been determined there in a need for a behavioral plan, the protocol for the administration of the PRN behavioral medication will be included. When it has been determined there is no need for a behavioral plan, a protocol with instructions for the administration of the PRN behavioral medication is written by the nurse as part of the health care plan. This applies to a unique population of clients served at CMH to give guidance to CMH staff and contracted staff for specific behavioral issues.

Procedure

1. Consultation with CMH nursing staff is always allowed and encouraged if in doubt about any medication or medical condition.

2. Consultation should occur with the assigned home nurse during CMH regular business hours whenever possible.

3. All after hour telephone calls to the on-call nurses, including those for authorization for the use of "prn per protocol" medications, should be approved by a Residential Corporation home supervisor/designee for clients residing in a specialized residential setting.

4. Care Plans will be in place in the home for every client's known health/medical related problems for the home supervisor/staff to follow when specialized nursing has been authorized.

5. On-call nursing staff can be consulted to determine if an emergency room visit is warranted in the case of injury or illness. The on call nurse will determine if the client needs to be transported to the Emergency Room for medical intervention. The home supervisor will notify/communicate with the guardian regarding the client's Emergency Room visit prior to treatment and to report findings and treatment after the visit.

6. Consultations must be documented in the client's record on a progress note, or Incident Report if appropriate, written by the person who initiated the consultation. The note must include the reason for the call, the information received from the nurse, and the subsequent action taken by the caller.

   The nurse must document the call within the first business day after receiving the call. A nursing consultation should occur and be documented in the following situations:

   A. Medical Issues:

      1. A client reports, or staff observe, a medical issue that, left untreated could endanger the client if left until the nurse is available during regular working hours, and staff are unsure what action to take.

      2. The client's health care plan stipulates it in the Plan of Action such as for continued seizure activity after medication administered.

      3. The client has an elevated temperature greater than 100 degrees axillary for more than 24 hours if not relieved with medications.

      4. The client has cold symptoms, vomiting, and/or fatigue for more than 24 hours.

      5. The client is noted with any rectal, vaginal (other than menses), or penile bleeding.

      6. The client is noted to be vomiting red blood, coffee ground, or vomitus contains medications.

      7. The client is noted with swelling of the genital area.

      8. The client is noted with a rash especially after starting a new medication.

      9. The client may be having a possible medication reaction.

      10. The client is noted with any respiratory problems including shortness of breath, cyanosis, congestion, or persistent cough not relieved with medication.

   B. Trauma Issues:

      1. The client has received an injury to the head.

      2. The client is noted with a bruise larger than the diameter of a baseball.

      3. The client is noted with a bruise that includes swelling to the area.

      4. The client is noted with any new swelling of the limbs.

5. The client is noted to be favoring or limiting the use of his/her limbs; possible fracture.

C. Pharmacy Issues:

1. A prescribed medication was not administered within one half hour before or one half hour after the designated time and now staff wants to administer the dose or the resident requests taking the dose.

2. The staff has contacted the pharmacy and cannot obtain an adequate supply of medication and this will result in the client going without medication.

3. Staff administering the medication needs clarification on the correct dose, strength, dispensing time or name of medication.

4. The client has missed a dosage of medication due to vomiting or refusal.

7. The home nurse will discuss the medical/medication/illness/injuries occurring during the weekend with the home supervisor/staff every Monday morning. Support coordinator will be notified by receiving a copy of the nurses' progress note.

8. "PRN per Protocol" behavior medication administration continues to require a nurse's authorization if stated in the Protocol/Health Care Plan. Protocols/Health Care Plans for "prn" use of behavior medications listed in the health care plan will continue to be written with guidelines for staff to follow.

COMMUNITY MENTAL HEALTH SERVICES OF MUSKEGON COUNTY

Nursing Guidelines December 2004

SEIZURE DESCRIPTIONS

Partial Seizures (also called focal seizures):

Simple Partial seizures: **No change in level of consciousness. May have weakness, numbness, dizziness, muscle twitching and / or unusual smells.**

Complex Partial Seizures: **Consciousness is altered. Symptoms may be similar to a simple partial seizure, but persons may have trouble interacting in the environment. May have repetitive behavior, lip smacking, unusual thoughts, uncontrollable laughing, visual hallucinations, and unpleasant odors.**

Generalized Seizures:

Grand Mal: **Also called "clonic tonic" seizures. Patients may experience an aura (unusual taste or smell) prior to the seizure. The person may abruptly fall and begin to have jerking movements of their arms, legs and head. Drooling, biting of the tongue, foaming at the mouth and loss of control of urine and bowels may occur. The person may be unconscious for a period of time. Person's may awaken and be confused for a period of time after a grand mal seizure. Persons may experience prolonged weakness after a grand mal seizure.**

Petit Mal Seizures: **Also called "absence seizures". Loss of consciousness only occurs, without associated motor movements. There usually is no aura (unusual taste or smell that precedes a seizure). Subtle motor movements may accompany the alteration in consciousness.**

Myoclonic Seizures: **Brief jerking movement that involves both sides of the body. The movement may be small or very dramatic.**

Status Epilepticus: **This is a prolonged repetitive seizure that lasts longer than 20-30 minutes in which the person is unconscious.** This is a medical emergency and 911 must be called.

SEIZURE GUIDELINES

DURING THE SEIZURE

Remain calm. **Stay with the person having a seizure. Do not try to stop the seizure, restrain movement or insert anything into the person's mouth.**

Keep the person safe. Keep the airway opened. **Assist the person to the floor, sitting or lying position. Remove the person's glasses. Remove any items that may be harmful away from the person.** Do not put anything in the person's mouth. **Stay with the person until the seizure ends.**

Keep the person comfortable. **If the person is not convulsing: Loosen tight clothing if possible. Cushion the person's head. Roll the person to one side.**

AFTER THE SEIZURE

Turn the patient to the side and allow the mouth to drain.

The person may remain tired and sleepy for a period of time after the seizure. Allow rest.

Continue to observe the person for level of consciousness.

Take vital signs within 5 minutes after the seizure stops and every 30 minutes for 1 hour after.

Follow seizure care plan **of when to notify nurse or give PRN medications.**

Do not give the person anything by mouth until they are fully awake.

Never leave person alone.

Call 911 if: **the person has** diabetes **or is** pregnant**, the seizure happened** in water (**seizure occurred in shower, tub, pool, and person was submerged or suspected to have went under), the seizure lasted** longer than 5 minutes **(unless nursing care plan states otherwise),**

the person stops breathing**, this is the** first seizure **for this person, or the person** does not regain consciousness **in 15 minutes (unless nursing care plan states otherwise).**

Document on the seizure log / progress note **(If a seizure log is used, also document in the progress notes). If this is a person's first seizure, document the time the seizure started, what the person was doing before the seizure started, how long the seizure lasted, what happened during the seizure and the level of alertness after the seizure. If there is an injury, complete an Incident Report and notify the RN if a head injury is involved.**

Community Mental Health Services Of Muskegon County
Nursing Guidelines

SKIN CARE

Maintaining Healthy Skin

- Include adequate amounts of fluid and vitamins A and C in the daily diet.
- Use humidifiers to maintain environmental humidity between 40% and 60%.
- Apply emollient lotions twice daily or as needed.
- Use emollient lotions immediately after bathing when the skin is moist.
- Gently massage the skin when applying lotions.
- Do not use rubbing alcohol.
- Avoid skin care products that contain alcohol or perfumes.
- Use small amounts of powder or cornstarch on areas of skin that rub together (especially during hot weather), but avoid excessive use of powders.
- Avoid multi-ingredient preparations because unnecessary additives may cause allergic responses.

Personal Care Practices

- Maintain the water temperature at about 90*F to 100*F.
- Make sure skin is rinsed well.
- Whirlpool bathing stimulates circulation, but the temperature should not be too hot.
- Apply emollient products after bathing, rather than using them in the bath water, to minimize the risk of falls on oily surfaces and to maximize the benefits of the emollient.
- Use emollient products containing petrolatum or mineral oil (e.g., Keri, Eucerin Aquaphor).
- If you use bath oils, take extra safety precautions to prevent slipping.
- If emollient products are applied to the feet, put on non-skid slippers or socks before walking.
- Make sure your skin is dried thoroughly, especially between your toes and other areas where your skin rubs together.
- When drying your skin, use gentle, patting motions, rather than harsh, rubbing motions.

AVOIDING SUN DAMAGE

- Wear wide-brimmed hats, sun visors, sunglasses, and long-sleeved garments when you're out in the sun.
- Cotton materials provide better protection from the sun than polyester fabrics because ultraviolet rays can penetrate polyester.

- Apply sunscreen lotions frequently, beginning 1 hour before sun exposure.
- Use sunscreen lotions with a sun protection factor (SPF) of at least 15.
- Avoid exposure to the sun between 10AM and 3PM.
- Protect yourself from ultraviolet rays even on cloudy days and when you're in the water.
- Artificial tanning booths use ultraviolet type A rays, which are advertised as harmless, but which have been found to cause damage in high doses.

Community Mental Health Services Of Muskegon County
Nursing Guidelines

WHEN YOU CALL THE DOCTOR OR NURSE

The more information you can provide, the more helpful we can be!

When you call the nurse or the doctor's office for help in making a health care judgment, have the following information available:

Key in on what's different from the client's normal.

"COLD" SYMPTOMS-

- When did symptoms start?
- Temperature
- Nasal drainage? (Amount, color)
- Cough (frequency, loose, tight, mucus, color of mucus)
- Appetite (normal, low)
- Fluid intake (normal, low, increased, forcing fluids)
- Other symptoms (tired, pain, etc.)
- What prn orders are available?
- What have you done so far? Response?

VOMITING/DIARRHEA-

- When did it start?
- How many times?
- How much?
- What does it look like?
- What was eaten in the last 24 hours?
- Are they taking fluids? How much?
- Temperature? Other vital signs
- Other symptoms?
- Is there a program or prns available?
- What have you done so far? Response?
- Were medications vomited?

FEVER-

- What is the normal temperature for this person?
- How was the temp taken?
- What is the number on the thermometer?
- How long?
- Other symptoms (aches, sore throat, pulling ears, etc?)
- Did you remove heavy clothing/blankets?
- Have you given prn Tylenol? When? Response?

CUT, SCRAPE, SCRATCH, BRUISE-

- How did it happen?
- How long ago?
- How long, how wide?
- Where?
- Swelling?
- Bleeding?
- Red streak? Drainage? What color?
- When was last tetanus?
- Are there prn orders or a program available?
- What have you done so far? Response?

PAIN-

- Where does it seem to be?
- What is client doing/saying to indicate pain?
- How long has it been going on?
- Swelling or redness?
- Possible reasons or causes?
- Vital signs?
- Are there prn orders for pain?
- What have you done so far? Response?

RASH-

- Where?
- How long?
- What does it look like?
- Itching?
- Ever had it before?
- Does anyone else have it?
- New product for laundry or hygiene?
- Something new in diet?
- New/current medications?
- Other symptoms of illness? (cough, runny nose, etc)
- Are there prn's or a program?
- What have you done so far? Response?

OTHER SITUATIONS-

- When did it happen or start?
- Contributing factors (why?)
- Where?
- What does it look like?
- What have you done so far?
- The more information, the better!

EMERGENCIES-

Call 911 - Call ambulance or go immediately to the Emergency Room, When:

NO BREATHING > Begin CPR immediately
NO PULSE RATE >

UNCONTROLLED BLEEDING - Apply direct pressure
Elevate when possible

UNCONSCIOUS OR LOSING CONSCIOUSNESS (except seizures)

ACCIDENT RESULTING IN SEVERE INJURY-
Suspected fractures of limbs
(Swelling, Severe bruising, Favoring or refusal to move a limb)

UNCONTROLLED BEHAVIOR – that is dangerous to self or others

INSTRUCTIONS FOR GIVING INSULIN INJECTIONS

1. Check client's blood sugar and record it.
2. Check insulin order and verify the 5 R's of med administration.
3. Gather supplies and wash your hands.
    a. Insulin
    b. Syringe
    c. Alcohol swabs
    d. Gloves
4. Roll insulin bottle in the palm of your hands. This will warm the insulin if it has been kept in the refrigerator. Roll a bottle of cloudy insulin until the white powder has dissolved
5. Clean rubber vial with an alcohol swab.
6. Put on gloves. Pull needle plunger back past amount of insulin to be withdrawn. Inject that amount of air into the bottle. With bottle upside down, pull plunger back pas the amount that you will give. Slowly push plunger up to the amount of insulin to be given.
7. Make sure to expel any air bubbles.
8. If the needle touches any object, consider it contaminated and discard that one and start over.
9. Double check insulin dose with another staff person or client if appropriate.
10. Choose sit for injection. Do not inject into skin that is bruised, inflamed or swollen.
11. To insure that insulin gets into subcutaneous tissue, pinch skin. If skin fold is one inch or less, inject needle at 45 degree angle. If skin fold is greater than 1 inch, insert needle at 90 degree angle.
12. Inject needle quickly and firmly, then release skin. Aspirate by grasping lower end of syringe barrel with nondominant hand. Move dominate hand to end of plunger. Avoid moving the syringe. If blood appears in syringe, remove needle, discard medication and syringe and repeat steps.
13. Inject medication slowly.
14. Immediately place syringe in "sharps" container.
15. Document on back of med sheet, type and amount of insulin given and site that was used. For example: Novolin N 25 units SQ R upper arm.

Dos and DON'Ts

1. Don't mix different types of insulin. Call an RN.
2. Don't give insulin to someone who can self-administer.
3. Do report a needle stick immediately.
4. Do not recap syringes.
5. Don't set the syringe down after it is used. Put directly in "sharps" container.
6. Do know the signs and symptoms of hypoglycemia.
7. Do make sure that the client will be eating shortly after giving the insulin.

Steps for preparing a single dose of Insulin

Follow these steps when preparing a single type of insulin for an injection.

1. Roll the bottle (vial) gently between your hands. This will warm the insulin if you have been keeping the bottle in the refrigerator. Roll a bottle of cloudy insulin until the white powder has dissolved.

2. Wipe the rubber lid of the insulin bottle with an alcohol wipe or a cotton ball dipped in alcohol. If you are using a bottle for the first time, remove the protective cover over the rubber lid.

3. Remove the plastic cap covering the needle on your insulin syringe (without touching the needle).

4. Pull the plunger of the syringe back and draw air into the syringe equal to the number of units or insulin to be given.

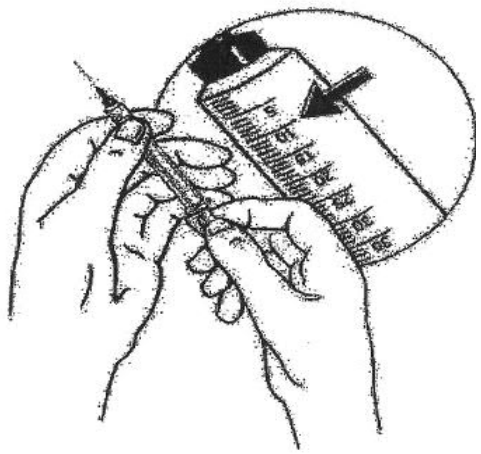


Illustration of Step 4.

5. Insert the needle of the syringe into the rubber lid of the insulin bottle. Push the plunger of the syringe to force the air into the bottle. This equalizes the pressure in the bottle when you remove the dose of insulin. Leave the needle in the bottle.

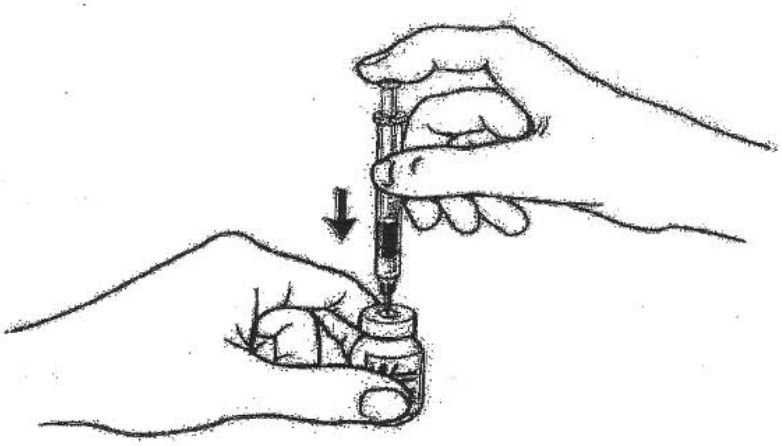


Illustration of Step 5.

6. Turn the bottle and syringe upside down and hold them in one hand. Position the tip of the needle so that it is below the surface of insulin in the bottle. Pull back the plunger to fill the syringe with slightly more than the correct number of units of insulin to be given.

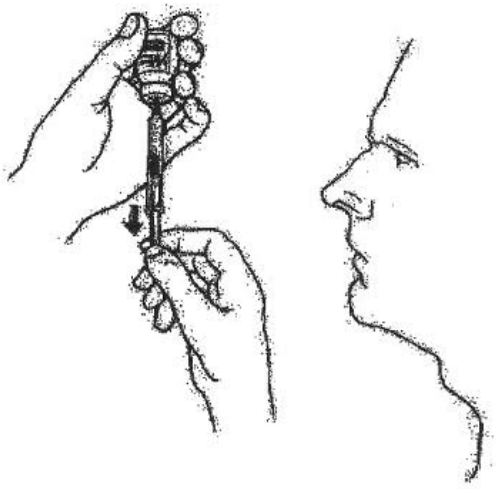


Illustration of Step 6.

7. Tap the outside (barrel) of the syringe so that trapped air bubbles move into the needle area. Push the air bubbles back into the bottle. Make sure you now have the correct number of units of insulin in your syringe.

Illustration of Step 7.

8. Remove the needle from the bottle. Now you are ready to give the injection.

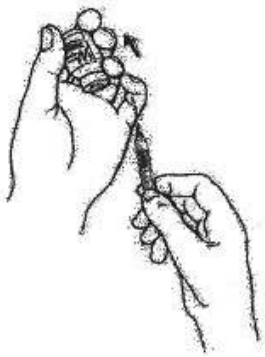
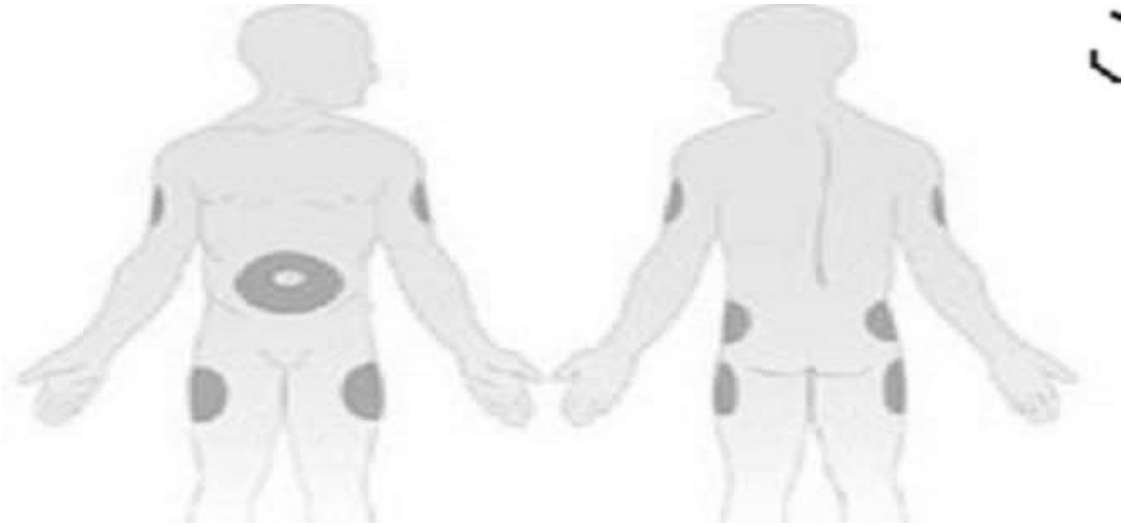


Illustration of Step. 8

Choosing the Site for an Insulin Shot

Choosing exactly where on your body you will give your shot(s) each day is very important.

Front Back



These drawings show **areas for your insulin shots** in red and white. You may need a family member to give your shot in some of them

The areas are divided into squares. Each square is a **site**, an exact place to give a shot. To keep skin, fat and muscle health, use a different site for each shot.

When you use all of the areas and the sites inside them, no one site has to be used too often.

Rotating Injection Sites

Rotating sites means following a regular plan of moving from site to site as you take your shots.

- **Use all the sites in one area before changing to another.** For example, use all the sites in both arms before moving to your legs. This will help keep your blood sugar more even from day to day.
- **If you take more than one shot each day, use a different area for each shot.**
- **Starting in a corner of an area, move down or across the sites, in order.** Jumping from site to site makes it hard to remember where you gave your last shot.
- **When you have used all the sites in an area, move to another.**

Medline Plus Medical Encyclopedia: Hypoglycemia

Hypoglycemia is relatively common in diabetics. It occurs when too much insulin or oral antidiabetic medication is taken, not enough food is eaten or from a sudden increase in the amount if exercise without an increase in food intake.

Relative hypoglycemia, where a newborn's blood glucose is low, is fairly common. Severe hypoglycemia may occur in an infant born to a woman with diabetes or gestational diabetes. In these cases, the child is referred to as an IDM for "infant of diabetic mother".

If, during the pregnancy, the mother's blood sugar is persistently high, the fetus' pancreas assists in controlling the excess blood sugar by producing extra insulin. When the infant is born, it no longer gets the mother's glucose but still produces increased insulin and the increased insulin drives the infant's blood sugar down to dangerous levels. This is a medical emergency that may result in seizures and damage to the baby's nervous system if not related.

Sometimes the cause of hypoglycemia is unknown (idiopathic). In these cases, people who are not diabetic and who do not have another known cause of hypoglycemia experience these symptoms.

Hypoglycemia can occur because of an insulin-secreting tumor of the pancreas, liver disease, or as a response to the ingestion of alcohol. It can occur in adults, infants and children and affects approximately 1 out of every 1,000 people.

Symptoms:

- Fatigue
- General discomfort, uneasiness or ill feeling (malaise)
- Nervousness
- Irritability or even aggression
- Trembling
- Headache
- Hunger
- Cold sweats
- Rapid heart rate
- Blurry or double vision
- Confusion
- Convulsions
- Coma

Additional symptoms that may be associated with this disease:

- Excessive sweating
- Sleeping difficulty
- Paleness
- Muscle pain
- Memory loss
- Palpitations or feeling your heart (heartbeat sensations)
- Hallucinations
- Fainting
- Different size pupils
- Dizziness
- Decreased consciousness

Signs and tests:

- Serum glucose or sugar level in the blood is low.