MEDICATION ASSISTANCE PROCEDURE STANDARDS

For Adult DD, Child DD, and ABI Waiver Providers

Developmental Disabilities Division
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PROVIDER REQUIREMENT

All Developmental Disabilities Division home and community-based waiver providers, who assist participants with medications, are required to comply with the Medication Assistance Standards, which were effective July 1, 2009 and revised April 19, 2011. Compliance with the standards includes providers having their own policies, procedures, and documentation tools implemented in accordance to these standards in order to ensure the health and safety of waiver participants who take medications. The policy standards are clarified in a Medication Assistance Policy document available on the Division's website under the "Medication Assistance Information" webpage. The Procedure Standards listed in this document shall be used by the provider to develop specific internal procedures, processes, and documentation tools to comply with the Division's policy.

For questions regarding provider requirements for Medication Assistance, contact a Division Nurse, either Paul Delap at 307-235-1182 or Dawn Wright at 307-856-9083, or contact your local Provider Support Specialist.

PRN PROTOCOL

The provider shall have policies and procedures for assisting with PRN medication, which are medications given "as needed" for a participant's illness or medical condition. The policy and procedures shall include:

1) Guidelines for how the PRN protocol in a participant's plan of care will be implemented.
2) Who will be designated to do the assessment for the need of a PRN.
3) Who will assist or administer the PRN,
4) Who will monitor the participant for side effects after it is taken,
5) How the usage of the PRN is to be documented, and
6) Who will analyze the patterns of PRN usage to assure an appropriately trained medical professional assesses, monitors, and re-evaluates the participant, at least annually, to determine if the PRN medication is still needed or is still appropriate for the participant's medical condition.
7) How frequent the monitoring will occur, but at least quarterly by the case manager and more frequently as needed for some participants or types of medication.

PRN BEHAVIORAL MODIFYING MEDICATION

The case manager shall be the second line monitor for medications given for the purposes of modifying a behavior, including prescribed PRN medications and non-prescription PRN sedating medications. The participant's physician or psychiatrist shall always be the first line monitor of a medication regimen.

The provider shall have policy and procedures for assisting and monitoring PRN behavior modifying medication in compliance with the Division's standards, to include the following:

1) The qualified person(s) responsible for assisting the participant with these medications.
2) The qualified person on the participant's team who will be designated to assure an appropriately trained medical professional continually assesses, monitors, and re-evaluates the participant to determine if the PRN behavioral modification medication is still needed, is having adverse effects on the participant, or is still appropriate for the participant's medical condition.
3) How the PRN medication will be used in accordance with the type, frequency, duration, route, and specific instructions as prescribed by the participant's licensed medical professional involved in his/her treatment plan.
4) How the positive behavior support plan in the participant's plan of care will be followed, including the use of less restrictive interventions before using a PRN
5) Specific PRN instructions for behavioral modifying medication, including:
    a) Documentation of the PRN as an internal incident report
    b) The qualified person evaluating the participant face-to-face within one (1) hour after the PRN is taken and documenting the participant's reaction to the PRN.

c) The types of incidents relating to PRN usage or administration that would be deemed "critical incidents" and reportable to the Division, Department of Family Services (DFS), Protection & Advocacy Systems Inc, the participant's case manager and guardian, if applicable.
d) The responsible person for reviewing the use of the PRN for behavioral modification purposes.
e) The requirements of the review, including:
    i) Verification that the provider's policies and procedures regarding medication assistance and the participant's PRN protocols in the plan of care were followed.
    ii) Verification that the positive behavior support plan for the participant was followed, including less restrictive techniques.
    iii) Determination if staff involved in the use and administration of the PRN had received appropriate training in accordance with the Division standards and utilized this training appropriately when assisting with the PRN medication.
    iv) Recording the review of each PRN used in the provider's information system and reviewed for:
        (1) Analysis of patterns of use.
        (2) History of use by personnel.
        (3) Environmental contributing factors.
        (4) Assessment of program design contributing factors.
        (5) If PRN usage is suspicious or raises concerns regarding the participant's health and safety, then the provider shall contact the participants licensed medical professional.

MEDICATION LABELING AND STORAGE

Provider policies and procedures shall adhere to the following standards for medication labeling and storage. Prescription medications and pharmaceutical samples prescribed by a physician or licensed health professional shall bear the original prescription label or written statement specifying:

1) Participant's name,
2) Medication name,
3) Amount and frequency of dosage, and
4) Name of prescribing physician or other health professional.

Non-prescription medications shall be stored in the original container and shall be accompanied by written instructions from the participant or legal guardian or medical professional specifying:

1) Participant name,
2) Medication name, and
3) Amount and frequency of dosage(s).

All medications shall be stored:

1) In a location and container that is inaccessible to participants.
2) Refrigerated medications will be in a container inaccessible to participants in the home or in a separate refrigerator.

Any medication that is not in the original dispensed container must have the name of who the medication is for, the name of the medication, the dosage, the frequency, and a brief description what the medication looks like on the packaging that is used.

MEDICATION RECORDS

The qualified person assisting with medications shall have immediate access to current individual records of all medications, including prescription and nonprescription medications used by the participant, both regularly scheduled and PRN, including:

1) Medication name
2) Frequency and Dosage, including strength or concentration
3) Instructions for use, including administration route
4) Potential side effects
5) Drug interactions
6) For prescription medications:
    a) Prescribing professional name and number
    b) Dispensing pharmacy and contact information

MEDICATION ASSISTANCE RECORD

The provider shall use a Medication Assistance Record (MAR), which meets the Division requirements, for each participant who receives assistance from the provider with medication. The MAR form shall ensure consistent support and assistance with medications and records each medication taken by the participant. Each participant requiring medication assistance shall have an MAR, including the following list of components:

1) Participant name
2) Allergies
3) Medication name(s)
4) Dosage and the strength or concentration of the medication(s)
5) Administration Route(s)
6) Special instructions, if applicable
7) Date and time of the medication assistance needed
8) Initials, signatures and title of person who assisted with the medication.

MEDICATIONS OFF-SITE

Used primarily by Special Family Habilitation Home, Residential Habilitation (RH), and "Host-home" RH providers, the following process shall be in place when medications are given off-site to other designated persons referred to in the plan of care, for reasons such as home visits, special trips, etc. The provider's policy and procedures shall ensure:

1) The following information and items are given to the receiving entity:
    a) A copy of the participant's Medication Assistance Record (MAR)
    b) Medications needed:
        i) The amount of medicine needed for the event is supplied
        ii) Medication stored and labeled in accordance with the Division's standards
        iii) Provider contact information
    c) The itemized list of medications, amounts, and information are given to the receiving entity and the entity's signature is acquired indicating that the entity has received the specified medications, amounts, and the required information.

MEDICATION INCIDENT REPORTING

Providers shall develop policies and procedures to comply with the following Division's standards for reporting and tracking medication errors and tracking other medication incidents. The provider policy and procedures shall include:

1) Medication Error categories reportable to the Division, to include any occurrence of the following due to staff error:
    a) Wrong medication
    b) Missed medication
    c) Wrong dosage
    d) Wrong participant
    e) Wrong route
    f) Wrong Time – Deviation from accepted standard time frame
2) Staff information collected, including:
    a) Name of staff, who made the error,
    b) Status and notes of retraining
    c) Date of retraining
3) Type of Provider, who made the error:
    a) Independent provider with no employees
    b) Provider Staff Member or Employee
4) Time of day the error occurred:
    a) Morning
    b) Afternoon

    c) Evening
    d) Late Night
5) Whether the medication was either:
    a) Scheduled Medication
    b) As-Needed medication
6) If the medication error resulted in hospitalization or physician visit
7) If the medication was a newly prescribed medication within the last 72 hours
8) Other Medication Incident Reporting categories for internal incidents, including:
    a) Refusal to take medication,
    b) Medications deemed inappropriate to be given or medications not able to be given due to safety concerns,
    c) Expired or damaged medication,
    d) Lost or missing medication,
    e) Other medication events determined to need action.
9) The method(s) used to rectify problems in a quick and appropriate manner, including possible consultation with the person's physician or other medical professional, including:
    a) The person responsible for reporting to other parties,
    b) The timeframe for reporting any incident,
    c) The other necessary parties to report such incidents, such as the case manager, guardian, etc.
    d) The responsible party who will review incidents for trends and quality improvement
    e) The system used to:
        i) Track incidents,
        ii) Analyze how the incident(s) happened,
        iii) How the incident(s) were rectified, and
        iv) If other concerns are noted for further follow up.
    f) Analysis of these events is to be performed at least quarterly by the case manager and must include follow up of identified trends.

Medication Errors reported to the Division do not have to be reported to Protection & Advocacy Systems, Inc., Department of Family Services, or police unless the medication error is considered suspected abuse, neglect, self-neglect, and/or a crime, such as medication diversion pursuant to Wyoming Medicaid rules Chapter 45.

All medication errors that meet the Division's criteria shall be reported to the Division through the Critical Incident Reporting process within 24 hours of the error. The Division shall review:

1) If the medication error is an incident that should be reviewed by other investigative parties for further follow up.
2) Provider follow up after the error to review that the action taken by the provider was appropriate in addressing and resolving the incident.
3) Trend analysis on reported errors.
4) If the provider needs to complete a Quality Improvement Plan within 15 days to address the concerns.
5) If other sanctions or follow up monitoring with the provider is necessary to ensure the health and safety of participants in the provider's care.