ABI EMERGENCY NOTIFICATION PROCEDURE

Immediate phone call notification to Administration includes, but is not limited to the following:

- Any incident involving a call to 911, police, fire or other public safety officials
- Any media involvement/requests including television, print media or other
- Any threats from or serious confrontations with neighbors or public officials
- Any other incident that may seriously jeopardize the health and safety of an ABI/MFP resident (e.g., illnesses requiring urgent care or ER visits, hospital admissions, auto accident, any life threatening events or death).
- Any allegations of abuse neglect and mistreatment
- Any incidents of missing individuals
- Any incidents of emergency relocations
- Any incidents of significant behavioral incident, e.g., dangerous aggression, suicidal ideation, threats of suicide, etc.
- Any incidents of intoxication or illegal drug use by the individual

When in doubt, please call your supervisor or on-call administrator.

How to provide immediate phone call notification:

- During business hours, Staff should call the House Manager; After business hours, staff should call the On-Call Administrator.
    - If unable to contact the House Manger on Duty, staff will call the ABI Program Director.
    - If unable to contact the ABI Program Director, staff will call the VP of Operations.
    - Repeat the procedure as needed to inform the people above.
- For incidents involving Medication Errors: Staff should notify the On-Call Administrator who will notify call the MAP Consultant and ABI Program Director.
- In the event of a Staffing Ratio Breach, immediately call the On-Call Administrator (each home's minimum staffing ratio can be found in the Safety Plan

Emergency phone numbers are to be posted on the bulletin board near the home office. If you use your cell phone as your primary phone, then the emergency numbers should be listed in your contacts.

ABI EMERGENCY PROCEDURES (MEDICAL, ILLNESS, ACCIDENT)

The following procedures are required when dealing with a serious illness or accident.

PROCEDURE:

1. Obtain help by calling **911** to activate the emergency response system. Remain with the individual if another person is available to place the emergency phone call. Always call if:
    a. The person appears very ill.
    b. Symptoms developed very suddenly and are significant enough to stop normal activity.
    c. The person has difficulty breathing.
    d. The person has chest pain or discomfort.
    e. The person has fallen and hit his/her head or an unwitnessed fall.

2. Treat the person using your First Aid/CPR according to your training. If the Heimlich Maneuver or CPR have been performed, 911 should be called for further evaluation.

3. Have available an updated list of the individual's current medications and the **Authorization to Secure Medical Treatment Form**.

4. A copy of the Emergency Fact Sheet will be kept on site and will also travel with the individual when receiving medical treatment.

5. Call your supervisor to report the incident. The ABI Program Director must be notified as quickly as possible following the call to 911. If after hours call The Emergency on call number. **Emergency phone numbers are to be posted on the bulletin board near the home office. If you use your cell phone as your primary phone, then the emergency numbers should be listed in your contacts.**

6. The ABI Program Director will be responsible for notifying the VP of Operations, the DDS Service Coordinator/Supervisor, and the President and CEO as needed. Submit a written report to the VP of Operations within 24 hours of any incident, accident, major illness or death. (See incident report form).

The following procedures are required when managing non-life-threatening illnesses or accidents.

PROCEDURE:

1. Always refer to your training in Signs and Symptoms of Illness.

2. If you think that there may be a health problem:

    a. Call or talk to the House Manager. If after hours contact the emergency on call. **Emergency phone numbers are to be posted on the bulletin board near the home office. If you use your cell phone as your primary phone, then the emergency numbers should be listed in your contacts.**
    b. Report what you see and what you have done to address the problem.
    c. If you think the individual is ill, call the primary care physician or 911 as appropriate.

3. If the individual is involved in a motor vehicle collision, even a minor one, it must be reported to The Arc of Plymouth and Upper Cape Cod and the individual must be examined by either an EMT or a physician ASAP. Follow emergency procedures. If 911 is called because of the motor vehicle accident notify the ABI Program Director and go with the individual either in the ambulance or following in a vehicle if riding with them is not possible.

It Is the policy of The Arc of Plymouth and Upper Cape Cod never to compromise the safety of an individual. All emergency telephone numbers must be posted by the phone and placed in the caregiver's cell phone. A copy of The Arc Missing Persons Procedure should be readily available to refer to. If an individual is lost or missing, the following procedures should be implemented immediately.

PROCEDURE

1. When an individual has been identified as missing, DO NOT WAIT. Call your local Police Department.

2. Fully cooperate with the efforts of the local Police Department.

3. Initiate a search, which will include: local neighborhood and other service locations, other places frequented by the individual and local hospital emergency rooms. Always have one person stay by the telephone. Bring your cell phone when you conduct the search.

4. Immediately notify the ABI Program Director (if not on site), and the Director of Program Operations. The Director of Operations is to notify the Executive Director.

5. If they cannot be reached, call the emergency phone number to notify The Arc administrator on call. (508) 209-1097.

6. Always keep a copy of the individual's Emergency Fact Sheet, to provide necessary information to authorities, as appropriate.

7. Once the individual is located, they should be checked for any injury and be seen by their PCP, Urgent Care or the local ER.

FOLLOW-UP

The ABI Program Director or Administrator On Call will notify the individual's family or guardian and/or the Department of Developmental Services, as appropriate, and initiate an investigation in compliance with DDS regulations. An Internal Incident Report and/or HCSIS incident report will be submitted within 24 hours.

STAFF RESPONSIBILITY WHEN 911 IS USED:

Ambulance Responsibilities

If 911 is accessed and an ambulance is used for transport to the hospital ER a decision will be made by the House Manager if an Arc staff member must ride in the ambulance with the individual based on the following conditions.

- If allowed, ride in the ambulance with the individual if they are seriously hurt, presenting with a great deal of pain, emotionally distraught, behaviorally upset or are asking staff to ride with them.

- If the individual is calm and the injury or reason for transport is mild, staff will not ride in the ambulance but will meet the individual at the hospital unless a request is made by the individual to accompany them in the ambulance.

Staff from The Arc will be responsible for bringing the individuals emergency fact sheet and any other critical medical information to the hospital to share with the attending team.

If staff ride in the ambulance with the individual it will be the responsibility of the House Manager to arrange for the staff to be picked up from the hospital and returned to their assigned work location.

Hospital Responsibilities

All individuals who are transported to the hospital must be met at the hospital by an Arc staff member regardless of caregiver/guardian/residential staff presence. Staff will directly support the individual if the caregiver/guardian/residential staff is not present, sharing necessary information with the attending team. If the caregiver/guardian/residential staff is present, the staff will respond to questions they may have regarding the reason for the trip to the ER.

If involving individuals from ABI Residential Program, staff will remain with the individual at the hospital until relieved. Individuals should be staffed at the hospital, exceptions will require approval by the President and CEO. For all other programs, Staff from The Arc will be able to leave the ER once the caregiver/guardian has arrived, all their questions have been answered, the individual is comfortable with staff leaving and the staff have received approval from the Program Director or VP of Operations. Staff who rode in the ambulance will contact the Program Director to let them know they will need to be picked up.

ABI PROGRAM PARTICIPANT CONSENT

Informed consent will be obtained from individuals or their guardians when required. All content related to the needed consent will be shared in the primary method/language used by the individual/guardian to ensure full understanding of information. Individuals and guardians will be informed that giving consent is voluntary and that the consent can be withdrawn at any time.

1. GENERAL CONSENT

Consents presented to all individuals residing in ABI homes include:

a. Program Participation
b. Emergency Treatment
c. Permission for Release of Photographic or Video Form
d. Release of Information (specific for each physician, etc.)

All consent forms will be maintained in the individual's confidential file.

2. BEHAVIORAL CONSENT

a. Consent must be obtained for all Level I and II behavioral strategies. The consent must be given by the individual if they are not under guardianship or if they are under guardianship their guardian must approve.

   To obtain approval the plan must be explained in a manner understood by the individual/guardian. The explanation will include:
   i. Intended outcomes
   ii. Risks/Benefits
   iii. Alternative Options
   iv. Inform that consent can be withdrawn at any time

   All questions regarding the treatment plan must be answered.

b. If restrictive practices are put into place that are intended for one individual that effects other individuals a written rationale will be needed. The rational is to be reviewed by HRC. Provisions must be made so as not to unduly restrict the rights of others.

3. Individuals and guardians will be informed of their human rights and how to file a grievance or who they should speak to if they have a concern. A packet will be sent to individuals and guardians that includes the following information.
   a. Cover letter which clarifies that the attached information is designed to help with advocacy to uphold basic human rights.
   b. Safeguarding Human Rights: The Role of Families and Guardians from DDS

ADMINISTRATIVE REVIEW PROCESS – DPPC MANAGEMENT

The Arc of Plymouth and Upper Cape Cod takes all allegations of abuse, neglect or mistreatment very seriously. Whenever a DPPC has been filed the following process will be implemented:

1. Staff/caregivers who receive any/all complaint related information will inform their Program Director immediately via telephone – if after hours in residential services the on-call administrator will be notified.

2. The Program Director will document when and from whom notification was received. Notifications may come from:
    a. Staff who filed if known
    b. DPPC/DCF
    c. DDS
    d. Community Partner/Sister Organization
    e. Family Member
    f. Anonymous
    g. Other

3. The on-call administrator, Program Director or designee will take immediate steps to ensure the safety of the individual, including seeking medical treatment if indicated. This includes immediate suspension, with consultation from the Program Director and Human Resources, of the alleged abuser pending the outcome of an Administrative Review. If suspension occurs after business hours, Human Resources will be contacted as soon as possible. In other cases, and only as approved by the President and CEO, the alleged abuser may be transferred to a different site/program and will not be allowed to have contact with the alleged victim until the administrative review is completed and a determination, made in conjunction with Human Resources, is reached.

4. The Program Director will immediately notify the VP of Operations or designee, who in turn will notify the President and CEO and the VP of Program Development who will serve as the gate keeper for all administrative review processes. Program Director will ensure that the funding source and guardian are notified as soon as possible of all formal allegations. Family will be notified unless otherwise indicated.

5. Once the person's safety has been ensured the President and CEO will determine if an Administrative Review is indicated and if so, will assign a Reviewer. Reviewers will be selected from a cadre of administrators who will initiate the Administrative Review as soon as possible. If the issue has been referred to law enforcement/District Attorney's office and/or is an allegation of sexual assault or rape The Arc of Plymouth and Upper Cape Cod WILL NOT perform an administrative review – this includes abstaining from typical managerial practices (e.g., interviewing staff; interviewing the person, etc.).

6. Whenever possible Reviewers will be selected from either a different service type or department. All attempts will be made to ensure the objectivity of the Reviewer; therefore, employees should not take lead in an Administrative Review involving individuals for whom they are administratively or clinically responsible.

7. All draft Administrative Reviews will be submitted to, edited and approved by the President and CEO prior to dissemination. The President and CEO will approve as evident by signature.

8. The VP of Operations, Reviewers, the VP of Program Development and the President and CEO will receive summary copies of all final Administrative Reviews with associated conclusions and recommendations. Included in the final admin review: The Administrative Review, Summary, Conclusion and Findings, and Recommendations.

9. The VP of Operations in conjunction with the Program Director will develop the Action Plan including action to be taken, timelines and who will be assigned.

10. The VP of Operations is responsible for ensuring that all follow-up has occurred within required timelines.

11. Once all follow up is completed, the VP of Operations will review and submit a completed action plan with a summary of recommendations and all specific actions taken to the VP of Program Development.

12. All supporting documentation relative to the action plan (e.g., training documentation, revised protocols, etc.) will be submitted to the VP of Program Development.

13. When requested, the Area Director or designee will receive the summary of The Arc of Plymouth and Upper Cape Cod's Review and Action Plan.

14. The Human Rights Committee will be apprised of the allegations of abuse and all subsequent findings, recommendations and actions taken.

The VP of Program Development will act as gatekeeper for all business associated with allegations of abuse, mistreatment and neglect of adults or children served by The Arc of Plymouth and Upper Cape Cod. The VP of Program Development will coordinate all efforts and house all documentation regarding Administrative Reviews completed at The Arc of Plymouth and Upper Cape Cod

AGENCY SUICIDE PROTOCOL

(CALL ABI HOUSE MANAGER AFTER HOURS, CALL EMERGENCY ON CALL)

*Emergency phone numbers are to be posted on the bulletin board near the home office. If you use your cell phone as your primary phone, then the emergency numbers should be listed in your contacts.

Suicide Attempt

- 1 Person is to stay with the individual and call 911
- If the person is injured follow the direction of the 911 operator while waiting for emergency services to arrive
- 2nd person (if available) should contact: Emergency On Call
    - Emergency On Call will contact: ABI-Program Director, the VP of Operations, Guardian and DDS. The VP of Operations will inform the President and CEO. The clinician will also be notified.
    - If 2nd person is not available, 1st person will call Emergency On Call # and they will make remaining calls ASAP.
- Upon completion of Screening/Intake all parties listed above will be contacted with results.
- All required paperwork will be completed and submitted within required timeframes per HCSIS/MassHealth, etc. (HCSIS, incidentreports@plymouthcapearc.org)
- Prior to discharge, the team will develop a safety plan.
- The safety plan will be forwarded to DDS/funding agency.
- All staff will be trained in the safety plan and document completion of training.

Suicide Threat

- Ensure that the individual is within line of sight at all times
- Call Emergency On Call # who will notify ABI Program Director.
- Take the individual to the ER for a screening or call 911 for ambulance transport.
- Call Emergency On Call-with outcome of screening. Emergency On Call will then notify ABI Program Director with the outcome of the screening
- If admitted
    - The team will meet prior to discharge to develop a safety plan.
    - All staff will be trained in the safety plan and document completion of training.
- If screened and released
    - Individual should be monitored closely for 24 hours (line of site during wake hours, bed checks as determined by the team).
    - If they have alone time, it should be suspended for 24 hours
    - A team meeting will be held to put protocols in place around suicide threats
    - All staff will be trained on protocols and document completion of training.
- All paperwork must be completed and submitted within required timeframes (HCSIS, incidentreports@plymouthcapearc.org)

Chronic Suicide Threat

- Treat as a Suicide Threat as stated above until or unless there are strategies in place that have been developed and signed off on by the consulting clinician, President and CEO, the individual's treating Psychiatrist, DDS, HRC.
- Regardless of having strategies in place, the Emergency On Call must be contacted each and every time a threat is made.
- If the Emergency On Call or other parties as listed above decides the person should be screened, it will over-ride the strategies.
- Data will be collected on frequency of threats
- All paperwork must be completed and submitted within required timeframes (e.g., HRC restrictive practices, approvals, etc., as well as HCSIS reports and internal incident reports submitted to incidentreports@plymouthcapearc.org)

BEHAVIORAL/CLINICAL EMERGENCIES

The Arc of Plymouth and Upper Cape Cod/ABI Program does not permit the use of physical restraint, mechanical restraint and/or chemical restraint. If there is a behavioral concern or behavioral emergency for a person supported, staff will immediately contact the ABI Program Director for further support and direction. If at any time staff feel the individual is unsafe and might harm themselves or others, and the staff feel they cannot keep him/her/others safe, call 911 immediately and then contact the ABI Program Director, etc.

DAYTIME RESIDENTIAL COVERAGE WHEN INDIVIDUALS ARE SICK

Residential programs will provide coverage during day services hours to allow for persons served to remain at home when ill to minimize the transmission of communicable conditions between individuals and staff and to allow for persons served to recuperate from illnesses in their own home.

If an individual is sick and needs to remain home, the house manager will:

1. Ensure medical care is sought if required.
2. Contact Primary Care Physician for advice if necessary.
3. Arrange for appropriate staffing.

Before returning to their day program/work, individuals must meet the criterion dictated by their Physician or Day Program policy.

ELECTRONIC HEALTH RECORDS

Transition Procedures

The Arc of Plymouth and Upper Cape Cod is currently transitioning to Electronic Health Records. The system being used is ICentrix.

Only those who have been selected based on position/role to engage with ICentrix are allowed to enter the system.

Do not share your username or password with any other person. All entries into the system are date/time and name stamped based on the username.

Anytime a new person has been added to the system or a change is made to the personal record, diagnosis or medication form a new emergency fact sheet will need to be created and at this time placed in the Confidential file along with the other changed forms.

The individual program will take the lead on changes to the Emergency Fact Sheet (EFS) etc. This will require communication between programs. If a change has been made and the individual is in multiple programs the other programs should be notified that there has been a change made in the EFS etc.

At no time should you walk away from your computer with ICentrix open. If you have to walk away, save and close what you are working.

ABI ENVIRONMENTAL SAFETY

The home will maintain a clean, safe, adequately lit and accessible environment based on the needs of the individual(s) with two means of egress (with easily operable door opened from inside without keys) from grade level for all individuals living within the home.

Carbon Monoxide: Carbon Monoxide Detectors are to be in working order and are tied into the comprehensive smoke detector system.

Smoke Detector/Fire Extinguisher: Smoke Detectors are to be in working order. The system is tied into the local fire department, whenever possible. An operable fire extinguisher will be located in the kitchen.

Bedrooms: The individuals' bedroom will have a place to store clothing, etc. and will have a lock on the door to allow for privacy. The door must be easily opened from the inside of the room without access of a key. The caregiver will have access to a key/pin to enter room in case of an emergency. If the bedroom has an egress, then the bedroom door will not have a lock, but the individual will have a lock box to secure items in. *** Personal Possessions Inventory Checklist** will be conducted upon move in and annually thereafter. A copy of the checklist will be kept in the individual's confidential file in the legal section.

Water Temperature: Water Temperature will be taken during regularly scheduled home visits. The water temperature is to remain within the acceptable temperature range as stated in the DDS regulations of between 110-120 degrees.

Cleaning Supplies: Cleaning supplies and cleaning agents (include EPA-registered disinfectants) will be stored in an agreed upon location away from food items and will be accurately labeled.

PPE: An adequate supply of PPE is maintained in the home.

Home Exterior: Egresses, driveways, walkways clear of debris, decks, ramps etc. in good repair.

ABI FIRE DRILL

In order to ensure a safe evacuation from the home, fire drills will be held as defined in the safety plan with at least two of the drills during asleep hours. Evacuation times will be recorded in a Fire Drill Record. The following information is to be recorded.

1. Date and time of drill (include a.m. or p.m.)
2. Address
3. Type of drill (asleep or awake)
4. Evacuation time
5. Location/Activity
6. Level of assistance
7. All people in the home at the time of the drill
8. All staff on shift

All individuals in the home MUST be able to evacuate within 2 ½ minutes with or without support. When someone new moves into a home a fire drill must be conducted in accordance with DDS regulations.

If any individual takes over 2 ½ minutes to evacuate the ABI Program Director must be notified. Another fire drill must be conducted within 24 hours in addition to implementation of a plan to support the person to be successful in this area if needed.

Fire Drill Record

To ensure the adherence of programmatic licensing requirements, fire drills are to be completed **quarterly**, with two being completed during "asleep" hours.

Address: _____

Date of Drill: _____ Time of Drill: _____

Staff Conducting Drill: _____

Type of Drill: ☐ Awake ☐ Asleep

Individual	**Location/Activity**	**Evacuation Time***	**Level of Assistant*** Ind., Prompts, Physical Assist

*Per Department of Developmental Services regulations, any evacuation time that exceeds 2 ½ minutes MUST be reported to the Program Director **IMMEDIATELY**. An incident report must be received by The Arc of Greater Plymouth within 24 hours, and another drill must be completed within 48 hours.

Were smoke detectors operational for drill? ☐ Yes N ☐

Comments/Additional Information	
Staff Signature & Date	**Staff Signature & Date**
HM Signature & Date Reviewed	**Director Signature & Date Reviewed**

ABI HUMAN RIGHTS PROCEDURES

Purpose:

- The purpose of the Human Rights Committee is to safeguard the human rights of people receiving services from The Arc of Plymouth and Upper Cape Cod.
- The Committee provides a review of behavior plans (both initial and annual review) as well as restrictions, restraints, DPPC reports and supportive and protective devices.
- The Committee ensures that Human Rights Policies and Trainings are current and appropriate to the needs of the individuals.

Membership: HR Coordinator, Nursing, Mental Health Clinician, Lawyer, Parents/Sibling, and an Individual served by The Arc of Plymouth and Upper Cape Cod. **Chair:** Elected Committee Member

Meeting Frequency: Quarterly

Feedback: A record of approval of behavior plans and restrictions. Apprisal of supportive and protective devices will be maintained by the Human Rights Committee. Minutes go out to all committee members, and DDS representative (HR Regional Specialist, DDS Program Monitor, DDS Plymouth Area Director).

Purview:

- Behavior Plans
- DPPC's
- Restrictions or Restricted Movement
- Restraints
- Supportive and Protective Devices
- Human Rights Policies
- Annual Human Rights Training
- Site Visits
- Any other HR issues brought to the committee's attention

Coordinator: The Arc Human Rights Coordinator is an assigned staff member, trained by administration and the DDS Regional Human Rights Specialist. The VP of Program Development will function as back up. The HR Coordinator is responsible for developing the agenda, submitting the agenda for approval to chairperson, disseminates information both prior and post meeting including meeting minutes to members. The coordinator communicates with the DDS Human Rights Specialist for the Southeast Region as needed and provides guidance to HR Officers for the Arc.

HR Officers: one per site

HR Policy: The Arc of Plymouth and Upper Cape Cod is committed to the affirmation, promotion and protection of the rights of individuals with developmental disabilities and family challenges. This policy summarized the expansive array of legal and civil rights of individuals with developmental disabilities.

HR Materials (**Included in the Appendix):** Arc Human Rights Booklet (Sign off), Info packet for Families and Guardians (Annual distribution).

GUIDELINES FOR INCIDENT REPORT SUBMISSION:

Internal Incident Report forms can be downloaded off the Share Drive, found under 'Risk Forms' and can also be found in this manual.

Steps included with completion of the report:

1) **On the same day staff observed the incident or first received information of the incident, an Internal Incident Report should be completed.**
2) **The person responsible for completion of the report is the staff person who observed the incident or first received information of the incident.**
3) **Staff who completed the Report will sign/date and submit to their PD the same day the form is completed.**
4) **Upon receipt of the form, the <u>PD is responsible for:</u>**
    a. **Reviewing the report**
    b. **Providing any follow up steps (if applicable, completion of HCSIS within allotted timeframes, Minor=3 days/Major=1 day).**
    c. **Sign/Date the report**
    d. **Submit the report to** incidentreports@plymouthcapearc.org **within 24 hours.**
5) **In any incidents involving allegations of abuse, death, hospital admissions, missing individuals, suicide attempts, emergency relocations, police involvement (911), and media/press involvement, Program Directors should notify the President and CEO.**
6) **If ABI or AFC, staff first notified of the incident will be responsible for filing the MassHealth Critical Incident Report, if applicable**

GUIDELINES FOR MINOR/MAJOR INCIDENT REPORTS:

Classification of Major Incidents

1.DDS/ HCSIS Major Incidents

As Per DDS/HCSIS: An incident requiring a major level of review is one that can compromise the safety of an individual and as a result, requires timely notification and a prompt response and meets one of the following criteria:

1. Suspected mistreatment where there is a life-threatening result
2. Where staff action or failure to act exposes the individual to serious personal or public safety risk
3. Has the potential for broad, negative publicity in the media
4. Law enforcement is involved in any capacity.

Examples of Major Incidents:

- Unexpected/suspicious death
- Suicide attempt
- Unexpected hospital visits with life threatening or serious injuries/illnesses
- Aggressive sexual behavior – alleged victim and/or alleged perpetrator
- Missing person
- Suspected mistreatment
- Criminal activity – alleged victim and/or alleged perpetrator
- Transportation accident
- Emergency relocation
- Unplanned transportation restraint
- Police Involvement

Timeframe for submitting Major HCSIS Incident Report:

The initial incident report for an incident that requires a major level of review must be submitted to HCSIS within one business day of the incident discovery. The final incident report must be completed and finalized within seven days of the initial incident report submission.

2. DDS/HCSIS Minor Incidents

Examples of Minor Incidents:

- Medical or Psychiatric intervention not requiring a hospital visit
- Significant behavioral incident
- Unexpected hospital visit – non-life threatening
- E.R. visit without admission
- Emergency psychiatric services evaluation
- Physical altercation – victim or perpetrator

Timeframes for submitting a Minor HCSIS Incident Report

For an incident requiring a minor level of review, the initial incident report must be submitted to HCSIS within three business days of the date of incident discovery. The final report must then be completed within HCSIS within seven days of the initial report submission.

Internal Incident Report

Directions for use: This report should be utilized to document any incidents involving injuries, medication occurrences (MOR's), unusual events or behaviors, DPPC's, 51A's (Child Abuse), or 19A's (Elder Abuse). If the individual(s) involved in the incident is enrolled in HCSIS, designated staff will be responsible for entry of the incident into HCSIS.

***All Internal Incident Reports should be sent to incidentreports@plymouthcapearc.org**

Date of Report:

Date of Incident:

Time of Incident:

Name of Individual(s) involved:

Name of Staff Reporting Incident:

Reviewed by Program Director on date:

Program Affiliation: (check all that apply)

***A copy of report should be given to all affiliated Arc Program Directors**

☐ AFC ☐ Archways ☐ Pathways ☐ AWC ☐ Shared Living

☐ I.H.S. ☐ ABI ☐ MRC ☐ DESE

Describe the Incident of Concern: (Include time; place; who was present; what happened just before the incident; details of the incident)

What actions were immediately taken by Staff: (Provide staff names, actions, date/time.)

Notifications made:

In any incidents involving allegations of abuse, death, hospital admissions, missing individuals, suicide attempts, emergency relocations, police involvement (911), and media/press involvement, Program Directors should notify the President and CEO immediately.

Please check all that apply

- ☐ **Guardian:**
- ☐ **Caregiver:**
- ☐ **Family Member:**
- ☐ **DDS/SC:**
- ☐ **President and CEO**
- ☐ **Day Program:**
- ☐ **Counselor/Prescriber:**
- ☐ **PCP:**
- ☐ **VP of Operations**
- ☐ **Other:**

A copy of this Incident report should be sent to:

- ☐ **Other Arc Program Director(s):**
- ☐ **IncidentReports@plymouthcapearc.org**

Signature of staff submitting report: **Date**

_____

Signature of PD approving the report: **Date**

_____

Please list any follow up actions provided by Program Director or Staff:

(Note date to be completed /responsible staff)

Date reviewed by Risk Team:

THIS REPORT WILL BE FILED IN THE INDIVIDUAL'S CONFIDENTIAL FILE

PROCEDURES:

In the event of the death of an individual: **IMMEDIATELY:**

1. Call Emergency Medical Assistance (911)

2. Call the ABI Program Director to inform them. If they cannot be reached, call the emergency #. Emergency phone numbers are to be posted on the bulletin board near the home office. If you use your cell phone as your primary phone, then the emergency numbers should be listed in your contacts.

3. The Program Director will contact the VP of Operations and/or the President and CEO immediately.

4. Complete an Incident Report and submit it to incidentreports@plymouthcapearc.org and/or HCSIS within 24 hours.

FOLLOW UP:

1. The Arc of Plymouth and Upper Cape Cod: Program Director or VP of Operations will contact DDS and the family as directed and indicated.

2. The Arc of Plymouth and Upper Cape Cod will cooperate and assist with arrangements for examination, autopsy, and burial, if deemed necessary.

3. Investigation will begin in accordance with DDS Regulations.

COMPLETING THE HCSIS PROCESS

DAILY

- Alerts in HCSIS MUST be monitored daily. The length of time they remain posted as an alert is somewhat unpredictable so weekly checks may result in loss of important alerts.

- Alerts will notify you of upcoming ISP dates, Assessments that are due, Goals and Objectives that are due, Strategies that are due, Progress Notes that are due, also items that are in danger of being out of compliance or are in fact out of compliance. Response to Alerts should be immediate.

STEPS TO ISP PROCESS IN and OUT OF HCSIS

- ISP date Alert will be posted.
- Immediately: schedule a Pre-ISP meeting with the individual to begin discussions about goals and objectives. This should occur approximately 30 days prior to ISP.
- Due in HCSIS 15 days before the ISP date.
    - Health Care Record
    - Safety Assessment
    - Financial Assessment
    - And other assessments as needed for the individual (i.e., med assessment, employment, community interest, etc.) (these can be sent separately)
- Due in HCSIS 7 days before the ISP data.
    - ISP Goals/Objectives (developed through Pre-ISP meeting with individual)
        - If the individual has a behavior plan or is working on self-medicating these must be included in the ISP as goals.
    - Support Strategies including monitoring method
- Due in HCSIS 7 days after the ISP is held.
    - If new objectives are agreed upon at the meeting must be submitted in HCSIS
    - New Objective Support Strategies including monitoring method
- DDS has 30 days to final approval. They can change anything during that time. Be prepared to receive alerts during that 30-day period. Alerts during this period must be responded to within 7 days unless otherwise stated in the alert.
- Due Semi-Annually
    - Progress notes on all goals/objects
    -

OTHER IMPORTANT NOTES

- An ISP must be developed for an individual new to the program within 60 days of arrival. All steps noted in the ISP steps must be completed.
- Alerts are NOT separated by location. The Arc in its entirety is posted on a single alert list. If it is an individual that is supported across programs check to be sure it is/isn't an alert meant for you.
- If it appears that you are getting close to an ISP date, and you haven't received an alert. Check the HCSIS ISP Dashboard for that person specifically.

The Arc of Plymouth and Upper Cape Cod is committed to providing a prompt, appropriate, and safe response to individuals who may be under the influence of alcohol or other intoxicating substances, or who may arrive at an Arc of Plymouth and Upper Cape Cod program or office in an intoxicated state.

Signs of Drug or Alcohol Intoxication

Acute alcohol poisoning occurs when a person has a dangerously high concentration of alcohol in the blood, which may cause seizures, coma and/or respiratory depression / respiratory arrest. This is a medical emergency and staff must call 911. Signs of Drug or Alcohol Intoxication, may include, but are not limited to:

1. Changes in speech (e.g., slurred speech, speaking loudly, using foul language, etc.)
2. Changes in coordination (e.g., impaired balance, inability to stand, staggering, etc.)
3. Change in behavior (e.g., overly friendly, speaking loudly, bragging, overly excited, agitation, erratic or unpredictable behavior, aggression, etc.)
4. Change in cognition (e.g., impaired attention or concentration, unable to follow directions, loss of train of thought, reduced judgment, confusion, etc.)
5. Change in vision (e.g., red eyes, dilated pupils, drooping eyelids, unable to focus or see clearly, closes or covers one eye to remove double vision, etc.)
6. Changes in the person's usual manner and appearance (e.g., smell of alcohol on breath, strong stale odor of alcohol, soiled or disheveled clothing, sweating, unusual or new behavior not characteristic of the person, any other physical or behavioral changes that might indicate that an intoxicating substance has been used.)

Staff Response

When an individual appears to be, or admits to being, under the influence of alcohol and/or other substances, the following procedures will be followed:

Staff should increase vigilance for their own personal safety, and that of all others, including the individual. Personal safety measures include steps such as:

1. Staff increasing personal distance, especially if the individual shows signs of agitation or aggression; scanning for potential weapons;
2. Asking another available staff person to assist in assessing or helping the person;
3. Making sure a phone is available at hand;
4. Asking other individuals to move away from the area or leave the area where the person served is located if safety cannot be maintained;

If safety cannot be maintained, call 911.

If possible, staff will obtain details from the individual as to the type and amount of substance used as this will be helpful information to relay to other Arc of Plymouth and Upper Cape Cod staff or medical professionals, contact the Program Director and/or VP of Operations, and/or Emergency On Call administrator. In consultation with Arc of Plymouth and Upper Cape Cod Administrative and Nursing staff, it will be determined as to whether the person served is safe to remain in the program under close observation or requires medical screening.

If there are any observable changes in the person's physical and/or behavioral state that present any immediate danger to him/herself and/or others, staff will call 911 and report the signs and symptoms to the dispatcher. Under no circumstances shall Arc of Plymouth and Upper Cape Cod staff transport a person served, in their car or program van, if the person is, or appears to be, intoxicated.

ABI MONEY MANAGEMENT PROCEDURES

- Each individual served will have a money management assessment to determine his/her capabilities. A training plan will be developed to eliminate or reduce the need for assistance unless there is a clinical evaluation that the individual cannot learn how to manage or spend his or her funds. Each plan will be agreed upon by the individual, guardian or conservator. The plan will establish the personal spending money which can be managed by the individual and specify the agency's responsibilities in its role. In the event that clinical evaluation determines that the individual cannot learn to manage or spend his/her money (any portion) and would not benefit from a training plan, then this will not be present. The ISP Team in lieu of one specific clinician, can review the individual's need for training in the area of financial management.

- The Arc of Plymouth and Upper Cape Cod recognizes the individual needs of each person served. Individuals may or may not be receiving government benefits and may or may not need Representative Payee or Conservator appointed. Input on these matters should come from the individual served, family members, Service Coordinator, and Agency staff. The Arc of Plymouth and Upper Cape Cod may become the Representative Payee for some individuals, but every effort will be made to identify an individual outside of the agency and/or its Caregivers. Total contribution for room and board will be no more than 75% of total income including earned and benefit income. If the negotiated rate should become a hardship for the individual, or if there are concerns about the calculation, the rate may be renegotiated at any time by contacting the President and CEO. Individuals frequently receive cost of living increases in their benefits during the course of the year. Room and board rates are reviewed each month based on the benefit income the individual receives.

- Annually, on or after January 1 (when new benefit letters arrive), or upon placement with the ABI residential home, an Authorization for Money Management Assistance and Charge for Care will be reviewed with the individual and signed by the individual and guardian (if applicable).

- Money management will be addressed according to individual needs. In some cases, budgets for specific expenditures will be developed and approved. The budget will be determined and approved at a meeting of the ISP team.

- It is The Arc of Plymouth and Upper Cape Cod's practice that Caregivers will not be Representative Payee's for the individuals who live with them.

- **Personal Spending:** All individuals are entitled to at least $200 per month for personal needs.

- **Checks –** All checks must be deposited either into the individuals' checking or savings account w within 10 days of receipt of the check. All checks must be deposited in the full amount.

- **Deposit Slips –** Deposit slips should match deposits recorded on check stubs and be attached to the check stubs.

- **Receipts –** Receipts are required for all purchases of $10.00 or more, this includes purchases made by check, unless otherwise specified in a money management assessment an ISP. Receipts for expenditures under $10.00 will be expected when they can be easily obtained by the vendor.
    - All money is dispersed in check form.
    - **Checks are given out and tracked in the individual's transaction logs.**

- Only original receipts will be accepted.
- Receipts will be presented for reconciliation attached, in order, to financial tracking form.
- For purchases of items over $100.00, the item needs to be seen by the ABI Program Director.

- **Bank Statement(s) –** Bank Statements from the previous month will be collected and placed in the individual's file at The Arc.

    - **Correspondence –** If applicable, any letters received from Social Security regarding benefits will be filed in the individuals record.

    - **Total Assets –** No individual's total combined assets can exceed $2,000.00. This includes money in all bank accounts and cash on hand. Whenever an individual's assets reach $1,500.00 a plan for spend down must be implemented.

Individuals will be encouraged to participate in program decisions regarding the hiring of staff, daily programming and community outcomes, and other areas that have a direct impact on daily life. Each program will develop forums and mechanisms for individuals to communicate their likes, dislikes, needs, and preferences to managers.

Participation in Staff Hiring
Individuals will have meaningful involvement in the selection of staff who directly provide services in the program. Individuals may interview final candidates for a position and provide feedback to the House Manager regarding his/her candidate preferences.

Program House Meetings
Each House Manager will establish a regular house meeting to be held at least monthly, during which program announcements will be made and individuals may discuss any aspect of the overall program. Minutes of each house meeting will be recorded and will include those actions that will be taken, or that have been completed, to respond to the wishes and needs of the individual. The minutes of the house meetings will be maintained at the site for a minimum of three years. Individuals will be provided with the opportunity to give input into program operations, such as meal planning, furniture purchasing, and program decorations. Individuals will be encouraged to participate through discussions at program community meetings.

Satisfaction
Annually, each individual will be offered the opportunity to provide direct feedback about their satisfaction of his/her own program by completing a satisfaction survey. Data from these surveys are to be reviewed by the ABI Program Director and a plan will be developed to address any concerns. The plan will be shared with individuals in the community meetings. Results of satisfaction surveys are used as part of the strategic planning process.

PET POLICY

Pets are permitted in properties owned or leased by the Arc of Plymouth and Upper Cape Cod as long as it does not present a risk to individual in the program or violate the terms of their lease. Individuals must assume primary, or share among housemates, responsibility for caring for the pet and agree to financially support the pet (e.g., veterinary care, food, etc.). Additionally, there must be physical space within the residence to accommodate the pet. This policy does not apply to Service Animals (as defined by the Americans with Disabilities Act); nor does this policy apply to pets and/or Emotional Support Animals (an animal not trained to perform a task or service that alleviates a person's disability) that belong to the family members, authorized representatives, or other guests of persons served residing in a property that is owned or leased by the Arc of Plymouth and Upper Cape Cod.

Pets that belong to employees of The Arc of Plymouth and Upper Cape Cod may not be brought to programs.

1. The Arc of Plymouth and Upper Cape Cod allows pets of persons served who live in homes owned or leased by The Arc of Plymouth and Upper Cape Cod, excluding those where persons served who have pet allergies reside or where the program's lease or program-specific policies and procedures prohibit pets.

2. Persons served moving into residential programs with pets will be informed that there is a pet in the program before the person's first visit to the program. If the person served has an allergy or fear of pets severe enough to affect the person moving into the program, staff will work with the funding agency to mitigate or find the person an alternative placement.

3. Prospective staff will be informed of the pets living at the residential setting(s) at which they are interviewing to be hired. If staff express unwillingness to work at site with a particular pet, or to take part in the care of the pet, staff will not be hired to work in that specific program. Human Resources will work with prospective staff who disclose having an allergy to the particular pet type (dogs, cats, etc.) to identify alternative program locations.

Pets Owned By the Program

1. When making the decision to adopt a pet for a program, all persons served must unanimously agree to adopt the pet. If an employee who is working at the program expresses an unwillingness to work at the site with a pet due to an allergy or fear of pet.

The Arc of Plymouth and Upper Cape Cod will work with the employee to transfer the employee to a different program where there are no pets.

2. The individuals and staff will develop an agreement regarding shared responsibility for the care of the pet. Also, individuals and staff will develop a plan to ensure that:

A. The cleanliness of the program and the well-being of the pet are maintained at all times; and

B. All veterinary care and pet vaccinations are up-to-date and properly documented.

3. A file for the pet will be maintained in the program's staff office, by the house manager and will be available to licensing, external reviewers, etc.

4. The President and CEO will decide if, or when, a pet needs to be relocated.

Pets Owned By Persons Served Living With Others In Arc of Plymouth and Upper Cape Cod Programs

1. The person served must obtain unanimous consent of others living in the program and ensure that the health of persons served, and staff will not be adversely affected (e.g., allergies) prior to bringing a pet into the program.

2. The ownership and financial responsibility for the pet falls solely on the person served who owns the pet. The program will document an agreement with the person served as to the care, feeding, cleanup of the pet. Staff will work with the owner of the pet to ensure adequate medical care (e.g., vaccinations) for the pet and that current health records are maintained.

3. If the person served who owns the pet is determined unable to care adequately for the pet, the program may adopt the pet or staff will help the owner put the pet up for adoption.

ABI RECORD ACCESS AND STORAGE

To ensure the privacy and confidentiality of information per HIPAA, Confidential Records for all individuals served by The Arc of Plymouth and Upper Cape Cod must be stored in designated secure locations. The storage unit must be locked at all times with the key placed in a location accessible only to those who have access privilege.

When a record is removed from the secured location by any staff it must be signed out using the posted sign out sheet. The sign out sheet will include the Individuals Initials, printed name of staff, and date/time signed out. The storage unit must be relocked when staff move away from it. When the file is returned to the secure location, staff are to document the date/time of return and initial that it has been returned on the sign out sheet. Staff are not to hand off a record to another staff without first signing it back in and having the new staff person sign it out. Once filled the sign out sheet should be sent to the VP of Operations to be maintained at the Armstrong Office.

Confidential Records are not to leave Arc sites (i.e., Armstrong, Archways, ABI) unless specifically approved by the Program Director of ABI, VP of Operations or President and CEO and signed out on an "Out of Building Form" (i.e. if a record is brought to a CCR meeting or ISP meeting) in addition to the posted sign out sheet. The form must be filled out in its entirety at time of removal and at time of return. Once completed it is to be sent to the VP of Operations.

Confidentiality of information is also critical when a record is in use. A confidential record should not be left open on a desk/table. If for any reason staff need to walk away from the record it should be closed to protect private information. If you need to walk away from your computer when in an individual's record (ICentrix) you will need to sign out of the individual file.

Filing of paperwork to be stored in a Confidential Record must be completed regularly (minimum of weekly). Documents not yet filed must be kept in a secure location until such time as they are entered into the Confidential Record.

If it is discovered that there has been a Breach of Information, (i.e., a record is missing from Storage or ICentrix) your supervisor, the VP of Operations and the President and CEO must be notified in person or via phone call immediately. The VP of Operations will be responsible for investigating the breach and completion of required follow up.

If the intake assessment concludes that the program can successfully support the individual, an acceptance letter is to be sent to the individual within the timelines required by the funding source.

Prior to Admission

Prior to moving into the home, an individual record set is to be created. This record set will contain the following:

1. The individual's needs will be assessed to determine what staff support is needed, as well as any assistive technology to ensure evacuation in the event of a disaster per funding source regulation.
2. The person served will be oriented to Human Rights information;
3. Completed Emergency Fact Sheet;
4. Signed consents and authorizations; *Consent for Program Participation and Emergency Medical Treatment, Arc Information Release Form (for each dr. etc.), Authorization to Secure Medical Treatment.*
5. Financial – Funds Management Agreement if applicable.
6. Signed Acknowledgement of Rights and Awareness of Grievance Procedures form.
7. If the program will be responsible to administer medication to the person served, current medication orders will be obtained and maintained on site. Arrangements will be made to have all medication and orders available for administration upon admission into the program.

Upon Admission

Upon admission to the program, the following will be completed:

1. Any critical or significant needs of the person served will be identified and documented in the Individual Record within 72 hours of admission.
2. The program staff will complete the applicable Orientation for the person served by the end of the first week of admission into the service, including inventory of personal belongings.
3. Staff will assist the person arrange his/her bedroom/apartment as needed. Individuals will be provided with a mechanism to secure valuables.
4. Staff will check in with the person frequently to ensure that his/her needs are being met and that the transition into the service is going smoothly.
5. Staff will begin the assessment and service planning process based on the requirements of the funding source.

Discharge Criteria

The Arc of Plymouth and Upper Cape Cod actively works collaboratively with individuals, guardians if applicable, and the funding source to provide services that are individualized based on the needs and wants of the person being supported. These individualized services clearly define goals for each person. All services will develop a discharge criterion agreed upon by The Arc of Plymouth and Upper Cape Cod and the funding sources that stipulate the minimal level of proficiency in various activities/goals that indicates an individual is ready to move to a less restrictive program, or if needed a setting that provides increased support and/or supervision. Programs will also develop criteria, based on the service contract with the funding source, for when an individual requires placement in a more restrictive environment; when they cannot be served adequately in the program; and exit criteria for when an individual prefers to leave the current program/services

RESIDENTIAL ROOM AND BOARD/ CHARGES FOR CARE

Programs thru The Arc of Plymouth and Upper Cape Cod are open to all individuals referred by the funding agency, regardless of ability to pay. However, most residential programs will charge a Room and Board fee based on funding source and contract specifications, scaled for income.

The Arc of Plymouth and Upper Cape Cod will ensure a fair standardized method for assessing the correct Room and Board fee for each individual. This process will ensure that each individual has adequate personal funds and will mitigate extraordinary costs for medication and other necessary expenses.

The amount of monthly Room and Board each individual is charged is a percentage of the person's total net income, based on funding source and contract specifications. Room and Board will be lowered if an individual does not have adequate money remaining for personal expenses (All individuals are entitled to at least $200 per month for personal needs) after paying the program fee, as stipulated by the funding source. The Program Manager will ensure that all individuals have the same range of services and opportunities to participate in activities in accordance with the Treatment/Support Plan of the person regardless of ability to pay. If the financial status of an individual precludes him/her from full participation in the program, the Program Manager will seek alternative methods of procuring resources to allow his/her full participation.

Income

All recurring entitlement benefits (Social Security Disability Income (SSDI), Supplemental Security Income (SSI), Veterans Administration benefits, Unemployment Compensation, Workers Compensation), recurring regular income, and earned income (in accordance with the earned income calculation) will be included in the Room and Board calculation.

Calculating Room and Board/Charges for Care

1. Room and Board is a charge for residential services and supports based on a percentage of income and stated in each Charges for Care Agreement.
2. Each program has a percentage of the above-outlined income that it charges individuals as Room and Board. Maximum percentages will be set within each contract and may differ within each program, and/or within each agreement.
3. The Program Manager will obtain current documentation of entitlements, earnings, and/or other income prior to calculating Room and Board. Individuals will be charged a percentage of all entitlement benefits (e.g., SSI, SSDI, Veterans benefits) and/or recurring regular net earned income up to the maximum amount, if any, as specified on the Room and Board list.

***For individuals on the ABI/MFP, after room and board has been calculated, a minimum of $200 must be remaining for personal spending.*

4. When an individual begins to receive services at an Arc of Plymouth and Upper Cape Cod program, the ABI Program Director will:
    a) ensure all financial information has been obtained;
    b) record all financial information on the Room and Board calculation worksheet

c) have the individual or guardian and representative payee (if applicable) sign the Charges for Care Agreement, which will be kept in the person's Individual Record.

Appealing Room and Board/Charges for Care

If the individual or guardian disagrees with the amount to be paid, they may appeal the residential fees, Charges for Care determined from Awards Letter. The President and CEO will review the appeal, making a decision and informing the individual and guardian of final decision in a timely manner.

RESPONDING TO ALLEGATIONS, COMPLAINTS AND GRIEVANCES

Abuse or mistreatment of individuals supported by the Arc of Plymouth and Upper Cape Cod is prohibited. All allegations of abuse, neglect and mistreatment must be reported to the Disabled Persons Protection Commission (DPPC). According to the Disabled Persons Protection Commission, the standard for reporting suspected abuse and neglect is "reasonable cause to believe" that abuse or neglect was committed against a person with a disability.

Types of abuse, mistreatment and neglect are defined as follows:

Physical	The use of physical force against someone in a way that injures or causes pain to that person.
Emotional/Verbal Abuse or Mistreatment	The use of threatening, humiliating, or intimidating words or actions
Neglect/Omission of Care	Failing to provide needed care for a person resulting in injury, or placing them at risk; or permitting another person to do the same
Sexual	When a caretaker or provider forces, tricks, threatens, coerces, exploits, or otherwise engages a person with a disability in a sexual activity or permits another person to engage in non-consentual sexual activity
Financial	The illegal or improper use of another person's funds, property or assets.

Any person who is a witness to abuse, mistreatment or neglect of an individual with a disability, has the responsibility as a mandated reporter, to notify the Disabled Persons Protection Commission. While not required, staff who witness abuse, mistreatment or neglect of an individual are encouraged to report their observations to Program Management or the Human Rights Officer in order to ensure safety of the individual and provide additional protections if necessary. Failure by staff to report any incidents of abuse, mistreatment or neglect will result in staff being subject to corrective action, up to and including termination.

The following list provides examples of abuse, mistreatment and neglect. This list is not all inclusive:

1. Sexual assault or sexual abuse;
2. Use of derogatory or obscene language to, or about, an individual;
3. Depriving an individual of his/her civil or human rights;
4. Use of unnecessary force or threat of force;
5. Corporal punishment such as hitting or striking;
6. Infliction of emotional or verbal abuse, such as screaming, name calling, or other activity which is damaging to a person's self-respect;
7. Intentional, or unintentional, failure to provide medical services;
8. Exploitation of an individual for financial gain or misuse of an individual's funds;
9. Any act in retaliation against an individual for reporting a complaint to Program Management.

Once Program Management has been made aware of an allegation of abuse, neglect or mistreatment they are to take action immediately. This may entail the following:

1. Take any action necessary to safeguard the individual;
2. Notify the appropriate funding source;
3. Notify the guardian, if applicable, and;
4. Notify any other relevant parties, if appropriate.

Contact Numbers to File Abuse Reports:

1. To report possible abuse or neglect by a caretaker of an adult with a disability, DPPC is to be notified at: 1-800-426-9009.

Grievances

A grievance is defined as a perceived cause for complaint that falls outside of the scope of human rights issues, abuse, neglect and mistreatment statutes.

A grievance can be filed by an individual, family member or a guardian. Grievances can be filed regarding a policy, procedure or condition at the Arc of Plymouth and Upper Cape Cod that does not entail imminent danger, and is not related to abuse, neglect, mistreatment, or the violation of an individual's human rights.

Grievances are to be filed in writing when possible. If a written statement cannot be obtained, the staff or ABI Program Director who has been notified of the grievance can complete the written statement. The ABI Program Director will initiate completion of the ABI Grievance Log. The ABI Program Director, or other assigned staff, will meet with all parties involved in the grievance to come to a resolution. This resolution will be formally communicated to those parties involved in the grievance via a written statement within three business weeks.

If the individual, family member or guardian who has made the grievance is not satisfied with the resolution, they may make a written appeal to the VP of Program Operations. Another meeting will be held for the appeal of the grievance and a resolution will be made within one business week. This resolution will be made in writing.

For ABI programs, written notification to the individual of the Arc of Plymouth and Upper Cape Cod's response and/or findings will occur within 30 days. A copy of the decision letter will then be placed in the grievance log at the program.

STANDING COMMITTEES: (Clinical Risk, High Risk, Human Rights, Safety)

1. CLINICAL RISK COMMITTEE

- **Purpose –**
  - Review of all significant incident reports to identify trends in incidents that need correlated process improvement plans
  - Identify matters within areas of purview that need to be shared with all agency programs
  - Identify operational procedures or agency policies that need to be put in place to mitigate risk
- **Membership** - Program Directors and/or Designees; VP of Program Operations, VP of Healthcare Services, VP of Program Development;
- **Meeting Frequency –** Monthly
- **Feedback**: Data regarding incidents will be aggregated for review by the committee as well as the High-Risk Committee. Trend areas or individual incidents of high risk will require action steps. The action steps/follow up will be documented through the Risk Management Meeting Minutes and will be shared with committee members for follow up. Progress will be monitored at subsequent meetings
- **Purview:**

- Allegations of abuse or neglect (DPPC)
- Attempted suicide/ideation
- Restraints
- Ingestion of any non-edible item or substance
- Injury involving more than first aid
- Elopement or missing person
- Emergency personnel contact
- Emergency department intervention
- Hospitalization
- Possession of contraband
- Summons or subpoena
- Medication occurrence including – wrong person, wrong medication, double dose, multiple missed doses where medical evaluation is needed
- Community incidents
- Concerning sexual contact between individuals served
- Consumer or community complaint
- TIER 3 PBSP review

- **Chair:** The assigned chair prepares monthly visual display of trends and quarterly reports for the Clinical Risk Committee and metrics relative to risk identified by the High-Risk Committee for review.

- **Clinical Risk Meeting Process**

- One week prior to Clinical Risk Meeting the submitted incident/accident forms and DPPC's will be reviewed by the Chair to determine trends and discussion focus. Program Directors will be notified if an incident from within their program is going to be specifically reviewed during the regularly scheduled meeting.
- At the meeting:
    a. Review of follow up requests from previous meeting
    b. Presentation of Data and discussion of trends
    c. The Director/Manager connected to each of the specifically reviewed incidents will be prepared to share the following information:
        i. Review of the incident
            1. What, when, where, who involved
            2. If appropriate (behavioral incidents), brief history of the person including dx, if a behavior plan is in place a clinical representative will be prepared to give a basic overview of the plan, any trends that have been noted.
            3. If within family home, the Director should be prepared to discuss relationship history with family and previous incidents (if needed).
        ii. What follow up has occurred to date:
            1. Training/retraining
            2. Staff disciplinary action
            3. Plan revisions
            4. Medical follow up if any
    d. PBS Tier III plans will be reviewed. This committee will function as the PBS Tier III Intensive Support Team.
        i. Data will be presented to the meeting members
        ii. Trends will be discussed
        iii. Any changes in plan(s) that were made since the previous meeting will be discussed
    e. Feedback from Meeting Members (will occur after each specific incident/accident/Tier III review)
    f. Follow up requested at the meeting (will occur after each specific incident/accident/Tier III review)
    g. Based on trend analysis the decision may be made to review this information in the High-Risk Meeting for discussion around agency policies and/or protocols that may need to be added or tweaked.
    h. Other Clinical Risk matters

- Within one week following the meeting, minutes will be sent out to all committee members.

2. HIGH RISK COMMITTEE

- **Purpose:**
    - Provide a high-level review of incidents and interventions developed as a part of action steps as stated in the Clinical Risk Management minutes.
    - Review of incidents, etc. that have been referred to High Risk from the Clinical Risk Committee.
    - Identify operational procedures or agency policies that need to be put in place to mitigate risk.
- **Membership –** President and CEO and the Senior Team
- **Meeting Frequency** – As needed, meetings can be requested at any time based on need.

- **Feedback**: Any additional recommendations for action steps will be identified and referred back to the Clinical Risk Committee for implementation.
- **Purview:**

- Trend analysis from Clinical Risk Committee
- Dashboard data regarding all significant incidents
- Unemployment
- Litigation
- Financial Exposure/Risks (Billing Fraud)
- Social Media Risks
- Public Relations/Press
- Insurance Risk
- Crisis Response Plan – COOP
- IT – Privacy/HIPAA Compliance
- HIPAA Compliance/Confidentiality Breaches
- Contract compliance/funder compliance

- **Chair:** prepares a quarterly agenda, a report of trends and quarterly report related to incidents, accidents, restraints, DPPC's and other metrics regarding agency risk which have been requested by the High-Risk Committee.
- **HIGH RISK MEETING PROCESS**

- Meeting will be held during the Executive Team meeting and will be chaired by VP of Program Development with the VP of Operations as backup.
- At the meeting:
  i. Review of follow up requests from Clinical Risk Committee
  j. Development of plan of action related to high-risk incidents referred to committee.
  k. Follow up from prior meetings
  l. Presentation of Data and discussion of trends
  m. Other Clinical/Corporate Risk matters
- Minutes will be maintained by the VP of Program Development.

3. HUMAN RIGHTS COMMITTEE

- **Purpose :**
  - The purpose of the Human Rights Committee is to safeguard the human rights of people receiving services from The Arc of Plymouth and Upper Cape Cod.
  - The Committee provides a review of behavior plans (both initial and annual review) as well as restrictions, restraints, DPPC reports and supportive and protective devices.
  - The Committee ensures that Human Rights Policies and Trainings are current and appropriate to the needs of the individuals.
- **Purview:**

- Behavior Plans
- DPPC's
- Restrictions or Restricted Movement
- Restraints
- Supportive and Protective Devices
- Human Rights Policies
- Annual Human Rights Training
- Site Visits

- **Chair:** Voting Member
- **Coordinator:** Agency designee. VP of Program Development will function as back up to Coordinator – coordinates the agenda and submits agenda for approval to chairperson, disseminates information both prior and post meeting including meeting minutes. Communicates with DDS Human Rights Specialist for Regional Office(s) as needed.

4. SAFETY COMMITTEE

- **Purpose:** The purpose of the Safety Committee is to look at all of the Arc of Plymouth and Upper Cape Cod Sites with an eye towards the safety of all. This will be accomplished through environmental audits, evacuation and emergency procedures and drills, active risk mitigation, health and safety processes and practices; data management and ongoing evaluation of efficacy.
- **Membership** –Executive Administrative Assistant, Senior VP of Business Operations, VP of Operations, other representatives across agency programs.
- **Meeting Frequency** – Monthly
- **Feedback**: Minutes from the meetings will be sent to all team members.
- **Purview:**

- Environmental Walk throughs
- Development and Review of Safety Procedures including Emergency Procedures
- Coordination and documentation of Emergency Procedure Drills
- Coordination of Environmental Inspections

- **Membership** – Human Rights Coordinator, Nursing, Mental Health Clinician, Attorney or paralegal, Parents/Sibling, and an Individual served by The Arc of Plymouth and Upper Cape Cod
- **Meeting Frequency** - Quarterly
- **Feedback**: A record of review of behavior plans, restrictions, medication treatment plans, supportive and protective devices, major incidents will be maintained by the Human Rights Committee. Minutes go out to all committee members, and DDS representative (Regional HR Specialist and Regional Area Director)

SEXUALITY AND SEXUALITY EDUCATION

The Arc of Plymouth and Upper Cape Cod is committed to supporting the rights of persons served to make choices about all aspects of their lives. For those individuals who choose to engage in sexual activity, sexuality education will be made available to all individuals in a manner that is consistent with their learning style. The Arc of Plymouth and Upper Cape Cod will provide staff with the information and training needed to support individuals with learning about sexuality and safe sexual practices as needed. To accomplish this, staff training is provided during New Hire Orientation, including provision of **The Arc's Intimacy, Sexuality and Relationships Handbook** which provides staff guidance and information on how to address a wide variety of topics that may arise with persons served.

Treating individuals with dignity and respect includes understanding that sexuality is part of adult life. It is imperative that individuals have access to accurate information so that they can make informed decisions.

To meet the varying needs of understanding of each individual, staff at The Arc of Plymouth and Upper Cape Cod will make available appropriate curriculum guides to managers and staff for use with persons served.

Regardless of whether an individual has a guardian, staff will notify the ABI Program Director if an individual expresses interest in this area. If an individual engages in sexual activity in a manner that could pose a threat of harm to him or herself, or to others, Program Management is to be notified immediately. If necessary, a plan will be developed by all required team members with the goal of eliminating any high-risk behaviors.

***See Appendix for the Arc Intimacy, Sexuality and Relationships Handbook**

STAFF COMMUNICATION

Due to the varying nature of staff schedules in programs it is necessary for programs within The Arc of Plymouth and Upper Cape Cod to maintain a Staff Communication Book to provide staff with a method of communicating programmatic information between shifts.

Staff Communication Book Specifications

A hardbound composition binder will be used for written staff communication. Programs can either staple all postings and memos sent from The Arc of Plymouth and Upper Cape Cod into the composition binder or can use a 3-ring binder as the Staff Communication book for postings and memos and place the composition book in the back sleeve of the 3-ring binder or attached with a binder clip. The House Manager will purge postings as they are no longer necessary.

The Staff Communication Book is the primary permanent record available to staff. All staff entries will be written legibly in ink. As with all records, White-Out is not permitted. Errors will be crossed out with a single line, initialed and dated, and the correction will follow. At the completion of each entry, staff will sign, date, and include their position. No pages will be removed from the hardbound composition binder. These are considered administrative records, and therefore must remain intact and be retrievable.

What to Document in the Staff Communication Book

Communication of information about the day-to-day administrative operations of the program. Examples include information about:

1. Appointments and medications for persons served using first name, last initial;*
2. Current medical or behavioral issues that need monitoring using first name, last initial;*
3. Community/Social Inclusion opportunities;*
4. Specific facility or administrative issues/problems;
5. Scheduling/coverage/arrangements/issues;
6. On-call information;
7. Staff task assignments;
8. Scheduled activities/meetings/events;
9. Agenda items for future meetings, etc.

*This does not replace the need for incident reports, Daily Log Notes, and/or Service Notes that belong in the Confidential Record. Use the minimum amount of information needed to convey information clearly to other staff of the program. All communication will be written in an objective, respectful, and professional manner. Because this book contains Personal Health Information (PHI), it should be safeguarded as with other PHI.

The Communication Book will not be used as a substitute for staff meetings, supervision, or face-to-face communication. Emergency phone numbers are to be posted on the bulletin board near the home office. If you use your cell phone as your primary phone, then the emergency numbers should be listed in your contacts.

Supports may be used only to achieve proper bodily position and balance, to permit the individual to actively participate in ongoing activities without the risk of physical harm from those activities, to prevent re-injury during the time that an injury is healing or to prevent infection of a condition for which the individual is being treated, or to enable provider staff to evacuate an individual who is not capable of evacuation. (115CMR 5.12)

Health related protections are ordered by a physician or other authorized clinician if absolutely necessary during a specific medical or dental procedure or the individuals protection during the time that a condition undergoing treatment pursuant to that clinician's order exists. When used in accordance with 115 CMR 5.12 it is not considered a type of restraint.

Documentation of Supports and Health Related Protections will be included in the ISP assessments unless temporary in nature (healing injury). It will be noted in the ISP reports.

The House Manager will inform the Human Rights Coordinator of all the Support and Health Related Protections so that apprisal can be provided to the Human Rights Committee.

Inspections will occur according to each Supports and Health Related Protection Plan to ensure it is in working condition. Copies of the inspection will be stored in the individual's confidential record.

Critical to the continued success of The Arc of Plymouth and Upper Cape Cod's ABI Program is a comprehensive training program. This program is divided into two major components: Pre-Service and In-Service

PRE-SERVICE TRAINING

1. Orientation

Prior to beginning services staff are required to complete Pre-Service Training. This training schedule includes:

a) Administrative orientation including a tour of the office and a description of The Arc of Plymouth and Upper Cape Cod's Mission Statement and Programs.

b) Meeting with the ABI Program Director on specific duties and responsibilities, program specific policies and procedures and information specific to individuals. The major objective is to ensure that the new staff has a solid understanding of his/her duties and responsibilities prior to working on site.

c) New Hire Agency Orientation: this includes First Aid/CPR which staff must complete before providing services alone. Renewal of certification must be completed as required and proof of certification must be submitted to The Arc of Plymouth and Upper Cape Cod.

2. ABI Program Training

a) Overview of Traumatic and Acquired Brain Injury (6-hour training)
b) Person Specific Training
- Review of medical needs for each resident
- Review of ISP goals and objectives for each resident
- Medical Protocols for each resident
- Behavior Support Plans or Guidelines, if applicable

b) Site Training (refer to site training checklist)
- Lifts in vans
- Safe Transport of Individuals
- Lifts in home
- Fire Safety
- Adaptive Equipment
- Petty Cash and Finances
- Environmental Safety

c) Review of Program Manual.

3. Other Required Trainings Include:

- Water Safety (if applicable)
- Safety Plan
- MAP

VISITATION IN RESIDENTIAL PROGRAMS

All individuals supported by The Arc of Plymouth and Upper Cape Cod may exercise their rights to maintain relationships with friends, family, and significant others. The Arc of Plymouth and Upper Cape Cod encourages visitors to programs while respecting the needs of both the program and the individuals.

1. Family members, friends, advocates, physicians, or attorneys of individuals will be permitted to visit at all reasonable times and will be provided with a suitable place to meet. It is the joint responsibility of the individual and staff to welcome visitors.
2. All visitors will sign in/out using the visitor log
3. All visits by former employees must be coordinated by the ABI Program Director and approval must be obtained from the VP of Program Operations prior to a visit being scheduled.
4. If any visitor presents a danger to the people in the program because of illegal activities, such as violence, theft, or dealing drugs, that visitor will be asked to leave and, if necessary, police will be called.
5. If any visitor proves to be disruptive, dangerous, threatening, etc., individuals may file a grievance that results in that visitor not being allowed to return to the program.
6. Any restrictions to visitation will be guided by discussion with the individuals and will be discussed during monthly house meetings

All program specific limitations to visitation will be documented and placed in the legal section of the confidential record.

If the right to visitation is denied or restricted, the ABI Program Director must document the reason for denial or restriction in the Confidential Record, notify the contact for the funding source, and inform the Human Rights Coordinator to ensure all due process requirements are met. An individual has the right to appeal to the ABI Program Director the denial or restriction of any visitor.

BLOOD GLUCOSE MONITORING

All MAP Certified staff at a program serving an individual requiring blood glucose monitoring will be trained in the procedure to monitor blood glucose levels. Trained Certified staff will perform blood glucose monitoring for those individuals served who are unable to do it for themselves and have a Health Care Provider order. Trained staff can and should observe individuals served who are unable to perform their own blood glucose monitoring, without some level of supervision.

INDIVIDUAL RESPONSIBLE: Program Manager

EFFECTIVE DATE: 2/2019

PROCEDURE

To prevent complications of Hyperglycemia (sugars too high) or Hypoglycemia (sugars too low) for individuals served who have Diabetes, MAP certified staff will monitor the blood glucose levels of all individuals served who have Health Care Provider orders for blood glucose monitoring.

1. The Program Manager will notify the Program Nurse when finger stick blood glucose monitoring is ordered for an individual served.
2. The Program Nurse and Program Manager will review the Health Care Provider's orders for blood glucose monitoring for MAP requirements.
3. Certified staff will enter the orders into Icentrix. Results of the blood glucose monitoring must be recorded on the Medication Sheet along with staff initials. The Program Nurse will review the transcription of the orders in ICENTRIXS.
4. Blood glucose parameters must be included in the Health Care Provider's orders. Staff will follow the Health Care Providers orders regarding the individual's specific parameters. Staff will contact the Program Nurse with further questions as to blood glucose monitoring or what to do about results outside parameters.
5. The Health Care Provider will be asked to complete the Note/Findings/Recommendations of the Health Care Provider Order form and document a plan for if/when the blood glucose level is out of normal limits (75-150) this plan should include the following:
    a. The level of staff assistance required for the individual served to test their blood sugar;
    b. Written parameters (e.g., Hold medication for blood sugar <70, and give juice and recheck in 15 min,) or Call Dr._____ if blood sugar is >350;
    c. Plan for Blood sugar readings not within the parameters established by the Health Care Provider, for example: If blood sugar reading is under 70, hold diabetic medications, give 8 ounces of juice or soda and recheck in 15 minutes. If following recheck still under 70, call MD, if under 50 call 911. If over 350 call HCP and program nurse or nurse on call.
6. Only MAP Certified staff who have been trained in Blood Glucose Monitoring of the program nurse may check an individual's or assist an individual to check, their blood sugar.

Blood Glucose Monitoring Training

1. The Program Nurse will provide training to MAP Certified staff as soon as possible after a Health Care Provider has ordered the blood glucose monitoring.
2. Prior to a MAP Certified staff performing blood glucose monitoring, he/she will receive training for blood glucose monitoring, from the Program Nurse, on the equipment and procedure involved. The training will include, at a minimum:
    a. Overview of blood glucose monitoring;
    b. Rationale for blood glucose monitoring, including anything specific to the individual served;
    c. Signs and symptoms of high and low blood sugar;
    d. Demonstration of the correct technique for blood glucose monitoring;

e. Safe glucose monitoring procedures;
f. Importance of gloves, clean technique and proper hand washing;
g. Following individual specific health care protocols, if applicable;
h. An emergency procedure guideline to follow, including but not limited to calling 911 and notification of the individual's Health Care Provider if the individuals served blood glucose levels fall outside the range/parameters prescribed by the Health Care Provider;
i. Overview of equipment (individual specific glucose monitoring/meter device, finger-pricking device, tests strips, etc.);
j. Obtaining and care of the equipment;
k. An understanding of the manufacturer's requirements for the performing of the test;
l. Proper disposal of used finger-stick devices (lancets); and
m. Overview of storage requirements.

Documentation of Staff Training

Documentation will include the date of the training, name(s) of staff trained, and the name, address, and telephone number of the trainer(s). The program will keep a list of all certified staff who have completed the blood glucose training. Documentation of the training will be kept in the program's training binder.

BUPRENORPHINE HYDROCHLORIDE AND NALOXONE (SUBOXONE)

Buprenorphine Hydrochloride and Naloxone (Suboxone) is a Schedule III controlled substance and all DPH MAP regulations apply when Buprenorphine Hydrochloride and Naloxone is being administered. All MAP Certified staff may administer Buprenorphine Hydrochloride and Naloxone at a DPH MAP registered site, if the medication was specifically ordered by an approved medical doctor (not a Nurse Practitioner or other authorized prescriber) for the purpose of narcotic treatment, opioid replacement therapy, or other similar term. The pharmacist can only dispense this medication when it is prescribed by an HCP, who is specially trained and registered, known as the DATA (Drug Addiction Treatment Act) waived prescriber.
This medication may not be prescribed and administered for the purpose of "Pain Management"or for detoxification in a DPH MAP registered site.
Buprenorphine Hydrochloride and Naloxone is considered a High Alert Medication by DPH MAP.
Any Arc of Greater Plymouth MAP certified site that implements Buprenorphine Hydrochloride and Naloxone therapy will adhere to this policy.

PERSON RESPONSIBLE: Program Manager

EFFECTIVE DATE: Not in effect at this time at any Arc program.

PROCEDURE

Buprenorphine Hydrochloride and Naloxone is a Combination Medication (defined as two or more medications in a single dosage form). *MAP Certified Staff may not administer single entity buprenorphine drug products in place of the combination drug product buprenorphine/naloxone without the prescribing MD's documentation of the individual's intolerance to naloxone.*
Any Arc of Greater Plymouth MAP certified site that implements Buprenorphine Hydrochloride and Naloxone administration will adhere to the following requirements:

1. There is an order by a medical doctor, who is a specially trained and registered DATA waived prescriber, regarding the person's need for Buprenorphine Hydrochloride and Naloxone that specifies narcotic treatment, opioid replacement therapy, or other similar term as the purpose for the medication.
2. A copy of the current medication list that includes the current dosage of all prescribed medication will accompany the person served to all Health Care Provider appointments.
3. If the HCP prescribes a new medication or the dosage of a previously prescribed medication has changed, the medical doctor who prescribed the Buprenorphine Hydrochloride and Naloxone must be called and made aware of the medication changes.

This contact with the prescriber of this high alert medication must be documented on the High Alert Medication Narrative Note and placed in the Medication Log.

Training

MAP Certified staff must be trained and aware of Buprenorphine Hydrochloride and Naloxone therapy in order to administer this medication.
As with all MAP Competency Training, the training and proof of understanding will be documented and maintained at the program site.

CLOZAPINE

Clozapine, also known as Clozaril, is a Schedule VI (M.G.L. Chapter 94C §2 and 3) controlled substance and all DPH MAP regulations and policies apply when Clozapine is being administered. All MAP Certified staff, including relief staff, may administer Clozapine at a DPH MAP registered site provided the Certified Staff have been trained in the administration of Clozapine. Clozapine is considered a High Alert Medication by DPH MAP. Any Arc of Greater Plymouth MAP certified site that implements Clozapine therapy will adhere to this policy.
If there is a medical emergency related to the administration of Clozapine staff will call 911 and follow Arc of Greater Plymouth's emergency on-call policy
As a prerequisite to administering Clozapine, MAP Certified staff must also have successfully completed Vital Signs Training.

INDIVIDUAL RESPONSIBLE: Program Manager

EFFECTIVE DATE: Not currently in effect at any Arc programs.

PROCEDURE

Clozapine is an atypical antipsychotic agent with superior efficacy in the management of individuals with treatment-resistant schizophrenia. The use of this agent carries a risk of agranulocytosis (low white blood cells) and has specific monitoring requirements as dictated by the Food and Drug Administration (FDA). The FDA requires ongoing bloodwork at regular intervals before it can be dispensed. Any individual served on Clozapine therapy should have their WBC/ANC counts entered regularly into their medical record.

1. Any individual served with receiving Clozapine therapy must have a Health Care Provider Order form that contains the following information:
    a. The specific medical condition or diagnosis that is the indication for Clozapine therapy;
    b. Written specific instructions for follow up when WBC/ANC are due and when the results may be outside the established range; and
    c. Specific Instructions to follow when the individual's Clozapine dosage is missed for any number of missed doses.
    d. When transcribing Clozapine onto the Medication Sheet, the next date(s) for the WBC/ANC lab draw(s) must be documented on the medication sheet under treatment and monitoring: choose the Clozaril/Clozapine Blood Draw (WBC, CBC, ANC) drop down choice. The laboratory test could also be ordered as a Complete Blood Count with differential (CBC with diff).

2. Whenever the Health Care Provider changes an individual's Clozapine orders (dose change, holding medication dosage, etc.):
    a. The Health Care Provider will contact the dispensing pharmacy with the new dosing orders; and
    b. The change will be communicated to all staff verbally and/or in writing in the Medication Log.

*Note: Acceptable lab values are **required** prior to dispensing and must also be **current** (no older than 7 days from the dispense date).*

For Individuals Served Starting Clozapine for the First Time

1. The Program Manager will complete the Clozapine Referral form, place the original in the Individual Record, and place a copy in the medication log book.
2. The Health Care Provider will register the individual served by phone or fax or directly through the National Registry Website.
3. Before dispensing the initial dose of Clozapine, the pharmacy will obtain all the required documentation and lab values prior to dispensing this medication.

Clozapine Training

All MAP Certified staff administering Clozapine must complete Clozapine Therapy Training conducted by an RN, NP, Pharmacist, or MD with demonstrated understanding on a regular and at least annual basis. Certified Staff who have not administered Clozapine in the previous twelve months or have not demonstrated understanding of safe Clozapine administration will take a supplemental Clozapine Therapy *retraining* (which can be done by RN, NP, Pharmacist, MD or LPN) prior to administering this medication. Staff training in Clozapine therapy includes:

a. Rationale for Clozapine administration (including individual specifics);
b. Overview of blood testing monitoring including the minimum range for White Blood Cell (WBC) Count and Absolute Neutrophil Count (ANC);
c. An understanding of the need to obtain frequent ANC and WBC counts;
d. An understanding that the pharmacy must have current and acceptable ANC and WBC counts to dispense the Clozapine;
e. Following individual specific health care protocols, if applicable;
f. An understanding of when to contact the Health Care Provider and/or the MAP Consultant;
g. Adverse effects of Clozapine therapy; and
h. An emergency procedure guideline to follow, including but not limited to calling 911 and notification of the individual's Health Care Provider.

As with all MAP Competency Training, the training and proof of understanding will be documented and maintained at the program site.

MAP CONSULTANTS

DPH defines a MAP Consultant as a registered nurse, registered pharmacist, or Health Care Provider, who is knowledgeable and skilled in medication administration systems, who will provide technical assistance and advice to MAP Certified staff. Registered Nurses have the support of the Board of Registration in Nursing Advisory Ruling.
DPH requires all MAP registered sites that have MAP Certified staff administering medication at the site to have a MAP Consultant available on a 24-hour basis (or whenever the program is providing services) to provide technical assistance or consultation. In addition, MAP regulations require that a MAP Consultant be contacted for every Medication Occurrence.
All Arc of Greater Plymouth MAP registered programs will have a MAP Consultant available 24 hours a day, seven days/week for consultations regarding MAP systems and policies.

PERSON RESPONSIBLE: Program Nurse

EFFECTIVE DATE: 2/2019

PROCEDURE

Any MAP Certified staff person who requires consultation regarding medication administration or MAP will contact the program MAP Consultant.

1. MAP Consultants provide advice, assistance, recommendations, and answers on medications and medication systems. This assistance may include, but is not limited to:
    a. Interpretation of Health Care Provider's Order for MAP Certified staff;
    b. Providing information on a medication's indications for use and side effects;
    c. Recommending appropriate actions to follow a Medication Occurrence (error involving wrong medication, individual, dose, time, or route of administration), including medical intervention if necessary; and,
    d. Guidance on how to follow MAP rules regarding transcription and administration of medication(s).

2. The information that the MAP Consultant supplies to the MAP Certified staff is broad-based, general information that does not require, but does not preclude, direct observation, information on the individual's medial history, or direct follow-up.

3. MAP Consultants function within their scope of practice (e.g., a Registered Nurse or Registered Pharmacist or Licensed Practitioner) and could clarify for MAP Certified staff a Health Care Provider's medication order, but only a licensed practitioner could order lab work. If the MAP Consultant believes that he/she has insufficient information and/or knowledge to make a recommendation concerning a particular occurrence, then the MAP Consultant should recommend that the MAP Certified staff contact the prescribing practitioner, dispensing pharmacist, or another MAP Consultant who is better able to provide information to the MAP Certified staff.

4. MAP is a direct authorization model under which MAP Certified staff function in accordance with the orders of a licensed practitioner. MAP Consultants do not control, supervise, or monitor MAP Certified staff's medication practices. The Service Provider, not the MAP Consultant, is responsible for the direct care of the individual, including medication administration by the MAP Certified staff.

5. In addition to the requirement that MAP Certified staff have 24-hour access to a consultant, MAP policies require that MAP Consultants be contacted immediately for every Medication Occurrence. This ensures MAP Certified staff will have:

a. Access to the technical assistance they need to interpret the Health Care Provider's order;
b. Information on appropriate actions following an occurrence; and
c. Guidance regarding the Medication Occurrence Reporting process should they require it.

MAP Consultants, while required to provide technical assistance in these matters, are not expected to file Medication Occurrence Reports with DPH/DMH/DDS. If a medication occurrence occurs, the MAP Certified staff person should also notify their On-Call Supervisor.

6. The MAP Consultant will:
    a. Help MAP Certified staff and supervisors determine whether or not a Medication Occurrence has happened;
    b. Advise what, if any, action(s) will be taken by direct care staff to care for the person served;
    c. Review with MAP Certified staff and supervisors the appropriate DPH/DMH/DDS reporting timelines; and offer guidance regarding the reporting process should they require it.
    d. Make recommendations to supervisors, where appropriate, as to the need for retraining of MAP Certified staff or revision of medication administration systems to reduce the chance of future errors.

7. MAP Certified staff will document in the appropriate section on the Medication Occurrence Report form the name of the MAP Consultant contacted and the date and time of contact.

8. Each site will retain a list of designated MAP Consultants for their specific program. Arc of Greater Plymouth will make every effort to ensure the MAP Consultant has knowledge of the specific program site in which they are acting as MAP Consultant and a letter of Agreement between both parties.

MED ROOM USE

The Medication Room is to be used for prepping, dispensing and storage of medications only. This room is not to be used for any other purpose.

The Medication Room is to be locked at all times.

The Medication Room key will be held at all times by either a MAP certified staff or nurse. The key can not be handed off to any noncertified staff. If the key holder is leaving the site it must be handed off to another MAP certified staff/nurse.

Noncertified staff are not to access this room.

At no time should there be food or beverage in this room.

MEDICATION ADMINISTRATION TIMES

In accordance with the DPH regulations, programs within The Arc of Greater Plymouth are required to identify the program's specific medication administration times for medications. (see DPH MAP Manual, appendix II, policy 6-5). This provides MAP Certified staff with guidelines for medication administration times.

PERSON RESPONSIBLE: Program Manager

EFFECTIVE DATE: 2/2019

PROCEDURE

The Arc of Greater Plymouth Guidelines/Protocol for Medication Administration Times

1. Standard Medication Times at programs within The Arc of Greater Plymouth will be 8:00am, 12:00pm, 4:00pm and 8:00pm unless the Health Care Provider states specific administration times on medication orders.
2. For all medications with the exception on those ordered QD/once per day; Health Care Provider's orders are not required to have exact administration times. Unless otherwise indicated in the Health Care Provider Order:
   A. Medication ordered once a day (**QD)** has to specify the actual time of administration on the Health Care Provider's order for actual administration time.
   B. Medication ordered twice a day (**BID)** will be administered at the morning and evening or bedtime medication administration times.(i.e.8am and 8 pm)
   C. Medication ordered three times a day (**TID)** will be administered at the morning, late afternoon, and evening or bedtime medication administration times. (8am, 4pm, 8pm)
   D. Medication ordered four times a day (**QID)** will be administered at the morning, midday, late afternoon, and evening or bed time medication administration times.(8am, 12n, 4pm, 8 pm)

3. For any other ordered frequency, MAP Certified staff will then seek the advice of the prescribing Health Care Provider as to medication administration times.

OVER THE COUNTER MEDICATIONS

In all Arc of Greater Plymouth programs, all Over-The-Counter (OTC) medications are to be administered according to the same procedures used to administer prescription medications so that individuals served receive the right medication, dose, amount, strength at the correct time, by the right route. Transcription onto the Medication Sheet, and the same administration procedures are required for all Over-The-Counter medications.

INDIVIDUAL RESPONSIBLE: Program Manager

EFFECTIVE DATE: 2/2019

PROCEDURE
Guidelines for the Administration of Over-The-Counter (OTC) Medications to Individuals Served

1. A Health Care Provider's order is required for the administration of all Over-The-Counter medications. All programs will obtain Over-The-Counter medication orders for each individual served, as necessary.
2. All Over-The-Counter medications will be kept locked and stored in the same manner as prescription medications.
3. When administering Over-The-Counter medications, MAP Certified staff will follow MAP Policies.
4. The Arc of Greater Plymouth will train all MAP Certified staff to administer the permitted Over-The-Counter medications as part of the Initial MAP Certification Training and MAP Refreshers.
5. MAP Certified staff will be trained to understand/interpret the bottle labeling.
6. Although a signed Doctor's order is required, a prescription is **not** required for the purchase of Over-The-Counter medications. MAP Certified staff may present the pharmacy with a copy of the Health Care Provider's order which will include the name of the individual served, the name of the medication, the strength of the medication, and the directions including: frequency, route, and expiration date of the medication ordered. The pharmacist can assist MAP Certified staff in purchasing the correct Over-The-Counter stock medications.

Guidelines for the Administration of Regular Over-The-Counter Medications

1. Whenever possible, Over-The-Counter medications will be labeled by a pharmacist. While a prescription from a Health Care Provider is not required for the purchase of Over-The-Counter medications, most pharmacies require a prescription to label the medication according to the Health Care Provider's order.
2. A label that reads "as directed" is not permitted. Specific instructions are needed on the pharmacy label to do the MAP authorized checks.
3. The Over-The-Counter medication or preparation must be in the original manufacturer's container with the original manufacturer's label affixed.

Guidelines for Labeling Over-The-Counter Medications

All Over-the-Counter medications (OTCs) and preparations require labeling to be managed in one of the two following ways:
1. *OTC Method A*: A label is applied by the pharmacy or Health Care Provider as prescription medications are labeled; or
2. *OTC Method B*: A licensed professional (Registered Nurse, Nurse Practitioner) must verify the contents of the OTC medication or preparation (if not labeled by the pharmacy or Health Care Provider). Verification is accomplished by:

a. Ensuring that the OTC medication or preparation is in the original manufacturer's container with the original manufacturer's label affixed;
b. Ensuring that the contents of the container reflects the Health Care Provider's order;
c. Comparing the manufacturer's label to the Health Care Provider order and verifying the contents by initialing the container;
d. Placing the name of individual(s) on the container using a fine point permanent marker in a light or dark color allowing for clear visibility.
e. Placing the date of verification on the container, and;
f. Noting the verification on the Health Care Provider's order.

Using OTC Method B requires verification of the contents by the licensed professional (Registered Nurse, Nurse Practitioner) to be performed every time a new container and/or updated HCP order of the medication or preparation is obtained.

3. Since MAP trainings do not instruct MAP Certified staff to administer medications without pharmacy or HCP labels, the MAP Consultant will complete a training on how to administer medications and preparations from a container without a pharmacy or Health Care Provider label.
4. Training, provided by the program's assigned MAP Consultant, must be documented. Documentation must include the date of the training, name(s) of MAP Certified staff trained, and the name, address, and telephone number of the trainer.

Guidelines for the Documentation of the Administration of Over-the-Counter Medications

1. Over-The-Counter medication orders will be transcribed onto the Medication Sheet when the Health Care Provider order is received until the order is discontinued.
2. MAP Certified staff will document the administration of Over-The-Counter medication in the same manner that prescription medication is documented on the Medication and Treatment Chart.
3. If the Over-The-Counter medication is ordered PRN, MAP Certified staff will document the reason for administration, if the desired effect was achieved, and any further action taken in a medication progress note on the back of the Medication Sheet.
4. If the Over-The-Counter medication is ordered PRN, the Health Care Provider's order will include the specific target symptoms and instructions for use (e.g. Tylenol 325mg. 2 tabs, PO, Q4 hrs. for temperature >101).
5. Any Over-The-Counter medication that is not administered according to the Health Care Provider's order is a Medication Occurrence and will be reported to the DMH/DDS/DPH per the requirements of the Medical Occurrence Reporting System.

Guidelines for Contacting a Consultant

1. As with all medications, MAP Certified staff will contact their MAP Consultant any time an Over-the-Counter medication is not administered according to the Health Care Provider's order.
2. The MAP Consultant will also be contacted any time the MAP Certified staff requires guidance or advice regarding the appropriate administration practices for Over-the-Counter medication or if they have questions about the effects or side effects of Over-The-Counter medications.

Guidelines for the Notification to the Health Care Provider of Herbal/Natural Supplements and/or Remedies

If MAP Certified staff becomes aware that an individual served is taking or intends to take herbal/natural supplements and/or remedies, MAP Certified staff will advise the individual served to inform their Health Care Provider to identify possible drug interactions.
MAP Certified staff require a physician's order to administer any herb/natural supplement and/or remedies.

OXYGEN

For individuals served with chronic lung disease and/or various other medical conditions (lung, heart and/or circulatory disease), supplemental oxygen may be an essential part of their lives. The Arc of Greater Plymouth will follow all MAP regulations in regard to the use of oxygen in the programs. The Program Nurse, and Director of Operations will approve all instances of oxygen use for individuals served in The Arc of Greater Plymouth programs. Oxygen is a medication and all MAP regulations and policies apply when oxygen is administered.
Use of supplemental oxygen within The Arc of Greater Plymouth residences is typically not accommodated due to safety hazards, however always assessed on an individualized basis.

INDIVIDUAL RESPONSIBLE: Program Nurse

EFFECTIVE DATE: Oxygen is not currently in place in Arc of Greater Plymouth Programs.

PROCEDURE

What is Oxygen?
Oxygen is a colorless, tasteless, odorless gas that is necessary for life. Oxygen is needed by our organs and tissues to convert the food we eat into heat and energy, to maintain life. Alcohol, smoking, poor diets, and lack of exercise all lower oxygen levels in your body.

Types of Oxygen Delivery/Equipment
1. Concentrated Oxygen
2. Compressed Air or Liquid Oxygen (Tanks) - (only allowed for Rolland, Day Hab, and IMGLE residents and for those living in Independent Housing or other settings that will be reviewed by the Nurse Manager and Director of Operations on a case by case basis).

Physician's Orders and Training
1. The Program Manager and/or Nurse will contact the Director of Operations if there is a need for an individual served to use oxygen while in a The Arc of Greater Plymouth program.
2. The Program Nurse will obtain written orders from Health Care Provider and will indicate specific parameters and instructions for follow up, including, dosage, route (nasal cannula, mask etc.), and time (continuous, intermittent, only at night, PRN etc.). The Program Nurse will provide training to all MAP Certified staff that will be responsible for administration of oxygen prior to the MAP Certified staff administering oxygen to the individual served. Training can be provided by the Program Nurse, VNA, Home Health Agency, doctor's office, and/or the Durable Medical Equipment (DME) provider. MAP Certified staff training will include Vital Signs Training as well as oxygen administration, but is not limited to the following:
    a. Overview of oxygen;
    b. Rationale of the use of supplemental oxygen;
    c. Demonstration of the correct technique;
    d. Recognition of signs and symptoms of inadequate oxygen;
    e. Safety and handling of oxygen;
    f. Adverse effects of oxygen treatment;
    g. Clean technique, proper hand washing;
    h. Proper cleaning techniques and when to replace nasal prongs;
    i. Emergency procedure guidelines for power outages, broken equipment, etc.
    j. Storage requirements;
    k. Use of a pulse oximeter (if oxygen saturation monitoring is ordered by the Health Care Provider); and
    l. Review of oxygen delivery system, oxygen delivery source, and oxygen delivery equipment.

All MAP Certified staff trainings must be documented and include date of training, MAP Certified staff names, and the name and telephone number of the trainer. All training records are kept at the program site.

Administration of Oxygen

The Program Nurse will work with the prescribing physician to order oxygen and necessary equipment from a durable medical equipment company in the program's area. When working with the durable medical equipment company, the Program Nurse will identify the need for portable oxygen supplies in addition to a concentrator if the individual served is ordered to be on continuous oxygen.
Further, MAP Certified staff must ensure the supplier can deliver and install equipment and have a delivery service 24/7. Oxygen is a medication and needs to be listed on the medication sheet.

Concentrated Oxygen Tanks

1. For concentrated oxygen tanks only - The percent of oxygen should be checked twice a day unless otherwise indicated by the doctor. The level of oxygen supplied should be checked frequently, and at least once a shift, by the trained MAP Certified staff.
2. The MAP Certified staff will document the administration of Oxygen on the Medication Sheet. Since too much oxygen can be harmful to the individual served, the oxygen level on tank will be checked twice daily by the trained MAP Certified staff to determine rate of oxygen flow is as ordered by the prescribing physician.
3. If staff note a change in the individual's condition, report the following signs or symptoms to the Program Manager and emergency On-Call, the Nurse Manager and Director of Operations. If the individual's situation becomes acute, staff will call 911; if the individual's situation becomes urgent, staff will additionally call the Health Care Provider for further instructions.

Low Levels of oxygen can cause these signs and symptoms:

1. Confusion/disorientation;
2. Tiredness;
3. Pale looking eyes;
4. Poor skin texture;
5. Headaches;
6. Anxiety;
7. Mood swings;
8. Irregular sleeping patterns;
9. Depleted concentration; and
10. Poor memory.

Too Much Oxygen can cause:

1. Headaches;
2. Confusion; and
3. Increased sleepiness.

Safe Usage of Oxygen in Community Programs

Oxygen is a safe gas as long as it is used properly. It is non-flammable; however, it supports combustion. Therefore, any material that is already burning will burn much faster and hotter in an oxygen-enriched environment. It is imperative to follow these precautions to ensure a safe environment when an individual served is required to use oxygen:

1. Notify the electric company if the individual served is using an oxygen concentrator system so they can make the individual's site a priority during a power outage.
2. Post "No Smoking" signs that indicate oxygen on the premises, on the entrance door of the site.
3. Always store the oxygen equipment in a well-ventilated area. Do not store or use them in a confined, closed in space such as a cabinet or closet. Always keep oxygen tank secured in a stand or cart to prevent tipping or falling over. If there are extra unsecured tanks, they should be placed flat on the floor.

4. Never use extension cords with any medical equipment.
5. Be sure to have a functional smoke detector and fire extinguisher in the program.
6. Have a backup oxygen tank in the event the electricity goes out or the oxygen runs out.
7. Do not store the oxygen equipment near any heat sources or open flames. This includes, but is not limited to, gas stoves and heaters, matches, cigarettes lighters, burning tobacco, candles, and petroleum products including lotions, alcohol, perfumes, aerosol cans or sprays such as air fresheners and hair spray. These products are very flammable and their combination with oxygen may cause an explosion.
8. Do not smoke or allow others to smoke in the same room as the oxygen system. The sparks from a cigarette may cause serious facial burns. Both the equipment and individual served should stay at least five feet away from anyone that is smoking.
9. Secure loose cords and extra tubing to avoid falls. Never use more than 50 feet of tubing. This can dilute the concentration of oxygen an individual served receives. Be sure the tubing does not come in contact with hot burners, pots, pans, or anything that could cause the plastic tubing to melt.
10. Electrical appliances (electric heaters, electric razors, and friction toys) that get hot or spark during operation should be kept at least five feet away from the oxygen system.
11. Do not use oil, grease, or Vaseline on oxygen equipment. Should frost form on the liquid oxygen system, do not allow the frosted portions of the equipment to come in contact with staff or individual's skin.
12. Always follow the instructions of the oxygen supply company regarding safe use and storage of oxygen.
13. Plan an emergency evacuation plan/escape route. Keep this in a designated space where staff and clients are able to meet while you wait for the fire department. Be certain everyone knows the exact location of this area. Do a dry run minimally twice a year so everyone knows where to go and what to do in case of a fire.
14. Lastly, NEVER change the liter flow without the individual's doctor's approval!

Transportation of Oxygen

Portable oxygen tanks may be transported in The Arc of Greater Plymouth vehicles. The oxygen tank must be secured to the back of a wheelchair or mobility device, or to the inside of the vehicle itself with a safety strap. This will prevent the tank becoming a hazard in case of a motor vehicle accident. Leave the window open slightly for ventilation so that oxygen will not accumulate in the car/vehicle.

VITAL SIGNS

In accordance with the DPH policy 08-1, Arc of Greater Plymouth programs will obtain written instructions and parameters from the Health Care Provider if Vital sign monitoring is required for the administration of a specific medication, to include blood glucose monitoring. MAP Certified staff will be trained and proficient in the monitoring vital signs for medication administration when vital signs are ordered. Vital Sign Training includes temperature, pulse, respiration, Blood Pressure, and Finger Stick Blood Glucose Monitoring if ordered. MAP Certified staff may be trained in any one or all listed vital signs, as required by the Health Care Provider order(s).

INDIVIDUAL RESPONSIBLE: Program Manager

EFFECTIVE DATE: 2/2019

PROCEDURE

1. A request for vital signs is included on Arc of Greater Plymouth's Medication Order form which includes:
    a. Which specific vital signs are required for medication administration of the medication;
    b. Specific written parameters that are required for medication administration (e.g. hold for pulse less than < 60, or greater than >120); and
    c. Action to be taken if the vital signs are not within the established parameters as ordered by the Health Care Provider, to include blood glucose monitoring if ordered.
2. MAP Certified staff will transcribe the Vital Sign Monitoring onto the Medication Sheet. If recording a temperature for a PRN medication, the temperature will be recorded on the progress note on the back of the medication administration sheet.
3. Arc of Greater Plymouth MAP Certified staff will follow the Health Care Provider's instructions if vital signs are outside the specific parameters the HCP ordered; staff will call the Health Care Provider and the Program Nurse and/or the MAP Consultant immediately. The Health Care Provider and the Program Nurse and/or the MAP Consultant will also be contacted if vital signs were not obtained.
    a. The Program Nurse or the MAP Consultant will provide instructions for specific follow-up.
    b. MAP Certified staff will document the instructions from the Program Nurse and or the MAP Consultant and the Health Care Provider on the back of the Medication Sheet; and
    c. If the Health Care Provider issues a change of medication order by telephone, MAP Certified staff will document the new order on the Telephone Medication Order form. The Health Care Provider will sign this form or send a written order to the program within 72 hours of the change. It is preferred if the Health Care Provider is able to fax an order to the program.
4. Training for vital signs (B/P, pulse, respirations, temperature, and blood glucose testing (if warranted)) is specific to the individual served and/or program for appropriate and safe medication administration. The Program Manager will contact the Program Nurse to arrange for vital signs training, on the equipment that will be utilized for obtaining vital signs for the individual served. Only a Heath Care Provider, RN, LPN, Pharmacist, Paramedic, or EMT can conduct Vital signs trainings.
5. The program will maintain a current list of trained MAP Certified staff that are proficient in vital signs training
6. The Vital signs training that is specific to the individual served or program will identify the specific equipment to be used by MAP Certified staff to monitor the vital signs based on the order by the Health Care Provider (i.e., Blood Pressure cuff, stethoscope, thermometer, blood glucose monitoring equipment).
7. Only MAP Certified staff who have been trained and deemed competent in taking vital signs will take the vital signs ordered by the HCP.

WARFARIN SODIUM

Warfarin Sodium, also known as Coumadin, is a Schedule VI (M.G.L. Chapter 94C §2 and 3) controlled substance and all DPH MAP regulations and policies apply when Warfarin Sodium is being administered. All MAP Certified staff, including relief staff, may administer Warfarin Sodium therapy at a DPH MAP registered site provided the Certified Staff have been trained in and are aware of Warfarin sodium therapy. Warfarin Sodium is considered a High Alert Medication by DPH MAP. Any Arc of Greater Plymouth MAP certified site that implements Warfarin Sodium therapy will adhere to this policy.
If there is a medical emergency related to the administration of Warfarin sodium therapy, staff will call 911 and follow Arc of Greater Plymouth's emergency on-call policy

PERSON RESPONSIBLE: Program Manager

EFFECTIVE DATE: Currently not in effect at any Arc of Greater Plymouth program

PROCEDURE

Warfarin Sodium is an anticoagulant, commonly referred to as a "blood thinner", used for the prevention of blood clots in the blood vessels and their migration elsewhere in the body (i.e. legs, lungs, etc.)
Any Arc of Greater Plymouth MAP certified site that implements Warfarin Sodium administration will adhere to the following requirements:

1. There is an order by a Health Care Provider regarding the person's need for Warfarin Sodium that includes:
    a. The specific medical condition or diagnosis that is the indication for Warfarin Sodium; and
    b. A written specific international normalized ratio (INR), sometimes referred to as PT/INR, target range/goal for the client. This blood test is needed to determine the effect of Warfarin Sodium for each client. It measures how long it takes for the blood to clot.

2. There is documentation of the notification of the Health Care Provider(s) when there is a change in the person's condition and any follow-up instructions/orders received.
3. Warfarin Sodium dosages received from an Anticoagulation Management Service have been ordered by a Health Care Provider or Prescribing Nurse Practitioner.
4. All Arc of Greater Plymouth MAP Certified sites that implement Warfarin Sodium administration must follow procedures for safe administration of Warfarin Sodium including, but not limited to:
    a. When transcribing Warfarin Sodium onto the medication sheet, the next date for the upcoming INR lab draw must be indicated on the Warfarin Sodium/Coumadin Event Tracking form.
    b. This Warfarin Sodium/Coumadin Event Tracking form will be placed in the Medication Log for the person served and will include Doctor's orders specifying dose strength, date, and stop date (if any);
    c. A Warfarin Sodium/Coumadin Telephone Order will be placed in the Medication Log for the person served.
    d. All staff trainings and staff competencies completed by Nurse, Nurse Practitioner, or MD will be maintained in the program's Training Log.
    e. Warfarin Sodium Blister Pack Monitoring will be completed at all programs. This requires staff to initial and date each pill popped from a blister pack upon administration. The staff person administering medication for the program will check the blister pack after medication administration to make sure the Warfarin Sodium was administered and signed off and the correct number of dosages remains.

f. If a second Certified staff is available during the Warfarin Sodium administration time, the second staff will also review and verify the Warfarin Sodium order with the pharmacy label and the medication sheet before the Warfarin Sodium is administered.
g. The second Certified staff who reviews and verifies the accuracy of the medication administration will document that the verification was completed by initialing in a "Second Staff" row. If a second Certified staff is not on shift and available to review and verify, the first staff will mark an "X" in a circle in the "Second Staff" row and will then write a progress notes on page two of the medication sheet. If a second staff person is not available, the medication may still be administered.

5. Whenever the Health Care Provider changes a person's Warfarin Sodium orders (dose change, holding medication dosage, etc.):
    a. The change must be communicated to all staff verbally and/or in writing on the Warfarin Sodium/Coumadin Event Tracking form maintained in the Medication Log;
    b. A progress note will be documented on the High Alert Medication form in the Medication Log; and
    c. The Warfarin Sodium medication container will be marked by the approved MAP method to indicate a change in the order. Arc of Greater Plymouth staff will indicate a change by affixing a Direction Change Sticker (or brightly colored sticker) to the medication container in close proximity to the pharmacy label. The sticker must be affixed to the medication container in a manner that does not destroy or obstruct the original pharmacy label. The sticker must have properties of sufficient chemical adhesion to remain permanently affixed to the container.

Note: This medication often requires frequent initial dose changes by the HCP in an effort to maintain therapeutic lab values. This medication may be administered with a label stating "as directed" until the blood levels (PT/INR) have stabilized.

The pharmacy will be contacted by the Health Care Provider with the new dosage requirements.

Warfarin Sodium Therapy Training

Certified staff administering Warfarin Sodium must complete Warfarin Sodium Therapy Training conducted by an RN, NP, PA, Pharmacist, or MD with demonstrated understanding on an annual basis. Staff training in Warfarin Sodium Therapy includes:

1. Overview of Warfarin Sodium and anti-coagulant therapy;
2. The goal and rationale for Warfarin Sodium administration (including client-specific);
3. Overview of blood testing monitoring including Prothrombin time (PT) and International Normalized Ratio (INR);
4. INR target ranges (including client-specific);
5. Rationale for frequent Warfarin Sodium dosage changes;
6. Importance of consistent administration of Warfarin Sodium (administered once a day at the same time each day);
7. Probable signs and symptoms associated with high and low INR results;
8. Overview of Warfarin Sodium interactions (i.e. medications, foods, beverages, herbal, over-the-counter medications, spices, etc.);
9. Overview of Warfarin Sodium telephone orders;
10. Safe Warfarin Sodium administration measures;
11. Person-specific health care protocols, if applicable;
12. Demonstration of the correct technique to document Warfarin Sodium transcription, telephone HCP orders, and administration of medication;
13. When to contact the Health Care Provider or the MAP Consultant;
14. Adverse effects of Warfarin Sodium therapy;

15. Injury prevention (i.e. caution with sharp objects, using soft-bristle toothbrush and waxed dental floss, electric razor, etc.); and
16. Emergency guidelines to follow including but not limited to calling 911 and notification of the person's Health Care Provider.
17. As with all MAP Competency Training, the training and proof of understanding will be documented and maintained at the program site.