

Part V *Health Care Services*

Section 49.0 *Health Care Services*

APPLICABILITY & DEFINITIONS

- 49.1 The Health Care Regulations described herein are the minimum standard of care to which agencies are expected to adhere when providing health care services for an individual. As stated previously, it is the expectation of the Department that each person's array of supports and services be customized to meet the individual needs and desires in the least restrictive environment. To that end, the support an individual receives in the area of health care must also be individualized and may fall within a continuum of services. For some, these services will be extensive and managed in total by the chosen agency. Others may request minimal participation of the agency or opt not to receive any assistance with health care management. This range of service will be reviewed with the individual, his or her family or advocate, and representatives from the chosen agency prior to the commencement of service, and health care services will be made available as appropriate.
- 49.2 Agencies shall maintain written health care and nursing policies and procedures in an "Agency Health Care Manual", that at minimum address all areas indicated and outlined in the BHDDH Health Care Guideline. Such policies and procedures are subject to the approval of the Department of BHDDH.
- 49.3 A current emergency fact sheet or other form for each individual receiving services shall be accessible and available in the agency files and any other relevant location as identified in the agency's policy and procedure. Information required includes, but is not limited to:
- a) Person's name, address, telephone number and date of birth;
 - b) Social Security number;
 - c) Medicaid number, Medicare number, and/or other insurance information;
 - d) Guardian and/or next of kin's name and telephone number;
 - e) Name and telephone number of the primary care physician, and other relevant health care providers/specialists;
 - f) Medical diagnosis
 - g) Date of last annual physical
 - h) Tetanus, TB, and Hepatitis B immunization status;
 - i) List of current medications and dosages; and,
 - j) List of any known allergies
- 49.4 Incident reports shall be maintained on serious incidents in accordance with the Office of Quality Assurance reporting requirements, as defined in the BHDDH Licensing Regulations. Examples of these include, but are not limited to:

- a) an injury that requires medical care or treatment beyond routine first aid;
 - b) series of repeated medication errors;
 - c) neglect;
 - d) unplanned / unexpected admission to a hospital including psychiatric admissions;
 - e) death.
- 49.5 Influenza, pneumococcal, and other adult vaccination policies and protocols shall be developed and implemented by the agency in accordance with the most current recommendations of The Advisory Council on Immunization Practices (ACP) Guidelines for these vaccinations, and as recommended and ordered by the person's physician or other licensed health care provider.
- 49.6 The agency shall have written policies to be followed for health care communication with family members and/or legal guardians regarding significant changes in medication and/or medical status of the person with developmental disabilities.

Medical Care

- 49.7 A physical examination shall be obtained annually. Components of the physical exam shall include a review of prescribed medication, over-the-counter medication and herbal/homeopathic supplements, completion of accepted primary care screenings such as pap smears, mammography, prostate screening, and colon screening. If routine screening is deferred by the person's physician or other licensed health care provider, documentation as to the reason for the deferral must be included in the person's health care record.
- 49.8 Prescribed Nutritional Diets - Any physician, dietician, or other licensed health care provider's prescribed diet order shall be implemented and a copy of the diet is kept the person's health care record.
- 49.9 Dental examinations and cleanings shall be performed as recommended by the American Dental Association, unless otherwise determined by the individual's licensed health care provider.
- 49.10 Vision / Audiology / Speech consults and/or examinations shall be performed if indicated. Assistive equipment shall be provided as prescribed and kept in good repair. The individual shall receive support to utilize and maintain assistive equipment.
- 49.11 Orthopedic/PT/OT evaluation and/or services shall be performed if indicated. Assistive equipment shall be provided as prescribed and kept in good repair. The individual shall receive support to utilize and maintain assistive equipment.
- 49.12 Medical specialties – any other specialties shall be consulted if indicated to maximize health.
- 49.13 The Agency shall document an individual's refusal of tests, exams, procedures or other health care recommendations in the individual's plan. Necessity of said procedures will be

periodically reviewed and ongoing efforts shall be made to achieve the desired health care goals(s). Documentation will be maintained in the individual's health care record.

- a) When necessary, the agency shall refer to BHDDH policy/procedure for substituted consent.

Documentation Standards and Maintenance of Health Care Records

49.14 Health care records shall include all pertinent health care related documents including physician or health care provider assessments and orders.

49.15 Documentation and corrections in health care information shall be made by in accordance with standard nursing practice.

49.16 All health care information shall be placed in the individual's record in reverse chronological order.

49.17 Health care records shall be kept for a minimum of seven years following the cessation of services.

49.18 The RN shall complete and document the findings of a nursing assessment on a minimum of an annual basis.

49.18.1 An assessment shall be completed and documented whenever there is a significant change in the individual's health status.

49.18.2 The Licensed Nurse shall complete nursing progress notes as determined by the nature and scope of the individual's health care needs, and the agency's policy and procedure for documentation.

49.19 Adaptive equipment (e.g., wheelchairs, braces, communication device) shall be obtained as needed and kept in good repair. Regular assessment for proper fit and usage shall also be completed.

Oxygen (O₂) Therapy Guidelines

49.20 The delivery of O₂ shall be administered according to orders written by the person's physician or other licensed health care provider. The order shall include, at minimum, the parameters for utilization of O₂ therapy.

49.21 Method of delivery of O₂ therapy in any residential and/or day program setting shall be determined by the licensed health care provider and/or licensed vendor of oxygen.

49.22 Agencies shall be required to maintain an appropriate backup source of O₂.

49.23 Storage and/or transportation of O₂ must meet the requirements of the applicable National Fire Protection Association's protocols for O₂ storage.

Medication Administration and Treatment

49.24 The agency shall have written policy and procedure for medication administration, including protocols for documentation and contact with the agency nurse and/or licensed health care provider in the event of a medication error and/or medication reaction.

49.24.1 The agency shall have a written policy and procedure describing medication safeguards and support protocols for people who self-administer their medications.

49.25 Medications shall only be administered by support staff who have:

- a) Received documented training in medication administration by a licensed nurse;
- b) Displayed appropriate competency to carry out said procedure and competency has been documented by the RN;
- c) Received annual training and competency assessment by the RN with appropriate documentation retained in the personnel file.

49.26 Medications and treatments shall be stored safely, securely and properly, following manufacturer's recommendations and the agency's written policy.

49.26.1 The dispensing pharmacy shall dispense medications in containers that meet legal requirements. Medications shall be kept stored in those containers. An exemption from storage in original containers is permitted if using a pre-poured packaging distribution system (e.g., medi-set).

49.26.2 A corrected label shall be provided by the pharmacist or noted to indicate change by the licensed nurse, correspond to the medication administration sheet, and shall be completed for any medication change orders.

49.26.3 The following guidelines apply to individuals who reside in licensed residences and/or receive 24 hour supports unless otherwise outlined in the individual's health care plan:

- a) medications shall be stored in a locked area;
- b) medications shall be stored separately from non-medical items;
- c) medications shall be stored under proper conditions of temperature, light, humidity, and ventilation;
- d) medications requiring refrigeration shall be stored in a locked container within the refrigerator; and,
- e) internal and external medications shall be stored separately
- f) Potentially harmful substances (e.g., urine test reagent tablets, cleaning supplies, disinfectants) shall be clearly labeled and stored in an area separate and apart from medications.

- 49.27 A licensed health care provider and/or nurse shall review the medication sheets on a monthly basis and shall sign and date the medication sheets at the time of the review. The medication record shall have a signature sheet of all staff authorized to administer medications, which includes the staff's signature and the initials he/she will be using on the medication sheet.
- 49.28 Medication sheets shall be maintained by the agency for all persons who do not self-administer their medications. Medication sheets will include:
- a) name of the person to whom the medication is being administered;
 - b) medication(s) name;
 - c) dosage;
 - d) frequency;
 - e) route of administration;
 - f) date of administration;
 - g) time of administration;
 - h) any known medication allergies or other undesirable reaction;
 - i) any special consideration in taking the medication, e.g., with food, before meals, etc; and,
 - j) the signature and initials of the person(s) administering the medication.
- 49.29 All prescriptions shall be reviewed and renewed annually at the time of the annual physical or as indicated by a physician or other licensed health care provider. Any and all medication changes require a new prescription.
- 49.30 PRN medications shall be specifically prescribed by a physician or other licensed health care provider and include specific parameters and rationale for use.
- 49.31 All PRN medications shall be documented on medication administration sheets. The documentation shall include:
- a) the name of the person to whom the medication is being administered;
 - b) the name, dosage, and route of the medication;
 - c) the date, time(s) and reason for administration;
 - d) the effect of the medication; and,
 - e) the initials of the person(s) administering the medication.
- 49.32 The name and dosages of PRN medications administered for the purpose of behavioral intervention shall be documented according to the written policy and procedures of the agency and as part of an approved plan in accordance with the BHDDH DD Licensing Regulations.
- 49.33 Medication checks for anyone taking psychotropic medications shall include contact on a regular basis between the person for whom the medications are prescribed and the physician, psychiatrist, or other licensed health care provider. The effectiveness of the medication shall be assessed on a regular basis by the multi-disciplinary clinical team.

49.34 AIM's testing shall be performed by the physician or other licensed health care provider as appropriate, and documented in the person's medical record.

Monitoring of Controlled Medications

49.35 Medications listed in Schedules II, III, IV, and V shall be appropriately stored, documented, and accurately reconciled.

49.36 Schedule II medications shall be stored separately from other medications in a double locked drawer or compartment, or in a separate storage location which is locked, has additional security restrictions such as a combination lock, and has been designated solely for that purpose.

49.37 A controlled medication accountability record shall be completed when receiving a Schedule II, III, IV, or V medication. The following information shall be included:

- a) name of the person for whom the medication is prescribed;
- b) name, dosage, and route of medication;
- c) dispensing pharmacy;
- d) date received from pharmacy;
- e) quantity received;
- f) name of person receiving delivery of the medication; and

49.37.1 Any and all controlled medications shall be counted and signed for at the end of each shift, or in accordance with the agency's written policy and procedure.

49.37.2 In independent living arrangements, the staff person shall comply with the agency's written policy and procedure for reconciliation of controlled medications.

49.37.3 The agency shall maintain signed controlled medication accountability records for all persons to whom meds are administered by agency personnel.

49.38 Administration of Controlled Medications: When a controlled medication is administered, the person administering the medication shall immediately verify and/or enter all of the following information on the accountability record and/or the medication sheet:

- a) name of the person to whom the medication is being administered;
- b) name of the medication, dosage, and route of administration;
- c) amount used;
- d) amount remaining;
- e) date and time of administration;
- f) signature of the person administering the medication.

Disposal of Medications

- 49.39 Disposal of Controlled Substances: Agencies shall have a written policy and procedure for the disposal of damaged, excess, discontinued and/or expired controlled substances. The policy and procedure shall outline the agency's protocol for the inventory and disposal of all such controlled medications in accordance with federal Drug Enforcement Administration (DEA) regulations and all other applicable federal, state, and local regulations.
- 49.40 Disposal of other Medications: Agencies shall have a written policy and procedure for the disposal of all non-controlled medications.

Transcription of Medication Orders

- 49.41 The agency shall have a written policy and procedure describing the conditions under which the support staff may copy a new written medication order from the pharmacy prescription label onto the appropriate documentation form. At a minimum, the procedure shall require the following:
- a) Identification of and training requirements for agency personnel who shall be permitted to copy the medication order from the pharmacy prescription label onto the appropriate documentation form.
 - b) Safeguards for ensuring that the information has been accurately copied
 - c) Protocols for verification by a Licensed Nurse according to agency policy.

Individualized Procedures

- 49.42 The Agency, in conjunction with the physician, the professional nurse, the individual and his or her family/advocate, shall develop the plan for supporting the individual in the event that they require an individualized procedure to maintain or improve their health status. This procedure is one that the individual would do for themselves but for their disability and is necessary for the health maintenance of the person. Appropriate training and documentation of competency in performing an individualized procedure shall be specific to the particular needs, risks and individual characteristics of the person and shall be completed before a support staff performs said task. The fact that a support staff may have been approved to perform an individualized procedure for one person does not create or imply approval for that support staff to perform similar procedures for another individual. When such a procedure is required the following standard for delegation of nursing activities shall apply.
- 49.42.1 Prior to the implementation of an individualized procedure, the RN shall assess the individual's condition as to whether or not it is of a stable and predictable nature.
 - 49.42.2 All training of support staff on the individualized procedure shall be completed by a licensed nurse or licensed health care provider.
 - 49.42.3 The professional nurse shall assess support staff for their knowledge and demonstrated competency prior to delegating the particular task for that person to

that support staff and communicate and document approval.

- 49.42.4 The professional nurse shall reassess support staff's competency on an annual basis at a minimum or as the individualized procedures change.
 - 49.42.5 The licensed nurse shall provide ongoing monitoring of the individual's health care needs and of the support staff's skills.
- 49.43 In the event that a professional nurse determines that a task or individualized procedure cannot be safely delegated she/he shall follow agency policy for communication and resolution while ensuring the health and safety of the individual.

Support Staff Training

- 49.44 Agencies shall have written policies and procedures for ongoing health care training as outlined in the Agency Health Care Manual for all support staff. Specific health care related training shall be conducted or supervised by a licensed nurse or a qualified instructor as specified in the agency's policies. Nursing staff shall delegate tasks only to support staff that have received training commensurate with the agency's protocols and have demonstrated competencies in each area of training. Support staff shall be deemed competent upon documentation of satisfactory completion of training. Satisfactory completion and documentation of training shall include knowledge and demonstration of the delegated task. A competency training checklist shall be completed by a professional nurse prior to the delegation of any health care task, including medication administration. The intent of the competency check is to ensure for the delegating nurse that the staff person has satisfactorily completed all required elements of the training program and has satisfactorily demonstrated skills and competencies in the designated areas.
- 49.45 Support staff shall receive annual training and a competency evaluation in the following health care/health and life education areas:
- 49.46 **Core Curriculum:** The support staff will demonstrate a working knowledge of comprehensive health care principles and procedures and shall demonstrate the ability to assist individuals to more fully understand their health care needs. The Core Curriculum is intended to provide a standardized guideline of minimum expectations for staff training and shall be followed by agency specific policies, procedures and protocols.
- 49.47 **Standard Precautions:** The support staff shall demonstrate the ability to apply measures to prevent communicable diseases, to recognize and report the presence or onset of communicable disease, and to carry out the recommended procedures.
- a. Communicable Diseases
 - b. Infection Control
 - c. Exposure Control Plan (OSHA)
- 49.48 **Wellness & Prevention of Illness:** The support staff shall demonstrate an understanding of a comprehensive, holistic approach to health care and positive, healthy behaviors which will enhance the individuals' overall physical and mental health.
- a. Nutrition/Food Handling

- b. Personal Hygiene
 - c. Sexual & Reproductive Health
 - d. Healthy Lifestyle
- 49.49 Signs & Symptoms of Illness & Injury: The support staff shall be able to recognize the signs and symptoms of illness and injury and take appropriate action.
- 49.50 Emergency Care: The support staff shall demonstrate an understanding of how to identify and respond to emergency situations and when to seek outside help.
- a. Basic First Aid
 - b. Cardio-Pulmonary Resuscitation – all staff who work with individuals supported shall maintain current CPR Certification and documentation of such shall be maintained in the employee’s personnel file.
- 49.51 Communication: The support staff shall understand and demonstrate the importance of clear communication and the compliance with agency policy regarding health care issues.
- 49.52 Medication Administration: The support staff shall safely administer, completely document and communicate appropriately on issues related to medication administration according to acceptable standards in accordance with Sect. HCG 10 Medication Administration and Treatment Guidelines.
- 49.53 Agency Specific Policy, Procedures and Protocols: The support staff shall demonstrate a working knowledge of the agency’s specific policies, procedures and protocols regarding healthcare.
- 49.54 Individualized Procedures: The support staff shall demonstrate competency in the provision of any individualized procedure as detailed in Section HC 11 prior to implementing the procedure.

Professional Nursing

- 49.55 The Professional Nurse shall follow the Rules and Regulations for the Licensing of Nurses with regard to delegation to unlicensed personnel. Delegation of nursing activities shall comply with the following requirements and must not require the direct support staff to exercise nursing judgment:
- 49.55.1 The professional nurse shall make an assessment of the person’s nursing care needs prior to delegating the nursing activity. A Licensed Practical Nurse, acting within the scope of his/her practice, may delegate to unlicensed assistive personnel when the registered nurse’s assessment allows such delegation to occur.
 - 49.55.2 The nursing activity shall be one that a reasonable and prudent nurse, utilizing sound judgment, would determine to be appropriate for delegation;
 - 49.55.3 The licensed nurse delegating the nursing activity shall be accountable for the quality of nursing care given to the individual through the process of delegation.

- 49.56 The following are nursing activities that are solely within the scope of nursing practice and cannot be delegated to support staff:
- 49.56.1 Any part of the nursing process, including nursing activities which require nursing assessment/data collection; nursing diagnosis; planning; intervention; and evaluation. Nursing activities, procedures, and interventions which require an understanding of nursing process or nursing assessment and judgment during implementation are licensed procedures.
 - 49.56.2 Physical, psychological, and social assessment which requires nursing judgment, intervention, referral or follow-up. However, in cases of accident, emergency or the acute onset of serious illness, support staff shall be authorized to call 911 or transport the person to the Emergency Room for evaluation and treatment, while following the agency's written policy and procedure for Emergency Room transport and notification of the agency nurse.
 - 49.56.3 Formulation of a nursing plan of care and evaluation of the person with developmental disabilities' response to the care provided.
 - 49.56.4 Receiving and transcribing verbal, telephone or faxed orders from physicians or other licensed health care providers.
 - 49.56.5 Wound care, including but not limited to:
 - a) complex sterile dressings beyond the parameters of simple wound care;
 - b) dressings to a central line; and,
 - c) irrigation, packing or sterile procedures such as cleansing or dressing penetrating wounds or deep burns.
 - 49.56.6 Any invasive procedures, including but not limited to:
 - a) insertion or re-insertion of a foley catheter, supra-pubic tube, or any other type of catheter or tube;
 - b) irrigation of a foley catheter, supra-pubic tube, or any other type of urinary catheter or tube;
 - c) re-insertion of a gastrostomy tube or tracheostomy tube; and/or,
 - d) removal of tubes or other foreign materials.
 - 49.56.7 Deep suctioning of a person with or without a tracheostomy.
 - 49.56.8 Injectables which require calculation of dose, are anti-coagulants, or are delivered I.M., with the exception of an Epi-pen.
 - 49.56.9 Intravenous (IV) therapy, including but not limited to:
 - a) starting or re-starting IV's;
 - b) assessment and evaluation of the IV site;

- c) dressing changes to the site;
- d) administration of medications through the IV;
- e) hanging/changing the IV solution bag;
- f) removal of any portion of the IV set-up; and,
- g) phlebotomy

49.56.10 Assessment for Administration of Oxygen (O₂) Therapy: The Professional Nurse (R.N.) shall perform an assessment of the person to be receiving O₂ therapy, and document the physician's or other licensed health care provider's O₂ order in the person's plan of care.

49.56.11 Interpretation of pulse oximetry for a person receiving Oxygen (O₂) Therapy.

49.57 The Agency shall have written policy and procedures regarding nursing support protocols for evening, weekend, and holiday coverage.

Variances

49.58 Requests for variances to Clinical Requirements OR Procedural Requirements of the Health Care Guidelines may be made by the Agency. Requests for variances and the relevant documentation shall be submitted in writing to the Department of BHDDH. Such requests and documentation shall also be maintained in the person's medical record.

Section 50.0 *Severability*

50.1 *If any provision of this chapter or the application thereof to any person or circumstance shall be held invalid, the invalidity shall not affect the provisions or application of this chapter which can be given effect without the invalid provision or application, and to this end the provisions of the chapter are declared to be severable.*