Adopted March 1977
Cur Rev 4-26-13, 12-6-13,
7-18-14; 4-8-15, 10-26-18,
3-22-19, 4-12-19

A W 4.6
PROCEDURES RELATED TO POLICY ON

CLIENT HEALTH

Handling, Storage and Destruction of Medication: for clients in supervised living and other situations offering supervision/medication training, the client's Person Centered Support Plan (PCSP) will address. Arrowhead West, Inc. (AWI) will comply with the Kansas Nurse Practice Act (K.S.A. 65-1124) where appropriate.

4.6.0 New clients admitted for services (or their guardians) will sign a release authorizing the agency to share their medical records with the local physician or other health care provider they may be referred to. A copy of medical records, prescriptions, etc. will be shared with the local health care provider to establish medical services.

4.6.1 Nurse will do a medication assessment for each new person enrolling in AWI day or community living services within 30 days of their admission to determine whether or not they fall under the provisions of the Nurse Practice Act. The assessment will be signed by the Nurse and placed in the case record. The assessment will be redone annually prior to the person's PCSP meeting. The Division Secretary provides a list of individuals due for the annual medication assessment via a copy of the monthly PCSP schedule (Form 5.3.0A).

4.6.2 The staff are responsible for training clients to become maximally responsible for their own medications and consideration of such training shall be given by the Case Manager in the development of the PCSP for those who can benefit from such training.

4.6.3 All staff supervising medications that are covered by the Nurse Practice Act will go through a training session offered by the Nurse prior to being delegated such responsibilities. This training will include observation by the Nurse of the staff person successfully assisting with medications. The training will be documented in the personnel file.

4.6.4 AWI is licensed as a non-medical facility and as such, encourages self-administration of medications by the client. Physical assistance may be given if it is necessary because of a physical illness or ailment that is determined by a physician to be temporary and minor, or because of a tremor, failing eyesight or a similar condition. Clients or their financial representative are responsible for payment of their medications directly to the pharmacy.

4.6.5 For clients who are able to self-administer medications it is their responsibility to take medications as prescribed. It is the staff's responsibility to monitor, remind or otherwise attempt to ensure that clients take medications prescribed at the correct time(s). Problems related to a client taking medication should be noted on the Medication Administration Record (MAR) and Medication Incident Report – Client 4.6.0C completed. If non-compliance with taking of medication becomes an issue, the PCSP team shall develop an appropriate goal/objective addressing the behavior.

4.6.6 Staff errors in supervising medications will result in disciplinary action; a Medication Incident Report – Staff 4.6.0 must be written. If the error(s) warrants an Employee Advisory Form (EAF) it will be forwarded to the Human Resource Manager.

4.6.7 AWI does not dispense medications. Prescriptions are normally delivered by the pharmacy and "checked in" by the nurse or assigned manager. If delivery is not available, a designated staff member will pick-up the medication. Only medications requiring a prescription by a physician or designated via a non-prescription medication release (AWI form 5.3.20 or physician's letter) will be utilized. A copy of the prescription(s) and/or release shall be placed in the case file. A copy of the current non-prescription medication release will also be kept at each service location.

4.6.8 All prescription containers must be labeled with person's name, name of medication, dosage, dosage intervals, name of M.D. and date prescription was filled. Samples are not used unless labeled accordingly.

4.6.9 The taking of medication must be charted on a medication data collection sheet or MAR for each client at the time of taking the medication; the data is maintained on file. For persons with "bubble pack" medications, the staff may initial and date the card(s). This process serves as an inventory tracking. Medications not packaged in bubble packs will have an inventory taken weekly by 2 assigned support staff.

4.6.10 All medications must be stored in locked containers with internal and external medications stored separately. Medications that require refrigeration will be stored in the refrigerator. Medications are protected from light when necessary.

4.6.11 A current list of medications (the medication log) shall be maintained at the program site(s) for each person receiving services. A listing will also be maintained at each facility (licensed) of all medications that fall under the Nurse Practice Act, any side effects, contraindications, etc. Information on side effects will be available in program records for all OTC & prescribed medications.

4.6.12 Direct service staff are to ensure clients receiving medication take it at the prescribed time.

4.6.13 The Nurse is responsible to ensure the initial prescription(s) are filled. Day service and residential staff may order medications that need to be refilled if the Nurse is unavailable. Clients who are capable should receive training in ordering their own medications. The agency will use pharmacies that deliver medications to program sites whenever possible.

4.6.14 The staff person supervising the client in taking medication should note on the MAR when the client refuses medication and document on the back in specific detail why the medication was refused. Clients will be given multiple opportunities to take any medications they initially refuse. A Medication Incident Report needs to be written at this time. The Physicians Desk Reference (PDR) should be consulted on the advisability of making up any missed medications. If necessary or in doubt the Nurse may be called or then the physician/pharmacist if the Nurse cannot be reached.

4.6.15 Notice or suspicion of adverse reactions to medication shall be documented and reported to the prescribing physician or Nurse. A Medication Incident Report will be written and the Case Manager will be informed. For persons taking psychotropic medications an assessment of abnormal, involuntary movements will be made at the initiation of treatment and every three months thereafter. The assessment will be documented in the case file.

4.6.16 Medications will be sent along with pertinent instructions in the event of client travel or home visits. In the event of a medication shortage over the weekend, the dispensing pharmacy will be called.

4.6.17 Whenever possible discontinued or outdated medications will be returned to the pharmacy for credit. If not possible they will be destroyed by a method recommended by KDHE (Kansas Department of Health and Environment) such as mixing with coffee grounds in a closed container. Staff member will note on Medication Incident Report the medication destroyed and date and sign. Destruction of medication must be witnessed by another staff member.

4.6.18 A medication that is controlled (schedule 2) will be counted daily and requires 2 (two) staff signatures. The nurse or a member of the management team will monitor medication procedures at least once weekly. No controlled (schedule 2) medication will be destroyed by direct support staff.

4.6.19 Medication will be used only for the individual for which it is prescribed and according to the current label. If the prescribing physician makes a change in the medication the Nurse must do the following:

a. Forward a Medication/Dosage Change form to all locations.
b. Make notation on the MAR.
c. Make change(s) immediately on medication log in client's file. Send a copy of updated log to the day program, residential program and Case Manager.
d. If the Nurse is on leave the Case Manager will handle.
e. Contact pharmacy for new prescription. Medication is to be in the facility when the change is made.
f. Get a copy of the written doctor's orders for the case file before the change is implemented if change was made over the phone.
g. If possible, discontinued medication will be returned to the pharmacy for repackaging.

4.6.20 A medication log is part of the master case file for each client. Current copies should be maintained at residential and day service sites as well. This form must be kept current and accurate at all times. An update to the profile is done at each PCSP or as determined necessary. At least annually, the PCSP team will review medications prescribed and possible side effects. A copy of the current medication log is to be attached to the PCSP.

4.6.21 In Infant-Toddler Services, medications will not be dispensed by staff. All medications necessary for a child in services are the sole responsibility of his/her parent.

4.6.22 Because of the infrequency of contacts in the Independent Living program, staff will not be involved (other than monitoring, if specified by PCSP) in medications taken by clients in this program.

4.6.23 Clients in a residential transition home or apartment who take medications at times when staff are not present, should be capable of self-medication at times staff are not present.

4.6.24 In the case of clients receiving self-medication training as described in their PCSP's, staff should not physically assist the client, but should supervise and train by giving verbal prompts or other cues as appropriate or necessary. (Refer to 4.6.4)

4.6.25 The following is a list of commonly used medical abbreviations to assist staff:

Medical Abbreviations

a - before
a.c. - before meals (usually l/2 hour)
b.i.d. - two times a day
c- with
cc - cubic centimeter d. - day or daily (example: q.d. - every day)
gm(s) - gram(s)
gr(s) - grain (s)
gtt(s) - drop(s)
h.s. - hour of sleep (bedtime)
I.M. - intramuscular
I.V. – intravaneous

mg., mgm - milligram(s)
n.p.o. - nothing by mouth
p - after
p.c. - after meals (usually l/2 hour)
p.o. - by mouth
p.r.n. - as necessary (order should indicate symptoms and intervals for use)
q - every (example: q.h. - every hour)
q.i.d. - four times a day
q.o.d. - every other day
s- without
sos - if necessary or required
stat - immediately (once)
t.i.d. - three times a day
t. - teaspoon (also l teaspoon equals 5 cc)
T - tablespoon (three teaspoons or l5 cc)
U - unit

Hearing Aids

4.6.26 To ensure proper functioning of hearing aids, upon request the agency Speech-Language Pathologist will instruct adult clients who are fitted for hearing aids, adult and Infant-Toddler Services staff and parents of children fitted for hearing aids, as to the correct procedure for checking the aids and how to record the results on the hearing aid checklist. Follow-up visits will be made as determined by the Speech-Language Pathologist and documented on the IFSP or IP. In CKD, hearing aids will be checked by a professional in the community.

Illness and Accident

4.6.27 Prior to a person entering a program, the following arrangements must be made:

a. Name, address and telephone number of a physician to be called in case of emergency.

b. Written permission of the parent, guardian or person receiving services, if applicable, for emergency care, to include: administering first aid, transporting or having transported the person to a hospital, clinic or physician for emergency care. (In Infant-Toddler Services, applies only to those children attending an agency service center.)

c. Written permission for the emergency care to be given in accordance with the requirements of the hospital, clinic, or physician where emergency care will be given. When an infection or contagious disease is known or suspected of a client, that person will be isolated. Isolation areas will be designated for each program.

4.6.28 A copy of the Emergency Health Plan, current Medication Log, Consent for Emergency Care and a copy of the medical card will be maintained at each program location for the clients served there.

4.6.29 An accident or illness report is filled out immediately and forwarded to the Case Manager/Infant-Toddler Services Manager for each occurrence by all staff members witnessing accident/illness. (If a staff person is involved in an accident, he/she should fill out an accident report on himself/herself.)

4.6.30 Render first aid in the event of accident resulting in minor injury.

4.6.31 Any person who comes to a program area ill or who becomes ill while there is to be returned to his/her place of residence as soon as possible. Those in Supported Living should go home immediately and those in Supervised Living should remain at day program site in sick room unless their PCSP team indicates they may stay at home alone. In those cases the person will be checked on periodically as stated in their PCSP. The Case Manager or other designated staff should check on the Supported Living client periodically if at home and ill.

4.6.32 In residential programs, when a client is too ill to report to work, the client should call the day program or his/her community-based employer. If necessary staff can assist and will notify the day program.

4.6.33 For those persons who become ill but cannot return to their home immediately, a quiet isolated and supervised area will be provided at the program area.

4.6.34 Make medication available only if previously prescribed for condition, and in keeping with procedures on medication.

4.6.35 The staff person present at appropriate facility makes decision as to whether an injury or illness requires a physician or hospital treatment, if an ambulance is necessary and if on-call is to be notified.

4.6.36 Notify physician, hospital or clinic that a person is being brought there if appropriate.

4.6.37 A staff member designated by the “on-call” person will accompany the person to the physician, clinic or hospital.

4.6.38 Staff member accompanying the person will take the written permission for emergency care and emergency information with him.

4.6.39 Staff member stays with person until relieved by parent, guardian, or other staff, or until released by person who assigned the duty, or the client.

4.6.40 If appropriate, complete workmen’s compensation insurance form.

4.6.41 All accidents/illnesses requiring hospitalization should be reported to the Division Manager/Infant-Toddler Services Manager as soon as possible.

4.6.42 The Safety Committee will review trends from accident/illness reports and will develop a corrective action plan for any trends identified. This information will be reviewed at the Safety Committee meeting and included in the minutes.

4.6.43 All serious illnesses/accidents are logged on OSHA Form 200 by the Human Resource Manager.

4.6.44 Worker’s Compensation (see Procedure 3.8.13)

Vehicle Emergency

4.6.45 In the event of accident or emergency while transporting clients, these procedures should be followed:

a. If emergency medical services are required, staff person should call 911 first. If staff person is injured, he/she should attempt to select a client who can make the call.
b. If time allows, a second call should be made to appropriate supervisor or, if after hours, to the on-call person.
c. Call appropriate police department to investigate accident and seek assistance.
d. If client is transported to hospital, staff person must stay with remaining clients until relieved.
e. If emergency medical services are not required, staff person should notify appropriate day program or, if after hours, on-call to arrange for relief transportation and assistance if necessary. Then call police to investigate accident.
f. The guardian/family etc. should be notified as soon as possible by the Case Manager or on-call if after hours.
g. In the event of emergency illness not related to an accident, staff person should transport client to nearest medical services or call an ambulance if deemed more appropriate, and call appropriate supervisor or on-call assistance and complete an accident/illness report.

Also refer to above procedures on "Illness and Accident". Pages 4 through 8 of this procedure will be kept in all vehicles used for client transportation.

Extended Illness

4.6.46 If an extended convalescence period is anticipated and requires expertise beyond the training or qualifications of AWI staff, the person will need to go home with their family or other arrangements need to be made until the person is able to function with "non-medical" care.

4.6.47 Families should be requested to notify AWI if a client is ill and unable to attend the day program or receive services at home.

Seizures

4.6.48 There is no way to shorten the typical convulsive seizure, but there are several things that can be done to reduce its impact. Here are a few DOs and DON'Ts on how to handle seizures.

a. DO move sharp objects out of the way.
b. DO remember that even though the person may look as if they are in pain, they actually feel nothing during the seizure.
c. DO remember, if they stop breathing for a few moments or show some temporary blueness or paleness, this doesn't mean they are in danger. It is a naturally occurring part of the seizure.
d. DO loosen tight clothing, especially around the neck, and wipe away any saliva around the mouth.
e. DO turn the person on their side in case they vomit during the seizure. They will not "swallow their tongue"; being on their side will keep the airway clear.
f. DON'T try to bring them out of the seizure by using cold water, slapping or shaking; it won't work, and the water could be harmful.

g. DON'T try to hold them down or restrain movements in any way.
h. DON'T try to give them medicine or any other substance during a seizure.
i. DON'T put anything hard in their mouth to keep them from biting the tongue or lips. Many people with epilepsy have suffered broken teeth and even inhaled bits of pencil following this kind of first aid. Also, DON'T put your fingers in the person's mouth. Remember, they don't know what they are doing and your fingers may get severely bitten.
j. DO remember there is no conscious behavior involved when a person has a seizure. Reassure them and see to their comfort when it is over.
k. Do not attempt to move them during the seizure unless in a dangerous location.

4.6.49 Observe and write down what happens during the seizure. Keep track of how long it lasts. Train yourself to check your watch quickly as it begins and note when the person comes round and how they behave. Write down the time of day and what the person was doing just before the seizure began. Note anything unusual that happened just before it started.

4.6.50 This information will be needed to write a seizure report and enter into the seizure record once the person is recovered. Follow the same procedures as for an incident or accident report. Chances are, the doctor will never see this person have a seizure. Your records are the best information the physician will have.

4.6.51 For clients who are seizure active, their physician may decide that if a seizure is longer than a specified time period, an ambulance must be called. If this is the case for a client, this time period will be noted in their PCSP. Staff who work with seizure active clients are to be familiar with this information.

4.6.52 The Safety Committee will review trends as related to seizure activity and will make recommendations for further training, etc.

4.6.53 For further information, see the following chart "Epilepsy: Recognition and First Aid".

<u>Nutrition</u>

4.6.54 Menus for residences are planned for a week at a time.

4.6.55 Periodically a meeting composed of clients and staff may be held to review menus and give input for change.

4.6.56 Nutritionist is consulted periodically to ensure quality and value of food served.

4.6.57 Special dietary menus are planned based on physician's recommendations for those in need of such.

4.6.58 Clients who are on special diets should have this noted in client file and changes or modifications should be noted in client log.

4.6.59 Governmental licensing standards relative to food, storage, and handling, sanitation, etc. should be adhered to.

4.6.60 Home canned foods shall not be served and food should be stored appropriately in covered containers and refrigerated where applicable.

4.6.61 Infant-Toddler Services staff give families literature on health and nutrition and refer them to Women Infant Children (WIC) program and other local resources if they need further assistance.

Health Assessments (Clients)

4.6.62 A health assessment for clients must be conducted by a licensed medical practitioner or a certified nurse clinician up to six (6) months before entry and prior to admissions.

4.6.63 The Case Manager or Family Services Coordinator will ensure the client is provided the necessary health examination forms.

4.6.64 The results of the health assessment will contain current lab and immunization records. If additional testing or immunizations are recommended documentation will be provided to show recommendation was followed. Results are maintained in client case records.

4.6.65 Health assessments should indicate a physician listing of disabilities, recommendations to cover special needs and remediation, and any restrictions placed on the person.

4.6.66 Health assessments must be completed every 2 years (at minimum) for adults and yearly for children enrolled in Infant & Toddler Services.

4.6.67 When a health assessment indicates the need for a specialized examination, the Case Manager or Family Services Coordinator will assist the client and family in making the proper arrangements.

4.6.68 Based on the nature of caseloads, clients' ages, etc., a consulting physician should advise on the frequency of preventive examination such as cancer screenings and other screenings designed to prevent or provide early detection of serious health conditions.

Safe Client Handling – Transfers and Lifts

4.6.69 The following objective criteria is to be used to determine what assistance is needed in transferring clients and should be listed in the client's PCSP.

a. Client can stand for 4 seconds bearing weight without assistance – gait belt or walking belt transfer is to be utilized.

b. Client can stand for less than 4 seconds bearing weight with some assistance – sit-to-stand mechanical lift is to be utilized.

c. Client is non-weight bearing – total body transfer is to be utilized.

d. Fallen client. A total body transfer should be utilized unless the client can get up on his or her own.

4.6.70 Staff can at any time increase the level of transfers from what is stated in the PCSP based on the clients ability to assist or comprehend the transfer (i.e. sit-to-stand transfers could be increased to a total lift transfer), however, the direct care staff can never reduce the level of assistance without a change to the PCSP.

4.6.71 Ongoing comparison of equipment vs. transfer needs should be written and documented by the department head.

4.6.72 Regular observations of the transferring of clients should take place through unannounced visits by supervisors and coordinators.

4.6.73 Violations of safe handling procedures by staff should be documented on the Employee Advisory Form (AWI 3.0.31) and can result in discipline up to and including termination of employment.

General

4.6.74 Health care needs of those served should be identified and arrangements made to provide services through staff, consultation or application for these needs. Services to be considered include, but are not limited to, the following:

a. physician services
b. nursing services
c. dental services
d. psychologist services
e. pharmaceutical services
f. dietary services
g. preventative, restorative and rehabilitation services
h. community medical support services, such as hospital, laboratory, x-ray, etc.
i. audiological
j. vision
k. immunizations

4.6.75 A sufficient number of staff should be trained in first aid and CPR to ensure at least one person with such training is on duty at all program locations whenever clients are present at these locations.

4.6.76 If necessary, based on client need, the Case Manager should seek consultation with a physician for special care or needs such as pulmonary care practices, seizure care, planned decreases in client's use of psychotropic drugs or other special needs.

4.6.77 First aid kits should be kept at each program location and in each vehicle. A "safety to go" kit will be available to all staff using personal vehicles to transport clients. Contents of these kits should be in keeping with client needs and a physician or nurse should be consulted based on the nature of the client caseload. An outline of steps to be taken beyond first aid shall be posted with first aid kits (Procedures 4.6.27 - 4.6.42).

General - Housekeeping

4.6.78 Laundry should be done in machines that allow for temperature control. Care should be taken to cleanse and/or air bedding, clothing, etc. that has been soiled with human waste. Staff should ensure that each client's clothing is returned to the proper owner after laundering. Each client's laundry is to done separately and not combined with other clients laundry.

4.6.79 Trash should be kept in covered containers and disposed of frequently.

4.6.80 Pest control companies should be engaged to treat each facility frequently enough to control and prevent infestations.

4.4.81 Cookware, dishes and dining utensils should be sanitized in all residential facilities. This may be accomplished by using the wash, rinse and air dry method or by automatic dishwashers.

4.6.82 The storage of cleansers and other potentially hazardous substances should not be stored with food items, but should be stored separately and controlled by staff in all supervised service locations. All cleaning supplies and other potentially hazardous substances will be kept in a container which is labeled to identify the contents. An SDS sheet

(Safety Data Sheet) will be kept on the premises for all cleaning supplies or other potentially hazardous substances including l:l0 solutions of household bleach (see Bloodborne Pathogens Procedures l.l2.50 to l.l2.59).

4.6.83 Each agency owned or leased facility will have on the premises a specific cleaning schedule indicating what is cleaned, how often, and with what materials. The supervisor for that facility will review and sign approval for the cleaning schedule.

4.6.84 Clients requesting a reasonable accommodation under the American with Disabilities Act (ADA) or the Americans with Disabilities Act Amendment Act (ADAAA) should make a request to their case manager referencing the disability and the accommodation requested. A request for an accommodation in conversation, or by other means is considered putting the case manager on notice and the words “reasonable accommodation” or “ADA” or “ADAA” need not be used. The case manager will then meet with client, to determine if an accommodation can be offered without causing an undue hardship to the agency. A determination will be made within 5 working days and a letter sent to the client. If for unforeseen circumstance, the determination cannot be made within this time period, the case manager will notify the client in writing of the delay.

If the disability is not obvious, the case manager may ask the client for medical documentation of the disability from an appropriate health care or rehabilitation professional during the interactive process.

The case manager does have the right to require an individual to go to a second health or rehabilitation professional if the information is insufficient from their first health care or rehabilitation professional. If AWI does request the client to go to health/rehabilitation professional of their choice, AWI will pay the cost of the visit if not covered by Medicare or private insurance.

Reasonable accommodation under the American with Disabilities Act (ADA) or the Americans with Disabilities Act Amendment Act (ADAAA) includes but is not limited to accommodations for the transportation provided to AWI clients by the agency.

If the resolution is unsatisfactory, complaints involving accommodations can be addressed to the United States Department of Justice, by clicking on the www.ada.com link under “Other Resources” on AWI’s website.