SUBJECT: MEDICAL SERVICES
OAR: 411-325-0120 (1) (a-g) (2a) A-D b (A-F) c-d (A-C (3) a (A-C) b (A-J) c (A-B) d-e (A-D) f (A-G) (4) a-b (5) (6) 411-380-0060 (1) (a-d) 411-380-0060 (2)

POLICY:

(1) a (2) a All individuals will receive care that promotes health and wellbeing. The individuals will see a primary physician or primary health care provider whom they, the parent, guardian or legal representative has chosen from among qualified providers. The individuals also will have a secondary physician in the event of an emergency. The individuals will see the physician a minimum of every two years, evidence of the examination will be placed in the individual's record.

PROCEDURES:

- Individual Health Care **(2) (A-D)**:

(1) g Benco will monitor the health-status and physical conditions of the individuals to assure early detection and prevention of infectious disease and act in a timely manner in response to identified changes in conditions that could lead to deterioration or harm. Benco will assist individuals with therapy and the use and maintenance of adaptive equipment and prosthetic devices as ordered by a physician.

All individual's medical records will be kept confidential, and no records will be copied or removed from the program by anyone other than approved Benco personnel.

Prior to a physician's visit Benco will complete a physician's order form with identifying information about the individual. The form will include the individual's current list of medications with dosage and include PRN medications, treatments and special diets. Benco will document the reason for the visit, including any complaints from the individual and any allergies on the physician's order form.

During the visit, the physician will write any changes in current orders on the form and sign it. After the visit, Benco will document any instructions or information the physician may give and the accompanying employee signs, dates and notes the time on the

bottom of the physician's order form. Benco will document the physician's visit in the individual's T-log.

Occasionally, in lieu of a physician's visit, a physician may prescribe changes in existing medications or prescribe a new medication by telephone. The physician may call the pharmacy and give the order as directed, if not, Benco will ensure that the order is received by the pharmacy. The pharmacy will deliver the medication, or Benco will pick up the mediation at the earliest possible time.

The employee who took the call will fill out a physician's telephone order form and indicate the date, time, name of the individual, name of the physician, name of the person taking the order and verbatim telephone instructions. The employee will make sure the telephone order includes the name of the medication, the dosage of the medication, the time of day and how many times per day the medication is to be given. The telephone order must give the route the medication is to be given, any special instructions and the length of time the medication is to be given. If the medication is a PRN, write the circumstances to which the medication is to be given on the telephone order.

Once the telephone order form is properly filled out it will be faxed or mailed to the physician, within two business days from the date the telephone order was written. A self-addressed stamped envelope will be included for prompt return of the telephone order if it is mailed. The Program Coordinator must call the physician to follow up if the telephone order has not been signed by the physician and faxed or mailed back within two weeks. When the signed original telephone order is returned, the Program Coordinator will discard the unsigned telephone order and place the original signed telephone order in the individual's records.

T-logs are used to keep current record of all medical or medically related events and to provide a means of following medical problems to resolution. Benco will document in the individual's T-log after a medically related incident, stating the facts and actions taken including any notification of others and any instructions that were received from a physician or Program Coordinator.

A GER will be filled out for any seizure according to the individual's seizure protocol. All seizures are to be documented on a seizure tracking form, be sure to document every detail of the seizure.

(1) b (2b) A-F All medications, other than basic first aid, will have a written physician's order signed by a physician or licensed health practitioner for the following: medication; prescription; non-prescription; PRN or treatment; special diet; adaptive equipment; or aids to physical functioning. The written order will be obtained prior to the administration or self-administration by an individual other than basic first aid. Medication requiring a physician prescription needs to be labeled to match the order. Non-prescription (over the counter) medications do require a physician order.

The Program Coordinator is responsible for preparing the 180-day medication review for the individuals' physician to review and sign. The current 180-day medication reviews will constitute a current physician's order for medication and non-prescription medications.

(2c) Benco will ensure that all physicians or qualified health care provider orders are implemented as soon as the order states.

(2d) A-C Benco will maintain records on each individual to aid physicians, licensed health professionals, and the program in understanding the medical history of the individual. The records will include a list of known health conditions, medical diagnoses, known allergies and immunizations. The individual's record will also include visits to licensed health professionals that include documentation of the consultation, any therapy provided and a record of known hospitalizations and surgeries. Employees will check the T-logs, logbook and each individual's medication administration record at the beginning of each shift. If more than one employee is working on shift, ensure that it is clear who will be responsible for administering medications and treatments to individuals on that shift.

Always wash hands thoroughly before administering medications and between giving topical medications or treatments. Always wear gloves when applying topical medications or treatments. Set up medications for only one individual at a time. Compare the medication order, container/bubble pack and label to the medication/treatment administration record for the individual being given the

medication/treatment. Employees will ensure they are giving the right medication, the right dose, using the right method of administration, at the right time, to the right individual.

Employees will compare the label with the medication/treatment administration record three times; before giving the medication; when giving the medication; and when putting the medication container away.

If there is a discrepancy between the medication or treatment administration record, the medication or treatment label or the 180-day medication review, do not give the medication without checking the original physician's order. Employees will call the Program Coordinator for questions, if the Program Coordinator is not available, employees will call the pharmacy or physician.

If medication is in a bubble pack, punch out the medication into a medication cup that corresponds to the date and time being administered. Medications or treatments may be administered between one hour before and one hour after the time prescribed for administration. Employees are to administer medications or treatments at the exact time prescribed whenever possible.

In the event of a medication or treatment being administered more than one hour before or one hour after the prescribed time refer to the individual's late or missed medication or treatment protocol for instructions. If no protocol is in place for the medication or treatment, call the individual's physician for a telephone order. Fill out a telephone order form with directions from the physician.

As a rule, medications should never be punched out of the bubble pack before the time of administration. Employees that accompany the individual will take the medication or treatment administration record with them for administering the prepared medication or treatment.

Exceptions would be for medications prepared for administration away from the program. If an individual is away from the program overnight or longer, employees may send the bubble pack with the person accompanying the individual. Employees are to prepare a separate medication or treatment administration record for the individual and keep the original at the program. If the employee is preparing medications or treatments for later administration, punch the

mediations into a medication envelope and write the individuals name, the name of the medication, dosage, method of administration, date and time of the medication or treatment on the outside of the envelope.

Employees that accompany the individual will take the medication/treatment administration record with them for administering the prepared medication/treatment. If the medication is not in a bubble pack, dispense the correct dosage into a disposable medication cup.

If the medication is topical, apply to the body or assist the individual to apply to the specific body part per the physician's order. If the medication is a liquid, dispense it into a measured medication cup or syringe. Remain with the individual until verification that all oral medication has been swallowed.

Immediately after administering the medication or treatment initial in the correct box on the medication or treatment administration record that the medication or treatment has been given.

Any documentation or administration or treatment irregularity will be documented by placing a circle around the applicable initial space on the front of the medication or treatment administration record. An explanation of all circled spaces will be documented on the back of the medication or treatment administration record. If the medication or treatment has been administered with some irregularity, employees will initial the applicable space and circle his or her initials. If the medication or treatment has not been administered, the employee will circle the initial space but leave it blank.

Documentation errors will be circled on the front of the medication or treatment administration record and explained on the back. A GER will be written for all medication/treatment administration irregularities with the sole exception of medications or treatments being sent home with relatives, to work, or away on a trip.

Administration errors include, not administering a medication or treatment, administering medication or treatment early or late, administering the wrong medication or treatment, administering the wrong dosage, administering the medication or treatment using the wrong route (oral vs. rectal or topical) administering medication that is expired or contaminated or from an illegible or unlabeled container.

Documentation errors include, failing to initial the medication or treatment administration record or PRN administration record after administering a medication or treatment, initialing the wrong space on the medication or treatment administration record or PRN administration record.

Medication or treatment irregularities include medication or treatment sent home, to work, or on an outing with another organization or person. Such irregularities do not require documentation of a GER or any documentation on the back of the medication or treatment administration record. However, medications or treatments to be given away from the program will be documented on the medication or treatment administration record, accordingly, using the following key codes; W=work; A=away; and H=hospital.

When a medication or treatment is refused, an "R" for refusal will be documented in the appropriate space on the medication or treatment administration record. The "R" will be circled on the medication or treatment administration record and documented on the back of the medication or treatment administration record and a GER will be written.

To avoid errors, always prepare medication for only one individual at a time; never administer medication or treatments prepared by another person; stay with the individual until that person has completely swallowed all oral medications. Do not leave medications with the individual or on the counter, never administer medication that is expired, contaminated, or from illegible or unlabeled containers. Never administer a medication if there is a question about it, contact the Program Coordinator, pharmacy or physician to clarify questions and always communicate with co-workers as to who will be giving the medications or treatments.

- Medications **(1) c (3a) A-C:**

All medications will be kept in the original container labeled by the dispensing pharmacy, product manufacturer or physician as specified per the written order of the physician or qualified health care provider. All medications will be kept in a secured locked area and stored as indicated by the product manufacturer.

(3b) A-J On a monthly basis Benco will develop a medication administration record (MAR) for each individual and record any prescription or non-prescription drug ordered by the individual's physician and administered to or by the individual. A separate form printed on colored paper will be developed for PRN's each month and will have the same information for each individual as the medication or treatment administration record for all regular medications or treatments.

The medication or treatment administration record will include the name of the individual, a transcription of the written order by a physician or qualified health care provider, including the brand or generic name of the medication, prescribed dosage, frequency, reason for taking and method of the administration.

For topical medications or treatments without the order of a physician or qualified health care provider, a transcription of the printed instructions from the package will be written on the medication or treatment administration record and/or PRN administration record.

Times, dates and method of administration or self-administration of the medication or treatment will be written on the medication or treatment administration and/or PRN administration record. The signature of the person administering or the person monitoring the self-administration of the medication or treatment will be on the medication or treatment administration record and/or PRN administration record.

An explanation of why a PRN medication or treatment was administered, and documentation of the effectiveness of the PRN medication or treatment administered or self-administered will be written on the PRN medication or treatment administration record. Documentation of the effectiveness will be recorded on the back of the PRN administration record no more than two hours after the medication or treatment was given.

An explanation of any medication or treatment administration irregularity will be documented on the back of the medication or treatment administration record and/or PRN administration record and documentation of any known allergy or adverse drug reaction will be written on the medication or treatment administration record and/or PRN administration record. Documentation of any known allergy or

adverse drug reaction will be written on the medication or treatment administration record and/or PRN administration record. If a medication or treatment irregularity or error occurs, the person recording on the front side of the medication or treatment administration record and/or PRN administration record will indicate referral to the backside by circling the box with the person's initial's requiring an explanation.

(3c) A-B For individuals who independently self-administer medications or treatments, there will be a plan as determined by the ISP team for the periodic monitoring and review of the self-administration of medications or treatments.

The program will ensure that individuals able to self-administer medications or treatments store them in a place unavailable to other individuals residing in the same residence and store the medications or treatments as recommended by the product manufacturer.

(3d) PRN (i.e., as needed) orders are not allowed for psychotropic medication.

(1) d (3e) A-D Safeguards to prevent adverse medication or treatment reactions will be utilized that include, obtaining all prescription medication or treatments, except samples provided by the physician for an individual from a single pharmacy which maintains a medication profile for each individual. Benco must document in the individual's record as to why all medications are not provided through a single pharmacy

Information about each prescribed medication or treatment effects and side effects will be maintained and ensure that all medications or treatments prescribed for one individual will not be administered or self-administered by another individual or employee.

If any apparent adverse reaction to a medication or treatment such as a rash, nausea, difficulty breathing, etc., is observed employees will immediately get instructions from the individual's physician. Employees will notify the Program Coordinator and write a GER.

If an employee observes any apparent adverse reaction of self-administered use of medical or recreational marijuana/cannabis or alcohol the employee will write a T-Log and continue to monitor the

individual. The employee will call 911 if they are concerned with the immediate health and safety of the individual.

f (A-B) (i-vii) All expired, discontinued, recalled, or contaminated medications, including over-the-county medications, will not be kept in a home and will be disposed of within 10 calendar days of expiration, discontinuation, or a provider's knowledge of a recall or contamination. Benco will dispose of the prescription medications for an individual who has died with 10 calendar days of the individual's death. Medications will be disposed of in coffee grounds with water added and placed in a plastic bag that seals. The plastic bag will be placed in a garbage bag and the garbage bag will be placed inside of another garbage bag and disposed of in the trash. A written record of the disposal will be maintained that includes, documentation of the date of disposal; a description of the medication, including dosage, strength and amount being disposed; the name of the individual the medication was prescribed for; the reason for the disposal; the method of the disposal; and the signature of a manager. For controlled substance medications, two manager's signatures will be on the disposal record.

- Nursing Services (4) a-b

(a) When an individual's health needs require nursing care, or the individual has been identified by a physician or registered nurse as requiring continuous nursing care, the individual will be immediately transferred to an appropriate program or facility. Benco will ensure that services are provided by and coordinated with licensed nursing employees.

(b) When nursing services are provided to the individual, Benco will coordinate with a registered nurse to ensure that the care being provided is sufficient to meet the individual's health needs. Benco will implement the nursing service plan as agreed upon by the Individual Support Plan (ISP) team and the registered nurse. Benco will ensure that the registered nurses provided will have a valid nursing license to practice nursing services in Oregon.

- Delegation and Supervision of Nursing Tasks (5)

(5) Nursing tasks will be delegated by a registered nurse to a provider in accordance with the rules of the Oregon State Board of Nursing.

- Direct Nursing Services (1) a-d (2)

(1) Direct Nursing Services will be delivered by the following enrolled Medicaid providers:

(a) A self-employed LPN or RN licensed under ORS 678.021 may also be an adult foster home provider or family member.

(A) An adult foster home provider must also be licensed under OAR 411-6360-0040.

(B) The decision to have an adult foster home provider or family member deliver direct nursing services must:

(i) Be made by the individual and the ISP team.

(ii) Be documented; and

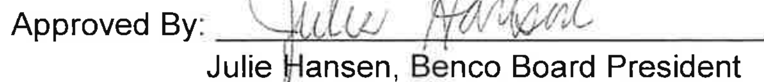
(iii) Not be for the convenience of the adult foster home provider or family member.

(b) Home health agency licensed under ORS 443.015 and meeting the requirements of OAR chapter 333, division 027.

(c) In-home care agency licensed under ORS 443.315 and meeting the requirements in OAR chapter 333, division 536.

(d) A direct nursing services agency meeting the requirements in OAR 411-380-0065.

(2) The legal representative of an individual is prohibited from providing direct nursing services.

Approved By:  Date: 8/17/23
Julie Hansen, Benco Board President