Self-Administration Assessment – Oxygen Administration

Individual's Name: _____ **Date of Birth:** _____

Location: □ Home □ ADS □ Other **Medication Type:** □ Routine □ As Needed □ Both

1. **Knows when oxygen is needed.** (i.e., by time, symptoms/shortness of breath, oxygen saturation reading, will ask for help, will confirm with someone else, or by use of technology, etc.).

   Yes □ Continue to #2 **No** □ Continue to #2

2. **Recognizes if oxygen is flowing at the prescribed flow rate.** (This includes any means that the individual uses to identify/verify flow rate, i.e., read the gauge, has memorized, confirms number with a picture will ask for help, will confirm with someone else, know who to tell if there is a problem).

   Yes □ Continue to #3 **No** □ Continue to #3

3. **Knows who to notify if there are problems with equipment.** (i.e., oxygen not flowing, leaks, concentrator not working, etc.)

   Yes □ Continue to #4 **No** □ Continue to #4

4. **Knows when new oxygen tanks are needed so oxygen supply never runs out** (i.e., only a few tanks left). **Will get additional tanks/refills.** (The individual knows who to tell to get additional tanks/refills; will seek assistance if needed for additional tanks/refills or if oxygen is not available.)

   Yes □ Continue to #5 **No** □ Continue to #5 **N/A** □ Continue to #5

5. **Knows safety precautions with oxygen use.** (i.e., safe location of tank, no smoking, etc.).

   Yes □ Continue to #6 **No** □ Continue to #6

6. **Able to get the tank/concentrator/oxygen supplies to and from storage.**

   Yes □ Continue to #8 **No** □ Continue to #8

7. **Able to connect/disconnect oxygen regulator to cylinder (if applicable), oxygen mask/nasal cannula to oxygen source.**

   Yes □ Continue to #9 **No** □ Continue to #9

8. **Able to turn on oxygen delivery device and adjust to the correct flow rate.**

   Yes □ Continue to #10 **No** □ Continue to #10

9. **Able to apply oxygen mask/nasal cannula.**

   Yes □ Continue to #11 **No** □ Continue to #11

10. **Able to clean and maintain equipment.** (i.e., nasal cannula/mask, humidifier bottle).

    Yes □ Continue to Assessment Result **No** □ Continue to Assessment Result

Assessment Result: *The OhioISP must indicate the result of the assessment and how medications will be administered. Based on the answers to questions 1-11, choose one of the results listed below:*

□ **Able to self-administer without assistance** (Questions 1-10 are "yes")

□ **Able to self-administer with assistance** (Questions 1-5 is "yes", any one or all of 6 through 10 are "no")

OAC 5123-6-02 specifies the three types of assistance that can be provided by uncertified personnel. Indicate the type or types of assistance that apply.

□ Reminders of when to administer oxygen, obtain oxygen saturation readings and observe to ensure the individual follows the prescriber's directions/orders.

□ Removing the oxygen tank/concentrator/supplies from storage area and returning to the storage area.

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□ Upon request, with consent, or at the individual's direction, providing physical assistance with any step of the process (i.e., connecting oxygen mask/nasal cannula to the oxygen source, turning on the oxygen delivery device, opening/closing tank, adjusting flow rate, applying oxygen mask/nasal cannula, cleaning equipment).

□ **Unable to self-administer with or without assistance** (The answer is "no" to any or all of Questions 1-5)

Choose one of the following:

□ The individual can do some steps of medication administration and a properly licensed or certified and authorized person completes the other steps of medication administration. (List details on OhioISP – fillable space for summary).

□ Medications must be administered by a properly licensed or certified and authorized personnel.

□ **Other Considerations** Through the person-centered planning process, the team has identified that the individual is unable to safely self-administer or self-administer with assistance. The OhioISP will identify appropriate supports necessary for safe medication administration. - fillable space for summary.

_____ _____

Name, Signature & Title of Person Performing Assessment **Date**

Annual Review	**Date of Review**	**Name, Signature & Title of Person Performing Assessment**
First Review		
Second Review		

Revised 3-2024