San Andreas Regional Center
Health-Related Best Practices
Residential Services, Supported Living & Adult Day Programs

Best Practices are intended to benefit those served by San Andreas and to help Providers optimize the health and safety of the individuals they serve by expanding upon the minimum standards set by regulations.

GENERAL EXPECTATIONS

- All service providers are expected to be competent in their knowledge of the Policy and Procedures of their facility and will have at least annual training on these topics.
- All service providers will have current CPR and First Aid certification.
- All service providers need to have a basic understanding of the qualifying conditions for Regional Center Services: Intellectual Disability, Cerebral Palsy, Epilepsy and Autism.
- People providing direct service to the individual must know the baseline (normal) condition of the individual, observe for changes, notify their supervisor, and take action based on the facility's or agency's procedure or the individual's Health Care Plan. This may include a 911 call and a report to their; supervisor, health professional(s), family member/conservator and Regional Center, as well as documentation in the facility file.
- When an individual is taken to Emergency Room or Urgent Care, Care Provider will remain with and advocate for the individual until the next responsible party has arrived. Care provider who stays with the individual needs to be knowledgeable about the conditions and baseline of the person. Care Provider must also be able to communicate clearly with doctors and hospital staff on the individual's behalf.
- When an individual has an appointment with a healthcare professional, the person accompanying them must be knowledgeable about their current condition, past medical history and be able to communicate clearly to advocate for the individual.
- When an individual receives a medical diagnosis, the Administrator/QIDP/Program Manager and Family Teacher, etc., is responsible to obtain from the treating physician instructions for care of the condition and provide training to staff adequate to meet the needs of that individual.
- Medical records/lab results/x-ray results/MD notes etc., need to be requested and obtained during a medical visit and a copy sent to the Service Coordinator within 48 hours.
- For CCL licensed facilities and Day Programs certain medical conditions require a Restricted Health Condition Care Plan and training of staff in accordance with Title 22 regulations 80090-80092 and 82090-82092, respectively which require annual review and training and also when a need is identified.

- Anyone who is responsible for assistance with self-administration of medications for a Regional Center client will attend medication training at least once at San Andreas (with a passing competency score of 80%), and periodically thereafter, in addition to the internal medication training provided by the facility.
- Residential Administrators and Day Program Directors are responsible for making sure direct care staff are knowledgeable about the baseline of the individuals in their care and for learning the signs and symptoms of illness which obligate them to take action. SARC provides a basic training in this area.
- Standard (Universal) Precautions must be used at all times. http://www.who.int/csr/resources/publications/EPR_AM2_E7.pdf

- Medical insurance problems (with the exception of private insurance) need to be brought to the immediate attention of the SARC Service Coordinator (SC) and Health Services Coordinator.
- Preventive care will be a priority and be discussed with the primary care physician. For example, obtain orders for flu shots, other vaccines, dental care, mammograms, prostate testing, and bone density testing. This includes discussion of risk factors for conditions such as skin breakdown, falls, fractures, pneumonia and urinary tract infections.
- Providers will become informed about end of life issues, including the Thinking Ahead program, POLST (Physician Orders for Life Sustaining Treatment), and funeral plans in order to participate in IDT discussions for medically fragile persons as well as adult and elderly populations.
- When life-changing medical situations arise, providers will be asked to participate in a meeting of the San Andreas Regional Center Bioethics Committee. If asked by a hospital to be part of a hospital bioethics team meeting, providers will insure San Andreas Service Coordinator and Manager is informed/invited as well. It is the responsibility of the Service Coordinator to inform the SARC nurse.

MEDICATION POLICY RECOMMENDATIONS

General medication storage and handling requirements are defined by Title 22 Section 80075.

1. Each agency or facility will have Medication Policy and Procedures regarding handling of medication and other health related treatments. These are subject to quality review. Refer to DDS check list to be sure you have addressed all the areas of medication management. (See Attachment A).
2. All med-certified staff are expected to be competent in their knowledge of the Policy and Procedures of their facility and will have at least annual training and competency certification on these topics.

3. The Administrator/Licensee will ensure each med-certified staff is able to see (wearing glasses or contact lenses as necessary) and are able to understand the MAR (Medication Assistance Record) and drug information sheets.
4. Consumer medication should be packaged individually in a single dose system (bubble packs).
5. Start date will be written on all bubble packs or vials/bottles in a manner that does not alter the pharmacy label in any way.
6. Medication records and bubble packs will be checked by the following shift to ensure the medication was given. Staff will take action per facility policy to clarify whether a documentation error or missed dose has occurred, and a Special Incident Report will be generated if a mistake has occurred.
7. Drug information sheets for each drug should be kept available to the staff and routinely used for reference and training.
8. Facility procedure for Schedule 1-4 drugs needs to include the process for ensuring correct use and accountability for these drugs. It is recommended that they be double locked due to the high potential for abuse, and that there is a change of shift count and documentation procedure to insure correct quantities are present. See link for details: http://www.drugs.com/csa-schedule.html
9. A change in a prescription requires the pharmacy to re-label and dispense the correct form or dose of the medication. Providers are not to calculate doses or alter the label.
10. REMINDER: (CCF ONLY) Suppositories/Enemas, even an order for "*one time use,"* requires a Restricted Health Condition Care plan and must be administered by a licensed professional or the individual may self-administer.

MEDICATION DELIVERY AND DOCUMENTATION

1. Individualized Medication Assistance Record (also called MAR, Medication Assistance Record, or Med Log) will be kept for each individual living in a Community Care Facility, Intermediate Care Facility, Family Teaching Model, Extended Family Teaching Model, ARFPSHN (962) home, and Specialized Residential Facility. The same is true for Supported Living Services unless there is a signed waiver by the individual served indicating SLS staff are not to assist with medications.
2. MAR's must have the month and year on each sheet.
3. Each staff assisting with medication must sign and initial the MAR. Check at the end of each shift to ensure the medication was given and signed off.

4. The MAR binder will have a page with printed names of medication-certified staff along with their signatures and initials.
5. Medications are to be prepared for one person at a time, immediately before they are passed.
6. Medications are considered "on time" if passed within one hour before or after the time listed on the MAR.
7. Medications will be signed off immediately after they are passed.
8. Inform the prescriber of the Title 22 requirements for PRN medication prescriptions, specifically how the order must be written and the requirements for notifying the prescriber when medication is passed.
9. All medications must have a doctor's order, including over the counter medications, vitamins, and herbal supplements. Keep a copy of the written prescription in the file of the individual.
10. When a medication is changed or discontinued cross out the current order on the MAR with a yellow marker. Write D/C or CHANGE, include the date and your initials. Whiteout is not acceptable. Write the new order on the MAR in the next available space with the start date (*this holds true for any medication change, whether it is a different dose or frequency of the same medication or a new medication).*
11. Document all communication with the prescriber in the consumer's file.
12. Each MAR should have a key explaining symbols and/or abbreviations. Examples: Ⓡ for refused, Ⓗ for held, ⒹⓅ for at Day Program.
13. Highlight (or use red ink pen) the list of all known allergies, including medication, food and environmental allergies on the face sheet and MAR.
14. If a medication is *refused*:
    a. Try to find out why and assist the consumer to resolve the reason and take the medication.
    b. Try at least twice to assist the person to take it.
    c. If he/she still refuses, draw a circle around the letter R "®" in the appropriate box on the MAR (or use whatever symbol is indicated in the Key).
    d. Notify the prescriber and follow through with new instructions (document this).
    e. Also document the reason for refusal and the attempts made to assist with self-administration.
    f. Submit a Special Incident Report for "Other" type of incident.
15. If a medication is on *hold*, the prescriber has determined the medication should not be given for a certain time or under certain conditions.
    a. On the MAR, draw a circle around the letter H in the appropriate box (or use whatever symbol is indicated in the Key).

b. Documentation of the reason or specific orders will be kept in the file.

16. Medications that are given only certain days or times of the month should have initials when given and straight line or XXX's in the remaining boxes.
17. Any medication error must be reported immediately to the prescriber and within 24 hours to the Regional Center in a Special Incident Report.
18. All prescribed treatments are to be listed on MAR or on a separate Treatment Record and documented when done. Includes special shampoos, skin care, and mouth care treatments.

MEDICATION DISPOSAL

1. The facility Medication or Med Policy must include a routine for checking expiration dates on PRN meds that are not frequently used.
2. Expired or discontinued medications must be disposed of properly by returning them to an alternate disposal site such as community medication disposal bins or a county household hazardous waste site. A waiver is required from CCL to address Title 22, Section 80075(I), which is about destroying meds.
3. Documentation of medication destruction must be done by two persons, neither of which can be a client. Specific rules about documentation and retaining records for one year are found in Title 22, Division 6, Chapter 1, Article 6 section 80071 (L)(1)(A through D).

COMMUNICATION WITH HEALTH CARE PROFESSIONALS

1. Facility Policy is to include a routine for checking accuracy of all information on each Emergency Face Sheet or "Grab and Go" documents. It is to kept updated, current and correct. Several copies should be available. Include any needed legal documents, such as Letters of Conservatorship, POLST, or Advance Directive.
2. Emergency Face Sheet or "Grab and Go" documents are to be taken to all Dr.'s appointments/ ER visits/ Hospital Admissions and copies provided to the health professionals.
   a. This includes MAR, Seizure Log, Vital Signs, Weight Record, BM Record, Blood Sugar Log or any other documents with pertinent health information to the appointment.
   b. Questions or issues to discuss should be written down and taken to the appointment, in order to get clear answers.
   c. Health professionals are asked to write down any changes to medications or treatment on your facility form or notes and asked to confirm by signing it. Remember to get a written prescription.

d. Instructions regarding lab work, next appointment, X-rays etc are to be documented on notes or facility forms before leaving a medical appointment. Remember to get a written referral or order form.

3. The prescribing physician/dentist/NP must be notified when a medication is held for any reason and whenever a medication error occurs.

a. Only the prescriber can decide if the medication is to be given or held and for what period.

b.Follow any direction given by the prescriber, communicate and document the instructions.

i. Document this information clearly on the Daily Notes with date and signature of the person receiving the order.

ii. A Special Incident Report must be filed for any medication error, including documentation errors.

4. Before calling a physician gather the following: signs and symptoms of illness or injury, what happened and when, have current medication list available, get vital signs if you have been trained, and write down any questions you want to ask.

5. Know who can legally sign consents for medical, dental or surgical procedures for each of the individuals you serve.

6. When an individual is in the ER or is admitted, be sure to provide the hospital with the main number of the San Andreas office and let them know there is an on-call manager after hours and on the weekends.

7. Before taking individual home from the hospital, always check their skin for pressure ulcers.

8. Before taking the individual home, check for Restricted Health Conditions and be sure there is an approved care plan in place and staff trained before the person goes home.

9. Contact SARC nurse if assistance is needed with hospital discharge planning.

Attachment A

CHECKLIST

Checklist Item	Yes	No
1. Does our facility/agency have written policies and procedures pertaining to the provision of assistance to consumers with the self-administration of medication?	☐	☐
2. Are these policies and procedures uniformly utilized on all shifts? In all of our agency's homes/settings?	☐	☐
3. Is supervisory staff (administrators/program directors/managers, lead staff) provided initial and ongoing	☐	☐

training with regard to these procedures?		
4. Is direct support staff provided initial and ongoing training with regard to these procedures?	☐	☐
5. Did our Facility/agency develop these policies and procedures specific to our consumers' needs?	☐	☐
6. Did our agency purchase these policies and procedures elsewhere?	☐	☐
7. Are our policies and procedures a combination of materials we developed and materials obtained elsewhere?	☐	☐
8. Are our agencies medication policies and procedures available in each consumer home where they are readily accessible to staff for reference?	☐	☐

Do our policies and procedures (P&Ps) contain/include the following:	**Yes**	**No**
1. Information about the importance of safe and accurate management of medication?	☐	☐
2. The "Six (6) Rights" of medication management?	☐	☐
3. The type of packaging that is used/preferred by our agency (bottle, bubble pack)?	☐	☐
4. A description of how to use each medication-related document used by our agency?	☐	☐
5. Specification of who (position) is responsible for oversight of medication management?	☐	☐
6. Specification of who (position) is responsible for initial and re-fill orders of medication?	☐	☐
7. An indication of which staff will fill in for staff primarily responsible for this function when they are unavailable (ill, on vacation, etc.) when initial ordering, re-ordering or discontinuation of a medication is needed?	☐	☐
8. Alternate plans for times when consumer is away from facility (home visit, day program, engaged in community activity) and it is time for medications? A way to document this?	☐	☐
9. Instructions on how medications are to be ordered?	☐	☐

Do our policies and procedures (P&Ps) contain/include the following:	Yes	No
10. Instructions on how medications are to be "checked in" to the facility when delivered, including proper documentation on Centrally Stored Medication Form?	☐	☐
11. Instructions for what staff should do if medications are not available when needed?	☐	☐
12. Instructions for what staff should do if medication dose is dropped or otherwise contaminated?	☐	☐
13. Specification of who is responsible for disposal (returning unused medication to the pharmacy or a drop-off site) of unused medications and how that will be accomplished?	☐	☐
14. A description of how controlled substances are to be managed differently than usual medications? Include Procedure for counting doses and steps to take for missing doses or inaccurate count, and documentation to be used.	☐	☐
15. A description of how PRN (as needed) medications are to be managed? Include documentation to be used.	☐	☐
16. A procedure for how drug information (such as a medication's side effects or special precautions) is to be communicated to staff? Written expectations of staff to read and learn the information?	☐	☐
17. The steps to take when consumer's medication changes or is discontinued (type, dose, etc.) and how this information shared with staff in a timely manner?	☐	☐
18. What "prompts" or "reminders" are used for staff to ensure medication is taken on time as ordered (text/cell phone messages, posted notes, chiming clocks, wrist watches that "beep" at med time, etc.)?	☐	☐
19. A definition of what constitutes a medication error, how it should be reported, to whom and within what timelines?	☐	☐
20. A means of evaluating medication errors when they occur to develop a plan to eliminate or reduce similar types of medication errors from occurring in the future?	☐	☐
21. A description of consequences that will result from med errors (corrective action steps involving employee; possible health consequences for consumer)?	☐	☐
22. Clear and specific Procedures (written step-by-step) for assisting of consumers with the self-adminstration of	☐	☐

Do our policies and procedures (P&Ps) contain/include the following:	Yes	No
medications, including various routes of administration?		
23. Competency skills testing of staff performing Procedures at least annually, with documentation?	☐	☐
24. A description of the location in which medications are to be stored (locked) and prepared (area that is free from distractions, clean, well-lit and able to be secured from unauthorized access)?	☐	☐
25. Protocols for dealing with such problems as a pharmacy not having medication available when order needs filling, inability to reach physician, issues related to funding or insurance, consumer refusal to take medication, etc.?	☐	☐
26. Forms commonly used as documentation of medication management, such as or similar to: Medication Assistance Record (Med Log), Centrally Stored Medication and Destruction Record, PRN Log, count of controlled substances, allergy record that includes all consumer allergies (not just med allergies), med sign-out form for use when consumer visits family, med re-order forms if appropriate, and other forms found to be useful by facility/agency?	☐	☐
27. A method by which our agency will periodically review our medication policies, procedures and protocols for quality, successful utilization and possible modification.	☐	☐

Please note: The items described in this checklist may or may not be required by regulation and are not entirely inclusive of all "best practices" but are offered as a starting point for vendors to begin to assess the quality and completeness of their systems of management and Assistance of medications and to begin dialogue with their staff and/or others about the very critical health and safety issues related to the use of medications in residential settings.