The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health (DPH)
Department of Mental Health (DMH)
Department of Children and Families (DCF)
Department of Developmental Services (DDS)
MassAbility

Medication Administration Program (MAP)

MAP Policy Manual

12/02/24

The policies in this Manual, some of which are revisions of existing policies, supersede all other policies on these topics previously issued by the State Agencies.

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DEPARTMENT GUIDANCE

Policy No. & Issue **01-1 Department Guidance Requirements**
Policy Source **MAP Policy Manual**

1) The Departments of Public Health (DPH), Developmental Services (DDS), Mental Health (DMH), Children and Families (DCF), and MassAbility have compiled all existing Medication Administration Program (MAP) Policies and MAP Advisories into one comprehensive document, the *MAP Policy Manual*.

2) For an explanation of terms frequently used within the *MAP Policy Manual*, *see Policy Section 01-Definition of Terms Used at MAP Registered Sites*.

3) The *MAP Policy Manual* is intended to provide Service Providers, MAP Trainers, Certified staff, and other interested parties with a single, topically organized source for MAP Policies.

   a) As a condition of registration, each MAP site registered with DPH must maintain both the current copy of the *MAP Policy Manual* and the current copy of the *MAP Training Curriculum*, as part of the required reference materials for MAP Certified staff.

      i) The *MAP Policy Manual* may be maintained as an electronic reference (*See Policy No. 14-4).*

      ii) The *MAP Training Curriculum* may be maintained as an electronic reference (*See Policy No. 14-4).*

Definition of Terms Used at MAP Registered Sites

The following definitions are intended to explain terms used within the *MAP Policy Manual*.

1) Individual: An adult person, over the age of 18, supported by programs funded, operated, or licensed by the Department of Developmental Services; or an adult person, over the age of 18, supported by programs funded, operated, or licensed by MassAbility; or a person (adult or youth) supported by programs funded, operated, or licensed by the Department of Mental Health; or a person (adult or youth) supported by programs funded, operated, or licensed by the Department of Children and Families, who receive medication through the Medication Administration Program.

2) Health Care Provider (HCP): A Massachusetts authorized prescriber (e.g., Physician, Dentist, Podiatrist, Advance Practice Registered Nurse, Physician Assistant, Registered Pharmacist, etc.) who is currently authorized to prescribe controlled substances in the course of their professional practice.

3) Certified Staff: A direct support worker, who has been trained in the Medication Administration Program, and possesses a current MAP Certificate authorizing them to administer medications at DPH MAP Registered sites.

4) Site Supervisor: The managerial Certified staff (e.g., House Manager, Residential Supervisor, Program Supervisor, etc.) responsible for supervising other Certified staff. In MAP, the Site Supervisor has the responsibility for assigning the task of administering medications; being present and signing as a witness for all disposal of expired and/or discontinued medications; ensuring that the 'Index' of the *Countable Controlled Substance Book* is accurate; and providing the supervisory review of all medication occurrences.

5) Licensed Staff: A nurse (i.e., Registered Nurse [RN], or Licensed Practical Nurse [LPN]) currently licensed in the state of Massachusetts, who is legally authorized to practice nursing.

6) MAP Quality Assurance Monitor (MAP Monitor): A Registered Nurse, meeting the requirements for a Medication Administration Program (MAP) Approved Trainer as set forth in MAP Policy 04-1. The MAP Monitor assists the MAP Certified staff in their role at Department of Mental Health (DMH) MAP Registered Youth Sites or Department of Children and Families (DCF) MAP Registered Youth Sites and provides the functions as listed in MAP Policy 02-2.

7) Administrative Staff: A person who is not regularly assigned to work within the MAP Registered site, who has managerial responsibilities for the Service Provider. The position that satisfies this role may vary based upon the appropriate title used by the Service Provider.

8) MAP Registered Site: A designated medication storage space within a community program site, whose address is licensed, operated or funded by DDS/DMH/DCF/MassAbility and has received from DPH, a current MAP Massachusetts Controlled Substances Registration (MCSR). The MCSR permits the storage of medication and authorizes MAP Certified staff to administer medication and perform medication-related tasks.

9) Medication Administration Process: A series of steps a Certified staff must follow when preparing, administering, and documenting medication administration. This process must be completed each time the Certified staff administers a medication.

10) Protocol: An extension of the Health Care Provider (HCP) Order, which describes a process or method to be followed regarding the administration of a medication (i.e., medical guideline) by Certified staff for an identified individual, related to a certain disease/diagnosis. In addition to medical guidelines, a Protocol can also give directions, including but not limited to, calling emergency numbers (e.g., 911, poison control, etc.) or when to notify the HCP. The Protocol must be signed/dated by the HCP and unless otherwise specified or there are changes, is valid for one year.

11) Service Provider Procedure: An established method a Service Provider will execute a MAP-related task. The procedure should describe a sequence of steps and specify for each step what needs to be done, including when the procedure should be executed and by whom.

12) Service Provider Policy: A set of customized principles and related guidelines that the Service Provider establishes to define how it will comply with the directives that are outlined in the *MAP Policy Manual*.

13) Staff Signature: Documentation of the staff's first and last name to signify their completion of a task. Usually a staff signature is hand-written; however, a staff signature could be an electronic symbol or digital signature if there is a guarantee that it is authentic.

14) Department of Public Health (DPH): The lead oversight state agency for the Medication Administration Program. The Department of Public Health is referenced as DPH within policies throughout this *MAP Policy Manual*.

15) Drug Control Program (DCP): The program responsible for implementing statutory standards for MAP, promoting effective medication security and accountability measures, and working to prevent theft, tampering, misuse and abuse of drugs.

16) State Agencies: The term collectively used when referring to the Departments of Developmental Services (DDS), Mental Health (DMH), Children and Families (DCF), and MassAbility.

17) Acceptable Codes: A code is a set of letters used on a Medication Administration Record created as an acceptable abbreviation of a longer phrase or that describes a specific medication responsibility, a change in medication responsibility and/or the responsibility for the medication administration to be done away from the individual's home.

    a) Acceptable Codes, their description, and definition for the Medication Administration Program (MAP) are:
        i) **A**-absent from site: (Used when medication is not administered due to unauthorized reasons beyond staff's control as the individual left the program without agreement or supervision or did not return as planned without agreement or supervision during medication administration time);
        ii) **DP**-day program/day habilitation: (Used when an individual's medication responsibilities are transferred to a day program or a day habilitation program);
        iii) **H**-hospital, nursing home, rehab center, respite: (Used when an individual's medication responsibilities are transferred to a hospital, nursing home, rehabilitation center, respite, etc.);
        iv) **LOA**-leave of absence: (Used when medication is transferred to a family/guardian/responsible party for administration while on a leave of absence);
        v) **NSS**- no second staff: (Used specific to a medication that requires dose verification prior to administration by a second staff such as, Warfarin sodium. This indicates there is no second staff available);
        vi) **OSA**-off-site administration: (Used when medication is administered by Certified staff at an off-site location, such as the movies, a community outing, etc.);

vii) **P**-packaged: (Used when the individual packages their own medication under staff supervision. This Code is used when an individual is learning to self-administer their medication);
viii) **S**-school: (Used when the individual's medication responsibilities are transferred to a
(i) school or after-school program);
ix) **V**-vacation: (Used when medication is to be administered by Certified staff when the staff accompanies an individual on a planned vacation); and
x) **W**-work: (Used when medication is to be administered by Certified staff at an individual's work location).

Policy No. & Issue **01-2 DPH MAP Waiver Request**
Policy Source **MAP Policy Manual** **Waiver Request Form 1/23/19**

1) The Department of Public Health (DPH) may waive the applicability of one or more of the MAP Policy requirements to a specific MAP Registered site upon finding that:
   a) compliance would cause undue hardship to the MAP Registered site;
   b) non-compliance does not jeopardize the health or safety of the individuals supported by the site; and
   c) the Service Provider has instituted compensating features that are acceptable to the DPH Drug Control Program.

2) The Service Provider must provide the DPH Drug Control Program with sufficient written documentation to support its request for a waiver. Waiver requests should be submitted to the DPH Drug Control Program Director at map.dcp@mass.gov .

02

Youth Community Programs

Policy No. & Issue **02-1 Medication Administration to Youth**
Policy Source **April 1997 MAP Advisory**

1) The medication administration criteria set out in DPH regulations at 105 CMR 700.003 apply to all MAP participants and are not specific to individuals under the age of eighteen (18) years of age; however, additional criteria may be set forth by the State Agencies.

2) In programs supported by the Department of Mental Health and/or the Department of Children and Families, direct care staff may be trained and Certified under the Medication Administration Program (MAP) to administer medications to individuals (both adults and youth).

   a) MAP Registered sites that support individuals under the age of eighteen (18) years must have a 'MAP Quality Assurance Monitor' (*MAP Monitor*) (*See Policy No. 02-2*).

3) In programs supported by the Department of Developmental Services or MassAbility, direct care staff are not trained nor Certified under MAP to administer medication to individuals under the age of eighteen (18) years.

1) MAP Registered sites that support individuals under the age of eighteen (18) years must have a 'MAP Quality Assurance Monitor' (*MAP Monitor*).
   a) *MAP Monitor-Definition:* A Registered Nurse, meeting the requirements for a Medication Administration Program (MAP) Approved Trainer as set forth in MAP Policy No. 04-1, who assists the MAP Certified staff in their role at Department of Mental Health (DMH) youth or Department of Children and Families (DCF) MAP Registered sites.
      i) In accordance with 105 CMR 700.003(E)(1)(i) and to prevent conflicts that could lead to potential licensure and certification consequences, a licensed health care professional, who is serving in the MAP Monitor role may not simultaneously perform direct care nursing activities under their license.
         (1) If a MAP Registered site chooses to use the same person to serve as both a direct care nurse and a MAP Monitor, the Service Provider must develop and maintain on site a written plan to ensure MAP responsibilities are completed.
   b) *MAP Monitor-Goal*: To safeguard medication administration while addressing the distinct needs and challenges presented in administering medication to minors.
   c) *MAP Monitor-Role:* To provide clinical assistance to the MAP Certified staff and the Certified Site Supervisor, who are working at MAP Registered sites serving youth. This includes, but is not limited to:
      i) assisting MAP Certified staff in their role by:
         (1) providing Quality Assurance by monitoring the MAP Registered site's Medication System to ensure compliance with DPH and DMH or DCF regulations, licensing requirements, MAP Policies, and Curriculum;
         (2) This is accomplished by conducting reviews of medication practices at regular intervals (and providing training when appropriate) including, but not limited to:
            1. observing Certified staff administer medication to verify they are following the Medication Administration Process including, 'Individual-Specific' Protocols (as applicable);
            2. verifying Certified staff have ensured the Health Care Provider (HCP) Orders are current and accurately transcribed (*See Policy Sections 08 and 11*);
            3. reviewing medication administration documentation completed by the Certified staff at the MAP Registered site;
               a. This includes checking documentation the Certified staff have administered medication in accordance with the HCP Orders (*See Policy Section 08*).
            4. ensuring that 'Individual-Specific' Protocols (e.g., Seizure Protocols, Blood Glucose Monitoring Protocols, etc.) are in place (when applicable), being followed, and HCP notification is documented (*See Policy Sections 18 and 19*);
            5. ensuring Certified staff have confirmed the:
               a. pharmacy supplied the MAP Registered site with the medication as ordered by the HCP; and
               b. medication ordered by the HCP agrees with the information printed on the pharmacy label (*See Policy Sections 08 and 10*).
            6. observing Certified staff conduct 'Shoulder-to-Shoulder' count(s) of the Countable Controlled Substances *(See Policy Section 12)*;

7. ensuring Certified staff follow medication security measures (*See Policy Section 12);* and
8. reviewing Medication Occurrence Reports (MOR Forms).
   a. This includes identifying training needs, providing training, and determining areas where additional intervention may be needed (*See Policy Section 17*).

ii) assisting the Certified Site Supervisor in their role by:
(1) conducting Quality Assurance reviews of Documentation Review Tool(s) completed by the Site Supervisor;
(2) providing training for Certified staff on issues as identified by the Site Supervisor;
(3) conducting Quality Assurance reviews of the Medication System utilized by the Site Supervisor;
(i) This includes ensuring that Certified staff, including relief staff, who administer medication at the MAP Registered site, have a current MAP Certification and have successfully completed required trainings and competencies (as applicable).
(4) ensuring any issues that pose a risk to the individual(s) are addressed immediately by the Site Supervisor; and
(5) identifying and reporting to the Administrative Staff issues that are not in compliance with MAP Regulations and Policies.

iii) assessing issues related to medication administration that are unique to youth (e.g., medication side effects, preparing and administering liquid medication, medication administration by routes other than oral, reference ranges for vital signs, etc.) and ensuring Certified staff are trained, and competent*;*

iv) providing training for Certified staff that attend medical appointments with youth, who may have complex medical and/or multifaceted psychological concerns;

v) observing each Certified staff (working at the MAP Registered site serving youth) conduct a Medication Administration Demonstration, no less than once every twelve (12) months;
(1) An observed Medication Administration Demonstration must include the preparation, administration, and documentation of HCP Ordered medication(s) consistent with MAP Policies, MAP Curriculum, and 'Individual-Specific' Protocols (as applicable).
(2) The observed Medication Administration Demonstration must be conducted 'in-person' as:
(i) a mock medication administration demonstration (i.e., classroom based); or
(ii) a medication administration to a youth at the MAP Registered site.
1. An observed medication administration that is viewed on a MAP Registered site's monitoring device (i.e., a video recording) is not permitted as a substitute for an 'in-person' Medication Administration Demonstration.
(3) The annual Medication Administration Demonstration observation must be documented on a form that includes, but is not limited to:
(i) Certified staff's name;
(ii) date of observation;
(iii) verification that the MAP Medication Administration Process was followed; and
(iv) MAP Monitor's signature.
1. The Medication Administration Demonstration form must be maintained on file at the MAP Registered site (*See sample 'Annual Observation of Medication Administration Competency Evaluation Form'*).
(4) When the staff completes a successful observed Medication Administration Demonstration, the Certified staff may continue to be assigned medication-related tasks, including the administration of medication.

(i) If the staff is unable to complete a successful observed Medication Administration Demonstration, the staff must immediately stop medication administration and may not be assigned medication-related tasks.
1. The staff is not permitted to administer medication until after completion of a successful observed Medication Administration Demonstration.

vi) ensuring that current versions of the *MAP Policy Manual* and the MAP Curriculum are readily available at each MAP Registered site (*See Policy No. 01-1);*
vii) working collaboratively with the MAP Registered site's Administrative staff and Supervisory staff to identify and address medication administration related remedial training needs for the Certified staff;
viii) communicating with applicable MAP Coordinator(s) regarding findings relative to Technical Assistance Reviews (when warranted) performed at the MAP Registered site serving youth; and
ix) reporting deficient practice (*See Policy No. 05-6*) by Certified staff (as applicable).

Annual Observation of Medication Administration Competency Evaluation Form

CLICK HERE TO ACCESS THE SAMPLE *Annual Observation of Medication Administration Competency Evaluation Form* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

03

SITE REGISTRATION REQUIREMENTS

1) The Medication Administration Program (MAP) authorizes medication administration by non-licensed Certified staff to individuals living in DDS, DMH, DCF and MassAbility licensed, funded, and/or operated community residential programs that are their primary residences and/or are participating in Day Programs or Short-term Respite Programs.
   a) Certified staff may administer or assist in the administration of Prescription Medication, Over-the-Counter Medication, and Dietary Supplement(s) to a non-self-administering individual, as addressed throughout this Policy Manual.
      i) Certified staff may not engage in other duties or obligations while performing medication administration associated tasks and medication-related documentation.
   b) To ensure the safe administration of medication to individuals supported by the MAP, all Certified/licensed staff must adhere to all MAP Requirements.

2) These Community Residential Programs, Day Programs, and Short-term Respite Programs may apply for a Massachusetts Controlled Substances Registration (MCSR) for the purpose of authorizing non-licensed employees to administer or assist in the administration of medications (*Refer to DPH Regulations 105 CMR 700.000 et. seq).*

3) All community program MAP sites are registered under the licensed corporate provider name (i.e., name of the Service Provider).
   a) The MCSR is issued to the licensed corporate provider (i.e., Service Provider) for the geographic site, where the medication is stored.
      i) For example, if there is a three family house with three separate staffed apartments (one on each floor) and all three apartments utilize MAP Certified staff to administer medication, then all three apartments must each obtain a separate MCSR.
         (1) The DPH Drug Control Program (DCP) issues three separate MCSRs, one for each apartment, not one MCSR covering the entire house. The name of the Service Provider will appear on all three MCSRs.

4) MCSRs are not transferable.

Policy No. & Issue **03-2 Massachusetts Controlled Substances Registration (MCSR)**
Policy Source **April 1997 MAP Advisory Supervisor's Training Manual**

1) The Department of Public Health (DPH) MAP Regulations are intended to address the medication administration needs of individuals who are living in DDS, DMH, DCF or MassAbility licensed, funded, or operated community residential programs that are their primary residences and/or are participating in Day Programs or Short-term Respite Programs (*See Policy No. 03-1).*

2) The DPH Drug Control Program (DCP) requires that Service Providers of these community programs register with the DCP for the purpose of authorizing non-licensed Certified staff to administer and/or assist with the administration of medication.

3) To register a program for a MAP Massachusetts Controlled Substances Registration (MCSR), an application process is required. Service Providers may submit an application for a new site and renew current MCSRs through the DPH online eLicensing System.
   a) Tutorials covering each step of the process are available on the DPH Health Professions Licensing System User Guide webpage. (*See the MAP MCSR Application webpage for additional information*).
   b) A site registration checklist is required for all new applications.

4) An application process is required:
   a) for any new MCSR;
   b) when the Service Provider changes;
      i) The new Service Provider must apply for a new MCSR in advance of the effective date of such change.
   c) when the address of the medication storage area changes;
      i) A new MCSR application is required when the MAP Registered site medication storage area address changes (i.e., relocates).
         (1) Prior to the move (relocation), an email should be sent to the DPH at map.mcsr@mass.gov .
            (i) The correspondence should include the date the new site will open and the date that the old site will close.
         (2) The Service Provider for the relocated site must apply for a new MCSR in advance of the effective date of the change in address.
   d) any renewal of the MCSR; or
   e) amending information for the MAP Registered site MCSR.

5) All MAP MCSRs are initially sent to the Service Provider's administrative email address. A copy of the MAP MCSR must be readily accessible at the MAP Registered site (i.e., where the medication is stored).
   a) The MAP Registered site will be required to reference the MCSR number when:
      i) communicating with the DCP;
      ii) completing a Medication Occurrence Report form (MOR form); and/or
      iii) documenting a disposal on a Controlled Substance Disposal Record.

6) The MAP MCSR is valid for one (1) year. All renewals are completed through the DPH online eLicensing System prior to the MCSR expiration date.

   a) A copy of the MCSR must be available and readily accessible in the medication storage area at the MAP registered site and at the Service Provider's administrative office

7) The MCSR that was issued to a MAP Registered site is no longer valid if:
   a) the MAP Registered site no longer houses individuals who are supported by either DDS, DMH, DCF, or MassAbility;
   b) all individuals supported at the MAP Registered site are deemed self-administering of their medications;
   c) the Service Provider changes; or
      i) When the MAP Registered site changes ownership, the previous Service Provider must immediately notify DPH by email at map.mcsr@mass.gov stating that the site has changed ownership, the date of the change, and a copy of the completed and signed Attestation Statement Regarding the Disposition of Controlled Substances at MAP Sites form must be submitted to the DCP. For additional information and the Attestation form, see the DCP MAP website.
   d) the MAP Registered site closes.
      i) If a site closes, the MCSR is no longer valid. The DPH must be notified by email at map.mcsr@mass.gov stating that the site is closed, the date of closure, and a copy of the completed and signed Attestation Statement Regarding the Disposition of Controlled Substances at MAP Sites form must be submitted to the DCP. For additional information and the Attestation form, see the DCP MAP website.

Policy No. & Issue **03-3 Preparation for Site Registration**
Policy Source **DCP MAP Advisory**

1) Prior to the DPH Drug Control Program (DCP) issuing the MAP Massachusetts Controlled Substances Registration (MCSR) for a community program, the Service Provider must attest that the site for which the registration is being applied meets all established criteria for compliance as set forth in 105 CMR 700.003(E) as well as M.G.L. c. 94C, the Controlled Substances Act and is ready to function as a MAP Registered site, once the MCSR is issued.
   a) Attestation is accomplished by the Service Provider completing the *Attestation of Medication Administration Program Controlled Substances Registration* Document (Attestation Document) for new/potential MAP site(s) via the DPH online eLicensing System. (*See the MAP MCSR Application webpage for additional information.)*

2) The established criteria for a new/potential MAP Registered site, includes:
   a) ***Step A***. Prior to opening, the potential MAP site should have a:
      i) dedicated key-lock medication storage area;
      ii) dedicated countable controlled substances storage container (with access to 'Countables' using two key-locks);
      iii) plan for obtaining Drug Reference Material (e.g., Drug Reference Manual and/or Medication Information Sheets) for all prescribed medications for the individuals supported at the site (to be obtained after opening) (*See Policy No. 14-2);*
         (1) Drug Reference Material must be dated within the last two (2) years.
      iv) current MAP Curriculum;
      v) current MAP Policy Manual;
      vi) list of Emergency Contact Numbers posted near the telephone;
         (1) One-page document for general reference (e.g., poison control, 911, pharmacy, etc.).
      vii) plan to address the need for 24/7 MAP Consultants (e.g., Pharmacy Service Contract Agreement, Service Provider Registered Nurse (RN), etc.);
      viii) Service Provider Policy Manual (with policies specific to MAP) (*See Policy No. 14-1*);
      ix) Chain of Custody Tracking System:
         (1) Medication Book/Record;
         (2) Countable Controlled Substance Book;
         (3) Pharmacy Ordering and Receiving Binder/System;
         (4) Controlled Substance Disposal Record Binder; and
         (5) Medication-Release Documents;
            (i) Leave-of-Absence (LOA) forms; and
            (ii) Transfer forms.
      x) Medication Occurrence Report forms Binder;
      xi) Staff Training Binder; and
         (1) Attendance Record(s), Training Content Materials, etc.
      xii) Licensed Nurses and/or Trained MAP Certified staff to administer medication, with Training Records on-site for MAP Certified staff including:
         (1) MAP Certification;
         (2) CPR card; and
         (3) First Aid card.
   b) ***Step B***. After completing ***Step A*** (above), in order to receive a MAP MCSR, the Service Provider must complete the online MCSR application.
   c) ***Step C.*** After receiving the MAP MCSR, the Service Provider must ensure that the:
      i) MCSR is readily accessible at the MAP Registered site;

ii) Drug Reference Material (e.g., Drug Reference Manual and/or Medication Information Sheets) for all prescribed medications for the individuals supported at the community program are available on-site (*See Policy No.* 14-2*);*
   (1) Drug Reference Material must be dated within the last two years.
iii) list of Emergency Contact Numbers is posted near the telephone with the emergency numbers listed in ***Step A*** (above), along with the 'Individual-Specific' references (e.g., Health Care Provider's contact information, MAP Consultants, etc.), and emergency contact numbers for Service Provider Managerial/Supervisory staff;
iv) medications are received directly from the pharmacy by Certified/licensed staff with countable controlled medications received in tamper-resistant packaging;
v) Medication Book/Record (i.e., Documents for each individual supported by MAP) is on-site including:
   (1) Health Care Provider Orders and Protocols;
   (2) Medication Administration Records;
   (3) Medication Progress Notes/Narrative Notes;
   (4) Emergency Fact Sheets listing current medication(s) name, dose and frequency; and
   (5) A current Medication List (if not included on Emergency Fact Sheet) including medication(s) name, dose and frequency.
vi) Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver is on-site (if applicable); and
vii) Training Competencies are on-site including (if applicable):
   (1) Routes other than oral;
   (2) Vital signs;
   (3) Blood Glucose Monitoring;
   (4) Oxygen Therapy;
   (5) Epinephrine via Auto-Injector Device;
   (6) Gastrostomy (G)-Tube and/or Jejunostomy (J)-Tube;
   (7) High Alert-Warfarin Sodium (Coumadin);
   (8) High Alert-Clozapine (Clozaril);
   (9) High Alert-Insulin via Insulin Pen
   (10) Hospice Care Services;
   (11) Transcription of Medication Management System Training*;* and
   (12) Other Specialized Trainings.

Policy No. & Issue **03-4 Application Forms for a MAP Massachusetts Controlled Substances Registration (MCSR)**
Policy Source **DPH Form**

A LINK TO THE MAP MASSACHUSETTS CONTROLLED SUBSTANCES REGISTRATION (MCSR) APPLICATION MAY BE ACCESSED FROM THE DPH MAP WEBSITE.

04

TRAINING AND CURRICULUM

1) Regulations at 105 CMR 700.003 (E)(2)(a) require that a MAP Trainer be a Registered Nurse, Nurse Practitioner, Physician Assistant, Registered Pharmacist, or Licensed Physician.

2) The MAP Trainer candidate must be currently licensed in Massachusetts as a Registered Nurse, Nurse Practitioner, Physician Assistant, Registered Pharmacist, or Physician.

   MAP Trainer candidates with less than two (2) years of experience in their profession are subject to an 'admission review process' by the applicable state agency MAP Director.
   a) Candidates must provide an up-to-date resume and proof of current Massachusetts licensure.

3) Candidates may contact a MAP Coordinator to register for a MAP Train-the-Trainer Program (MAP TTT Program).

4) To become a MAP Trainer, the candidate must complete the 'MAP TTT Program'.

   a) All components of the 'MAP TTT Program' must be completed within three (3) months.

5) To maintain MAP Trainer approval status, the Trainer must:

   a) be knowledgeable of all current DPH MAP Regulations, Policies and Advisories;
   b) remain current by viewing required webinars and attending mandatory meetings; and
   c) conduct at least one (1) MAP Certification Training per year using only the DPH approved MAP Curriculum and Required Components.
      i) MAP Trainers may co-train a full MAP Certification Training provided that all Trainers actively participate in the training.

6) MAP Trainers not meeting the requirements to maintain MAP Trainer approval status may be notified that their MAP Trainer status has been revoked.

   a) MAP Trainers who have missed scheduled MAP Trainer webinars and/or meetings, or who have not met the requirements to maintain their active status may contact a MAP Coordinator for instruction on how to regain MAP Trainer approval status.

7) It is the responsibility of the Service Provider to ensure that the MAP Trainer utilized is a current 'approved MAP Trainer'.

   a) Staff MAP Certification Training and MAP Recertification Testing are not accepted from a MAP Trainer who has not met the Trainer criteria for approval.
   b) Service Providers may contact the state contracted testing vendor to verify current MAP Trainer approval status.

Policy No. & Issue **04-2 Training Direct Care Staff**
Policy Source **MAP Training Policy**

1) Regulations at 105 CMR 700.003(E)(2), 115 CMR 5.15(7)(a) and 104 CMR 28.06(13)(b) require all training programs to meet specifications jointly established by the Department of Public Health (DPH), Department of Developmental Services (DDS), Department of Mental Health (DMH), Department of Children and Families (DCF), and MassAbility.
   a) MAP Certification Training must be a minimum of 16 hours in length including instruction and all Required Components of the training.
      i) MAP Certification Training instruction must be presented as a 'hybrid' (i.e., combination) model including:
         (1) the online MAP Certification course entitled '*Responsibilities in Action Massachusetts MAP Certification Training'*; and
         (2) 'face-to-face' (i.e., in-person or live virtual) components to enhance what is presented online.
2) MAP Certification is only valid in DDS adult MAP Registered sites, MassAbility adult MAP Registered sites, DMH youth and adult MAP Registered sites, and DCF youth and adult MAP Registered sites.
3) MAP Trainers must use the most current DPH approved MAP Curriculum and Required Components.
   a) All of the MAP Curriculum must be taught and Required Components fulfilled.
   b) Recommendations for changes to the MAP Curriculum by an approved MAP Trainer may be submitted to a MAP Coordinator.
4) MAP Certification is transferrable across all DPH MAP Registered sites therefore no part of the curriculum may be omitted.
5) Verification of completion of MAP Certification Training must be maintained, including but not limited to:
   a) proof of staff attendance; and
   b) Required Components completion date(s).
      i) Verification of completion of MAP Certification Training must be available upon request.

Policy No. & Issue **04-3 Completion of MAP Certification Training**
Policy Source **MAP Policy Manual**

1) To be eligible for MAP Certification Testing, the MAP Trainer must ensure that the staff has successfully completed:
   a) a full MAP Certification Training.
      i) Completion of the online MAP Certification course entitled '*Responsibilities in Action Massachusetts MAP Certification Training*', including the Instruction and Required Components, meets the specifications for the MAP Certification Training.
2) If the staff does not pass one or more of the Required Components, the MAP Trainer may, at their discretion:
   a) offer additional selective training for retaking the Required Component(s); or
   b) require that the full MAP Certification Training be repeated.

Policy No. & Issue **04-4 Revocation of MAP Trainer Approval Status**
Policy Source **MAP Policy Manual**

1) The Department of Public Health may revoke a MAP Trainer's Approval Status if the MAP Trainer:
   a) fails to view/attend scheduled MAP Trainer webinars and/or meetings (*See Policy No. 04-1);*
   b) fails to complete the required number of yearly MAP Certification Trainings (*See Policy No. 04-1);*
   c) fails to conduct Trainings in accordance with current MAP Training standards;
   d) falsifies any of the Certifications or other documents associated with MAP Trainings; or
   e) commits a violation of M.G.L c. 94C, The Controlled Substances Act.

2) The Service Provider shall be responsible for reporting any actions or concerns involving the MAP Trainer to the applicable MAP Coordinator.

05

STAFF CERTIFICATION

Policy No. & Issue **05-1 MAP Certification Eligibility and Guidelines**
Policy Source **April 1997 MAP Advisory**

1) MAP Certification is valid for use only in adult Department of Developmental Services (DDS) programs; adult MassAbility programs; youth and adult Department of Mental Health (DMH) programs; youth and adult Department of Children and Families (DCF) programs that possess a current and valid Massachusetts Controlled Substances Registration (MCSR) issued by the Drug Control Program (DCP) within the Department of Public Health (DPH).

2) Direct care staff, including licensed nurses, who are working in positions that do not require a nursing license, must be Certified in MAP in order to administer medication in MAP Registered sites.

3) Staff must be at least eighteen (18) years of age to become MAP Certified.

    a) MAP Certification Training may be completed prior to the staff turning 18 years old; however, that staff must wait until their 18th birthday to become eligible for MAP Certification Testing.

        i) MAP Certification Testing must be completed within three (3) months of the completion of MAP Certification Training.

Policy No. & Issue **05-2 MAP Certification Testing Process**
Policy Source **April 1997 MAP Advisory**

1) Staff meeting the eligibility criteria for MAP Certification Testing *(See Policy No. 05-1)* may begin the Certification Testing process.

   a) Staff may not administer medication at a MAP Registered site until they pass all of the components of the state contracted testing vendor administered MAP Certification Test. The components include the Knowledge Test, and the Medication Administration Demonstration Skill Test.

2) Staff who have successfully completed Certification Training (*See Policy Section 03*) have three (3) months from the date of completion of the MAP Certification Training to pass all components of the MAP Certification Test to become MAP Certified.

   a) If the staff does not complete the MAP Certification Testing process within three (3) months, they must complete the full MAP Certification Training to regain eligibility to be tested by the state contracted testing vendor.

3) The state contracted testing vendor conducts all initial MAP Certification Testing.

   a) The MAP Certification Test consists of two (2) components (i.e., Knowledge Test, and the Medication Administration Demonstration Skill Test).
      i) If after three failed attempts, of any combination of components, staff must complete the full MAP Certification Training, or, at the Trainer's discretion, complete Remedial Training.
         (1) Remedial Training must be completed by the MAP Trainer of Record.
            (i) If the Trainer of Record is no longer employed by the Service Provider, then the Remedial Training may be provided by another current MAP Trainer, who is employed by the same Service Provider.
         (2) After successful completion of the Remedial Training, the staff is eligible to re-test through the state contracted testing vendor.
            (i) Remedial Training may only be offered once.
            (ii) If staff receives three (3) failed attempts after Remedial Training, they must complete the full MAP Certification Training to regain eligibility to be tested by the state contracted testing vendor.
         (3) Remedial Training does not extend the initial three-month testing timeline.

4) MAP Certification is effective on the date that the test results are posted (indicating that the staff passed the MAP Certification Test) on the Massachusetts Registry located on the state contracted testing vendor website (*See Policy No. 23-1*).

5) MAP Certification is valid for two (2) years from the last day of the month in which the test was passed. For example, if a staff passes the MAP Certification Test on 7/10/2023 and another staff passes the test on 7/28/2023, the expiration date in both scenarios is 7/31/2025.

6) It is the responsibility of both the Service Provider and the MAP Certified staff to track the MAP Certification expiration date to assure MAP Certification remains current and valid.

Policy No. & Issue **05-3 Acceptable Proof of MAP Certification**
Policy Source **February 1998 DMH Memo**

1) The following two documents are acceptable proof of MAP Certification to administer medications at MAP Registered sites:
   a) a printout of the current copy of the Certification;
      i) This can be found on the state contracted testing vendor's Massachusetts Registry (*For Contact Information, see Policy No. 23-1).*
   b) a signed copy of a successfully completed *MAP Recertification Competency Evaluation Form.*
      i) The current updated MAP Certification printout must replace this form as soon as it is available on the state contracted testing vendor's Massachusetts Registry.

2) Acceptable proof of MAP Certification must be maintained at each MAP Registered site in which the Certified staff (including relief staff) is assigned medication administration and/or medication-related tasks.

3) A staff's MAP Certification status can be verified at any time by searching the state contracted testing vendor's Massachusetts Registry (*For Contact Information, see Policy No. 23-1).*

Policy No. & Issue **05-4 MAP Recertification**
Policy Source **Recertification Evaluation Manual**

1) MAP Certification is valid for two (2) years from the last day of the month in which the Certification is issued.

2) A Certified staff is eligible to become MAP Recertified if they are in good standing in the state contracted testing vendor's Massachusetts Registry (*For website information, see Policy No. 23-1*).

3) To become Recertified, staff must pass the Recertification Test (*See Policy No. 05-5*).

   a) The Recertification Test process allows staff to test up to ninety (90) days before the expiration date of their current Certification.
      i) Even if a staff's Certification is current, once the staff fails a Recertification attempt, they are no longer permitted to administer medication and/or perform any medication-related tasks.

4) Staff have one (1) year to complete the Recertification Test process.

   a) If the Recertification Test process is not completed within the one (1) year timeline, the staff must complete the full MAP Certification Training to regain eligibility for the Certification Test process (*See Policy No. 05-2*).
      i) If a staff receives three (3) failed attempts during the Recertification Test process, (consisting of the Medication Administration Demonstration Skill Test), they must complete the full MAP Certification Training to regain eligibility for the Certification Test process (*See Policy No. 05-2*).

5) If a staff receives a failure (after any attempt) during the Recertification Test process, the staff is 'no longer permitted' to administer medication and/or perform any medication-related tasks until the staff passes the Recertification test.

   a) If the staff receives three (3) failed attempts during the Recertification Test process, (consisting of the Medication Administration Demonstration Skill Test), they must complete the full MAP Certification Training to regain eligibility for the Certification Test process.

6) If a staff's Certification expires (is not current) during the Recertification timeline, the staff is 'no longer permitted' to administer medication and/or perform any medication-related tasks.

7) It is the responsibility of both the Service Provider and the Certified staff to track the MAP Certification expiration date to ensure MAP Certification remains current and valid.

Policy No. & Issue **05-5 MAP Recertification Testing Processes**
Policy Source **Recertification Evaluation Manual**

1) MAP Recertification Testing may be completed by one of two processes, either:
   a) the State Contracted Testing Vendor Recertification Test Process (i.e., Vendor Process); or
      i) The Vendor Process includes demonstrated competence in medication administration via the use of standardized tests *(See Policy No. 05-5.1).*
   b) the Approved MAP Trainer Recertification Evaluation Process (i.e., MAP Trainer Process).
      i) The MAP Trainer Process (*See Policy No. 05-5.2*) includes demonstrated competence in:
         (1) Medication Administration.
            (a) The observed medication administration must be conducted 'in-person' or via a virtual process.
               (i) For a staff who is currently Certified (i.e., has not expired or received a failed a recertification test attempt) the observed medication administration may be conducted as either:
                  1. a 'mock' medication administration demonstration (i.e., classroom based, or virtual process); or
                  2. a medication administration to an individual at the MAP Registered site (must be completed 'in-person').
               (ii) For a staff who is currently 'not' Certified (i.e., has expired or received a failed a recertification attempt) the observed medication administration must be conducted only as:
                  1. a 'mock' medication administration demonstration (i.e., classroom based, or virtual process).

2) Once a Recertification Test Process option (e.g., Vendor Process or MAP Trainer Process) is chosen, the staff must remain with that process (e.g., if a staff starts with the Vendor Process they are not permitted to switch to the MAP Trainer Process).

Policy No. & Issue **05-5.1 MAP Recertification Process Through State Contracted Testing Vendor**
Policy Source **Recertification Evaluation Manual**

1) Recertification Testing is available through the state contracted testing vendor.
   a) Staff interested in Recertification via the state contracted testing vendor should contact the vendor directly to inquire about their testing policies, procedures, and to schedule a Test (*For Contact Information, see Policy No. 23-1).*
2) Staff will be tested on demonstrated competence in Medication Administration via the use of a standardized skills test.
3) Upon completion of the Recertification Test, the test results will be available online through the state contracted testing vendor's Massachusetts Registry.
   a) Employers are required to check the vendor's Massachusetts Registry for test results no later than the second business day after the test.
4) If the Certified staff takes the MAP Recertification Competency Evaluation through the state contracted testing vendor, they may continue to administer medications until the results are posted on the vendor's Massachusetts Registry.
   a) If the MAP Recertification Test results show that the staff has 'failed', the staff is 'no longer considered to be MAP Certified' and they must immediately stop administering medications and performing medication-related tasks even if their *Massachusetts MAP Certification* document has not yet expired.
   b) If the MAP Recertification Test results show the staff has 'passed', the 'Certified staff may continue' to administer medications and perform medication-related tasks uninterrupted.

05-5.2 MAP Recertification Process Through the Service Provider

1) Staff seeking MAP Recertification through the Service Provider will be evaluated by an Approved MAP Trainer. The Approved MAP Trainer will evaluate staff on demonstrated competence in Medication Administration.
    a) The Approved MAP Trainer:
        i) observes medication administration by the Certified staff. The observed medication administration may be conducted 'in-person' or via a virtual process:
            (1) When a staff is 'currently Certified' (i.e., Certification has not expired or staff has not previously failed a Recertification Test attempt) the observed medication administration may be conducted either as a 'mock' medication administration demonstration (e.g., classroom based, or virtual process) or a medication administration to an individual at the MAP Registered site which must be completed 'in-person'.
            (2) When a staff 'Certification is no longer current' (i.e., Certification has expired less than one year after the Certification expiration date or staff has failed a Recertification Test attempt) the observed medication administration must only be conducted as a 'mock' medication administration demonstration (e.g., classroom based, or virtual process).

2) An Approved MAP Trainer, using the *MAP Recertification Competency Evaluation Form*, (See *MAP Recertification Evaluation Guide* for assistance in Form completion) will determine if the staff is 'Eligible' or 'Not Eligible' to be Recertified and select the applicable option on the Form.
    a) The results of all Recertification Evaluation attempts must be electronically entered by the Approved MAP Trainer into the state contracted testing vendor website (*For Contact Information, see Policy No. 23-1*).
        i) The Approved MAP Trainer must enter each Recertification Evaluation attempt at the time immediately following each evaluation.
            (1) If the staff fails an attempt, (medication administration demonstration), staff may not administer medication and may not perform any medication-related tasks (even if their current *Massachusetts MAP Certification* document has not yet expired).
                (i) If a staff receives three (3) failed attempts during the Recertification Test process, (consisting of the Medication Administration Demonstration Skill Test), they must complete the full MAP Certification Training to regain eligibility for the Certification Test process (*See Policy No. 05-2*).

3) The completed and signed *MAP Recertification Competency Evaluation Form* is forwarded by the Approved MAP Trainer to the Service Provider designated supervisory staff.

4) Upon receipt of the *MAP Recertification Competency Evaluation Form*, the Service Provider designated supervisory staff reviews the 'Form' to determine if the staff has been deemed 'Not Eligible' or 'Eligible' by the Approved MAP Trainer.
    a) For a staff deemed 'Not Eligible':
        i) the designated supervisor must check the applicable box (i.e., 'acknowledge that the above-named staff is not eligible to administer medication under the MAP as a result of this evaluation') on the *MAP Recertification Competency Evaluation Form*.
            (1) Staff deemed 'not eligible' may not administer medication and may not perform medication-related tasks at any MAP Registered site.
    b) For a staff deemed 'Eligible':
        i) the designated supervisor must determine whether the staff is 'Recommended' or 'Not Recommended' for Recertification.
            (1) For a staff who is deemed 'Recommended', the designated supervisor must:

(i) check the applicable box (i.e., 'recommend the above-named staff'); and
1. Staff who have been deemed 'Eligible' and 'Recommended' for Recertification may administer medication and perform medication-related tasks.

(ii) sign and date the Form and return to the Approved MAP Trainer.

(2) For a staff who is deemed 'Not Recommended', the designated supervisor must:

(i) check the appropriate box (i.e., 'do not recommend the above-named staff'); and
1. Staff who have been deemed 'Eligible' by the Approved MAP Trainer; however, have been deemed 'Not Recommended' for Recertification by the designated supervisor may not administer medication and may not perform medication-related tasks at any MAP Registered site.

(ii) sign and date the Form and return to the Approved MAP Trainer.
1. When the staff has been deemed 'Not Recommended', a copy of the *MAP Recertification Competency Evaluation Form* must be forwarded to the applicable MAP Coordinator for review.

5) The completed, signed, and dated *MAP Recertification Competency Evaluation Form* will be maintained by the Service Provider and the Approved MAP Trainer.

6) The Approved MAP Trainer will update the Staff's Record in the state contracted testing vendor website to indicate Recertification (*For Contact Information, see Policy No. 23-1).*

a) The current *Massachusetts MAP Certification* document will then be available to print from the state contracted testing vendor's Massachusetts Registry.

05-5.3 MAP Recertification Evaluation Guide
Approved MAP Trainer's Guide for Use with the MAP Recertification Competency Evaluation Form

1) **Identifying Information:** This section is to be completed by either the staff applying for Recertification or the Approved MAP Trainer.

2) **Checklist:** This section is to be completed by the Approved MAP Trainer administering the skills evaluation. Check 'Yes', if the staff demonstrates the skill correctly. Check 'No', if the staff does not demonstrate the skill correctly. Comments regarding their performance in regards to a specific skill may be written on the corresponding line under 'Comments'. Additional comments may be added.

   a) **Staff identifies the correct Medication Administration Record:** When the staff is told by the Approved MAP Trainer the identity of the individual to whom they will administer medications ('actual' or 'mock'), the staff is able to locate the correct Medication Administration Record for that individual.

   b) **Staff identifies the correct medication(s):** When the staff is told by the Approved MAP Trainer the date and time of the medication they will be administering to the identified individual, staff is able to review the Medication Administration Record to determine the medication to be administered and is able to retrieve the correct medication from the storage unit.

   c) **Staff confirms the correct Health Care Provider (HCP) Order(s):** Staff is able to confirm the correct HCP Order that matches the medication retrieved.

   d) **Staff compares the Pharmacy Label to the Medication Administration Record:** Staff compares the Pharmacy Label on the medication container to the corresponding entry on the Medication Administration Record and verifies the Five (5) Rights agree.

   e) **Staff prepares the correct dose(s):** Staff pours the correct dose of medication and correctly prepares the medication for proper administration (i.e., crushed, dissolved, diluted, etc. [if applicable]).

   f) **Staff compares the Pharmacy Label to the Medication Administration Record:** Once the medication(s) are poured and prepared, the staff compares the Pharmacy Label on the medication container to the corresponding entry on the Medication Administration Record and verifies the Five (5) Rights agree.

   g) **Staff correctly administers the medication(s):** Staff identifies the correct individual, explains to that individual what medications are being administered, provides that individual with water or the HCP Ordered agent for administration (e.g., juice, pudding, etc.), and verifies that the medication was successfully ingested or applied (i.e., administered via the right route) and safely disposes of the applicable medication administration supplies.

   h) **Staff completes a 'look back', and then correctly documents the administration:** Staff does a 'look back' to ensure that the medication was administered correctly. Staff documents their initials in the medication box corresponding with the date and time of the administration. Staff includes additional documentation that may be indicated (e.g., the administration of a PRN, a countable medication, etc.).

   i) **Staff stores and manages medication(s) in a secure manner:** Throughout the Medication Administration Process, the staff demonstrates an understanding that medications must be maintained in a manner that keeps the individuals safe from accidental or intentional ingestion of those medications. For example, medications are under the

observation and control of staff at all times when the medication storage unit is open; otherwise, the medications are secured with a key-lock(s).

3) **Eligibility:** To be deemed 'Eligible' for Recertification, the staff must receive a 'Yes' on every item on the *MAP Recertification Competency Evaluation Form* checklist.

   a) The Approved MAP Trainer who conducted the Recertification evaluation indicates whether the staff is 'Eligible' or 'Not Eligible', and prints and signs their name.

   b) A staff who is deemed 'Not Eligible' for Recertification may not administer medication and may not perform any medication-related tasks.

   c) The dated and signed 'Form' is forwarded to the Service Provider designated supervisory staff after each evaluation attempt for supervisory staff sign-off.

MAP Recertification Competency Evaluation Form

CLICK HERE TO ACCESS THE REQUIRED *MAP Recertification Competency Evaluation Form* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

Policy No. & Issue **05-6 Revocation of MAP Certification**
Policy Source **April 1997 MAP Advisory**

1) A MAP Certification may be revoked in accordance with regulations of the Department of Developmental Services at 115 CMR 5.15(7)(a), the Department of Mental Health at 104 CMR 28.06(13)(b), the Department of Children and Families and/or MassAbility. A MAP Certification may be withdrawn or rejected if the Department/Commission finds, after an informal hearing, any of the following regarding the holder of the Certification:
   a) has been convicted of a crime involving controlled substances; or
   b) has furnished or made any misleading or false statement in the application for, or renewal of, Certification; or
   c) has failed to exercise proper regard for health, safety and welfare of community program residents (i.e., individuals); or
   d) is unfit to perform the duties for which the Certification was granted.
2) The Service Provider shall be responsible for notification to the applicable MAP Coordinator(s) any concern(s) and/or action(s) taken, regarding the holder of the Certification, related to any condition(s) as listed in number one (1) above.

06

ROLE OF NURSING

Policy No. & Issue **06-1 Board of Registration in Nursing Guidance**
Policy Source **Massachusetts Board of Registration in Nursing**

1) The Board of Registration in Nursing does not regulate a nurse's practice in accordance to setting or episodes of care.
2) Throughout the course of care, a nurse may perform nursing activities for which that nurse has the adequate training (competence) and is within their scope of practice.

Policy No. & Issue **06-2 Role of Nursing in MAP**
Policy Source **1997 BoRN Advisory**

Massachusetts Board of Registration in Nursing
Advisory Ruling on Nursing Practice

Title: The Role of the Licensed Nurse in the Department of Public Health Medication Administration Program

Advisory Ruling Number: 9401

Authority: The Massachusetts Board of Registration in Nursing (Board) is created and authorized by Massachusetts General Laws (M.G.L.) c. 13, §§ 13, 14, 14A, 15 and 15D, and G.L. c. 112, §§ 74 through 81C to protect the health, safety, and welfare of the citizens of the Commonwealth through the regulation of nursing practice and education. In addition, M.G.L. c.30A, § 8 authorizes the Board to make advisory rulings with respect to the applicability to any person, property or state of facts of any statute or regulation enforced or administered by the Board. Each nurse is required to practice in accordance with accepted standards of practice and is responsible and accountable for his or her nursing judgments, actions, and competency. The Board's regulation at 244 CMR 9.03(6) requires all nurses to comply with any other law and regulation related to licensure and practice.

Date Issued: February 16, 1994

Date Revised: May 14, 1997, November 12, 1997, July 10, 2002, July 14, 2010, September 11, 2013, June 8, 2016, July 8, 2020

Scope of Practice: Registered Nurse, Licensed Practical Nurse
Purpose:
To guide the practice of the registered nurse (RN) who is employed specifically to provide training, consultation or monitoring within the context of the MA Department of Public Health (DPH) Medication Administration Program (MAP). To guide the practice of the licensed practical nurse (LPN) who is employed to provide training in accordance with approved MAP policies and procedures.
Established at 105 CMR 700.003(F) and under the oversight of the DPH Drug Control Program, the MAP is a direct authorization, non-nurse delegation model of service delivery in a DPH-registered "Community Program." For the purposes of this Advisory Ruling, "Community Program" refers to any residential or day program registered with the Department of Public Health Drug Control Program and funded, operated, or licensed by the MA Department of Mental Health (DMH), Department of Developmental Services (DDS), the Massachusetts Rehabilitation Commission (MRC), or Department of Children and Families (DCF) with the exception of programs funded under Title XIX of the Social Security Act. This advisory ruling does not apply to programs that are not funded, operated or licensed by DMH, DDS, MRC and/or DCF.

Advisory:
The nurse licensed by the Massachusetts Board of Registration in Nursing (Board) is expected to engage in the practice of nursing in accordance with accepted standards of practice. Nurses must only assume those duties and responsibilities within the scope of practice for which they have acquired and maintained necessary knowledge, skills, and abilities.
It is the Board's position that licensed nurses, when providing training, consultation, or monitoring within the MAP:

- Do not bear responsibility and accountability for the outcome of the medication administration practice of the MAP-certified unlicensed community program staff that the licensed nurse has taught;
- Does retain responsibility and accountability for his or her nursing judgments, actions, and competence for the content taught to unlicensed staff;
- Meet applicable requirements for a Trainer established jointly by the DPH and the DMH, DDS MRC or DCF to instruct the didactic and practice components of the standardized MAP training curriculum leading to MAP certification;
- May provide or arrange for technical assistance and advice when questions arise regarding appropriate administration practices or the effects of medications, including, but not limited to
    - Transcribing orders from a duly authorized prescriber;
    - Ordering medications from pharmacy;
    - Procuring;
    - Storing and destroying medications; and
    - Documenting all related activities;
- Must direct or refer clinical inquiries from community program staff related to an unanticipated change in medical condition or change to medication order to the appropriate duly authorized prescriber in accordance with approved DPH policies; and
- In the event that an event involving medication administration is inconsistent with a duly authorized prescriber's order or anticipated outcome, may recommend action consistent with approved DPH policies, e.g., a healthcare provider, clinic, or emergency room visit. It is not within the scope of practice of the RN or LPN to implement recommendations (e.g., order lab work, order hospitalization, change a medication order) prior to confirmation from a duly authorized prescriber.

References:

104 CMR 28.00*: Licensing and Operational Standards for Community Programs*

105 CMR 700.000: *Implementation of M.G.L. c. 94C*

115 CMR 5.00: *Standards to Promote Dignity*

Medication Administration Program Policy Manual

Medication Administration Program

Advisory Ruling

The Role of Nurses (Registered Nurses and Licensed Practical Nurses) in the Medication Administration Program

Re: The Role of Nurses (Registered Nurses and Licensed Practical Nurses) in the Medication Administration Program

The Board of Registration in Nursing prohibits registered nurses and licensed practical nurses from delegating the administration of medication to unlicensed individuals (i.e., unlicensed staff), except in limited circumstances within public and private schools, citation 244 CMR 3.05(5).

The Medication Administration Program (MAP) utilizes the direct authorization model[*]. Accordingly, neither an RN or LPN is allowed to delegate or supervise the administration of medication by unlicensed individuals (i.e., unlicensed staff) in the Medication Administration Program.

Therefore, the policy of the Medication Administration Program (MAP), is that when a registered or licensed practical nurse elects to become a Site Supervisor within a MAP Registered site that has MAP Certified staff administering medications in the direct authorization model, that nurse must become MAP Certified in order to oversee the administration of medications. The nurse may not simultaneously practice under a nursing license and as a Site Supervisor at the MAP Registered site.

[*] In the direct authorization model, the unlicensed MAP Certified staff are trained and Certified to administer medications under the direct orders of the individual's Health Care Provider(s). The individual establishes and maintains a one-on-one relationship with their Health Care Provider. The Health Care Provider, not the MAP Certified staff, has the responsibility for ongoing assessment, development of an active treatment plan, and for periodic evaluation of that plan. MAP Certified staff are responsible for following the instructions of the Health Care Provider(s).

07

MAP CONSULTANTS

Policy No. & Issue **07-1 Role of the MAP Consultant**
Policy Source **MAP Consultant Policy**

1) A MAP Consultant is a licensed professional who provides technical assistance and advice to MAP Certified staff.

2) A MAP Consultant must be an Authorized Prescriber-Health Care Provider (e.g., Physician, Dentist, Nurse Practitioner, Physician Assistant, etc.), Registered Nurse, or Registered Pharmacist.

3) A MAP Consultant must be available to MAP Certified staff twenty-four (24) hours a day, seven (7) days per week.

    a) It is recommended that the designated MAP Consultant(s) have knowledge of the Medication Administration Program (MAP) and the MAP Registered site; and that there be a formal agreement (written or otherwise), for the consulting service.

4) For each of their MAP Registered sites, the Service Provider must maintain a current list of designated MAP Consultants.

    a) The list of designated MAP Consultants must be readily available for the MAP Certified staff at each MAP Registered site.
        i) The MAP Registered site must contact a MAP Consultant immediately for every Medication Occurrence discovered.

5) MAP Consultants provide MAP Certified staff with:

    a) the technical assistance they may require to interpret the Health Care Provider Order(s);
    b) recommendations of appropriate actions, including medical intervention if necessary, when notified of a Medication Occurrence; and
    c) guidance regarding additional notifications (e.g., contacting another MAP Consultant, calling Poison Control, etc.) should they require it.

6) The Service Provider has the responsibility to:

    a) determine what, if any, actions (e.g., call 911) will be taken by MAP Certified staff to care for the individual; and
    b) contact the MAP Consultant when there has been a Medication Occurrence.
        i) The Service Provider must ensure that the MAP Consultant's recommendation(s) are followed and notification(s) to DPH and the applicable State Agency are within the established time-frames.

08

HEALTH CARE PROVIDER (HCP) ORDERS

Policy No. & Issue	08-1 Required Components of Health Care Provider Medication Orders	
Policy Source	MAP Policy Manual	DMH Licensing and Operational Standards

1) Health Care Provider (HCP) Orders, including standing Orders and Protocols are valid for one year, typically corresponding with an annual preventative health care visit (e.g., annual physical). If an annual visit cannot be scheduled before the HCP Order expires, the HCP Order may remain valid until the day after the annual visit actually occurs, under the following circumstances:
   a) an individual's health insurance plan requires a predetermined amount of time between annual physicals (e.g., one year and one day); and
   b) the Service Provider has made a good faith effort to obtain an appointment with the HCP on the earliest practical date permitted by the insurer.

2) All Medications and Dietary Supplements prescribed for administration at a MAP Registered site require an HCP Order.
   a) Only an authorized prescriber, registered with the state of Massachusetts to prescribe, may order medications for individuals supported at a MAP Registered site.
      i) A copy of the prescription, for the HCP ordered medication, may be utilized as an HCP Order, at the MAP Registered site.
         (1) Prescription medications ordered for administration by Certified staff must not be experimental and must be currently approved by the U.S. Food and Drug Administration for marketing in the United States.
   b) Each HCP Order must specify, at a minimum, the:
      i) Name of individual;
      ii) Allergies;
         (1) Prescriptions utilized as HCP Orders will not have allergies listed.
      iii) Date of the order (i.e., mm/dd/yr);
         (1) The time the order is written is preferred but not required.
      iv) Name of the drug;
      v) Dosage;
         (1) A prescription must include the medication strength and the amount to administer (i.e., the dose).
      vi) Route of administration;
      vii) Frequency and duration of administration;
         (1) For once daily medications only:
            (a) the MAP Registered site should seek clarification from the HCP to indicate what part of the day (e.g., morning, evening, suppertime, bedtime, etc.) the daily medication should be given (e.g., Trazadone 25 mg by mouth once daily at bedtime).
         (2) HCP Orders are not required to have exact medication administration times (e.g., 8 AM and 8 PM); however, the HCP may want to specify this information.
            (a) If the HCP does not specify exact times, frequencies such as twice daily, three times daily, etc. are acceptable.
      viii) Reason (i.e., indication for use) the medication is prescribed (unless the reason is maintained in the individual's historical record);
      ix) Number of day(s) the individual may package and hold medication (if the individual is currently learning to self-administer);
      x) Period of time medication is to be administered (if medication is to be ordered for a set period of time); and

(1) All pre-medical appointment and/or medical procedure HCP Orders must specify when the medication is to be administered in relationship to the appointment/procedure (e.g., one hour before EEG).

xi) Health Care Provider (HCP) signature.

(1) Acceptable HCP signatures include:

(a) a 'wet' signature (i.e., the order is signed with pen and ink by the HCP);

(i) If there is more than one page of HCP Orders:

1. each page must be signed and dated by the HCP; or
2. only the last page will have a wet signature by the HCP provided that:
   a. each page is numbered (e.g., page 1 of 4, page 2 of 4, etc.);
   b. each page is dated; and
   c. all HCP Order pages are fastened together as one unit.

(b) an 'image' of the HCP's signature (i.e., the order, as received, depicts a representation of the HCP's actual signature); or

(i) If there is more than one page of HCP Orders:

1. each page must have an image of the HCP's signature and be dated by the HCP; or
2. only the last page will have an image of the HCP's signature provided that:
   a. each page is numbered (e.g., page 1 of 4, page 2 of 4, etc.);
   b. each page is dated; and
   c. all HCP Order pages are fastened together as one unit.

(c) an 'electronic' signature. Valid electronic signatures include:

(i) An electronic signature generated by the HCP through an electronic system that is compliant with federal law regarding the safety and security of electronic health care records, and is received by the MAP Registered site in a system which is also compliant and can verify the HCP electronic signature.

(ii) A written order presented electronically, such as an email, where the HCP intends for the communication to be treated by the MAP Registered site as an HCP Order, and the MAP Registered site can reasonably attribute the writing to the HCP. This criterion could be met through an HCP email with clear language showing that it is an HCP order, where the MAP Registered site has taken steps to confirm that the email address sending the order is the address of the HCP.*

1. When HCP Orders are received, unaltered, through an electronic system:
   a. only the last page of the HCP Order needs to be 'electronically' signed and dated by the HCP; and
   b. all HCP Order pages must be fastened together as one unit.

3) A current list of medications, including dose, frequency and special instructions, must be provided to all current, or potential, Authorized Prescriber(s).

4) Each individual supported by the DMH or DCF, who receives psychotropic medications, shall be seen at clinically appropriate intervals by the HCP prescribing the psychotropic medications to assess/review the:

   a) appropriateness of the current medication dosage;
   b) reconciliation of all medications being taken by the individual;
   c) side effects;
   d) reason for use of the medications; and
   e) effectiveness of the medications.

5) Any change in the medication HCP Order is considered a new Order, and:

   a) the change must be communicated to all Certified/licensed staff;
   b) the change must be documented as a progress note in the Individual's Record;

c) the pharmacy must be contacted regarding the HCP Order change; and
d) if indicated, the pharmacy medication container(s) must be flagged by the approved method (*See Policy No. 10-4*).

6) HCP Orders may not be marked on (i.e., edited, altered, or tampered) by Certified/licensed staff after the 'Orders' are signed and dated by the HCP.

**The process of confirming an HCP's email address need not be taken each time the HCP sends an order via email. However, an HCP's email address should be re-confirmed after a reasonable interval has passed.*

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

Policy No. & Issue	**08-2 Health Care Provider Orders Received by Fax, Email, Telehealth, and Telephone**
Policy Source	**December 1994 MAP Advisory 1995 DDS Memorandum**

1) Health Care Provider (HCP) Orders received by Certified/licensed staff via fax, email, telehealth, and/or telephone are legal Orders and therefore usage is acceptable by DPH and the State Agencies.

2) HCP Orders 'received by fax' (i.e., facsimile) have the following requirements:
   a) the HCP Order must include all required components (*See Policy No. 08-1*);
   b) the means of transmission must be sufficiently secure and reliable; and
   c) each page of the Order must be signed and dated by the HCP.

3) HCP Orders 'received by email' have the following requirements:
   a) the HCP Order must include all required components (*See Policy No. 08-1*);
   b) the means of transmission must be sufficiently secure and reliable; and
   c) the MAP Registered site, as the recipient of the email, must take additional steps to verify the identity of the HCP, as the sender, (e.g., examining the email address of the sender).

4) HCP Orders 'received by Telehealth' (i.e., Telehealth HCP Orders) have the following requirements:
   a) the HCP Order must include all required components (*See Policy No. 08-1*);
   b) Certified/licensed staff must speak directly to the Authorized Prescriber when given an HCP Telehealth Order;
   c) the Order must be recorded on an *HCP Telehealth Order* form (*See list of requirements in Number 5 below*);
   d) when a medication is ordered, all five (5) rights of medication administration, reason for use, and special instructions are obtained;
   e) the HCP Order must be 'read back' by the Certified/licensed staff to the Authorized Prescriber word-for-word to ensure accuracy; and
   f) the HCP Telehealth Order must be 'posted' and 'verified' twice.
      i) 'First': after the HCP Order is recorded, transcribed, or otherwise noted; and
      ii) 'Second': after receipt of the signed HCP Order.
         (1) Staff must ensure that the HCP did not make any changes.

5) When an HCP Order is received via Telehealth, the *HCP Telehealth Order* form must be completed. The Form must include, but is not limited to:
   a) identifying MAP Registered site information:
      i) Address; and
      ii) Telephone and Fax Numbers.
   b) identifying individual information:
      i) Individual's name; and
      ii) Any documented Historical Allergies.
   c) identifying HCP information:
      i) Name of the prescribing HCP; and
      ii) Contact information (telephone and fax numbers).
   d) the HCP Order(s) and/or other instructions:
      i) Must include all required components (*See Policy No. 08-1*).

e) signature of the MAP Certified/licensed staff obtaining the HCP Telehealth Order; and
f) date and time the HCP Order is received.

6) An HCP Order received by Telehealth is valid for up to 72 hours while waiting to obtain the HCP signature.

   a) An unsigned HCP Telehealth Order is used until the signed HCP Order is obtained. Once the signed HCP Telehealth Order is received, it supersedes (i.e., replaces) the unsigned HCP Order.

7) HCP Orders 'received by telephone' (i.e., Telephone HCP Orders) have the following requirements:

   a) the HCP Order must include all required components (*See Policy No. 08-1*);
   b) Certified/licensed staff must speak directly to the Authorized Prescriber when given an HCP Telephone Order;
   c) the Order must be recorded on an *HCP Telephone Order* form (*See list of requirements in Number 8 below*);
   d) when a medication is ordered, all five (5) rights of medication administration, reason for use, and special instructions are obtained;
   e) the HCP Order must be 'read back' by the Certified/licensed staff to the Authorized Prescriber word-for-word to ensure accuracy; and
   f) the HCP Telephone Order must be 'posted' and 'verified' twice.
      i) 'First': after the HCP Order is recorded, transcribed, or otherwise noted; and
      ii) 'Second': after receipt of the signed HCP Order.
         (1) Staff must ensure that the HCP did not make any changes.

8) When an HCP Order is received by telephone, the *HCP Telephone Order* form must be completed. The Form must include, but is not limited to:

   a) identifying MAP Registered site information:
      i) Address; and
      ii) Telephone and Fax Numbers.
   b) identifying individual information:
      i) Individual's name; and
      ii) Any documented Historical Allergies.
   c) identifying HCP information:
      i) Name of the prescribing HCP; and
      ii) Contact information (telephone and fax numbers).
   d) the HCP Order(s) and/or other instructions:
      i) Must include all required components (*See Policy No. 08-1*).
   e) signature of the MAP Certified/licensed staff obtaining the HCP Telephone Order; and
   f) date and time the HCP Order is received.

9) An HCP Order received by telephone is valid for up to 72 hours while waiting to obtain the HCP signature.

   a) An unsigned HCP Telephone Order is used until the signed HCP Order is obtained. Once the signed HCP Telephone Order is received, it supersedes (i.e., replaces) the unsigned HCP Order.

Policy No. & Issue **08-3 PRN Health Care Provider Medication Orders**
Policy Source **April 1997 MAP Advisory**

1) Health Care Provider (HCP) Orders for a PRN (i.e., as needed) medication must include, but is not limited to:

   a) 'reason' for use (e.g., 'pain' or 'fever');
   b) specific 'target signs and symptoms' (e.g., Tylenol 325 mg by mouth every 6 hours as needed for 'complaint of headache');
   c) 'instruction(s) for its use' (e.g., Tylenol 325 mg by mouth every 6 hours as needed 'for a temperature above 101');
   d) time between PRN and/or scheduled doses of the same medication;
   e) 'when the HCP wants to be notified' (e.g., 'notify HCP if temperature remains above 101 for 6 hours'); and
   f) 'not to exceed' instructions only when less than maximum daily dose is warranted (e.g., Tylenol 325 mg by mouth every 6 hours as needed for complaint of headache. 'Not to exceed 2 doses in 24 hours').

2) Certified staff may only administer PRN medication according to the 'target signs and symptoms' listed on the HCP Order.

   a) For example, in Number 1(a) (above), the HCP Order for Tylenol may not be given for any reason other than a 'complaint of headache' (e.g., may not be administered for 'right leg pain').

3) Administration of PRN medication requires additional documentation including, but not limited to:

   a) the date and time the PRN medication was administered;
   b) the name and dose of the PRN medication administered;
   c) the 'specific target signs and symptoms' for which the PRN medication was administered;
   d) the signature of the staff who administered the PRN medication; and
   e) objective and/or subjective observations about the PRN medication's effectiveness.

Policy No. & Issue	**08-4 Transcribing, Posting and Verifying of Health Care Provider Orders**
Policy Source	**MAP Policy Manual**

1) Health Care Provider (HCP) Orders must be reviewed, recorded, transcribed or otherwise noted. Once completed, the HCP Order must be 'posted' and 'verified' by two transcription trained Certified and/or licensed staff.

   a) Only Certified staff, including Relief staff, who have successfully completed the Service Provider's *Transcription of Medication Management System Training (See Policy No. 11-3)* may:
      i) Transcribe HCP Orders;
      ii) Post and/or Verify HCP Orders; and
      iii) Complete Monthly Accuracy Checks of HCP Orders *(See Policy No. 08-5)*.
   b) Each HCP Order page must be posted and verified below the HCP signature.
   c) When posting and verifying the HCP Order, each transcription trained Certified or licensed staff must document that they either:
      i) posted the HCP Order, including their signature (full first name and last name), date and time of posting; or
      ii) verified the HCP Order, including their signature (full first and last name), date and time of verification.

2) The transcription trained Certified or licensed staff who transcribes the HCP Order initially may administer (if a second Certified or licensed staff is unavailable) the ordered medication(s) before verification is completed. However, another transcription trained Certified or licensed staff must verify the HCP Order prior to a second staff administering the ordered medication(s).

3) When an HCP discontinues a medication or changes a medication (e.g., dose, frequency, etc.), the transcription trained Certified/licensed staff should indicate the discontinuance or change in the following manner:

   a) In the left-hand margin (next to the medication order the HCP has discontinued or changed), document:
      i) discontinued (i.e., D/C);
      ii) the date; and
      iii) Certified/licensed staff's initial.

See example on the next page.

Example:

Health Care Provider Order

Name: *xxxxxxx* Allergies: *xxxxxx*

	Medication	Dosage	Frequency	Route	Special Instructions	Reason for Medication
D/C 1/30/yr MR	*xxxxxxxxx*	*xxxxxxxx*	*xxxxxxxxxx*	*xxxxxxxxx*	*xxxxxxxx*	*xxxxxxxx*
	Medication	Dosage	Frequency	Route	Special Instructions	Reason for Medication
	xxxxxxxxx	*xxxxxxxx*	*xxxxxxxxx*	*xxxxxxxxx*	*xxxxxxxxx*	*xxxxxxxxx*

Health Care Provider Signature: *xxxxxxxxxxxx*

b) Apart from documenting in the left-hand margin, (*See example 3 a. iii. 1.)*, the discontinuation of a medication HCP Order, (in accordance with instructions from the HCP), Certified/licensed staff may not alter or cross out any information recorded on an HCP Order.

Policy No. & Issue **08-5 Monthly Accuracy Check of Health Care Provider Orders**
Policy Source **1995 DDS Memorandum**

1) The Five (5) Rights of medication administration (i.e., individual, medication, dose, frequency/time and route) listed on the Health Care Provider (HCP) Orders, Pharmacy Labels and Medication Administration Records must all agree.

2) To ensure that on-going HCP Orders are followed, all Medication Administration Records (electronic, computer-generated, or hand-written) must undergo a two-person 'monthly accuracy check' (quality check).

   a) Only Certified staff, including relief staff, who have successfully completed the Service Provider's *Transcription of Medication Management System Training (See Policy No. 11-3)* and/or licensed staff may complete Monthly Accuracy Checks of HCP Orders; and

   b) Medication may only be administered after the two-person accuracy checks have been performed.

      i) The two-person (transcription trained Certified and/or licensed staff) 'monthly accuracy check' must be completed prior to the start of the first day of the new month.

         (1) The two transcription trained Certified/licensed staff completing accuracy checks must document:

            (a) Staff one: signature (full first name and last name), date and time; and

            (b) Staff two: signature (full first name and last name), date and time.

Policy No. & Issue **08-6 Medication Reconciliation and Discharge Health Care Provider Orders**
Policy Source **MAP Policy Manual DMH Licensing and Operational Standards**

1) The MAP Registered site must have a complete and current list of all prescribed medication for each individual supported by the Medication Administration Program (*See Policy No. 08-1).*
   a) A copy of the individual's current *Medication List*, including the dosage and frequency of all prescribed medication, must accompany the individual to all Health Care Provider (HCP) encounters (e.g., Primary Care Physician appointment, Psychiatrist appointment, Dentist appointment, Emergency Room Visit, Urgent Care, Hospitalization, etc.).
2) To ensure an accurate *Medication List*, 'medication reconciliation' must be done every time a new medication is prescribed, a current medication is discontinued, a medication dosage and/or frequency has been changed, etc.
   a) 'Medication reconciliation' is the process of generating the most complete and accurate *Medication List* of the individual's currently prescribed medication.
3) When an individual has been assessed in the Emergency Department, Urgent Care, HCP office or other outpatient setting, new HCP Orders are not required unless there are changes.
   a) HCP Orders must be obtained for all changes.
4) When an individual is being discharged from a Health Care Facility (e.g., Hospital, Skilled Nursing Facility, Rehabilitation Center, etc.) and the care of the individual is being transferred back to the MAP Registered site, HCP medication orders must be reconciled.
   a) HCP Orders must be obtained for all changes.
      i) All HCP Orders that were in place (at the MAP Registered site) prior to the Health Care Facility admission must be reconciled with the new Health Care Facility discharge orders to create a complete and accurate *Medication List*.

Medication Reconciliation/Discharge HCP Orders Checklist

CLICK HERE TO ACCESS THE SAMPLE *Medication Reconciliation/Discharge HCP Orders Checklist* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

09

SAMPLE MEDICATION

Policy No. & Issue **09-1 Labeling Guidelines of Sample Medication**
Policy Source **DCP Policies and Guidelines**

1) Schedule VI 'sample' medication may be received from a Health Care Provider (HCP) and administered to an individual only when:
   a) the amount of the sample doses received from the HCP is no more than 'a one-time' thirty (30) day supply;
      i) Larger supplies of Schedule VI sample medication (up to ninety (90) days), may be dispensed as part of a manufacturer's indigent patient drug program.
      ii) If after using the sample medication, the HCP wants to continue its use, a prescription for the medication must be submitted to the pharmacy and the medication must be dispensed to the MAP Registered site from the pharmacy.
   b) the sample medication is received in the original manufacturer's packaging along with the original manufacturer's package insert (medication information sheet); and
      i) The sample medication (in its original packaging) may be placed in a larger container (e.g., a re-closable plastic bag, plastic box, etc.) with a label affixed to the container holding the sample medication. Only one type of drug sample may be in each container.
   c) the label generated by the HCP is affixed to the sample packaging or to the container holding the samples and includes:
      i) authorized prescriber's name and address;
      ii) date of dispensing;
      iii) name of individual;
      iv) name of medication;
      v) dosage and strength of the sample medication;
      vi) clear, simple, and brief directions for use;
      vii) any necessary cautionary statements; and
      viii) date the medication will expire.

2) Schedule II, III, IV or V sample medications are limited to a single dose or to a quantity, which in the opinion of the practitioner (i.e., Health Care Provider), is needed for immediate treatment.

10

PHARMACY

Policy No. & Issue **10-1 Acceptable Prescription Medication Packaging**
Policy Source **April 1997 MAP Advisory**

1) Prescription medication, for use at a MAP Registered site, must be packaged by a pharmacy. Medication packaging includes prescription bottles, containers, blister packs, bingo cards, tamper-resistant cassettes, tamper-resistant syringes, etc.

2) Each type of medication must be clearly labeled with required components (*See Policy No. 10-3*).

3) Acceptable packaging for 'Schedule II-V' (i.e., countable controlled substances) medication and 'high-risk Schedule VI' medication (*See Policy No. 12-2*) includes:

   a) all 'Schedule II-V' (i.e., countable controlled substances) medication and 'high-risk Schedule VI' medication must be received and maintained by the MAP Registered site, in tamper-resistant unit-dose packaging (e.g., blister packs, bingo cards, tamper-resistant cassettes, tamper-resistant packaged syringes or other similar tamper-resistant packages);
      i) 'Schedule II-V' (i.e., countable controlled substances) medication and 'high-risk Schedule VI' medication may contain only one (1) unit (e.g., one tablet, one capsule, etc.) per unit-dose packaging (e.g., 'window', 'bubble', 'cartridge', or other tamper-resistant section).
         (1) The unit must be uniform throughout the package.
   b) 'Schedule II-V' (i.e., countable controlled substances) medication and 'high-risk Schedule VI' medication dispensed as a liquid must be received from the pharmacy in unit-dose tamper-resistant packaging;
   c) all 'Schedule II-V' (i.e., countable controlled substances) medication must be marked by the pharmacy with an identifier (e.g., 'C', 'N', etc.) to designate that it is a countable controlled medication; and
      i) Service Providers need to know the identifier used by the pharmacy dispensing the medication.
   d) varying strengths of the same medication must be in its own separate packaging and clearly labeled.
      i) Half (½) tablets must be packaged separately from full tablets.

4) Acceptable packaging for Schedule VI (i.e., controlled substances) medication includes prescription bottles, containers, blister packs, bingo cards, tamper-resistant cassettes, tamper-resistant syringes, etc. Schedule VI medications are not required to be in tamper-resistant packaging.

   a) When tamper-resistant packaging is used, each individual uniform dose of a Schedule VI (i.e., controlled substances) medication that contains the same strength and amount of medication may be in the same 'window', 'bubble', 'cartridge' or other section; or
      i) The contents of all 'windows', 'bubbles', 'cartridges' (i.e., unit within the same package of medication) must be identical; and
      ii) The contents of each unit (e.g., 'window', 'bubble', 'cartridge', etc.) must be uniform throughout the package.
   b) When tamper-resistant packaging is used, each individual dose of a Schedule VI (i.e., controlled substances) medication may be in the same 'window', 'bubble', 'cartridge' or other section; or
      i) Varying strengths of the same medication may be packaged in the same 'window', 'bubble' 'cartridge' or other section; and

ii) The dose within each unit (e.g., 'window', 'bubble', 'cartridge', etc.) must be uniform throughout the package.
    (1) If a medication is packaged in a pill bottle, all contents must be identical.

c) Multiple different medications may be packaged by the pharmacy in the same 'window', 'bubble', 'cartridge' or 'unit' within tamper-resistant packages (i.e., 'multi-dose medication packaging'). Multi-dose medication packaging requirements include but are not limited to:
    i) when a MAP Registered site utilizes 'multi-dose medication packaging' the Service Provider must have a 'Pharmacy Packaged Multi-Dose Medication Packaging Policy' that includes procedures for Certified staff to follow. The procedures must include, but are not limited to:
        (1) administrative procedures to be followed when there is a medical emergency related to the administration of a medication packaged in a multi-dose package.
            (a) The 'Pharmacy Packaged Multi-Dose Medication Packaging Policy' can reference the Service Provider's overall Policy that specifies the administrative procedures to be followed when there is a medical emergency relating to a medication.
    ii) safe medication administration practices of medications packaged in a multi-dose package, including:
        (1) only medications scheduled to be administered to the same individual on the same date and time may be included in the package;
            (a) 'Schedule II-V' (i.e., countable controlled substances) medication and 'high-risk Schedule VI' medication may ***not*** be included in the 'multi-dose packaging'.
        (2) all medications included in the multi-dose medication package must be labeled by the pharmacy, with all required components, on the pharmacy label;
            (a) Each 'bubble', 'cartridge', or 'unit' must contain the individual's name in addition to the medication name and strength of tablet or capsule.
        (3) if there is a new changed HCP order for a medication already packaged in the multi-dose medication package, staff will immediately coordinate with the pharmacy to return the multi-dose medication packets to the pharmacy to be repackaged and labeled to reflect the new changed HCP order;
            (a) If a new changed HCP order is obtained on a day or time in which it cannot be repacked by the pharmacy, the Service Provider must have a plan to ensure correct administration of medication until the pharmacy is able to repackage the card.
        (4) all medications included in the 'multi-dose medication package' must be transcribed onto the Medication Administration Record;
        (5) all newly HCP ordered medications and medication changes must be immediately communicated to the pharmacy and program staff; and
        (6) there must be a system in place to manage dropped or wasted pills.
    iii) the Service Provider must have a signed agreement with the pharmacy agreeing to the terms and conditions outlined in this policy regarding the packaging and management of multi-dose medication packaging.
    iv) Certified staff are appropriately trained how to complete the required Medication Administration Process using the multi-dose packaging label.
        (1) Documentation of *Pharmacy Packaged Multi-Dose Medication Packaging Training* must include, but is not limited to:
            (a) name and contact information of the Trainer(s);
            (b) date of the training(s) and names of Certified staff trained (i.e., attendance list); and
            (c) a complete set of training materials used to train Certified staff.

5) Packaging for Medications (prescription and Over-the-Counter) and Dietary Supplements must always be intact. In MAP, Certified/licensed staff are 'not permitted to alter' (e.g., no cutting, no gluing, no stapling, no taping, etc.) the Medication packaging and/or the Dietary Supplement packaging.

   a) Unless guidelines are given by the Law Enforcement Representative or the Drug Control Program Investigator due to tampering (*See Policy No 12-7*), any packaging that becomes compromised (e.g., blister cracked, bubble damaged, package unglued, cassette broken, etc.), the Medication or Dietary Supplement (within the compromised blister, bubble, package, cassette, etc.) must be disposed (*See Policy Section 15*).

Policy No. & Issue **10-2 Receiving Medication from the Pharmacy**
Policy Source **1995 DDS Memorandum 04-04-18 DCP Advisory**

1) Medication dispensed by the pharmacy, for use in a MAP Registered site, must be received directly from the pharmacy. Only Certified or licensed staff may receive medications dispensed by the pharmacy.
   a) Certified/licensed staff must receive or pick up medication only for the individuals residing at the MAP Registered site for which the Certified/licensed staff formally works and only during the Certified/licensed staff's work hours (*See Policy No. 12-5*).
   b) All medication received by the MAP Registered site must have medication inventory supporting documentation (*See Policy No. 10-5*).
      i) To ensure the accuracy of the medications delivered, a review of the medication is required upon receipt, just prior to securing them.
   c) Individuals 'learning to self-administer medications' may pick up medications from the pharmacy according to their Teaching/Support Plan as authorized by the HCP (*See Policy No. 20-4*).
2) Each type of medication must be clearly labeled (*See Policy No. 10-1*).
3) All medication received by the MAP Registered site from the pharmacy must be in a form that allows for administration of the ordered dose.
   a) All tablets, capsules, pills, etc. that are required to be split to equal a dose ordered must be split by the pharmacy.
4) 'Schedule II-V' (i.e., countable controlled substances) medication and 'high-risk Schedule VI' medication must be received in unit-dose, tamper-resistant packaging (*See Policy No. 10-1*).
5) All medications received from the pharmacy must have a pharmacy label affixed to the medication container (*See Policy No. 10-3*).
   a) In MAP, Certified/licensed staff are not permitted to alter (e.g., write, mark on, highlight, etc.) a pharmacy label.
6) When received from the pharmacy, all 'Schedule II-V' (i.e., countable controlled substances) medication and 'high-risk Schedule VI' medication must be logged into the *Countable Controlled Substance Book* (*See Policy No. 12-3*).
   a) If split tablets (e.g., ½ tablets, ¼ tablets, etc.) are received from the pharmacy, each split tablet is entered into the *Countable Controlled Substance Book,* on the 'Count Sheet' page, in the 'amount' column as 'one' unit.
   b) If oral dosing pre-filled syringes are received from the pharmacy, each pre-filled syringe is entered into the *Countable Controlled Substance Book,* on the 'Count Sheet' page, in the 'amount' column as 'one' unit.
7) When an individual requires medication administration at two different locations, two separate labeled packages of medications must be received from the pharmacy with one for the primary MAP Registered site and the other for:
   a) the secondary MAP Registered site (e.g., Day Program); or
   b) a non-MAP location of administration (e.g., Day Habilitation, School, family home, etc.).

Policy No. & Issue **10-3 Components of a Pharmacy Label**
Policy Source **1995 DDS Memorandum**

1) All medication received from the pharmacy for use at a MAP Registered site must have a label affixed to the medication container (e.g., medication bottle, blister pack, etc.) that indicates the:
   a) name of individual;
   b) name of medication including the interchange (IC) name, (if applicable);
      i) The interchange (IC) name of the medication must be listed when the pharmacy dispenses a substitution (i.e., a generic medication or another brand name medication is substituted by the pharmacy for the prescribed medication).
         (1) When the 'generic' named medication is prescribed and the 'generic' form of the medication is supplied by the pharmacy, no interchange (IC) medication name is required.
   c) strength and amount;
   d) frequency;
   e) route of administration;
   f) name of the prescribing Health Care Provider;
   g) directions for use;
   h) cautionary statements, (if any);
   i) total quantity of medication dispensed;
   j) date prescription was filled;
   k) pharmacy name, address;
   l) prescription number; and
   m) filling Pharmacist's initials.

2) If a pharmacy label is either lacking the required components, illegible, worn, damaged, and/or missing, the pharmacy must be contacted.

Policy No. & Issue **10-4 Exhausting the Current Supply of Medication**
Policy Source **1997 DMH Memorandum**

1) When the prescribing Health Care Provider (HCP) orders a change in directions of a current medication, the MAP Registered site must always attempt to obtain the medication as ordered from the pharmacy.

   a) If unable, due to pharmacy/insurance requirements, the current supply of medication may be exhausted until the new prescription can be filled. This applies only when there has been a change in either the dosage and/or the frequency.

2) Exhausting the current supply of medication may be done, provided all of the following criteria apply:

   a) the prescribing HCP supplies a new HCP Order reflecting the change in dosage and/or frequency to the MAP Registered site (*See Policy No. 08-1*);
   b) the Certified/licensed staff contacts the MAP Consultant and documents that the MAP Consultant verified the pill, capsule, tablet, etc. is in a form that allows for 'proper medication preparation' reflecting the new HCP Order;
      i) For example, a 'dose change' for a medication ordered as '20 mg' (supplied as 10 mg tabs) could be properly prepared if the HCP Order was changed to '30 mg'.
      ii) For example, a 'frequency change' for a medication ordered 'daily in the morning' could be properly prepared if the HCP Order was changed to 'twice daily'.
   c) the Medication Administration Record (MAR) reflects the change of directions by:
      i) discontinuing the previous transcription; and
      ii) transcribing the new HCP Order onto the MAR.
   d) the pharmacy label on the medication container has been 'flagged' by the approved method to alert the Certified/licensed staff administering the medication to the new, changed order; and
      i) The approved method of flagging requires a 'directions change' sticker be affixed to the medication container in close proximity to the pharmacy label. The sticker alerts staff that there is a new HCP Order and the pharmacy label directions are no longer accurate.
         (1) A brightly colored sticker may be used in place of a 'directions change' sticker. The 'directions change' sticker or the brightly colored sticker should be adhered to the medication packaging as to not destroy or obstruct the original pharmacy label yet have the properties of sufficient chemical adhesion to remain permanently affixed to the container.
         (2) Labeling and affixing of pharmacy labels may only be done by a pharmacy.
            (a) Certified/licensed staff must never:
               (i) write or mark directly on the medication package or pharmacy label; and/or
                  1. This does not preclude Certified/licensed staff from documenting their initials, date, and time on the reverse side of a blister pack if performing Blister Pack Monitoring per the Service Provider's policy/procedure (if applicable).
               (ii) affix a new pharmacy label onto the medication package even if the label was provided by the pharmacy.
         (3) The 'directions change' sticker or brightly colored sticker is only valid for up to thirty (30) days.

e) Within thirty (30) days, a new-labeled container of medication reflecting the new HCP Order must be obtained from the pharmacy.

3) The 'current supply' of medication must be disposed per MAP Policy *(See Policy No 15-1),* when:

a) the 'current supply' of medication cannot be exhausted; and/or
b) the 'new supply' of medication ordered by the HCP is received from the pharmacy.

Policy No. & Issue **10-5 Maintaining a Sufficient Supply of Medication**
Policy Source **1995 DDS Memorandum**

1) The MAP Registered site must maintain a sufficient supply of all medication that is ordered by the Health Care Provider (HCP).

2) The MAP Registered site must not store more than a thirty-seven (37) day supply of prescription medication (*See Policy No. 12-1).*

   a) When the insurance prescription plan utilized by the individual requires a purchase in excess of a thirty-seven (37) day supply, the MAP Registered site must maintain documentation of such requirement.

3) The Service Provider must have a documented medication *Ordering and Receiving System* in place that ensures a sufficient supply of medication is 'on-hand at all times'. This requirement includes both automatic-refill and electronic-refill orders. The *Ordering and Receiving System* (i.e., Documented Record) must include the following:

   a) Ordering medication:
      i) Certified/licensed staff must:
         (1) perform an inventory of medication;
            (a) Conducting a regularly scheduled inventory ensures a sufficient supply of medication is available.
         (2) ascertain if the medication supply is low (i.e., a seven (7) day supply or less);
            (a) To ensure a sufficient supply is available, the quantity (i.e., the number of tablets, capsules, pills, mL, etc.) required for a seven (7) day refill-timeline 'must be determined'.
               (i) The seven (7) day refill-timeline is based on the dose and frequency ordered by the HCP and the strength of medication supplied by the pharmacy. (For example, if the HCP orders a medication as 100 mg twice daily and the pharmacy supplies the medication as a 50 mg tablet, a seven (7) day supply of the medication is twenty-eight (28) tablets).
                  1. If the seven (7) day refill-timeline is not permitted due to insurance coverage, the Service Provider may need to follow the prescription plan guidelines.
                     a. The MAP Registered site must maintain documentation of such insurance requirement.
         (3) order medication (i.e., request a refill); and
            (a) Medication must be ordered from the pharmacy before the medication supply is depleted.
         (4) complete documentation.
            (a) The MAP Registered site must maintain a Documented Record of all medication ordered to include:
               (i) when a medication is 'ordered' by Certified/licensed staff; or
                  1. A Documented Record must be generated after 'completing the regularly scheduled inventory of medication'.
               (ii) when the pharmacy is providing 'automatic-refills'; or
                  1. A Documented Record must be generated of 'what the MAP Registered site is expecting' the pharmacy to dispense.
               (iii) when the pharmacy utilizes an 'electronic-refill system'; and

1. A Documented Record must be generated of 'what the MAP Registered site requested' the pharmacy to dispense.

(iv) the date and signature of the Certified/licensed staff who ordered the medication.

b) Receiving medication:

i) Certified/licensed staff must:

(1) reconcile (i.e., compare) the quantity (e.g., the number of tablets, capsules, pills, mL, etc.) of medication received (i.e., what the pharmacy dispensed) to what was ordered on the Documented Record;

(a) The reconciliation (i.e., comparison) must be completed as soon as the medication is received from the pharmacy (or from the pharmacy delivery staff).

(i) Any discrepancies noted (i.e., found) must be immediately referred to the pharmacy and documented.

(2) review the number of refills remaining; and

(a) If there are zero (0) refills remaining, the Certified/licensed staff must (at this time) contact the HCP to request that a new prescription be sent to the pharmacy.

(i) Contacting the HCP immediately, allows thirty (30) days for a new prescription to be received by the pharmacy.

(3) complete documentation.

(i) The MAP Registered site must maintain a Documented Record of all medication received to include:

1. the medication and quantity received;
   a. A Documented Record must be generated of the quantity (e.g., the number of tablets, capsules, pills, mL, etc.) of the medication received.
2. remaining refills; and
   a. A Documented Record must be generated listing the number of refills remaining.
3. the date and signature of the Certified/licensed staff who accepted the medication.

4) Day Programs that do not receive medication directly from the pharmacy may use an alternate verification method (e.g., Medication Transfer forms, etc.) that indicates the medication and quantity received.

5) The Service Provider must have a system in place that ensures Certified/licensed staff communicate (verbally and/or in writing) to other staff when there is contact with the:

a) Pharmacist/Pharmacy (e.g., ordering medications, changes in medication, refill requests, etc.); and

b) Health Care Provider (e.g., requesting a prescription, prior authorization, alternate pharmacy usage, etc.).

6) Pharmacy manifests (e.g., delivery slips, receipts, etc.) must be kept at the MAP Registered site for a minimum of ninety (90) days.

a) If the pharmacy manifest is used to document medications received from the pharmacy, the manifest becomes part of the MAP Registered site's medication *Ordering and Receiving System.*

Policy No. & Issue **10-6 Over-the-Counter (OTC) Medications and Dietary Supplements**
Policy Source **March 1996 Training Manual**

1) Over-the-Counter (OTC) Medications and Dietary Supplements require a Health Care Provider (HCP) Order.
   a) Exceptions to this requirement (i.e., an HCP Order is not required) include sunscreen, insect repellant, and nonprescription personal hygiene products (e.g., shampoos, lotions, creams, ointments, toothpaste, etc.).
      i) The Service Provider, in consultation with the individual's HCP, may determine if a product in the list of exceptions above, more appropriately requires an HCP Order for tracking or evaluation purposes.

2) All HCP ordered OTC Medications and Dietary Supplements must be managed in one of the two following ways:
   a) ***OTC Medications and Dietary Supplements with a Pharmacy Label***: A label is applied by the pharmacy as prescription medications are labeled; or
   b) ***OTC Medications and Dietary Supplements without a Pharmacy Label***: In absence of a pharmacy label, a Service Provider designee (e.g., Licensed Nurse, Registered Pharmacist, HCP, or if need be, MAP Certified Supervisor) must verify the contents of the OTC Medication or Dietary Supplement. Verification is accomplished by:
      i) *Verification*: The Service Provider designee must 'verify' that the manufacturer's label of the OTC Medication or Dietary Supplement agrees with what the HCP ordered.
         (1) If a MAP Certified Supervisor is responsible for verification, the Supervisor must confer with the pharmacist (or other MAP Consultant) to ensure that the OTC medication or Dietary Supplement purchased agrees with what the HCP ordered.
      ii) The *Verification Procedure* is accomplished by the Service Provider designee:
         (1) ensuring that the OTC Medication or Dietary Supplement is in the original unopened manufacturer's container with the original manufacturer's label affixed;
         (2) ensuring that the manufacturer's label on the container concurs with the HCP Order;
         (3) ensuring that the strength of the OTC Medication or Dietary Supplement supplied is in a form that allows for 'proper preparation' of the OTC Medication or Dietary Supplement ordered;
            (a) Certified staff may not split, cut, or break a tablet, pill, or capsule to equal a dose ordered.
         (4) initialing marking their initials directly onto the container of OTC Medication or Dietary Supplement indicating that the verification between the manufacturer's label and the HCP Order is complete and correct;
         (5) marking the date of verification directly onto the container of OTC Medication or Dietary Supplement;
         (6) marking the name of the individual(s) (if more than one individual has an order for the same OTC Medication or Dietary Supplement of the same strength, the name of each individual may be marked on the same container after verification) directly onto the container; and
         (7) noting the completed verification on the HCP Order (i.e., initials and date of verification), in the margin next to the corresponding HCP Order.

(a) Using OTC Medications and Dietary Supplements without a pharmacy label requires verification of the contents by the Service Provider designee be performed every time a new container and/or updated HCP Order of the OTC Medication or Dietary Supplement is obtained.

3) The following applies to all OTC Medication and Dietary Supplements ordered by an HCP:
   a) Certified/licensed staff must document the administration of OTC Medications and Dietary Supplements in the same manner that prescription medication is documented;
   b) OTC Medications and Dietary Supplements when in its original manufacturer's package must be in an amount that is usual and customary;
   c) OTC Medications and Dietary Supplements must be stored in the same manner as prescription medication; and
   d) an OTC Medication or Dietary Supplement that is not administered according to the HCP Order is a Medication Occurrence and must be reported to the DPH and State Agencies per the requirements of the Medication Occurrence Reporting System, as applicable (*See Policy Section 17*).

4) MAP Registered sites that utilize OTC Medications and Dietary Supplements without a Pharmacy Label must ensure that:
   a) there is a Service Provider Policy for the administration of OTC Medications and Dietary Supplements without pharmacy or HCP labels; and
      i) The Service Provider Policy must ensure at a minimum:
         (1) the *Verification Procedure* is completed for all OTC Medications and Dietary Supplements in the absence of a pharmacy or HCP label;
            (a) the Pharmacist and/or HCP is consulted 'regarding interactions'.
   b) Certified staff are trained in the administration of each differing OTC Medication and Dietary Supplement (from the original manufacturer container) without a pharmacy or HCP label (i.e., *OTC Medications and Dietary Supplements Without a Pharmacy Label Training*).
      i) Training for Certified staff must be conducted by a Licensed Nurse, Registered Pharmacist, HCP, or if need be, MAP Certified Supervisor.
         (1) Each Training must include, but is not limited to:
            (a) a review of the HCP Order;
               (i) Any time there is a changed HCP Order for the previously prescribed OTC Medication or Dietary Supplement, the Certified staff must be re-trained.
            (b) how to read the OTC Medication or Dietary Supplement manufacturer's label;
            (c) how to complete the required checks of the Medication Administration Process in absence of a pharmacy or HCP label;
            (d) the specific amount to prepare based on the HCP Order; and
            (e) when to obtain a new container of OTC medication and/or Dietary Supplement (and have it 'verified') to maintain a sufficient supply.
      ii) Documentation of the OTC Medications and Dietary Supplements Without a Pharmacy Label Training must be maintained at the MAP Registered site and include at a minimum:
         (1) name and contact information of the Trainer(s);
         (2) date of the training and name(s) of staff trained (e.g., attendance list); and
         (3) a complete set of training materials used to train staff.
            (a) Training materials must be present for each (different) OTC Medication and Dietary Supplement ordered for each individual.

OTC Medication or Dietary Supplement Without a Pharmacy Label Training Template

CLICK HERE TO ACCESS THE SAMPLE *OTC Medication or Dietary Supplement Without a Pharmacy Label Training Template* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

Policy No. & Issue **10-7 Labeling of Pre-filled Syringes Received from the Pharmacy**
Policy Source **December 1994 MAP Advisory**

1) Pre-filled syringes, with or without an attached needle, received by the MAP Registered site from the pharmacy must:
   a) be labeled by the pharmacy, including but not limited to:
      i) the individual's name;
      ii) medication name;
      iii) medication strength;
      iv) route of administration; and
      v) directions for use (e.g., frequency, amount, etc.).
   (b) have a pharmacy label affixed to the container for the syringe or the syringe itself, as appropriate.

11

MEDICATION ADMINISTRATION RECORD

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

Policy No. & Issue **11-1 Required Components of a Medication Administration Record**
Policy Source **1995 DDS Memorandum**

1) Within the Medication Administration Program (MAP) a Medication Administration Record (MAR) is a monthly record of Medications and Dietary Supplements administered to an individual as ordered by the Health Care Provider (HCP).

2) An MAR must include an area for each of the following:

   a) name of individual;
   b) address of MAP Registered site as listed on the Massachusetts Controlled Substances Registration (MCSR);
   c) allergies;
   d) month, days of month, and year;
   e) name of medication (e.g., generic, brand);
   f) dose;
   g) strength;
   h) amount;
   i) route;
   j) time/frequency;
   k) reason (indication) for use;
   l) start date;
   m) stop date;
   n) hour column;
   o) documentation for administration;
   p) including space for second Certified/licensed staff's initials/verification (when applicable).
   q) target signs and symptoms for PRN (i.e., as needed) medication;
   r) special instructions for administration (e.g., parameters for when to give or hold medication, guidelines for when to notify the HCP, etc.);
   s) acceptable codes used and their description*;*
   t) Certified/licensed staff signature with corresponding initials or verified electronic signature;
   u) accuracy checks; and
   v) a corresponding document to record the medication progress note or narrative note.
      i) The back of the MAR can be used to document the medication progress note.

3) Data collection (when applicable):

   a) When data collection (e.g., vital signs, bowel tracking, lab work, etc.) is required for medication administration, the data must be recorded on the MAR.
      i) The data collection should be documented above, below, consecutive to, or electronically linked to the medication to be administered.

Policy No. & Issue **11-2 Transcribing Required Information onto the Medication Administration Record**
Policy Source **1995 DDS Memorandum**

1) All Medications and Dietary Supplements must be transcribed onto the Medication Administration Record (MAR).
   a) The medication information (i.e., name, dose [strength and amount], frequency, route) must be transcribed (i.e., copied) letter for letter, as found on the individual's Health Care Provider (HCP) Order(s) and Pharmacy Label(s).
2) Only Certified staff, including Relief staff, who have successfully completed the Service Provider's *Transcription of Medication Management System Training,* may transcribe HCP Orders *(See Policy No. 11-3).*
3) Transcription onto the MAR must be completed error-free, (e.g., without cross outs, mark overs, edits, etc.).
   a) In the event a correction is needed, the HCP Order must be re-transcribed.
4) The Reason/Indication each Medication and Dietary Supplement is ordered must be transcribed onto the MAR.
   a) This information must be obtained directly from the prescribing HCP.
      i) If the Reason/Indication continues to be appropriate, historical documentation in the Individual's Record is acceptable (if the reason/indication originated from the HCP).
      ii) If the Reason/Indication is changed by the HCP, the original MAR entry must be discontinued, and the new HCP Order with the updated Reason/Indication transcribed.
5) Specific Parameters or Lab Work ordered by the HCP, related to medication administration, (when applicable) must be documented on the MAR (e.g., under special instructions, etc.).
   a) When Specific Parameters (e.g., bowel tracking data, vital signs, etc.) or Lab Work are required for medication administration, Data Collection documentation must:
      i) be above, below, or consecutive to the medication to be administered; or
         (1) If Data Collection is required for medication administration and is initially tracked in a location not on the MAR, the Data must be transferred onto the MAR.
      ii) electronically linked to the medication to be administered.
         (1) If Data Collection is required for medication administration and is initially tracked in a location not on the MAR, the Data must be transferred onto the MAR.
6) Medication orders that are discontinued by the HCP must be discontinued on the MAR.

1) Medication Administration Program (MAP) Certified staff, including Relief staff, who will be responsible for the Transcription of Health Care Provider (HCP) Order(s) at MAP Registered sites, must be trained by the Service Provider that employs them specific to the 'Transcription of Medication Management System' (TMM System) utilized by the Service Provider.

   a) The Service Provider TMM System includes, but is not limited to:
      i) management of the Transcription of medication HCP Orders;
      ii) Posting and Verification of HCP Orders; and
      iii) Monthly Accuracy Checks of HCP Orders.
   b) As a prerequisite to the Service Provider TMM System Training, staff must be currently MAP Certified and their record must be in good standing in the state contracted testing vendor's Massachusetts MAP Certification Registry *(For website information see Policy No. 23-1).*

2) The Service Provider TMM System utilized must be in compliance with all DPH MAP Regulations, Policies and Curriculum.

3) Service Providers that utilize Certified staff to complete the Transcription of HCP Orders, must have a *Transcription of Medication Management System Policy* that includes procedures for Certified staff to follow when HCP Orders are obtained. The procedures must ensure, at a minimum, that:

   a) Certified staff responsible for the Transcription of HCP Orders are appropriately trained and competent in the skill;
      i) The Service Provider must ensure that there are transcription trained Certified staff or licensed staff available to complete Transcriptions when HCP Orders are obtained.
   b) a MAP Consultant is to be contacted if questions arise during the Transcription of HCP Orders;
   c) there is a process for communicating changes in HCP Orders to all Certified/licensed staff responsible for Medication Administration; and
   d) there is a process for contacting an IT (i.e., Information Technology) person if questions arise related to the TMM System used, if applicable.

4) Certified staff, who will be assigned the task of Transcription, must successfully complete a Service Provider *Transcription of Medication Management System Training* (i.e., TMM System Training).

   a) The TMM System Training must be completed initially and on a biennial basis.
      i) Demonstrated competence must be completed at least biennially (i.e., every two (2) years) or if the TMM System changes.
         (1) For tracking purposes, it is recommended that the biennial demonstrated competency be completed following the Certified staff being Recertified (*See Policy Section 05*).
   b) Each Service Provider must develop a customized 'TMM System Competency Evaluation Tool' specific to the 'TMM System' utilized.

5) The Service Provider 'TMM System Training', for all currently Certified staff who will be responsible for transcribing HCP Orders, must be conducted by the designated Service Provider

'TMM System' Instructor (e.g., Approved MAP Trainer, MAP Certified Supervisor, etc.) who is proficient in the skill of transcription specific to the 'TMM System' utilized.

6) The Service Provider TMM System training, using a customized 'TMM System Competency Evaluation Tool' must include, but is not limited to:
   a) an overview of the 'TMM System' utilized [i.e., Service Provider 'paper' documents (e.g., HCP Orders and Medication Sheets); Electronically-generated paper documents (e.g., MedSoft v7.0 or pharmacy-generated HCP Orders/Medication Sheets, etc.); Electronic HCP Orders and Medication Administration Record (MAR) (e.g., Therap, etc.)].
   b) components of the 'TMM System' utilized, including:
      i) how a new HCP Order is generated and received by the MAP Registered site;
      ii) how to transcribe a medication order using information obtained from the HCP Order and the Pharmacy Label (*See Policy No. 08-4*);
         (1) How to contact the MAP Consultant if the HCP Order and Pharmacy Label do not agree (*See Policy No. 07-1*);
      iii) how to document a discontinued medication on the Medication Sheet/MAR;
      iv) how to Post and Verify an HCP Order (*See Policy No. 08-4*); and
      v) how to complete a Monthly Accuracy Check of HCP Orders (*See Policy No. 08-5*).
   c) how changes in HCP Orders are communicated; and
   d) who to contact if there is an 'IT' issue, if applicable.

7) If the Certified staff is involved in a Transcription error resulting in a Medication Occurrence, a TMM System re-training must be completed.

8) Documentation of virtual or in-person *Transcription of Medication Management System Training* includes, but is not limited to:
   a) name and contact information of the Instructor(s);
   b) date of the training;
   c) a complete set of training materials used to train Certified staff;
   d) name(s) of Certified staff trained (i.e., attendance list); and
   e) a completed Service Provider 'TMM System Competency Evaluation Tool' for each Certified staff trained.
      i) 'TMM System Training' documents must be maintained at the MAP Registered site.

Policy No. & Issue **11-4 Medication Administration Record Documentation**
Policy Source **1995 DDS Memorandum**

1) Administration of all Medications and Dietary Supplements must be documented on a Medication Administration Record (MAR) as outlined in the approved Medication Administration Program (MAP) Curriculum: '*Responsibilities in Action' (i.e., RIA).*

   a) All MAP associated documentation must be completed in blue or black ink or font color.

2) All Medications and Dietary Supplements must be administered 'on-time'.

   a) In the MAP, 'on-time' means within the 'one (1) hour window' (i.e., before or after one (1) hour of the time scheduled on the MAR).
      i) The 'one (1) hour window' does not apply to the administration of a 'PRN' (i.e., an 'as needed' Medication and/or Dietary Supplement).

3) All 'documentation' of the administration of Medications and/or Dietary Supplements must be completed in 'real-time' (i.e., the same time as the event actually happened).

   a) When a Medication or a Dietary Supplement is administered but not 'documented on-time' (within the one [1] hour window) on the MAR, documentation of the administration must be completed as a 'late-entry' Medication Progress Note.
      i) When documenting, staff must include the date and time the documentation is actually taking place. If required, the documentation may reference a previous or future date/time situation.

4) When documenting the administration of a regularly scheduled Medication and/or Dietary Supplement, Certified/licensed staff must document their initials in 'real-time' on the MAR.

   a) Certified/licensed staff's initials on the MAR signify that the Medication and/or Dietary Supplement has been administered (at the MAP Registered site) as ordered by the Health Care Provider (HCP).

5) To identify a set of initials with a name, each Certified/licensed staff must initial and sign the signature legend located on, or electronically linked to, the MAR.

   a) Initials and signatures must be documented if the Certified/licensed staff's initials are documented on the MAR.
   b) Initials and signatures should be 'legible' and include the Certified/licensed staff's 'proper name' (full first name and last name).

6) When documenting the administration of a Medication and/or Dietary Supplement that is ordered as a PRN, Certified/licensed staff must document both their 'initials' and the 'time of administration' on the MAR.

   a) A Medication Progress Note must also be documented, for all PRN Medications and/or PRN Dietary Supplements administered, including but not limited to the:
      i) current date and time;
      ii) name and dose of the PRN administered;
      iii) date and time the PRN was administered;
      iv) target sign(s) and symptom(s) for which the PRN was administered; and
      v) effectiveness of the PRN medication (objective and/or subjective observations).

(1) Documentation of the effectiveness of a PRN medication must be completed by the Certified/licensed staff that administered the PRN medication and when applicable, the subsequent Certified/licensed staff who is responsible for monitoring the individual.

7) When the individual 'is not present at the MAP Registered site', at the scheduled Medication or Dietary Supplement administration time, 'only Acceptable Codes may be used' on the MAR (*See Policy Section 01-Definition of Terms).*

8) When the individual 'is present at the MAP Registered site', but the Medication or Dietary Supplement is not administered (e.g., the medication is not available, etc.), 'Certified/licensed staff must document this' on:

   a) the MAR by circling their initials;
   b) a Medication Progress Note, including but not limited to:
      i) the reason why the Medication or Dietary Supplement was not administered;
      ii) who was contacted and recommendations given; and
      iii) actions followed.

12

MEDICATION SECURITY

Policy No. & Issue **12-1 Medication Storage**
Policy Source **1995 DDS Memorandum**

1) The MAP Registered site must have a specific area devoted strictly to the storage of all Schedule II-VI Prescription Medications, Over-the-Counter (OTC) Medications, Dietary Supplements, medication-related supplies, and records relevant to medication administration.

2) The area designated for 'medication storage' must be key-locked and all 'Schedule II-V' (i.e., countable controlled substances) medication and 'high-risk Schedule VI' medication must be double key-locked (*See Policy No. 12-2*).

   a) A Biometric Authentication Medication Security System may be utilized, by a MAP Registered site, in place of key-lock(s) (*See Policy No. 12-9*).

3) The 'Medication Storage Area' must comply with the following requirements:

   a) the printed or electronic copy of the Massachusetts Controlled Substances Registration (MCSR) is on-site and readily accessible (at the MAP Registered site);
   b) oral medications are stored separately (e.g., different shelf or in separate storage containers) from medications administered by other routes;
   c) Medications and Dietary Supplements requiring refrigeration are stored in a (key-locked) container within the shared refrigerator (e.g., kitchen refrigerator), or stored in a separate (key-locked) refrigerator dedicated to medication storage; and
   d) the MAP Registered site does not store on-site more than a thirty-seven (37) day supply of:
      i) Prescription medications; and
         (1) If the insurance prescription plan utilized requires that the individual purchase an amount of medication in excess of thirty-seven (37) days at one time, an excess may be permitted, provided documentation of such an insurance prescription plan requirement is available at the MAP Registered site (*See Policy No. 10-5*).
      ii) Over-the-Counter (OTC) medications and/or Dietary Supplements.
         (1) When the OTC medication and/or Dietary Supplement is in its original manufacturer's package, an excess of thirty-seven (37) days may be permitted, provided the OTC medication is in an amount that is usual and customary (*See Policy No. 10-6*).

4) The MAP Registered site must have a Service Provider Policy, which includes procedures to follow that limit the day-to-day access to the Medication Storage Area.

   a) Possession of the Medication Storage Key(s) must be limited to the authorized Certified or licensed staff, who is responsible for medication administration and medication security.
      i) Only Certified or licensed staff, who are assigned the security of the Medication Storage Area may have 'access' to the Medication Storage Area.
         (1) When there are no 'Schedule II-V' (i.e., countable controlled substances) medications or 'high-risk Schedule VI' medications stored at the MAP Registered site, there should be a procedure that identifies the Certified or licensed staff responsible for control of the Medication Storage Key.

5) When there are no Certified or licensed staff assigned to medication administration responsibilities or medication security (i.e., there is no Certified or licensed staff on-site), the Medication Storage Key(s) must be housed in a designated locked container (e.g., realtor box).

a) Housing the Key(s) in the designated locked container is permitted only when there are no Certified or licensed staff at the MAP Registered site.
b) Only the Medication Storage Key(s) are permitted to be housed in the designated locked container (e.g., realtor box).

6) Only Certified or licensed staff, who are assigned medication administration or medication security responsibilities, are permitted to access the Medication Storage Key(s) from the designated locked container (e.g., realtor box).

7) If at any time the Medication Storage Key(s) are lost, misplaced, or damaged, the designated Service Provider administrative staff must be notified immediately.
   a) The MAP Registered site must have 'only one (1) back-up set' of Medication Storage Key(s) that are kept in a separate locked location.
      i) Knowledge of how to access the 'back-up set of Key(s)' shall be restricted to only off-site Service Provider administrative staff.
         (1) The position that satisfies the Service Provider administrative staff role may vary based upon the applicable title used by the Service Provider.

Policy No. & Issue **12-2 Schedule II-V Medication Security Measures**
Policy Source **1995 DDS Memorandum**

1) Schedule ll-V (i.e., countable controlled substances) are medications with a high potential for abuse and must have additional security measures.

2) The MAP Registered site must have a specific area dedicated to the storage of all Schedule ll-V (i.e., countable controlled substances) medication, as well as, any Schedule VI (i.e., controlled substances) medication identified by the Drug Control Program (DCP) as having a high-risk potential for abuse (i.e., 'high-risk Schedule VI' medication).

3) All 'Schedule II-V' (i.e., countable controlled substances) medication and all 'high-risk Schedule VI' medication must be secured and double key-locked (e.g., a key-locked box within a key-locked cabinet).

   a) A Biometric Authentication Medication Security System may be utilized, by a MAP Registered site, in place of key-lock(s) (*See Policy No. 12-9*).

4) All 'Schedule II-V' (i.e., countable controlled substances) medication and all 'high-risk Schedule VI' medication must be 'Reconciled' (i.e., the process of reviewing and counting the medication to ensure that what is on hand is what is documented in the *Countable Controlled Substance Book*). Reconciliation must occur:

   a) every time the control of the Medication Storage Key(s) 'change hands' (e.g., change of shift, partial-shift assignment, Service Provider nurse oversight review, relief staff assignment, more than one Certified/licensed staff is assigned to administer medication during the same shift, etc.);
   b) every time the Medication Storage Key(s) will be placed into the designated locked container (i.e., realtor box); and
   c) every time the Medication Storage Key(s) are removed from the designated locked container (i.e., realtor box).
      i) MAP Registered sites (e.g., Day Programs) that are not operational 24-hours per day/7-days per week (e.g., open Monday-Friday only) are exempt from reconciling the 'Schedule II-V (i.e., countable controlled substances) medication and all 'high-risk Schedule VI medication' on the days the Program is closed (i.e., no staff or individuals are present at the site).

5) A 'Shoulder to Shoulder' count (i.e., the method used for reconciliation in MAP) must be completed with two (2) Certified and/or licensed staff (i.e., 'Two-Person Count') every time 'Schedule II-V' (i.e., countable controlled substances) medications and 'high-risk Schedule VI' medications are 'Reconciled'.

   a) A 'Single-Person Count' is prohibited (i.e., one (1) Certified or licensed staff conducting the Count), unless 'two necessary conditions' are met.
      i) 'Necessary Condition One': a second Certified or licensed staff is not scheduled to be on-site when the responsibility of the control of the Medication Storage Key(s) needs to be passed; and
      ii) 'Necessary Condition Two': the required 'Two-Person Count' has been conducted within the preceding twenty-four (24) hours.
         (1) Once the 'two necessary conditions' are met and after a 'Single-Person Count' has been conducted, the following 'Steps' must be undertaken:

(a) 'Step One': the single Certified or licensed staff must sign the Countable Controlled Substance Book and note that the 'Count' was conducted by a single-person rather than two-persons, as otherwise required; and
(b) 'Step Two': at the first practical opportunity, and no later than twenty-four (24) hours after the last 'Count' was conducted by two-persons, a required 'Two-Person Count' must be conducted.

6) The Certified or licensed staff assigned medication administration responsibilities and the security of the Medication Storage Area must keep the Key(s) on their person during their entire assigned shift/assignment.
   a) If the assigned Certified or licensed staff needs to leave the MAP Registered site and there is another Certified or licensed staff scheduled to remain on-site, a 'Two-Person Count' must be conducted and documented in the *Countable Controlled Substance Book*. The Medication Storage Key(s) then 'change hands'.
      i) If the Certified or licensed staff returns to the site, and will resume medication administration responsibilities and the security of the Medication Storage Area, another 'Count' must be completed.
   b) If the assigned Certified or licensed staff needs to leave the MAP Registered site and there is no other Certified or licensed staff available (i.e., no other Certified or licensed staff are scheduled at the site or scheduled to come to the site) to conduct a 'Two-Person Count' then a 'Single-Person Count' must be conducted and documented in the *Countable Controlled Substance Book*. The Medication Storage Key(s) should then be placed in the designated locked container (e.g., realtor box).
      i) If the Certified or licensed staff returns to the site, and will resume medication administration responsibilities and the security of the Medication Storage Area, another 'Count' must be completed.
   c) If the assigned Certified or licensed staff needs to leave the MAP Registered site, along with all other scheduled Certified or licensed staff (i.e., all Certified or licensed staff are leaving the site, no Certified or licensed staff will remain on-site, and no Certified or licensed staff are scheduled to come to the site), a 'two-Person Count' must be conducted and documented in the *Countable Controlled Substance Book*. The Medication Storage Key(s) should then be placed in the designated locked container (e.g., realtor box).
      i) The second Certified or licensed staff will sign the *Countable Controlled Substance Book* in the role of a 'witness' to the 'Count'.
         (1) If either or both Certified or licensed staff return to the site, and one of them will resume medication administration responsibilities and the security of the Medication Storage Area, another 'Count' must be completed.

7) Any suspicious discrepancy noted in the 'Countable Controlled Substance Count' must be reported:
   a) immediately to the Site Supervisor (or designee) of the MAP Registered site;
   b) within twenty-four (24) hours of discovery of the discrepancy, to the Drug Control Program (DCP) (*See Policy No. 12-8*); and
   c) to the applicable MAP Coordinator by the Site Supervisor (or designee) of the MAP Registered Site.

Policy No. & Issue **12-3 Countable Controlled Substance Book**
Policy Source **MAP Policy Manual**

1) The MAP Registered site must utilize a bound *Countable Controlled Substance Book* for recording documentation specific to Schedule II-V (i.e., countable controlled substances) medication and Schedule VI (i.e., controlled substances) medication that are identified by the Drug Control Program (DCP) as having a high-risk potential for abuse.

   a) In the Commonwealth of Massachusetts, <u>all</u> prescription medications are recognized as 'controlled substances' (Schedule II-VI).

2) The *Countable Controlled Substance Book:*

   a) is assigned to the MAP Registered site and may not be transferred to another MAP Registered site;
   b) contains the address of the MAP Registered site as listed on the Massachusetts Controlled Substances Registration (MCSR); and
   c) is chronologically numbered starting with the 'Number 1'.
      i) This allows for a historical accounting of all *Countable Controlled Substance Book(s)* for the MAP Registered site.

3) The *Countable Controlled Substance Book* must have:

   a) a binding (i.e., the pages cannot be removed);
   b) preprinted, consecutively numbered pages;
   c) an 'Index';
   d) 'Count Sheet' pages; and
   e) 'Count Signature Sheet' pages.

4) It is the responsibility of the Site Supervisor of the MAP Registered site to ensure the 'accuracy of the Index' (e.g., acknowledging removal of a medication, acknowledging page transfers, etc.) in *the Countable Controlled Substance Book*.

5) When a *Countable Controlled Substance Book* transfer of information is required (e.g., there are no remaining lines on the 'Count Signature Sheet' pages, etc.), the Site Supervisor of the MAP Registered site, along with another Certified/licensed staff, must transfer all of the information from the existing *Countable Controlled Substance Book* to a new *Countable Controlled Substance Book*.

   a) When a new *Countable Controlled Substance Book* is required, all currently remaining 'Schedule II-V' (i.e. countable controlled substances) medication and all 'high-risk Schedule VI' medication must be transferred to the new *Countable Controlled Substance Book.*
      i) Only one (1) *Countable Controlled Substance Book* may be active (in use) at a time at each MAP Registered site.

Policy No. & Issue **12-4 Transfer of Medication**
Policy Source **MAP Policy Manual**

1) Any time medications that are the responsibility of a MAP Registered site are transferred from/to a MAP Registered site; the medication must be secured and transported by a Certified/licensed staff (*See Policy No. 12-5*).

2) Medication may be transferred from:

   a) a Health Care Facility (e.g., hospital, nursing home, crisis stabilization unit, rehabilitation center, etc.) to a MAP Registered site;
   b) one MAP Registered site to another MAP Registered site;
   c) a MAP Registered site to a Day Program, Day Habilitation, or School;
   d) an individual's family home to a MAP Registered Temporary Respite site;
   e) an individual's family home to a MAP Registered site; or
   f) a MAP Registered site to the pharmacy for repackaging (e.g., for Leave of Absence [LOA], etc.).

3) Medication may be transferred from a Health Care Facility (e.g., hospital, nursing home, crisis stabilization unit, rehabilitation center, etc.) to a MAP Registered site provided:

   a) there is a current signed Health Care Provider Order for the medication;
   b) the medication has an appropriate pharmacy label (i.e., there are no hand-printed changes on the label);
   c) the directions have not changed;
   d) the medication is in a tamper-resistant (i.e., packaged by/received from the pharmacy in such a manner that prevents the contents from being altered) container (e.g., blister pack, unit dose, tamper-resistant cassette, etc.); and
   e) a dated Medication-Release (*Transfer Form*) document has been signed by a Certified/licensed staff, from both the Health Care Facility and the MAP Registered site; listing the inventory of all the medications, including the amount transferred, between the Health Care Facility and the MAP Registered site.

4) Medication may be transferred from one MAP Registered site to another MAP Registered site provided:

   a) there is a current signed Health Care Provider Order for the medication;
   b) the medication has an appropriate pharmacy label (i.e., there are no hand-printed changes on the label);
   c) the directions have not changed;
   d) the medication is in a tamper-resistant (i.e., packaged by/received from the pharmacy in such a manner that prevents the contents from being altered) container (e.g., blister pack, unit dose, tamper-resistant cassette, etc.); and
   e) a dated Medication-Release (*Transfer Form*) document has been signed by a Certified/licensed staff, from both the preceding MAP Registered site and the subsequent MAP Registered site; listing the inventory of all the medications, including the amount transferred, between sites.

5) Medication may be transferred from a MAP Registered site to a Day Program, Day Habilitation, or School provided:

a) there is a current signed Health Care Provider Order for the medication;
b) the medication has an appropriate pharmacy label (i.e., there are no hand-printed changes on the label);
c) the directions have not changed;
d) the medication is in a tamper-resistant (i.e., packaged by/received from the pharmacy in such a manner that prevents the contents from being altered) container (e.g., blister pack, unit dose, tamper-resistant cassette, etc.); and
e) a dated Medication-Release (*Transfer Form*) document has been signed by a Certified/licensed staff, from both the MAP Registered site and the Day Program, Day Habilitation, or School; listing the inventory of all the medications, including the amount transferred, between the MAP Registered site and the Day Program, Day Habilitation, or School.

6) Medication may be transferred from an individual's family home to a MAP Registered Temporary Respite site provided:
   a) there is a current signed Health Care Provider Order for the medication;
      i) If a copy of a prescription is utilized in this circumstance, the prescriber must be contacted to ensure that the medication order is unchanged.
   b) the medication has an appropriate pharmacy label (i.e., there are no hand-printed changes on the label);
   c) the directions have not changed;
   d) the medication is in a tamper-resistant (i.e., packaged by/received from the pharmacy in such a manner that prevents the contents from being altered) container (e.g., blister pack, unit dose, tamper-resistant cassette, etc.);
   e) a dated Medication-Release (*Transfer Form*) document has been signed by a designated family member and a Certified/licensed staff, from the MAP Registered Temporary Respite site; listing the inventory of all the medications, including the amount transferred, between the family home and the MAP Registered Temporary Respite site; and
   f) a dated Medication-Release (*Transfer Form*) document completed when the individual leaves the MAP Registered Temporary Respite site.
      i) The document should be signed by a Certified/licensed staff, from the MAP Registered Temporary Respite site and a designated family member; listing the inventory of all the medications, including the amount transferred, between the MAP Registered Temporary Respite site and the individual's family home.

7) Medication may be transferred from an individual's family home (e.g., for individuals who are in the process of moving from their family home to a MAP Registered site) to a MAP Registered site provided:
   a) there is a current signed Health Care Provider Order for the medication;
   b) the medication has an appropriate pharmacy label (i.e., there are no hand-printed changes on the label);
   c) the directions have not changed;
   d) the medication is in a tamper-resistant (i.e., packaged by/received from the pharmacy in such a manner that prevents the contents from being altered) container (e.g., blister pack, unit dose, tamper-resistant cassette, etc.); and
   e) a dated Medication-Release (*Transfer Form*) document has been signed by a designated family member and a Certified/licensed staff, from the MAP Registered site; listing the inventory of all the medications, including the amount transferred, between the family home and the MAP Registered site.

8) Medication may be transferred from an individual's family home (e.g., individuals living in their family home and attending Day Program) to a MAP Registered Day Program site provided:

   a) there is a current signed Health Care Provider Order for the medication;
   b) the medication has an appropriate pharmacy label (i.e., there are no hand-printed changes on the label);
   c) the directions have not changed;
   d) the medication is in a tamper-resistant (i.e., packaged by/received from the pharmacy in such a manner that prevents the contents from being altered) container (e.g., blister pack, unit dose, tamper-resistant cassette, etc.); and
   e) a dated Medication-Release (*Transfer Form*) document has been signed by a designated family member and a Certified/licensed staff, from the MAP Registered Day Program site; listing the inventory of all the medications, including the amount transferred, between the family home and the MAP Registered Day Program site.

9) Medication may be transferred from MAP Registered site to the Pharmacy (e.g., for repackaging, etc.) provided:

   a) there is a current signed Health Care Provider Order for the medication;
   b) the medication has an appropriate pharmacy label (i.e., there are no hand-printed changes on the label);
   c) the directions have not changed; and
   d) a dated Medication-Release (*Transfer Form*) document (if applicable) has been signed by a pharmacy personnel and a Certified/licensed staff from the MAP Registered site; listing the inventory of all the medications, including the amount transferred (e.g., for repackaging, etc.) between the pharmacy and the MAP Registered site.

Policy No. & Issue 12-5 Transportation of Medication
Policy Source 04-04-18 DCP MAP Advisory

1) Certified staff must transport medications only for the individuals (i.e., 'Ultimate User' *1) residing at the MAP Registered site for which the Certified staff formally works and only during the Certified staff's work hours. Certified staff must not transport medications for individuals residing outside of the staff's work site or on the staff's own time.

   a) Transportation of medications includes, but is not limited to:

      i) picking up medications from the pharmacy;
      ii) transporting/transferring medications to the pharmacy for repackaging (e.g., for Leave of Absence [LOA], etc.);
      iii) transporting/transferring medications from the MAP Registered site to/from another MAP Registered site;
      iv) transporting/transferring medications from the MAP Registered site to/from a Hospital, Day Program, Day Habilitation, Respite, School, etc.;
      v) transporting/transferring medications from the MAP Registered site to a family member, guardian, or responsible party for an LOA;
      vi) transporting sample medications from the Health Care Provider;
      vii) backpacking medications to individuals living at non-MAP Registered sites for subsequent medication administration; and
      viii) transporting medications for individuals to receive on an off-site medication administration (OSA), or Vacation (V) staffed by Certified/licensed staff.

[1] "Ultimate User": a person who lawfully possesses a controlled substance for his own use or for the use of a member of his household or for the use of a patient in a facility licensed by the department or for administering to an animal owned by him or by a member of his household. M.G.L. c. 94C, § 1 and 105 CMR 700.001
"Ultimate User": a person who has lawfully obtained, and who possesses, a controlled substance for his own use or for the use of a member of his household or for an animal owned by him or by a member of his household. 21 U.S.C. § 802(27)

Policy No. & Issue **12-6 Syringe Security and Storage**
Policy Source **MAP Policy Manual**

1) Syringes with an attached needle, including pre-filled labeled syringes, must be stored in the locked 'Medication Storage Area' (*See Policy No. 10-7 and Policy No. 12-1).*

   a) Pharmacy labeled pre-filled syringes containing a 'Schedule II-V' (i.e., countable controlled substance) medication or a 'high-risk Schedule VI' medication must be:
      i) received from the pharmacy in 'tamper-resistant packaging';
      ii) 'double key-locked'; and
         (1) A Biometric Authentication Medication Security System may be utilized, by a MAP Registered site, in place of key-lock(s) (*See Policy No. 12-9*).
      iii) added to the *Countable Controlled Substance Book*.
         (1) When pharmacy labeled pre-filled syringes, containing a 'Schedule II-V' (i.e., countable controlled substance) medication or a 'high-risk Schedule VI' medication are received from the pharmacy, each pre-filled syringe is entered into the *Countable Controlled Substance Book*, on the 'Count Sheet' page, in the 'amount' column as 'one' unit.

2) The MAP Registered site must maintain a documented accounting of the 'Schedule II-V' (i.e., countable controlled substance) medication and 'high-risk Schedule VI' medication pre-filled syringes (*See Policy No. 12-3*).

   a) The documented accounting of the 'Schedule II-V' (i.e., countable controlled substance) medication and 'high-risk Schedule VI' medication pre-filled syringes must be reconciled whenever control of the medication storage keys are passed.

3) The number of pre-filled syringes in the locked storage container is limited to a thirty-seven (37) day supply (*See Policy No. 12-1*).

   a) Non-filled (empty) syringes do not require a documented accounting.

Policy No. & Issue **12-7 Drug-Tampering and Suspected Drug-Tampering**
Policy Source **DCP MAP Advisory**

1) To comply with state regulations, drug-tampering and suspected drug-tampering that involves any prescription medications (i.e., Schedule II-VI) must be reported to the DPH Drug Control Program (DCP) within twenty-four (24) hours after discovery.
   a) Drug-tampering (e.g., adulterating, altering, substituting a medication, repackaging of a prescribed medication with an alternate substance, etc.) is a serious event with potential criminal consequences.
   b) Drug-tampering incidents are not errors or mistakes and can have a direct impact to the health and safety of individual(s) supported at the MAP Registered site.
      i) The individual's Health Care Provider (HCP) must be contacted immediately for any drug-tampering or suspected drug-tampering incident.

2) When drug-tampering is known or suspected:
   a) contact the individual's HCP immediately and reference the possible tampering;
      i) The HCP may recommend that the individual be evaluated.
         (1) Follow the instructions and guidelines from the HCP.
      ii) If the known or suspected tampered medication constitutes the individual's entire medication supply, staff should contact the pharmacy for a refill and/or the HCP for a new prescription.
   b) the known or suspected drug-tampering should be immediately reported to the DCP and the local police;
      i) Complete and submit a copy of the Drug Incident Report (DIR) to the DCP.
         (1) A Drug Incident Report form is available on the DCP website.
      ii) Follow instructions and guidelines from the Police and/or the DCP.
   c) the known or suspected tampered drug involved should be immediately secured at the MAP Registered site;
      i) The Site Supervisor (or designee) should remove the drug involved from the medication storage area and lock it in an area/container that only they have the key.
         (1) If the medication is also documented in the *Countable Controlled Substance Book,* it should be removed from the Count Book.
   d) except for removal by a DCP Investigator or another Law Enforcement Representative (e.g., Police), the known or suspected tampered drug involved is considered evidence and should never be removed from the MAP Registered site by anyone; and
      i) When the drug involved is removed from the MAP Registered site, by the DCP Investigator or the Law Enforcement Representative, a Medication-Release document (*Transfer Form*) should be completed.
         (1) If the drug involved is not removed from the MAP Registered site by the DCP or a Law Enforcement Representative and once the investigation is complete, the drug involved may be disposed (*See Policy Section 15*).
   e) after notifying the DCP, the Site Supervisor (or designee) should notify the applicable MAP Coordinator.

Policy No. & Issue **12-8 Drug Loss**
Policy Source **DPH Policy**

1) To comply with state regulations, drug losses for all prescription medications (i.e., Schedule II-VI) or written prescriptions (i.e., Schedule II-VI) must be reported by the MAP Registered site to the DPH Drug Control Program (DCP).

2) Drug losses must be reported to the DCP within twenty-four (24) hours after discovery by submitting a Drug Incident Report (DIR), available on the DCP website.
   a) Drug losses unto themselves are not medication occurrences; however, if the drug loss leads to the omission of a medication, the omission of the medication must be reported as a medication occurrence (*See Policy No. 17-3*).
   b) After notifying the DCP, the Site Supervisor (or designee) should notify the applicable MAP Coordinator.

Policy No. & Issue **12-9 Biometric Medication Security**
Policy Source **MAP Policy Manual**

1) A 'Biometric Authentication Medication Security System' may be utilized, by a MAP Registered Site, in place of key-lock(s).
    a. The medication storage area is accessed through use of a biometric lock, and the 'Schedule II-V' (i.e., countable controlled substances) medication and 'high-risk Schedule VI' medication is accessed through a second biometric lock.
        i. If the Service Provider prefers, a key-lock may be utilized to access the medication storage area (*See Policy No. 12-1*), and a biometric lock may be utilized to access the 'Schedule II-V' (i.e., countable controlled substances) medication and 'high-risk Schedule VI' medication.

2) Biometrics are biological measurements or physical characteristics that can be used to identify a person (e.g., fingerprint or iris recognition, etc.).
    a. The Certified or licensed staff will access the secured medication through the use of a biometric.
        i. Biometric authentication does not include the use of a code or password.
            1. If a biometric authentication medication security system is utilized, the system must maintain a trackable history of staff access.

3) MAP Registered Sites utilizing biometric locks for medication security, must have a 'Biometric Authentication Medication Security System' Service Provider Policy, which includes but is not limited to:
    a. procedures to follow that limit the day-to-day access to the Medication Storage Area;
        i. Access to the Medication Storage Area must be limited to the authorized Certified or licensed staff, who is responsible for medication administration and medication security.
            1. The MAP Registered site must maintain a documented listing of medication administration duty staff assignments.
    b. procedures to follow if authorized Certified or licensed staff are unable to access the medication through use of the biometric lock; and
    c. oversight of access to the medication storage area procedures (i.e., a comparison of the staff medication administration duty assignments, to the Count Book documentation history, to the biometric history log) to ensure that only authorized staff are accessing the medication storage area at the appropriate times.

4) All Schedule 'II-V' (i.e., countable controlled substances) medication and all 'high-risk Schedule VI' medication must be 'Reconciled' (i.e., the process of reviewing and counting the medication to ensure that what is on hand is what is documented in the Countable Controlled Substance Book) each time 'Medication Administration Responsibilities' change (i.e., the assignment of medication administration duties changes from one staff member to another).

5) A 'Shoulder to Shoulder' count (i.e., the method used for reconciliation in MAP) must be completed with two (2) Certified and/or licensed staff (i.e., 'Two-Person Count') every time

‘Schedule II-V’ (i.e., countable controlled substances) medications and ‘high-risk Schedule VI’ medications are ‘Reconciled’.

a. A ‘Single-Person Count’ is prohibited (i.e., one (1) Certified or licensed staff conducting the Count), unless ‘two necessary conditions’ are met.
    i. ‘Necessary Condition One’: a second Certified or licensed staff is not scheduled to be onsite when the responsibility of the control of the Medication Storage Key(s) needs to be passed; and
    ii. ‘Necessary Condition Two’: the required ‘Two-Person Count’ has been conducted within the preceding twenty-four (24) hours.
        1. Once the ‘two necessary conditions’ are met and after a ‘Single-Person Count’ has been conducted, the following ‘Steps’ must be undertaken:
            a. ‘Step One’: the single Certified or licensed staff must sign the Countable Controlled Substance Book and note that the ‘Count’ was conducted by a single person rather than two-persons, as otherwise required; and
            b. ‘Step Two’: at the first practical opportunity, and no later than twenty-four (24) hours after the last ‘Count’ was conducted by two-persons, a required ‘Two Person Count’ must be conducted.

13

MEDICATION ADMINISTRATION

1) The Service Provider for the MAP Registered site must ensure that any individual who requires assistance with medication administration has trained Certified staff or licensed nurses on-site during timelines when medications are to be administered.

2) Certified staff may not engage in other duties or obligations while performing medication administration associated tasks and medication-related documentation.

   a) To ensure the safe administration of medication to individuals supported by the Medication Administration Program (MAP), all Certified/licensed staff must adhere to all MAP requirements.

3) All MAP Registered sites must have current Medication Administration Records for each individual supported at the site.

4) All Medications and/or Dietary Supplements are to be administered:

   a) whole with water, unless there is a Health Care Provider (HCP) Order stating otherwise (e.g., may be crushed and mixed with applesauce or pudding, etc.); and
   b) within one-hour before and up to one-hour after (i.e., one-hour window) the time scheduled on the MAR.
      i) The one-hour window does not apply to the administration of PRN (i.e., as needed) medication.
      ii) The MAP Registered site must have a Medication Administration Time(s) schedule (*See Policy No. 14-2*).

5) Medications and/or Dietary Supplements must never be prepared at any time except immediately prior to the administration of that Medication as defined in the Medication Administration Process.

   a) Medications and/or Dietary Supplements must be prepared and administered to one individual at a time. When a Medication and/or Dietary Supplement is prepared in advance (pre-poured) by Certified/licensed staff, the identity and integrity of that Medication and/or Dietary Supplement can no longer be guaranteed.
      i) The Medication and/or Dietary Supplement must be prepared and administered to one individual, before moving on to preparing the next individual's Medication and/or Dietary Supplement.
         (1) In MAP, Certified/licensed staff are not permitted to 'pre-pour' medication.
   b) Certified/licensed staff may only administer Medications and/or Dietary Supplements that they have prepared.

6) To administer any Medication and/or Dietary Supplement, the Medication Administration Process, as outlined in the MAP Curriculum *Responsibilities in Action*, must be followed.

   a) If the Medication Administration Process cannot be followed utilizing the HCP Order, Pharmacy Label, and Medication Administration Record (MAR), a MAP Consultant must be contacted for a recommendation of how to proceed.
      i) The recommendation(s) given and action(s) taken must be documented in the Individual's Record.

7) The administration of all Medications and Dietary Supplements must be documented on the MAR (*See Policy No. 11-4*).

8) If an individual is not at the MAP Registered site during the time the medication is scheduled to be administered, this must be documented on the MAR (*See Policy No. 11-4*).

9) Each Certified/licensed staff that documents on the MAR must be able to be identified (e.g., signature list, digital signature, etc.), (*See Policy No. 11-4*).

10) Routes, other than oral, require additional training by an HCP, Registered Pharmacist, Registered Nurse (RN), Licensed Practical Nurse (LPN), or a MAP Trainer.

    a) MAP Certification Training includes only the 'oral route' for medication administration.
    b) The Trainer must have the necessary knowledge, skills, and abilities to conduct routes (other than oral) training.
    c) Certified staff are permitted to administer medication by routes other than oral (e.g., inhalation, nasal, rectal, topical, etc.) provided they have received additional training specific to the HCP Ordered route of administration.

Policy No. & Issue **13-2 Medication Refusals**
Policy Source **MAP Policy Manual October 1996 MAP Advisory**

1) In MAP, a medication refusal is when an individual actively or passively refuses, or is not receptive, to taking their medication.

2) All medication refusals must be reported to the 'prescribing Health Care Provider' (HCP) or 'covering HCP', unless there is an HCP Order and guidelines in place to stipulate otherwise.
   a) Documentation of the refusal event is required when an individual refuses to take any or all of their prescribed medication.
      i) Documentation of the refusal event needs to tell a clear story of the event, including but not limited to:
         (1) the date and time of the refusal;
         (2) reason for refusal (if known);
         (3) HCP notification;
         (4) HCP recommendations (if any); and
         (5) Certified and/or licensed staff observations and actions taken.

3) It is recommended that there be HCP Order(s) (e.g., HCP Guidelines, HCP Protocol, etc.) in place for individuals who persistently and/or chronically may not be receptive to taking their medication.

4) Events that are not within the staff's control (such as medication missed due to an individual's refusal) that leads to an omission of the medication do not require reporting via a Medication Occurrence Report (*MOR Form*).
   a) Service Providers should have internal reporting procedures for documenting refusals and similar events (e.g., incident reports, data tracking forms, etc.) to maintain appropriate care and quality assurance standards.
      i) The internal reporting procedures are in addition to informing the HCP of a medication refusal, and/or following the HCP Order(s) for refusal events.

Policy No. & Issue **13-3 Day Program Medication Requirements**
Policy Source **MAP Policy Manual**

1) When a Day Program utilizes Certified and/or licensed staff to administer medication, the Day Program must possess a MAP Massachusetts Controlled Substances Registration (MCSR) *(See Policy No. 03-2).*

2) When an individual requires a medication while at the MAP Registered Day Program, and
   a) resides at a MAP Registered Residential site:
      i) The Pharmacist must be asked by the MAP Registered Residential site to split the medication supply into two tamper-resistant containers (i.e., 'split-packaged'): one for use at the Day Program and one for use at the MAP Registered Residential site.
         (1) The 'split-packaged' Day Program medication supply may be transported/transferred from the MAP Registered Residential site to the Day Program provided:
            (a) a Medication-Release Document (e.g., *Transfer Form*) is completed (*See Policy No. 12-4); and*
               (i) Both sites (MAP Registered Residential site and Day Program site) must maintain a copy of the signed and dated Medication-Release Document.
            (b) medication is transported by an authorized MAP Certified and/or licensed staff (*See Policy No. 12-5).*
      ii) It is the responsibility of the MAP Registered Residential site to supply the Day Program with copies of all Health Care Provider (HCP) medication orders.
         (1) The Day Program will maintain copies of all HCP medication orders; however, the Day Program is only required to transcribe onto the Medication Administration Record (MAR) the medications for which the Day Program is responsible to administer.
            (a) The frequency (time), as ordered by the HCP, must be transcribed in the Hour Column on the MAR.
               (i) If the individual will be attending an outing and departing from the Day Program with MAP Certified or licensed staff when medication administration will be required during that outing, Day Program staff should indicate the 'off-site administration' of the medication by documenting 'OSA' on the MAR (*See Policy No. 16-2).*
      iii) When medication, including PRN medication, is scheduled to be administered while the individual is attending the Day Program, it is the responsibility of the MAP Registered Residential site to supply the Day Program with an adequate supply of medication.
         (1) If the PRN medication is not stored at the Day Program, a plan must be in place on how the Day Program will obtain the medication to ensure that PRN medication is administered in a timely manner.
            (a) It is the responsibility of the Day Program Certified and/or licensed staff to ensure that an adequate supply of medication is received from the MAP Registered Residential site.

b) resides at a non-MAP Registered site (e.g., the family home):
    i) The Pharmacist must be asked to split the medication into two containers (i.e., 'split-packaged'): one for use at the non-MAP Registered site (e.g., the family home) and one for use at the Day Program.
        (1) The 'split-packaged' Day Program medication must be:
            (a) Labeled and packaged by the pharmacy in tamper-resistant packaging.
                (i) The medication may be transferred from the non-MAP Registered site (e.g., family home) to the Day Program provided:
                    1. a Medication-Release Document (e.g., *Transfer Form*) is completed (*See Policy No. 12-4*); and
                    2. the Day Program maintains a copy of the signed and dated Medication-Release Document.
    ii) When medication, including PRN medication, is scheduled to be given while the individual is attending Day Program, it is the responsibility of the Day Program Certified and/or licensed staff to ensure there is an adequate supply of medication available on-site.
        (1) If the PRN medication is not stored at the MAP Registered Day Program, a plan must be in place on how the Day Program will obtain the medication to ensure that PRN medication is administered in a timely manner.
    iii) It is the responsibility of the Day Program MAP Certified and/or licensed staff to obtain and maintain HCP Orders and an adequate medication supply.

3) A communication system must be established between the individual's home (e.g., MAP Registered Residential site, family home, etc.) and the MAP Registered Day Program for any medication-related issues (e.g., PRN medication use, data tracking, etc.) and/or concerns.

14

POLICIES, PROCEDURES AND RECORD KEEPING

Policy No. & Issue **14-1 Service Provider MAP Policies**
Policy Source **December 1994 MAP Advisory**

1) The MAP Registered site must maintain a copy of their current 'Service Provider MAP Policies'.
   a) A Service Provider MAP Policy is a set of customized principles and related procedures that the Service Provider establishes to define how it will comply with the directives that are outlined in the *MAP Policy Manual*.

2) The Service Provider is required to have at a minimum, the following Service Provider Policies related to MAP:
   a) Trained Certified Staff Policy;
      i) The 'Trained Certified Staff' Service Provider Policy should include information that ensures that only licensed staff and/or appropriately trained Certified staff administer medication at the MAP Registered site. The Policy should also ensure training related to routes of administration (*For full requirements, see Policy Section 05 and Policy No. 13-1).*
         (1) The Service Provider for the MAP Registered site must ensure that any individual who requires administration of their medication or assistance with medication administration has licensed nurses and/or appropriately trained Certified staff on-site during timelines when medications are to be administered.
   b) Access to MAP Consultants Policy;
      i) The 'Access to MAP Consultants' Service Provider Policy should include information regarding how MAP Certified staff will have access to MAP Consultants twenty-four hours a day, seven days a week (i.e., 24-7), (*For full requirements, see Policy No. 07-1).*
   c) Medical Emergencies Related to Medication Administration Policy;
      i) The 'Medical Emergencies Related to Medication Administration' Service Provider Policy should include information regarding the administrative procedures to follow if there is a medical emergency related to medication administration.
         (1) The Policy should include how the Service Provider will ensure that there is a current listing of emergency contact information (e.g., 911, Poison Control, MAP Consultants, including Authorized Prescribers/Health Care Providers with contact numbers, etc.) readily available to MAP Certified staff that clearly indicates who should be contacted on a twenty-four hours a day, seven days a week (i.e., 24-7) basis (*For full requirements, see Policy No. 03-3, Policy No. 07-1, and Policy Section 17).*
   d) Transcription of Medication Management System Policy;
      i) The 'Transcription of Medication Management System' Service Provider Policy should include the procedure for transcription trained Certified staff to follow when Health Care Provider Orders are obtained. The Policy should include how the Service Provider will ensure that Certified staff responsible for the Transcription of medication HCP Orders are appropriately trained; that there is a process for contacting a MAP Consultant if issues or concerns occur during the Transcription of HCP Orders; how changes in HCP Orders are communicated to all Certified and licensed staff responsible for Medication Administration, etc. *(For full requirements, see Policy No. 11-3).*
   e) Leave of Absence (LOA) Policy*;*
      i) The 'Leave of Absence' Service Provider Policy should include the procedure Certified/licensed staff should follow to obtain, prepare, and transfer LOA medication.

The Policy should also include information regarding identifying and educating persons (e.g., family, friends, etc.) responsible for the LOA medication preparation and administration.

(1) The Policy should also include a procedure to follow regarding Certified/licensed staff responsibilities following the LOA, after the individual has returned to the MAP Registered site (*For full requirements, see Policy No. 16-4, Policy No. 16-5, and Policy No. 16-6).*

f) Off-Site Administration (OSA) of Medication Policy;

i) The 'Off-Site Administration of Medication' Service Provider Policy should include the procedure for Certified/licensed staff to follow for off-site medication administration. The Policy should also include information regarding identifying and educating Certified staff responsible for off-site medication administration (*For full requirements, see Policy No. 16-2).*

g) Vacation (V) Policy;

i) The 'Vacation' Service Provider Policy should include the procedure to follow when Certified/licensed staff accompanies individual(s) on vacation within the community. The Policy should include how the staff will transport, store, and administer medications during the vacation (*For full requirements, see Policy No. 16-3).*

h) Backpacking Policy;

i) The 'Backpacking' Service Provider Policy should include the procedure to follow when Certified/licensed staff administer medications to individuals living in the community (off-registered site). The Policy should also include administrative practices to follow when there is a medical emergency related to medication administration while 'backpacking' (*For full requirements, see Policy No. 16-7).*

i) Vital Signs Policy;

i) The 'Vital Signs' Service Provider Policy should include the procedure to follow to ensure that instructions are obtained from the Health Care Provider regarding the need for staff to obtain an individual's vital signs; any vital signs monitoring necessary for medication administration; vital sign parameters; any required notifications; etc. The Policy should also include how the Service Provider will ensure that staff are appropriately trained in monitoring vital signs (*For full requirements, see Policy No. 18-1).*

j) Obtaining Properly Labeled Containers Policy;

i) The 'Obtaining Properly Labeled Containers' Service Provider Policy should include the procedure to follow when an individual receives medication in two or more locations. The Policy should include the procedure to follow for obtaining properly labeled medication from the pharmacy for each location, keeping the medication secure, and the process to follow to ensure that there are properly labeled container(s) when there is a change in the prescribed medication (*For full requirements, see Policy Section 10).*

k) Access to the Medication Storage Area Policy;

i) The 'Access to the Medication Storage Area' Service Provider Policy should include the procedures to follow that ensure only persons who are authorized will have access to the medication storage area.

(1) If keys are used to access the Medication Storage Area:

(a) The Policy should include the procedures for tracking the Medication Storage Area Key(s) when there are no 'Schedule II-V' (countable controlled substances) medication or 'high-risk Schedule VI' medication at the MAP Registered site; how access to unauthorized persons is to be restricted; under what conditions authorized persons may have access to the Medication Storage Area; etc. (*For full requirements, see Policy No. 12-1 and Policy No. 12-2).*

(2) If biometrics are used to access the Medication Storage Area:

(a) The Policy should include oversight procedures of access to the medication storage area (i.e., a comparison of the staff medication administration duty assignments, to the Count Book documentation history, to the biometric history log) to ensure that only authorized staff are accessing the medication storage area at the appropriate times. (*For full requirements, see Policy No. 12-9).*

l) Health Care Provider Order Policy; and
   i) The 'Health Care Provider Order' Service Provider Policy should include procedures to address how the Certified/licensed staff will obtain required documentation from the Health Care Provider to specify for each individual: the name and dosage of a prescribed medication; the indication for use; possible contraindications; allergies; special instructions; etc. The Policy should include procedures that ensure Health Care Provider Orders and medication changes received by Fax, Email, Telehealth, or Telephone are accurately received and documented (*For full requirements, see Policy Section 08).*

m) Medication Policies.
   i) The Service Provider should ensure that there are medication-specific policies (when applicable), including:
      (1) 'Warfarin Sodium Therapy' Service Provider Policy (*For full requirements, see Policy No. 19-7);*
      (2) 'Clozapine Therapy' Service Provider Policy (*For full requirements, see Policy No. 19-8);*
      (3) 'Medications Requiring Additional Monitoring of an Individual' Service Provider Policy (*For full requirements, see Policy No. 19-6);*
      (4) 'OTC Medications and Dietary Supplements' Service Provider Policy (*For full requirements, see Policy No. 10-6);*
      (5) 'Blood Glucose Monitoring' Service Provider Policy (*For full requirements, see Policy No. 18-2);*
      (6) 'Oxygen Therapy' Service Provider Policy (*For full requirements, see Policy No. 19-2);*
      (7) 'Auto-Injectable Epinephrine' Service Provider Policy (*For full requirements, see Policy No. 19-3);* and
      (8) 'Medication Administration via Gastrostomy (G) or Jejunostomy (J) Tube' Service Provider Policy (*For full requirements, see Policy No. 19-4 and Policy No. 19-5).*
      (9) 'High Alert Insulin via Insulin Pen Therapy' Service Provider Policy (*For full requirements, see Policy No. 19-9*); and
      (10) 'Schedule VI Injectable Medication' Service Provider Policy (*For full requirements, see Policy No. 19-10).*

Policy No. & Issue **14-2 Site Record Keeping Requirements**
Policy Source **4/04/18 MAP Advisory** **MAP Policy Manual**

1) As a condition of DPH Registration, each MAP Registered site must maintain the following:
   a) MAP Reference Sources, including the current:
      i) MAP Policy Manual and MAP Advisories;
      ii) MAP Curriculum;
      iii) Drug Handbook and/or Medication Information Sheets;
         (1) Each MAP Registered site must retain either a current (less than two [2] years old) Drug Reference Book and/or printed Medication Information Sheets that are received from a pharmacy, for all prescribed Medications and/or Dietary Supplements ordered for the individual(s) who are supported at the MAP Registered site.
            (a) If the pharmacy is unable to provide Medication Information Sheets, copies may be obtained and printed from a reputable source.
               (i) As Dietary Supplements are not considered medications, if the pharmacy is unable to provide Dietary Supplement Information Sheets, an alternate reputable source may be used to print the information sheets.
      iv) Service Provider Policies (*See Policy No. 14-1*);
      v) Service Provider Procedures, including, but not limited to:
         (1) Medication Refusal Procedure;
            (a) The 'Medication Refusal' Service Provider Procedure should include the Service Provider's internal reporting measures (e.g., incident reports, data tracking forms, etc.) for when an individual refuses medication (*For full requirements, see Policy No. 13-2).*
         (2) Medication Incident Procedure; and
            (a) The 'Medication Incident' Service Provider Procedure should include the Service Provider's internal reporting systems; quality assurance standards; actions taken that address medication incidents that are not medication occurrences; etc. *(See Policy No. 17-1).*
         (3) Emergency Fact Sheet (EFS) Procedure.
            (a) The 'Emergency Fact Sheet (EFS)' Service Provider Procedure should include Service Provider measures for Certified/licensed staff to follow to ensure that all current medications, dosages, frequencies, etc. are listed on the EFS or attached to the EFS. The Procedure should include the measures used to ensure that the current Medication List is shared with all pertinent Health Care Providers (HCP[s]) *(For full requirements see Policy No. 08-1).*
   b) Registrations, including:
      i) current MAP Massachusetts Controlled Substances Registration (MCSR) (*See Policy No. 03-2);*
      ii) current Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver (if applicable), (*For Contact Information, see Policy No. 23-1);* and
      iii) current Drug Control Program granted waivers (if applicable), (*See Policy No. 01-2*).

c) Staff (as well as Relief Staff) Certifications:
   i) current MAP Certifications;
      (1) Printed copies or readily-accessible electronically filed copies available on-site.
   ii) current CPR Certifications;
   iii) current First Aid Certifications;
   iv) current Massachusetts Certified Nurse Aide (CNA) certification (if applicable);
d) Staff (as well as Relief Staff) Trainings (if applicable), including:
   i) Gastrostomy Tube Training
   ii) Jejunostomy Tube Training
   iii) Warfarin sodium Therapy Training
   iv) Clozapine Therapy Training
   v) Epinephrine via Auto-Injector Device Training
   vi) High Alert Insulin via Insulin Pen Therapy Training
   vii) Schedule VI Injectable Medication Training
   viii) Routes (other than oral) Medication Administration Training
   ix) Vital Signs Training
   x) Oxygen Therapy Training
   xi) High-Risk Medication (as identified) Training
   xii) Blood Glucose Monitoring Training
   xiii) Transcription of Medication Management System Training
e) Emergency Contact List
   i) The Emergency Contact List is single page document listing the emergency telephone/contact numbers (listed in the sequence below). Contact information on the Emergency Contact List should include, but is not limited to:
      (1) Universal Emergency Telephone Number (i.e., 911);
      (2) Poison Control Telephone Number;
      (3) All MAP Consultants (i.e., HCP[s], Pharmacist[s], Registered Nurse[s]) Contact Telephone Numbers; and
      (4) Service Provider Managerial/Supervisory staff Contact Telephone Numbers.
f) 'Internal MAP Monitoring System';
   i) Documentation of the completed Tool(s), Checklist(s), etc. used for monitoring, or to complete a review/audit, should be maintained at the MAP Registered site.
g) Health Care Provider (HCP) Orders used to administer medications;
   i) A minimum of twelve (12) months of each individual's HCP Orders must be available on-site.
h) 'DPH Required Forms';
   i) The MAP Registered site must maintain a copy of all 'DPH Required Forms', including:
      (1) Controlled Substance Disposal Record form(s) (*See Policy No. 15-2).*
      (2) Medication Occurrence Report(s) (*MOR Form*[*s*]).
      (3) Drug Incident Report(s) (DIR) (*For Website Information, see Policy No. 23-1*).
i) 'Chain of Custody' tracking documentation, including:
   i) Medication Ordering and Receiving Documentation (*See Policy No. 10-5*).
   ii) Medication Book/Record;
      (1) The Medication Book/Record should include all current HCP Orders and Medication Administration Records (MAR[s]).
         (a) There must be a minimum of twelve (12) months of MAR(s), available on-site.
   iii) Countable Controlled Substance Book(s);and
      (1) The completed *Countable Controlled Substance Book* (*Count Book*) must be kept at the MAP Registered site for a minimum of two (2) years.
         (a) The 2-year timeline for the *Countable Controlled Substance Book* (*Count Book*) begins after the last entry in the *Count Book* has been documented and the

transference of the pertinent information into the new *Count Book* has been completed.

(i) If the applicable State Agency requires retention for more than two (2) years, the MAP Registered site must also follow these instructions.

j) 'Medication-Release' Documents.

i) *Leave of Absence Forms* (LOA Forms) should be maintained in the Individual's Record (*See Policy No. 16-6).*

ii) *Transfer Forms* should be maintained at the MAP Registered site (*See Policy No. 12-4).*

k) Medication Administration Time(s) schedule; and

i) The 'Medication Administration Time(s)' schedule should be established by the MAP Registered site and is based on:

(1) the frequency of each individual's medication HCP Orders and the scheduled time of each individual's 'Activities of Daily Living' (ADLs).

(a) Unless the HCP has ordered a specific time for the medication to be administered, the 'Medication Administration Time(s)' schedule will determine the 'time' (i.e., time to be listed in the hour column on the Medication Administration Record) the medication is to be administered.

(i) When the HCP has not ordered a specific time of administration, the Medication Administration Time(s) schedule should be followed.

l) 'Annual Medication Administration Demonstration Observation' documentation for 'MAP Registered youth sites' *(See Policy No. 02-2).*

MEDICATION ADMINISTRATION PROGRAM
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Policy No. & Issue	**14-3 Retention Period for MAP Program Records**		
Policy Source	**MAP Policy Manual**	**03/29/23**	**MAP Advisory**

1) Retention Period for MAP Program Records 105 CMR 700.006(B) states that all Massachusetts Controlled Substances Registration (MCSR) registrants shall retain for at least two years records that the regulation requires to be created or maintained. As applied to MAP Registered sites, this requirement applies to records that MAP Registered sites are required to keep by 105 CMR 700.000: Implementation of M.G.L. c. 94C, particularly 105 CMR 700.003(E), the MAP Policy Manual, and associated Departmental Advisories.

2) The two-year retention period is timed from the date of the record.
   a) For a stand-alone record such as a Medication Transfer Form or Leave of Absence Form, the “date of the record” appears on the face of the record. It is the date when the form was created/issued.
   b) Where a record is a collection of multiple entries, such as the Countable Controlled Substance Book (Count Book) or the Medication Administration Record (MAR), the “date of the record” is the date of the last entry in the record. For the Count Book this would be the date of the final entry in the book before it was retired. For a MAR, it would be the date of the last medication administration recorded on the MAR sheet.

3) Two years’ worth of relevant MAP documentation must be made available to any government inspector/investigator upon request. MAP Registered sites may choose, for their own operational or legal reasons, to retain MAP records for a longer period, but they are not required to do so by the Drug Control Program (DCP).

Policy No. & Issue **14-4 Electronic Reference Materials**
Policy Source **MAP Policy Manual** **04/04/18** **MAP Advisory**

1) The MAP Registered site may elect to maintain an 'electronic (digital) version' of the required 'reference material(s)' provided:
   a) the electronic version is readily-available to all Certified/licensed staff at the MAP Registered site, twenty-four hours a day, seven days a week (i.e., 24-7);
      i) Electronically filed required reference materials must be readily-accessible and available for oversight and review upon request of the DPH and/or State Agencies.
   b) the medication-related electronic (i.e., online) reference(s) is maintained by a state or federal government or other reputable source;
   c) all electronically filed reference materials are the most current and latest version(s);
   d) All Certified/licensed staff have been trained to access the electronic (i.e., online) reference materials and documentation is maintained at the MAP Registered site; and
   e) there is a contingency plan in place in the event that the MAP Registered site's computer or internet service is not functioning and/or the Service Provider has instituted compensating features that are acceptable to the DPH Drug Control Program to ensure that all required reference material is maintained and is readily-available at the MAP Registered site.

Policy No. & Issue **14-5 Allergies**
Policy Source **1997 DMH Memorandum**

1) All allergies must be listed on all health-related documents, including but not limited to:
   a) Health Care Provider Order(s)/Consult(s)/Encounter Form(s)/Protocol(s);
   b) Medication Administration Record(s); and
   c) Emergency Fact Sheet(s).
      i) If the individual does not have any known allergies (i.e., No Known Allergies), then this information must be listed.

2) If preferred by the Service Provider, the Allergy List may be formatted to assist in readily identifying the allergies (e.g., circling the Allergy List with a red pen, electronically generated Allergy Alert 'text box', etc.).
   a) In MAP, highlighting and different font colors are prohibited.

15

MEDICATION DISPOSAL

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

Policy No. & Issue **15-1 Medication Disposal Guidelines**
Policy Source **April 1997 MAP Advisory**

1) All expired and/or discontinued medication must be rendered unusable at the MAP Registered site or a MAP Registered site may participate in an 'anonymous' or 'non-anonymous' take-back medication program.
   a) Medications are not permitted to be returned to the pharmacy for disposal.
2) According to Regulations at 105 CMR 700.003(E)(3)(c): 'Disposal occurs in the presence of at least two witnesses and in accordance with any policies at the Department of Public Health' (DPH). DPH requires that disposal occur in the presence of two Certified and/or licensed staff, of which one of the two is a supervisory staff (i.e., Site Supervisor).
   a) When an individual refuses a prepared medication or when a pill/tablet/capsule, etc. is inadvertently dropped; it is permissible for two Certified and/or licensed staff (if a Site Supervisor is unavailable) to render these medications unusable, in accordance with acceptable MAP disposal practices.
3) Oral medication returned to the MAP Registered site from an Off-Site Administration (OSA) that is not permitted to be used must be rendered unusable.
   a) When prepared by the Certified/licensed staff, the unused oral OSA medication returned to the MAP Registered site is not permitted to be used (*See Policy No. 16-2*).
4) Oral medication returned to the MAP Registered site, from a Leave of Absence (LOA) is not permitted to be used and must be rendered unusable (*See Policy No. 16-4*).
5) Whenever medications are rendered unusable, regardless of the quantity, the DPH approved *Controlled Substance Disposal Record* form (i.e., *Disposal Form*) must be used (See Policy No. 15-2).
   a) The *Disposal Form* must be used for all Schedule II-V (i.e., countable controlled substances) medication disposals and all Schedule VI (i.e., controlled substances) medication disposals.
      i) The *Disposal Form* may also be used for all Over-The-Counter (OTC) medication and Dietary Supplement disposals.
6) Unless prohibited by local ordinance, acceptable practices for medication disposal include:
   a) compliance with specific disposal instructions on the medication information sheet, or drug label.
      i) Certain medication labeling specifically instructs that discontinued and/or expired medication be flushed. Flushing should be restricted to those medications so labeled.
         (1) Some Schedule II-V (i.e., countable controlled substances) medications carry instructions for flushing to reduce the danger of unintentional use.
   b) if not instructed otherwise, medications should be rendered unusable and then disposed of in the trash.
      i) There is no single method for rendering medications unusable. Typically, to render the medication unusable, a sequence of steps should be followed. The steps, to be completed by two Certified and/or licensed staff, of which one of the two is a supervisory staff (i.e., Site Supervisor), include:
         (1) take the medication out of its original container;

(2) put the medication into a sealable bag;
(3) mix the medication with an unpalatable substance, (e.g., liquid soap, dirt, kitty litter, etc.);
(4) seal the bag and put the mixture into an impermeable, non-descript container, (e.g., detergent bottle); and
(5) place the non-descript container containing the mixture into the trash.

7) A MAP Registered site may dispose of medication at an 'anonymous' or 'non-anonymous' take-back medication program.

a) When the MAP Registered site would like to participate in an 'anonymous' drug take-back program, whereby documentation of the medication disposal will not be offered (e.g., National Prescription Drug Take-Back Day), steps should be followed. The steps to be completed by two Certified and/or licensed staff, of which one of the two is a supervisory staff (i.e., Site Supervisor), include:
   i) render the medication unusable;
   ii) document the disposal on the *Disposal Form*;
   iii) check the 'Take-Back' block on the *Disposal Form;* and
   iv) take the unusable medication to the 'anonymous' drop-off program for disposal.

b) If the MAP Registered site would like to participate in a 'non-anonymous' drug take-back program, whereby participants are instructed to bring medications in the original container with the affixed pharmacy label to the take-back program (e.g., Household Pharmaceutical Take-Back Program), steps should be followed. The steps to be completed by two Certified and/or licensed staff, of which one of the two is a supervisory staff (i.e., Site Supervisor), include:
   i) arrange to bring the medications, in their labeled original containers to the 'Take-Back Program';
   ii) transport the medication to the 'Take-Back Program' in a locked-container;
      (1) Staff should also bring the *Disposal Form* to the 'Take-Back Program' site.
   iii) while at the 'Take-Back Program', the two staff should document on the *Disposal Form* that the medications were rendered unusable or that the medication was turned over to a federal, state, or local law enforcement-sanctioned take-back program by checking the 'Take-Back' block on the form; and
   iv) bring the completed *Disposal Form* back to the MAP Registered site.

8) After any medication is rendered unusable, the prescription label on the medication container must be removed and all identifying personal information obliterated.

Policy No. & Issue **15-2 Disposal Form**
Policy Source **April 1997 MAP Advisory**

CLICK HERE TO ACCESS THE REQUIRED *Controlled Substance Disposal Record* FORM ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

16

OFF-SITE MEDICATION ADMINISTRATION, CERTIFIED/LICENSED STAFFED VACATION, LEAVE OF ABSENCE, BACKPACKING

Policy No. & Issue	**16-1 Medication Administration at Locations other than MAP Registered Sites**	
Policy Source	**December 1994 MAP Advisory**	**April 1997 MAP Advisory**
	1997 DMH Memorandum	**MAP Advisory 06/24/20**

1) Medication may be administered to individuals supported by the Medication Administration Program (MAP) at locations other than MAP Registered sites provided that the applicable MAP Policy within Policy Section 16 is followed, including:

   a) Off-Site Administration (OSA) of Medication Policy (*See Policy No. 16-2);*
   b) Vacation (V) Policy (*See Policy No. 16-3);*
   c) Leave of Absence (LOA) Policy (*See Policy No. 16-4);* or
   d) Backpacking Policy (*See Policy No. 16-7).*

Policy No. & Issue **16-2 Off-Site Administration of Medication**
Policy Source **MAP Advisory 06/24/20**

1) 'Off-Site Administration' (OSA) of medication occurs when medication is administered at an off-site location to an individual, who is supported by the Medication Administration Program (MAP), by a Certified/licensed staff.
   a) 'Off-Site Administration' of medication by Certified/licensed staff includes, but is not limited to:
      i) when an individual will leave their home (i.e., the MAP Registered site) with residential Certified/licensed staff to go on a community outing (e.g., the movie theater, the mall, the grocery store, etc.) and the individual will be receiving their prescribed medications while attending the outing; or
      ii) when an individual will leave the Day Program (i.e., the MAP Registered site) with the Day Program Certified/licensed staff to go the individual's work site or other location, and the individual will be receiving their prescribed medications while at work or other location.

2) 'Off-Site Administration' of medication requires that an individual receive only a portion of their dispensed medication at the off-site location.
   a) When the Certified/licensed staff will be administering medication at an off-site location to an individual during a time-period of 'more than twenty-four (24) hours', the medication must be packaged by the pharmacy.
   b) When the Certified/licensed staff will be administering medication at an off-site location to an individual during a time-period of 'less than twenty-four (24) hours', the medication may be packaged by the Certified/licensed staff.
      i) Whenever possible, medication to be administered at an off-site location should be packaged by the pharmacy.
         (1) If the pharmacy is unable to package the medication for an OSA of 'less than twenty-four hours', the OSA medication may be packaged by the Certified/licensed staff, provided the Certified/licensed staff responsible for the off-site administration is the preparer of the medication.
            (a) When preparing the medication, the Certified/licensed staff responsible for the off-site medication administration must:
               (i) use an appropriately sized container (e.g., coin envelope), so that the required information can be marked directly on the container;
               (ii) use a separate container for each type of OSA medication;
               (iii) determine the amount of each medication needed for the OSA and transfer that amount from the original medication container directly into the corresponding OSA container; and
               (iv) mark each OSA container with all the necessary information.
                  a. The necessary information should be taken directly from the original medication container and must include at least the following:
                     i. individual's name;
                     ii. name of medication;
                     iii. strength of medication;
                     iv. directions for usage (clearly stated; including specific doses and administration times);
                     v. prescribing Health Care Provider's name;
                     vi. date of preparation;
                     vii. any necessary cautionary statements (e.g., take with food.); and
                     viii. the amount of medication in the OSA container.

3) All ‘Schedule II-V’ (i.e., countable controlled substances) medication and ‘high-risk Schedule VI’ medication prepared for off-site administration must be accounted for and documented as ‘OSA’ in the *Countable Controlled Substance Book*.

4) The Certified/licensed staff responsible for the off-site administration of medication must initially document on a medication progress or narrative note, information regarding the OSA including the location of where the OSA medication will be administered.

    a) A second medication progress or narrative note must be completed by the Certified/licensed staff upon return from the OSA indicating the medication was administered.
        i) If for any reason the medication was not administered as ordered, the Certified/licensed staff must complete all necessary follow-up and document the completed follow-up on a medication progress or narrative note.

5) During the OSA timeline, the Certified or licensed staff must have a copy of their current MAP Certificate readily available (on hand) or verification of their nursing license, (as applicable).

6) At the MAP Registered site, during the scheduled time of the individual’s medication administration, the Certified/licensed staff, responsible for the task of medication administration, must document ‘OSA’ in the applicable medication box on the individual’s Medication Administration Record (MAR).

    a) All documentation must be completed in ‘real time’.

7) Any unused oral OSA medication, that was packaged by the pharmacy, in tamper-resistant packaging, may be returned to the MAP Registered site for future use.

    a) When a ‘Schedule II-V’ (i.e., countable controlled substance) or ‘high-risk Schedule VI’ OSA medication, that was packaged by the pharmacy, is being returned to the MAP Registered site, the amount of OSA medication returned must be added back into the *Countable Controlled Substance Book*.

8) Any unused oral OSA medication that was packaged by the Certified/licensed staff may not be returned to the MAP Registered site for future use.

    a) When an OSA medication packaged by the Certified/licensed staff is returned to the MAP Registered site, it must be rendered unusable and documented in the approved manner (*See Policy No. 15-1*).

9) The OSA Policy may not be used to replace the Backpacking Policy (*See Policy No. 16-7*).

Policy No. & Issue **16-3 Vacation Accompanied by Certified/Licensed Staff**
Policy Source **December 1994 MAP Advisory April 1997 MAP Advisory**
MAP Advisory 6/24/20

1) Vacation (V), medication administration occurs when medication is administered by Certified/licensed staff, when the Certified/licensed staff accompany the individual(s) supported by the Medication Administration Program (MAP) on a Vacation.

2) The Service Provider must have a 'Vacation Policy' specifying the procedure to follow when medication will be administered by Certified/licensed staff while accompanying an individual on a Vacation. The Policy must include, but is not limited to, the requirements for:
   a) administrative procedures to be followed when there is a medical emergency relating to medication;
   b) training for Certified/licensed staff on the 'Vacation Medication System'; and
   c) a current list of MAP Consultants and applicable Service Provider staff (Contact List) for Certified/licensed staff to have readily-available (on hand) for each Vacation.
      i) The 'Contact List' should clearly indicate who should be contacted during the timeline of the Vacation.

3) Vacation medication must be packaged by the pharmacy for the individual(s), who will be participating in the Vacation.
   a) Vacations often require that the individual will only receive a portion of the originally dispensed medication.
      i) When the individual will only receive a portion of their dispensed medication, the pharmacy must 'split-package' the medication into two tamper-resistant packages, one for the MAP Registered site and one for the Vacation location.

4) Certified/licensed staff must be knowledgeable of the 'Vacation Medication System' including, but not limited to, how medications will be transported, secured, and administered.
   a) All MAP Policies regarding medication security must be followed before, during, and after the Vacation (*For full requirements see Policy Section 12*).
      i) Pharmacy packaged medication that will be administered on the Vacation must be transported by Certified/licensed staff and stored in a key-locked container.
         (1) 'Schedule II-V' (i.e., countable controlled substances) medications and 'high-risk Schedule VI' medications must be transported and stored in a double key-locked container.
   b) Staff must have a 'Vacation copy' of the individual(s) Health Care Provider's Orders, a 'Vacation copy' of the Medication Administration Records (MAR[s]), and a 'Vacation copy' of the Medication Information Sheets, along with the pharmacy-packaged medication.
      i) The Medication-Related documents must be brought to and from the Vacation location.
   c) The Certified/licensed staff responsible for the administration of the Vacation medication must document the administration on the 'Vacation copy' of the individual's MAR(s).
      i) 'At the MAP Registered site', during the scheduled time of the individual's medication administration, the Certified/licensed staff responsible for the task of medication administration, must document 'V' in the applicable medication box on the individual's original MAR(s).
         (1) All documentation must be completed in 'real time'.

ii) Vacation MAR(s) are to be maintained as part of the Individual's Record upon return to the MAP Registered site.

5) The Certified or licensed staff accompanying the individual(s) on the Vacation must have a copy of their current MAP Certificate readily-available (on hand) or verification of their nursing license (as applicable), as well as, Service Provider validation documentation verifying the Certified/licensed staff is able to transport and administer medication to the individual(s) during the Vacation.

a) Staff must be trained on how the 'Vacation Medication System' is to be managed.
   i) The Service Provider should maintain a current list of trained staff.
      (1) A copy of the list must be available at the MAP Registered site.

Policy No. & Issue **16-4 Definition and Criteria for a Leave of Absence**
Policy Source **December 1994 MAP Advisory** **April 1997 MAP Advisory**
1997 DMH Memorandum

1) Leave of Absence (LOA) occurs when medication is released from a MAP Registered site to a person authorized to administer the medication (e.g., family member, guardian, or responsible party) while the individual is on the Leave of Absence.
   a) The Service Provider must have a Leave of Absence Policy that includes:
      i) the procedure to follow for obtaining, preparing, and transferring LOA medication;
      ii) the requirement for identifying and educating persons responsible for the LOA; and
      iii) the procedure to follow when an individual returns to the MAP Registered site following the LOA.

2) When the LOA is 'planned', the medication must be packaged by the pharmacy.
   a) When packaging medication for the 'planned' LOA, the pharmacy must 'split-package' the medication into two tamper-resistant packages, one for the MAP Registered site and one for the LOA (*See Policy No. 10-2*).
      i) Leave of Absences often require that the MAP Registered site retain only a portion of the originally dispensed medication and the other 'split-packaged' medication is released from the MAP Registered site to the family member, guardian, or responsible party.

3) When the LOA will be 'seventy-two (72) hours or more', the medication must be packaged by the pharmacy.
   a) When packaging medications for the 'seventy-two (72) hours or more' LOA, ('planned' or 'unplanned') the pharmacy must 'split-package' the medication into two tamper-resistant packages, one for the MAP Registered site and one for the LOA *(See Policy No. 10-2).*
      i) Leave of Absences often require that the MAP Registered site retain only a portion of the originally dispensed medication and the other 'split-packaged' medication is released from the MAP Registered site to the family member, guardian, or responsible party.

4) For 'unplanned' LOAs that are 'less than seventy-two (72) hours', the Certified/licensed staff should contact the pharmacy to request that the LOA medication be packaged. If the pharmacy cannot package the medication for the LOA, it is permitted for the Certified/licensed staff to package the 'less than seventy-two (72) hours' LOA medication (*See Policy No. 16-5*).
   a) In MAP, except for packaging medication for an 'unplanned' and 'less than seventy-two (72) hours' LOA, Certified/licensed staff are not permitted to package or repackage medication.

5) A dated *LOA Form* must be completed by the Certified/licensed staff listing both the inventory of all the LOA medication and the amount released to the family member, guardian, or responsible party.
   a) The *LOA Form* must be signed by both the giver (e.g., the Certified/licensed staff who is releasing the medication to the family member, guardian, or responsible party) and the receiver (e.g., family member, guardian, or responsible party, who is receiving the medication).
      i) The dated and signed *LOA Form* must be filed at the MAP Registered site in the Individual's Record.
      ii) A copy of the *LOA Form* should be given to the family member, guardian or responsible party.

6) The family member, guardian, or responsible party receiving the LOA medication should receive some training on administration and potential side effects of the medication from the Certified/licensed staff releasing the LOA medication.

   a) The Service Provider should have a procedure in place regarding staff responsibilities when an individual's medication is transferred from the MAP Registered site to the family member, guardian, or responsible party for an LOA.

7) When the individual returns to the MAP Registered site following the LOA, the Certified/licensed staff at the site should inquire of the family member, guardian or responsible party if all of the LOA medications were administered to the individual during the LOA.

   a) The Service Provider should have a procedure in place regarding staff responsibilities when an individual returns to the MAP Registered site from an LOA.

8) Unused oral LOA medication may not be returned to the MAP Registered site for reuse.

   a) Certified/licensed staff must dispose of these medications in an approved manner (*See Policy Section 15*).

Policy No. & Issue **16-5 Preparation of Medication for a Leave of Absence**
Policy Source **December 1994 MAP Advisory** **April 1997 MAP Advisory**

1) For all Leave of Absences (LOA[s]), the Certified/licensed staff must contact the pharmacy and request that the pharmacy 'split-package' the individual's prescribed medication, one for the MAP Registered site and one for the LOA (*See Policy No. 10-2*).
   a) LOA medication should be received from the pharmacy in a tamper-resistant container (e.g., blister pack, unit dose, tamper-resistant cassette, etc.) in such a manner that prevents the contents from being altered.
      i) Only the exact number of doses necessary for the LOA should be packaged.
2) LOA medication must be packaged by the pharmacy when:
   a) the LOA is planned; and/or
   b) the LOA is seventy-two (72) hours or more.
3) LOA medication is permitted to be prepared and packaged by Certified/licensed staff 'only when':
   a) the pharmacy is unable to package the medication for the LOA;
   b) the LOA is unplanned;
   c) the LOA is less than seventy-two (72) hours; and
   d) the LOA medication is prepared and released by the same Certified/licensed staff.
4) The Certified/licensed staff who prepares and packages the 'unplanned' and 'less than seventy-two (72) hours' LOA medication must:
   a) determine the amount of medication needed for the LOA;
      i) Only the exact number of doses of medication required for the LOA should be packaged.
   b) place each medication strength in a separate and appropriately sized container, (e.g., coin envelope);
   c) include the required information marked directly on the container that is enclosing the LOA medication; and
      i) The required information should be taken from the original medication package or original medication container and must include:
         (1) individual's name;
         (2) name and strength of medication;
         (3) directions for usage (clearly stated; including specific doses and administration times);
         (4) prescribing Health Care Provider's name;
         (5) any necessary special instructions (e.g., take with food); and
         (6) the amount of medication in the LOA container.
   d) transfer the LOA medication to the family member, guardian, or responsible party.
5) Unused oral LOA medications may not be returned to the MAP Registered site for reuse.
   a) Certified/licensed staff must dispose of the unused oral LOA medication in the approved manner (*See Policy Section 15*).

Policy No. & Issue	**16-6 Documentation of a Leave of Absence**	
Policy Source	**December 1994 MAP Advisory**	**April 1997 MAP Advisory**
	1997 DMH Memorandum	**1995 DDS Memorandum**

1) A dated Leave of Absence (LOA) Medication-Release form (*LOA Form*) must be completed by the Certified/licensed staff who prepared the medication for release.
   a) The *LOA Form* should list both the inventory of all the LOA medication and the amount released to the family member, guardian, or responsible party.
2) Documentation on the *LOA Form* should include that the family member, guardian, or responsible party, who has received the prepared LOA medication, has also been provided Medication Information Sheets, instructions for administering the LOA medication, and technical assistance contact information.
   a) The *LOA Form* should include any special instructions for the preparation and administration of the LOA medication and contact information (e.g., who to call, how to contact, etc.) when technical assistance is required during the LOA.
      i) The Service Provider should have a procedure in place regarding staff responsibilities for completing the *LOA Form* and reviewing the medication administration information with the family member, guardian, or responsible party.
         (1) Whenever possible, the LOA medication administration information should be reviewed with all parties who will be administering the LOA medication.
            (a) If it is not possible to review the LOA medication administration information with all parties, then the Certified/licensed staff should review the information with at least one person who will be administering the medication.
   b) Upon completion of the review of information on the *LOA Form* given by the Certified/licensed staff to the family member, guardian, or responsible party, the *LOA Form* must be signed and dated by both the giver (e.g., the Certified/licensed staff who provided the review and released the medication) and the receiver (e.g., family member, guardian, or responsible party who attended the review and received the medication) indicating the information was reviewed and the medication was released and accepted.
   c) The original signed and dated *LOA Form* is part of the Individual's Record.
      i) A copy of the *LOA Form* should be given to the family member, guardian, or responsible party.
3) All 'Schedule II-V' (i.e., countable controlled substances) medication released for the LOA must be documented and accounted for in the *Countable Controlled Substance Book* by the Certified/licensed staff removing the medication from the 'Count Book'.
   a) The Certified/licensed staff who removes the 'Schedule II-V' medication from the 'count' must also be the person who will be releasing the 'Schedule II-V' medication to the family member, guardian, or responsible party.
4) All 'high-risk Schedule VI' medication released for the LOA must be documented and accounted for by the Certified/licensed staff utilizing the applicable tracking system (*See Policy 12-2*).
   a) The Certified/licensed staff who removes the 'high-risk Schedule VI' medication from the tracking system must also be the person who will be releasing the 'high-risk Schedule VI' medication to the family member, guardian, or responsible party.

5) At the MAP Registered site, during the scheduled time of the individual's medication administration, the Certified/licensed staff responsible for the task of medication administration must document 'LOA' in the applicable medication box on the individual's Medication Administration Record (MAR).

   a) All documentation must be completed in 'real time'.

6) When an individual returns to the MAP Registered site from the LOA, the Certified/licensed staff at the MAP Registered site must inquire of the family member, guardian, or responsible party if all of the LOA medications were administered.

   a) The Service Provider should have a procedure in place regarding Certified/licensed staff responsibilities when an individual returns to the MAP Registered site following an LOA.
   b) After inquiring if the LOA medications were administered, the Certified/licensed staff should document the response and report any concerns.

7) Any oral LOA medication brought back to the MAP Registered site may not be used.

   a) The oral LOA medication returned to the MAP Registered site must be rendered unusable and documented on the *Disposal Form* (*See Policy Section 15*).

Policy No. & Issue **16-7 Transporting Medications to Administer to Individuals Living at a Location Other than the MAP Registered Site; 'Backpacking'**
Policy Source **MAP Policy Manual**

1) MAP Registered sites supporting individuals residing in the community (e.g., individual's own apartment, individual's family home, etc.), who are supported by the Medication Administration Program (MAP) may have Certified/licensed staff 'backpack' (i.e., transport) their medication and administer the medication at their community location.

2) Medications that are 'backpacked' (i.e., transported) into the community setting for administration must be stored at a MAP Registered site.

3) Certified/licensed staff, including relief staff, may 'backpack' medication from the MAP Registered site to a community setting provided:

   a) there is a Service Provider 'Backpacking Policy' in place;
      i) The Backpacking Policy must include, but is not limited to:
         (1) procedures to be followed specific to Certified/licensed staff responsibilities when they are backpacking medications into the community that must include:
            (a) how to store, transport, secure, and handle the individual(s)' medication(s); and
            (b) how to administer the backpacked medication in the community setting.
         (2) administrative procedures to be followed when there is a medical emergency related to the administration of backpacked medication; and
            (a) The Backpacking Policy can reference the Service Provider's overall Policy that specifies the administrative procedures to be followed when there is a medical emergency related to a medication, (if the Policy would be applicable when there is a medical emergency related to backpacking).
         (3) training requirements for Certified/licensed staff, including relief staff, who will be transporting and administering backpacked medication.
   b) the Certified/licensed staff have readily-available (on-hand) a list of Emergency Contact names and numbers;
   c) the medications are packaged and labeled by the pharmacy;
      i) Certified/licensed staff may not repack, relabel or pre-pour medications.
   d) the medications are transported by the Certified/licensed staff in a locked portable carrying container (e.g., locked backpack);
      i) 'Schedule II-V' (i.e., countable controlled substances) medication and 'high-risk Schedule VI' medication must be double locked (*See Policy No. 12-2*).
   e) the Certified staff have a copy of their current MAP Certificate readily-available (on-hand) and/or the licensed staff have verification of their nursing license (as applicable);
   f) the Certified/licensed staff have readily-available (on-hand) a copy of Service Provider validation documentation verifying the staff is able to transport and administer medications to individuals, supported by MAP, in the community setting;
   g) all necessary components (e.g., Health Care Provider Orders, Pharmacy Labeled Medication, Medication Administration Records, etc.) are available for the Certified/licensed staff at the community location to ensure accurate completion of the 'Medication Administration Process';
   h) all appropriate MAP procedures for medication administration are followed;
      i) Medication may only be prepared immediately prior to administration.
         (1) Medications must never be prepared ahead of time (i.e., pre-poured).

(a) When a medication is 'pre-poured' by Certified/licensed staff, the integrity of the medication can no longer be guaranteed.

i) Countable Controlled Substance counts are conducted;
   i) A Countable Controlled Substance count must be conducted when 'Schedule II-V' (i.e., countable controlled substances) medications and 'high-risk Schedule VI' medications are transferred from the MAP Registered site's Medication Storage Area into the locked portable carrying container (e.g., locked backpack); and
   ii) when the 'Schedule II-V' (i.e., countable controlled substances) medications and 'high-risk Schedule VI' medications are transferred from the locked portable carrying container (e.g., locked backpack) back to the MAP Registered site's Medication Storage Area.
j) following return from the community setting to the MAP Registered site, all of the individual(s)' medications are secured and locked within the MAP Registered site's Medication Storage Area; and
   i) If any of the medication transported to/from the community setting is a 'Schedule II-V' (i.e., countable controlled substances) medication or a 'high-risk Schedule VI' medication, they must be removed from the portable carrying container, added back into the 'Count Book', and double key-locked, (i.e., a key-lock within a key-lock).
   ii) If 'Schedule VI' (i.e., controlled) medications remain in the locked portable carrying container, (e.g., locked backpack), the backpack must be stored via a key-lock within the MAP Registered site's Medication Storage Area.
k) the Certified/licensed staff, including relief staff, are trained in the Service Provider's 'Backpacking Procedures'.
   i) Documentation of the Backpacking Procedures Training should include the date of training; name(s) of staff trained, and contact information of the Trainer.
      (1) The Service Provider must maintain a current list of trained staff at the MAP Registered site.

17

MEDICATION OCCURRENCES

Policy No. & Issue **17-1 Definition of a Medication Occurrence**
Policy Source **October 1996 MAP Advisory**

1) The 'five (5) rights' of medication administration include:
   a) the 'Right Individual';
   b) the 'Right Medication';
   c) the 'Right Dose';
   d) the 'Right Time'; and.
      i) The definition of 'Right Time' is further clarified to include medications administered:
         (1) 'within the appropriate time frame'; or
            (a) For example, a medication is ordered to be administered 'daily in the morning' and is scheduled for 8 AM. It is now 10 AM. 10 AM is within the ordered timeframe of 'daily in the morning'. Based on the Health Care Provider (HCP) order, the MAP Consultant may recommend that Certified staff administer the medication.
               (i) This permits a MAP Consultant designated by the MAP Registered site to help determine if a medication occurrence has taken place by using the HCP Order as their guide and to recommend an intervention if needed.
         (2) 'within the HCP's established parameters'.
            (a) For example, a medication is ordered to be held if the systolic (top number) blood pressure is 110 or below. The Certified staff obtains a blood pressure reading of 130/60. Certified staff should administer the medication because the established parameters (systolic blood pressure reading was above 110) have been met.
   e) the 'Right Route'.

2) A 'Medication Occurrence' is defined as a 'breach' of one of the 'five (5) rights' of the Medication Administration Process.

3) There are five types of reportable medication occurrences. For the purpose of reporting, a Medication Occurrence must be reported when it is determined that there was a 'breach' of one of the 'five (5) rights' denoted as one of the 'five (5) wrongs'.
   a) The 'five (5) wrongs' include:
      i) the 'Wrong Individual';
      ii) the 'Wrong Medication';
         (1) Wrong Medication also includes administering a medication:
            (a) without a Health Care Provider (HCP) Order;
            (b) without target signs or symptoms being met; or
            (c) with an expired HCP Order.
      iii) the 'Wrong Dose';
      iv) the 'Wrong Time'; and
         (1) Wrong Time also includes:
            (a) an omission of a medication; or
            (b) administering a medication without complying with established parameters.
      v) the 'Wrong Route'.

4) A Medication Refusal is not considered a Medication Occurrence.

   a) Service Providers should maintain their own internal procedures that address Medication Refusals and other Medication Incidents that do not fall under the designation of a Medication Occurrence (*See Policy No. 13-2 and Policy No. 14-2*).

Policy No. & Issue **17-2 Hotline Event Medication Occurrences**
Policy Source **April 1997 MAP Advisory**

1) A 'Hotline Event' is a Medication Occurrence (*See Policy No. 17-1*) that is followed by:
   a) Illness;
   b) Injury;
   c) Medical Intervention; and/or
   d) Death.

2) Medication Occurrences that are 'followed' by illness (i.e., deviation from the individual's physical/mental health baseline), injury (i.e., physical trauma or harm), medical intervention (i.e., medical assessment, treatment, care), and/or death are reportable directly to the DPH, within twenty-four (24) hours of the discovery of the medication occurrence, via the Medication Occurrence 'Hotline Event' reporting process (*See Policy No. 17-3*).
   a) There need not necessarily be a demonstrated causal relationship between the medication occurrence and the illness, injury, medical intervention, and/or death in order for an occurrence to be reportable to the DPH.
      i) Submission of the Medication Occurrence Report (MOR) does not constitute an admission that a Medication Occurrence caused or contributed to the 'Hotline Event'.

3) Medical Intervention(s) are actions taken following a Medication Occurrence that includes medical assessment, treatment, and/or care provided to the individual. Any event that requires medical intervention, regardless of the outcome of the medical intervention, must be reported directly to the DPH as a 'Hotline Event'.
   a) Medical Interventions include, but are not limited to:
      i) an encounter with the Health Care Provider (HCP);
         (1) Telehealth Visit, HCP Visit, Dispatch Health Home Visit, etc.
      ii) Clinic/Urgent Care Visit;
      iii) Hospitalization;
      iv) Emergency Room Visit;
      v) Lab work;
      vi) EKG/ECG (Electrocardiogram);
      vii) CT (Computed tomography) scan;
      viii) Emergency Medical Services (e.g., EMT, Paramedic, etc.) evaluation; and/or
      ix) X-rays.

4) Medical Intervention(s) does not include contacting the MAP Consultant nor does it include adjustments made to the medication regimen.
   a) An example of a recommended action by the HCP or Pharmacist that is not considered a medical intervention would be: 'skipping the missed dose and administering the next dose as scheduled' or 'Vital Signs monitoring by trained Certified staff'.

Policy No. & Issue **17-3 Requirements for Reporting and Follow-Up of Medication Occurrences**
Policy Source **October 1996 MAP Advisory**

1) It is the responsibility of the MAP Registered site to identify, report, and complete follow-up of all Medication Occurrences.
   a) In the event there is a question if a medication occurrence has happened, the Service Provider should contact the MAP Coordinator for clarification.

2) Actions of a Certified staff or licensed nurse (i.e., Registered Nurse [RN] or Licensed Practical Nurse [LPN]) that lead to a Medication Occurrence require that the MAP Registered site submit a Medication Occurrence Report (MOR).
   a) After following the immediate guidance of the MAP Consultant spoken to, the MOR Form should be completed by the MAP Registered site.
      i) The MOR Form should only be completed after the individual's immediate needs for care or medical intervention have been met.

3) The MAP Registered site must immediately contact a MAP Consultant upon discovery of every Medication Occurrence (*See Policy No. 07-1*).

4) A Medication Occurrence is identified based upon the Health Care Provider (HCP) Order, and not solely upon the MAP Registered site's medication schedule.
   a) For example, a medication ordered by the HCP for 'two times a day' is not necessarily a reportable medication occurrence if it is administered at 8 AM and 8 PM rather than at the times of 8 AM and 5 PM as scheduled by the MAP Registered site.
      i) The Service Provider should maintain their own internal reporting procedures that address medication incidents that do not fall under the category of a medication occurrence (*See Policy No. 14-2*).

5) An MOR must be submitted by the MAP Registered site for 'every reportable Medication Occurrence' including 'Non-Hotline Event(s)' and Hotline Event(s)'.
   a) 'Non-Hotline Event(s)'
      i) Reporting timeline:
         (1) within seven (7) days of discovery.
      ii) Submitted to:
         (1) The applicable MAP Coordinator (*See Policy Section 23 for Contact Information)* at the:
            (a) Department of Developmental Services (DDS) by:
               (i) electronically submitting an MOR via the 'Home and Community Services Information System' (i.e., HCSIS).
            (b) MassAbility by:
               (i) electronically submitting an MOR via 'Qualtrics'.
            (c) Department of Children and Families (DCF) by:
               (i) Electronically submitting an MOR via 'iFamilyNet'.
            (d) Department of Mental Health (DMH) by:
               (i) completing a paper or electronic copy of the *MOR Form* and submitting it to the applicable MAP Coordinator.
                  1. Click **here** to access the *MOR Form*.

b) 'Hotline Event(s)'
   i) Reporting timeline:
      (1) within twenty-four (24) hours of discovery.
   ii) Submitted to the:
      (1) DPH through the online DPH Hotline Reporting System; and to the
      (2) applicable MAP Coordinator (*See Policy Section 23 for Contact Information)* at the:
         (a) Department of Developmental Services (DDS) by:
            (i) electronically submitting an MOR via the 'Home and Community Services Information System' (i.e., HCSIS).
         (b) MassAbility by:
            (i) electronically submitting an MOR via 'Qualtrics'.
         (c) Department of Children and Families (DCF) by:
            (i) electronically submitting an MOR via 'iFamilyNet'; and
            (ii) completing a paper or electronic copy of the *MOR Form* and submitting it to the applicable MAP Coordinator.
               1. Click **here** to access the *MOR Form.*
         (d) Department of Mental Health (DMH) by:
            (i) completing a paper or electronic copy of the *MOR Form* and Submitting it to the applicable MAP Coordinator.
               1. Click **here** to access the *MOR Form*.

6) MORs should be filed and retained at the MAP Registered site (where the Medication Occurrence happened).

   a) Paper MOR forms must be the original, unaltered version; or

   b) Electronic MOR forms are maintained in an electronic file.

7) For each identified Medication Occurrence, follow-up actions (e.g., supervised 'med pass', staff training/retraining, environmental issues addressed, review of correct procedure/process, etc.), must be implemented by the Service Provider to assist in preventing similar medication occurrences from happening in the future.

   a) Follow-up actions (e.g., supervised 'med pass', staff training/retraining, environmental issues addressed, review of correct procedure/process, etc.) should focus on contributing factors that may have led to the medication occurrence to minimize future occurrences.

Policy No. & Issue **17-4 Instructions for Completion of Medication Occurrence Report (*MOR Form*)**
Policy Source **October 1996 MAP Advisory**

1) When completing the Medication Occurrence Report *(MOR Form)*, fill in all areas on the form before submitting to the applicable MAP Coordinator.

2) To complete the *MOR Form*:
   a) *Heading Section*:
      i) On the Left Side of the *Heading Section* of the *MOR Form*, fill in the name of the Service Provider, the individual's name, the MAP Registered site's address and telephone number with area code.
      ii) On the Right Side of the *Heading Section* of the *MOR Form*, fill in the date/time of discovery of occurrence, date/time of occurrence, and the MAP MCSR Number.
         (1) The MAP Registered site's Massachusetts Controlled Substances Registration (MCSR) Number is found on the certificate and starts with 'MAP' or 'COM' followed by five (5) digits.
   b) *Section A*:
      i) Select the type of medication occurrence that has taken place.
         (1) Only one type of occurrence should be selected.
   c) *Section B*:
      i) List each medication involved in the occurrence as it is ordered by the Health Care Provider (HCP) in the 'As Ordered' field(s).
         (1) Document the name of the medication ordered by the HCP next to 'As Ordered', as well as the dosage, frequency/time(s), and route.
            (a) Attaching a Medication List does not meet this requirement.
               (i) If a medication was administered without an HCP Order or if the HCP Orders were expired, then 'Not ordered' should be written in all 'As Ordered' fields.
               (ii) If a medication was administered to the wrong individual, then 'Not ordered for this individual' should be written in all 'As Ordered' fields.
      ii) List each medication involved in the occurrence as it was received by the individual in the 'As Given' field(s).
         (1) Document the exact medication, dose, frequency/time(s), and route by which the medication was received by the individual next to 'As Given'.
            (a) Attaching a Medication List does not meet this requirement.
               (i) If a medication was omitted, 'Omission' should be written in the 'As given' field including the dates and times of the omission.
               (ii) If the medication was administered to the 'wrong individual', list the 'exact time' the medication was ingested by the individual in the frequency/time field and not the time the medication was ordered for the 'intended' individual.
      iii) *Section B* has fields for three medications to be recorded.
         (1) If more than three medications were involved in the medication occurrence, document the additional medications on the reverse side (side two) of the *MOR Form* using the 'As Ordered/As Given' format.
            (a) Attaching a Medication List does not meet this requirement.
   d) *Section C*:
      i) Select the title of the MAP Consultant that the Certified/licensed staff 'spoke to'.

(1) Document the MAP Consultant's information including their name (e.g., 'Fred Jones') and not the name of the pharmacy (e.g., 'Greenleaf Pharmacy'), as well as the date, and time contacted.
(a) Leaving a message for the MAP Consultant does not meet this requirement.
(2) If more than one MAP Consultant was contacted, select all that apply, and then document each MAP Consultant's name, date, and time contacted.

e) *Section D*:
i) Select the appropriate 'yes'/'no' answer to designate if Illness, Injury, Medical Intervention and/or Death ('Hotline Event') followed the occurrence (*See Policy No. 17-2*).
(1) If 'yes' was selected, check all the applicable boxes (i.e., Illness, Injury, Medical Intervention and/or Death) that apply.
(a) When 'yes' is selected, notify (within twenty-four (24) hours of the discovery of the 'Hotline Event') the DPH and the applicable MAP Coordinator.
(b) If no Illness, Injury, Medical Intervention and/or Death followed the occurrence, then 'no' would be the appropriate selection.
(i) Since contact with the MAP Consultant is standard protocol for all Medication Occurrences, such consultation in and of itself would not constitute a Medical Intervention for the purposes of the reporting requirement.

f) *Section E*:
i) Select the appropriate 'yes'/'no' answer to designate if Medical Intervention followed the occurrence (*See Policy No. 17-2*).
(1) If yes, check off all applicable Boxes.
(a) If the Medical Intervention received by the individual is not listed on the *MOR Form,* check 'other', and document the intervention(s) received within the 'Please describe' box (e.g., EKG, chest x-ray, etc.).
(i) 'Other' should only be selected for any 'Medical Intervention(s)' received.

g) *Section F*:
i) *Section F* should be completed by the Certified Site Supervisor (or designee) of the MAP Registered site.
(1) The Certified Site Supervisor (or designee) should review the factors involved in the occurrence and select all those that apply.
(a) The list provided in *Section F* includes the most common factors that may have contributed to a Medication Occurrence.
(i) (1.) Failure to properly document administration (e.g., medication administered was not documented on the Medication Administration Record).
(ii) (2.) Medication not available (e.g., medication not ordered from the pharmacy).
1. This includes when a Health Care Provider is not contacted for issues including, but not limited to:
2. prior authorization;
3. delay in pharmacy delivery; or
4. refills not available.
(iii) (3.a) Medication administered by non-certified staff (includes incidences of expired or revoked Certification).
1. When the staff responsible does not hold a current MAP Certification, the Supervisor, completing the report, should indicate the lack of MAP Certification by selecting Contributing Factor 3a within *Section F* on the *MOR Form.*
a. The Supervisor should also select any other factors which may apply (i.e., factors 1-2 or 4-8).
(iv) (3.b) Medication administered by a licensed nurse employed on-site (includes LPN and RN).

1. When the staff responsible is a licensed nurse, it is permissible for the person completing *Section F* to be a Nurse Supervisor.
    a. When the licensed nurse (i.e., LPN or RN) is employed by the Service Provider, the Supervisor completing the report, should indicate this employment by selecting Contributing Factor 3b, and the applicable job title box (i.e., LPN or RN), within *Section F* on the *MOR Form*.
    b. The Supervisor should select any other factors that may also apply (i.e., factors 1-2 or 4-8).

(v) (3.c) Medication administered by a licensed nurse not employed on-site (e.g., VNA).
1. When the staff responsible is a licensed nurse, it is permissible for the person completing *Section F* to be a Nurse Supervisor.
    a. When the licensed nurse (i.e., Registered Nurse or Licensed Practical Nurse) is not employed by the Service Provider, the Supervisor completing the report, should indicate this employment by selecting Contributing Factor 3c within *Section F* of the *MOR Form*.
    b. The Supervisor should also select any other factors that may apply (i.e., factors 1-2 or 4-8).

(vi) (4.) Non-compliant procedure (e.g., failure to accurately follow the MAP Medication Administration Process).

(vii) (5.) Failure to accurately record and/or transcribe an order (e.g., not transcribing the HCP Order onto the Medication Administration Record correctly).

(viii) (6.) Failure to accurately take or receive a telephone order (e.g., not documenting a Telephone HCP Order as it was communicated by the HCP).

(ix) (7.) Medication had been discontinued (e.g., medication was administered that had been discontinued by the HCP).

(x) (8.) Other (Narrative required).
1. If no contributing factors listed on the *MOR Form* are involved, then Number '8' 'other' should be selected.

ii) After selecting the applicable boxes in *Section F*, the Supervisor must comment in the *Narrative Section.* The Supervisor should document all information discovered during the review of the medication occurrence. Documentation in the *Narrative Section* should include, but is not limited to:
(1) the status of individual;
(2) why the medication occurrence happened or any contributing factors;
(3) recommendations given by the MAP Consultant;
(4) any events that followed the medication occurrence; and
(5) what training/retraining was provided for the staff responsible.
(a) Additional space is available on the reverse side (side two) *Section F-1* for completion of the Narrative.
(b) The Supervisor does not need to identify the Certified/licensed staff responsible.
(c) After completion of the Narrative Review/Follow up, the Supervisor must enter their printed name, job title, contact telephone number, email address, and the date the *MOR Form* was completed.

3) *See Policy 17-3* for reporting requirements.

Policy No. & Issue **17-5 Medication Occurrence Report (*MOR Form)***
Policy Source **October 1996 MAP Advisory**

CLICK HERE TO ACCESS THE *Medication Administration Program Medication Occurrence Report* FORM ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

Policy No. & Issue **17-6 Pharmacy Errors**
Policy Source **MAP Policy Manual**

1) Actions of a Pharmacist/Pharmacy (e.g., pharmacy errors in labeling or packaging medication) that lead to a medication occurrence do not require reporting via a MAP Medication Occurrence Report (*MOR Form*) provided that Certified/licensed staff could not have discovered or prevented the error.

2) If there are any questions about the reporting of pharmacy errors, contact the Board of Pharmacy directly *(For Contact Information, see Policy No. 23-1)*.

Policy No. & Issue **17-7 Health Care Provider Errors**
Policy Source **MAP Policy Manual**

1) Actions of a Health Care Provider (i.e., Authorized Prescriber) that lead to a medication occurrence do not require reporting via a MAP Medication Occurrence Report (*MOR Form*) provided that Certified/licensed staff could not have discovered or prevented the error.

2) If there are any questions about the reporting of Health Care Provider errors, contact the applicable Board of Registration directly *(For Contact Information, see Policy No. 23-1)*.

18

ANCILLARY PRACTICES BY CERTIFIED STAFF

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

Policy No. & Issue **18-1 Vital Signs Monitoring Related to Medication Administration by Certified Staff**
Policy Source **MAP Policy Manual**

1) To ensure safe medication administration, some medications ordered by the Health Care Provider (HCP) may require 'Vital Signs Monitoring'.
   a) In order to administer medications that require 'Vital Signs Monitoring', Certified staff must be proficient in this skill.
2) Service Providers must have a 'Vital Signs Policy' that includes, procedures for Certified staff to follow for attaining and adhering to guidance from the individual's HCP(s) regarding the requisite for 'Vital Signs Monitoring' in relation to medication administration. The procedures must ensure that:
   a) Certified staff are appropriately trained;
   b) Certified staff obtain direction from the HCP that clearly states whether Vital Signs are/are not required for medication administration.
      i) This may be achieved by adding a statement to the HCP Order Form (e.g., 'Please indicate if Vital Signs are required for the administration of this medication').
         (1) If Vital Signs Monitoring is required, specific written Vital Signs 'Parameters' must be obtained from the HCP.
   c) instructions are attained from the HCP for any required follow-up (e.g., when Vital Signs are outside of the established parameters; when there is a failure to obtain Vital Signs; etc.); and
   d) documentation is completed for the:
      i) Vital Sign(s) obtained;
      ii) HCP notification;
      iii) follow-up orders received; and
      iv) instructions followed.
3) Documentation of the Vital Signs should be positioned on the Medication Administration Record (MAR) in close proximity (e.g., above, below, or electronically 'linked' to the medication on the MAR) to the medication that requires 'Vital Signs Monitoring';
4) Only Certified staff that are trained and proficient in 'Vital Signs Monitoring' are permitted to administer medications that require Vital Signs being obtained.
   a) Documentation of the 'Vital Signs Training' (with demonstrated proficiency) is to be maintained at the MAP Registered site.
      i) It is recommended that Certified staff who demonstrated proficiency during their 'Vital Signs Training', but are not responsible for 'Vital Signs Monitoring' on a regular basis, be provided with a periodic review.

5) ‘Vital Signs Training’ for Certified staff should be conducted by a Health Care Provider, Licensed Nurse (i.e., Registered Nurse or Licensed Practical Nurse), Pharmacist, Paramedic or Emergency Medical Technician.

   a) ‘Vital Signs Training’ must include, but is not limited to, how to:
      i) take Vital Signs including ‘hands on’ use of the specific equipment (e.g., blood pressure monitor, stethoscope, thermometer, etc.) that will be used to obtain the individual’s Vital Signs;
         (1) An ‘in-person demonstration’ must be completed by the Trainer and a ‘return demonstration’ completed by the Certified staff.
      ii) document Vital Signs, including the date and time Vital Signs were taken;
      iii) recognize ‘parameters’ (e.g., when to hold or administer a medication based on the instructions included in the HCP Order);
      iv) interpret HCP reporting requirements; and
      v) document reporting and follow-up instructions.
   b) Documentation of ‘Vital Signs Training’ must include, but is not limited to:
      i) name and contact information of the Trainer(s);
      ii) date of the training;
      iii) a complete set of training materials used to train Certified staff including:
         (1) a list of the equipment (e.g., blood pressure monitor, stethoscope, thermometer, etc.) used to train Certified staff to monitor Vital Signs.
            (a) The manufacturer’s instructions for how to operate the specific equipment used should be readily available at the MAP Registered site.
      iv) name(s) of Certified staff trained (i.e., attendance list); and
      v) completed Competency Evaluation documents for each Certified staff.
         (1) Trainers may use the sample *Competency Evaluation Tool for Vital Signs.*

Competency Evaluation Tool for Vital Signs Training

CLICK HERE TO ACCESS THE SAMPLE *Competency Evaluation Tool for Vital Signs Training* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

Policy No. & Issue **18-2 Blood Glucose Monitoring by Certified Staff**
Policy Source **1998 DMH Letter**

1) To ensure safe medication administration, some health conditions and medications ordered by the Health Care Provider (HCP) may require Blood Glucose (i.e., blood sugar) Monitoring*.
   a) When Blood Glucose Monitoring (BGM) is required relative to a prescribed 'oral' medication or for checking a 'disease stable health condition', Certified staff who are responsible for testing the individual's blood glucose level, must be proficient in this skill.

2) When an individual has an HCP Order for BGM, Service Providers must have a Blood Glucose Monitoring Policy that includes procedures for Certified staff to follow for attaining and adhering to guidance from the individual's HCP(s) regarding the requisite for BGM. The procedures must ensure that:
   a) Certified staff are appropriately trained;
   b) Certified staff obtain direction from the HCP that clearly states whether BGM is required;
      i) If BGM is required, specific written Blood Glucose 'Parameters' must also be obtained from the HCP.
         (1) This may be achieved by adding a statement to the HCP Consult/Order Form (e.g., 'Please include both upper and lower blood glucose level parameters').
   c) instructions are obtained from the HCP for any required follow-up (e.g., when blood glucose levels are outside of the established parameters, when there is a failure to obtain blood glucose levels, etc.); and
   d) documentation is completed for the:
      i) blood glucose levels obtained;
      ii) HCP notification;
      iii) follow-up HCP Orders received; and
      iv) instructions followed.

3) BGM may be performed at the MAP Registered site provided there is an HCP Order and/or Protocol regarding the individual's need for the monitoring of the blood glucose. The HCP Order and/or Protocol should include, but is not limited to:
   a) all required components of a valid HCP Order (*See Policy No. 08-1*);
   b) the specific medical condition or diagnosis that is the indication for the BGM; and
   c) instructions for follow-up with the HCP when blood glucose levels are outside of the established parameters.

* NOTE: Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of individual's test results regardless of where the test was performed. Service Providers are advised to contact the state CLIA program for assistance in obtaining a CLIA Certificate of Waiver, as applicable. The Clinical Laboratory Program contact information is available through the Massachusetts portal (*For Contact Information, see* Policy No. 23-1).

4) Certified staff, including relief staff, may perform 'finger-stick' blood glucose level testing using a blood glucose meter (e.g., Accu-Chek, One Touch Ultra, etc.) for an individual relative to a prescribed 'oral' medication or for checking a 'disease stable health condition' in accordance with a valid HCP Order and/or Protocol, provided the Certified staff successfully:

   a) completes a 'General Knowledge' BGM Training;
   b) completes an 'Individual-Specific' (e.g., blood glucose level testing protocols, instructions for use of the individual's glucometer, etc.) BGM Training;
   c) demonstrates proficiency in the skill of blood glucose level testing;
   d) performs the BGM in accordance with the individual's HCP Order; and
   e) follows the blood glucose meter (i.e., glucometer) manufacturer's requirements for the performing of the blood glucose level testing.

5) Only Certified staff that are trained and proficient in BGM may obtain a blood glucose level.

   a) Documentation of the Blood Glucose Monitoring Training (with demonstrated proficiency) must be maintained at the MAP Registered site.
      i) It is recommended that Certified staff who have demonstrated proficiency during their Blood Glucose Monitoring Training but are not responsible for BGM on a regular basis, be provided with a periodic review.

6) Training for Certified staff must be conducted by a Health Care Provider, Pharmacist, or Licensed Nurse (i.e., Registered Nurse or Licensed Practical Nurse) and should include both 'General Knowledge' and 'Individual-Specific' BGM Training.

   a) 'General Knowledge' BGM Training must include, but is not limited to:
      i) overview of BGM;
      ii) rationale for BGM;
      iii) signs and symptoms of a high blood glucose and a low blood glucose;
      iv) safe BGM procedures;
      v) importance of gloves, clean technique and proper hand hygiene;
      vi) proper disposal of used lancing devices (lancets); and
      vii) overview of storage requirements.
   b) 'Individual-Specific' BGM Training must include, but is not limited to:
      i) review of the individual's HCP Order and/or Protocol for BGM;
         (1) Any change in the HCP Order for BGM requires a review.
      ii) reason given by the HCP for the BGM when ordered for the individual;
      iii) emergency procedures/guidelines (e.g., calling 911, notification of the individual's HCP, etc.) to follow, when warranted;
      iv) overview of the individual's specific equipment (e.g., blood glucose meter, lancing device, test strips, etc.);
      v) demonstration of the correct technique for BGM by the Trainer with a return demonstration by staff;
      vi) how to obtain and care for the individual's specific equipment; and
      vii) an understanding of the manufacturer's requirements for the performing of the test.

c) Training and competency must be appropriately documented and maintained at the MAP Registered site.
   i) Documentation of Blood Glucose Training must include, but is not limited to:
      (1) name and contact information of the Trainer(s);
      (2) a complete set of training materials used to train Certified staff including:
         (a) a list of the equipment (e.g., blood glucose meter, lancing device, test strips, etc.) used to train Certified staff to monitor blood glucose.
            (i) The manufacturer's instructions for how to operate the specific equipment used should be readily available at the MAP Registered site.
      (3) date of the 'General Knowledge' training and names of Certified staff trained (i.e., attendance list); and
         (a) Trainers may use the optional *Competency Evaluation Tool for 'General Knowledge' of Blood Glucose Monitoring.*
      (4) date of the 'Individual-Specific' training and names of Certified staff trained (i.e., attendance list).
         (a) Trainers may use the optional *Competency Evaluation Tool for 'Individual-Specific' Blood Glucose Monitoring*.

Competency Evaluation Tools for Blood Glucose Monitoring

CLICK HERE TO ACCESS THE OPTIONAL *Competency Evaluation Tool for 'General Knowledge' of Blood Glucose Monitoring* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE OPTIONAL *Competency Evaluation Tool for 'Individual-Specific' Blood Glucose Monitoring* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

19
SPECIALIZED TRAINING RELATED TO MEDICATION

Policy No. & Issue **19-1 Specialized Training Programs**
Policy Source **MAP Training Policy**

1) To ensure safe medication administration, DPH and the State Agencies require that Certified staff successfully complete an approved Specialized Training Program prior to administering:
   a) Oxygen;
   b) Epinephrine via Auto-injector Device;
   c) High- Alert Warfarin sodium;
   d) High-Alert Clozapine;
   e) any High-Alert Medication requiring additional monitoring of an individual;
   f) any medication(s) via a Gastrostomy (G) or Jejunostomy (J) Tube;
   g) High-Alert Insulin via Insulin Pen; and
   h) Schedule VI Injectable Medication.

2) Specialized Trainings include, but are not limited to:
   a) Oxygen (*See Policy No. 19-2*);
   b) Epinephrine via Auto-Injector Device (*See Policy No. 19-3*);
   c) Medication Administration via a Gastrostomy (G) Tube or a Jejunostomy (J) Tube (*See Policy No. 19-4 and Policy No. 19-5*);
   d) High-Alert Medication(s) Requiring Additional Monitoring of an Individual (*See Policy No. 19-6*);
   e) High-Alert Medication-Warfarin sodium (Coumadin), (*See Policy No. 19-7*);
   f) High-Alert Medication-Clozapine (Clozaril), (*See Policy No. 19-8*);
   g) High-Alert Insulin via Insulin Pen Therapy, (*See Policy No. 19-9); and*
   h) Schedule VI Injectable Medication, (*See Policy No. 19-10).*

3) All Trainers providing Specialized Training for Certified staff must be 'Qualified Trainers'.
   a) Criteria for Trainer qualifications are identified in each specific Specialized Training Policy.

4) All Trainers must use the required Specialized Training documents.
   a) No deviation from the required Specialized Training documents is permitted.

Policy No. & Issue **19-2 Oxygen Therapy**
Policy Source **MAP Policy Manual**

1) Oxygen is a medication and all MAP Regulations and Policies apply when Oxygen is administered. This applies to all methods of delivery including Oxygen cylinders and Oxygen concentrators.
   a) Oxygen Therapy is the administration of Oxygen at concentrations greater than that of room air.
   b) Oxygen is used to treat or prevent hypoxemia (not enough Oxygen in the blood).

2) When an individual has a Health Care Provider (HCP) Order for Oxygen, the Service Provider must have an Oxygen Policy that includes procedures for Certified staff to follow. The procedures must include, but are not limited to:
   a) administrative procedures to be followed when there is a medical emergency related to the administration of Oxygen;
      i) The Oxygen Policy can reference the Service Provider's overall Policy that specifies the administrative procedures to be followed when there is a medical emergency relating to a medication (if the Policy would be applicable when there is a medical emergency related to Oxygen).
   b) safe administration of Oxygen procedures, including:
      i) the correct practice for proper Oxygen administration;
      ii) clean technique, proper hand hygiene, and additional Personal Protective Equipment (if indicated);
      iii) accurate use of pulse oximeter (if Oxygen Saturation Monitoring is ordered by the HCP);
      iv) safe Oxygen handling procedures; and
         (1) The Service Provider may contact the Oxygen Supply Company for guidance on safe oxygen handling and storage practices.
      v) processes for communicating changes in Oxygen HCP Orders to Certified/licensed staff, including documenting changes in the Individual's Record.
   c) Certified staff are appropriately trained.
      i) The Service Provider for the MAP Registered site must ensure that any individual who has an HCP Order requiring the administration of Oxygen, or the assistance with the administration of Oxygen, has trained Certified/licensed staff on-site during timelines when Oxygen is to be administered, including as needed (PRN) administration.

3) Certified staff, including relief staff, may administer Oxygen at the MAP Registered site provided there is an HCP Order and/or Protocol regarding the individual's requirement for Oxygen. The HCP Order and/or Protocol should include, but is not limited to:
   a) all required components of a valid HCP Order (*See Policy No. 08-1*);
      i) Any change in the HCP Order for supplemental Oxygen administration requires a review.
   b) the specific medical condition or diagnosis that is the indication for Oxygen;
   c) parameters and instructions for administration, including instructions for follow-up with the HCP when Oxygen needs are outside of the established parameters;
   d) 'Individual-Specific' adverse effects; and
   e) when to call 911 and/or the HCP.

4) As a prerequisite to administering Oxygen, Certified staff, including relief staff, must successfully complete 'Vital Signs Training' and then demonstrate proficiency on a regular basis (*See Policy No. 18-1*).

5) Certified staff, including relief staff, may administer Oxygen in accordance with a valid HCP Order and/or Protocol, provided the Certified staff successfully:

   a) completes a '*General Knowledge' Oxygen Therapy Training;*
   b) completes an '*Individual-Specific' Oxygen Therapy Training* (e.g., Oxygen delivery device, instructions for use of a pulse oximeter, etc.);
   c) demonstrates proficiency in the skill of administering Oxygen; and
   d) performs the administration of Oxygen in accordance with the individual's HCP Order and/or Protocol.

6) Training for Certified staff in Oxygen Therapy may be conducted by a Health Care Provider, Licensed Nurse (i.e., Registered Nurse or Licensed Practical Nurse), or Respiratory Therapist, provided the Trainer has demonstrated initial and continued competency of the knowledge of safe administration of Oxygen.

   a) The Training may also be conducted by a Trainer from the Oxygen Supply Company.

7) Certified staff, who have not administered Oxygen in the previous twelve (12) months, or who have not demonstrated an understanding of safe Oxygen administration, must repeat Oxygen Therapy Training to include both 'General Knowledge' and 'Individual-Specific' Oxygen Therapy Training.

   a) Subsequent Retraining for Oxygen Therapy may be conducted by a Health Care Provider, Licensed Nurse (i.e., Registered Nurse or Licensed Practical Nurse), or Respiratory Therapist.
      i) A Trainer from the Oxygen Supply Company or a Respiratory Therapist Assistant, who is able to demonstrate initial and continued competence of safe Oxygen administration, may provide subsequent retraining.

8) Training for Certified staff should include both '*General Knowledge' Oxygen Therapy Training* and '*Individual-Specific' Oxygen Therapy Training*.

   a) When supporting more than one individual receiving Oxygen, Certified staff, who have previously completed the '*General Knowledge' Oxygen Therapy Training* are only required to receive the '*Individual-Specific' Oxygen Therapy Training(s)* when:
      i) the Certified staff has completed the '*General Knowledge' Oxygen Therapy Training* within the previous twelve (12) months; and
      ii) have demonstrated an understanding of safe Oxygen administration.

9) '*General Knowledge' Oxygen Therapy Training* must include, but is not limited to:

   a) overview of Oxygen Therapy;
   b) rationale for supplemental Oxygen administration;
   c) signs and symptoms of inadequate oxygenation;
   d) importance of Oxygen safety;
   e) safe Oxygen handling and storage procedures;
   f) adverse effects of Oxygen Therapy;
   g) importance of clean technique and proper hand hygiene;
   h) overview of the components of the Oxygen delivery system, including the Oxygen delivery source (e.g., Oxygen concentrator, etc.), Oxygen delivery equipment (e.g., pressure regulator, gauge, flow meter, etc.) and the delivery device (e.g., nasal cannula, etc.); and

i) use of a pulse oximeter (when Oxygen Saturation Monitoring is ordered by the HCP).

10) *'Individual-Specific' Oxygen Therapy Training* must include, but is not limited to:

   a) a review of the individual's HCP Orders and/or Protocol, and rationale for Oxygen administration;
      i) Any change, in the HCP Order and/or Protocol for supplemental Oxygen administration, requires a review.
   b) 'Individual-Specific' adverse effects of Oxygen Therapy;
   c) observation of Trainer demonstrated safe administration of Oxygen Therapy;
   d) return demonstration of safe administration of Oxygen Therapy;
   e) care of the individual's specific Oxygen equipment;
   f) identification of power source and back-up power source for the individual's specific equipment;
   g) contact information for the Oxygen Supply Company;
   h) contact information for the individual's HCP; and
   i) emergency procedures to follow including but not limited to calling 911 and notification of the individual's HCP.

11) Certified staff Training and Competency in Oxygen Therapy must be documented and maintained at the MAP Registered site.

   a) Documentation of Oxygen Therapy Trainings must include, but is not limited to:
      i) name and contact information of the Trainer(s);
      ii) a complete set of training materials used to train Certified staff ;
      iii) date of '*General Knowledge' Oxygen Therapy Training* and names of Certified staff trained (i.e., attendance list); and
         (1) Trainers may use the optional *Competency Evaluation Tool for 'General Knowledge' Oxygen Therapy* form.
      iv) date of '*Individual-Specific' Oxygen Therapy Training* and names of Certified staff trained (i.e., attendance list).
         (1) Trainers may use the optional *Competency Evaluation Tool for 'Individual-Specific' Oxygen Therapy* form.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

Competency Evaluation Tools for Oxygen Therapy

CLICK HERE TO ACCESS THE OPTIONAL *Competency Evaluation Tool for 'General Knowledge' of Oxygen Therapy* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE OPTIONAL *Competency Evaluation Tool for 'Individual-Specific' Oxygen Therapy* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE OPTIONAL *Oxygen Therapy Protocol* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

Policy No. & Issue **19-3 Epinephrine Administration via Auto-Injector Device(s)**
Policy Source **MAP Policy Manual**

1) Epinephrine is a Schedule VI controlled substance (medication) and all MAP Regulations and Policies apply when Epinephrine is administered.

2) When an individual has a Health Care Provider (HCP) Order and/or Protocol to administer Epinephrine via an auto-injector device, the Service Provider must have an 'Epinephrine via Auto-Injector Device Policy' that includes procedures for Certified staff to follow. The procedures must include, but are not limited to:
   a) administrative procedures to be followed when there is a medical emergency related to the administration of Epinephrine;
      i) The 'Epinephrine via Auto-Injector Device Policy' can reference the Service Provider's overall Policy that specifies the administrative procedures to be followed when there is a medical emergency relating to a medication (if the Policy would be applicable when there is a medical emergency related to Epinephrine).
   b) safe administration of Epinephrine procedures, including how to:
      i) safely administer Epinephrine;
      ii) safely transport Epinephrine;
      iii) safely dispose of Epinephrine;
      iv) routinely check the expiration date of Epinephrine; and
      v) communicate any changes in the individual's HCP Epinephrine Order and/or Protocol and/or the prescribed Epinephrine auto-injector device with all Certified/licensed staff and how to document the changes in the Individual's Record.
         (1) If there is a change in the type of prescribed auto-injector device for Epinephrine, a Training for Certified staff must be completed by a qualified Trainer.
            (a) The *Auto-Injector Device for Epinephrine Training* must be done prior to the Certified staff administering Epinephrine via the newly prescribed auto-injector device.
   c) Certified staff are appropriately trained.
      i) The Service Provider for the MAP Registered site must ensure that any individual who has an HCP Order and/or Protocol requiring the administration of Epinephrine via an auto-injector device has a licensed nurse and/or trained Certified staff on-site during timelines when the Epinephrine may need to be administered (PRN).

3) When an individual has an HCP Order and/or Protocol to administer Epinephrine via an auto-injector device, the MAP Registered site must ensure that a licensed nurse or a trained Certified staff is available for PRN (i.e., as needed) Epinephrine administration.

4) Certified staff, including relief staff, may administer Epinephrine via an auto-injector device, provided there is an HCP Order and/or Protocol regarding the individual's requirement for Epinephrine. The HCP Order and/or Protocol should include, but is not limited to:
   a) all required components of a valid HCP Order (*See Policy No. 08-1*);
      i) Any change in the HCP Order and/or Protocol for Epinephrine requires a review.
   b) the specific medical condition or diagnosis that is the indication for Epinephrine;
   c) the specific allergen(s) requiring the need for Epinephrine;
   d) 'individual-specific' adverse effects to observe for; and
   e) when to call 911 and/or the HCP.

5) As a prerequisite for administering Epinephrine, Certified staff, including relief staff, must have a current CPR certification, current First Aid certification and have successfully completed Vital Signs Training with demonstrated proficiency on a regular basis (*See Policy No. 18-1*).

6) Certified staff, including relief staff, may administer Epinephrine in accordance with a valid HCP Order and/or Protocol, provided the Certified staff successfully:

   a) completes an annual '*General Knowledge' Epinephrine via Auto-Injector Device Training*;
      i) A 'repeat training' is required when the Certified staff has not demonstrated an understanding of safe Epinephrine administration.
   b) completes an annual 'Individual-Specific' *Epinephrine via Auto-Injector Device Training* including an *Epinephrine via Auto-Injector Device 'Return-Demonstration'*;
      i) The Certified staff must complete an individualized training, specific to 'each individual' that the staff supports, who has an HCP Order and/or Protocol for Epinephrine.
         (1) When supporting more than one individual with an HCP Order and/or Protocol for Epinephrine via an auto-injector device, Certified staff, are required to only complete the '*General Knowledge' Epinephrine via Auto-Injector Device Training* 'once' on an annual basis provided:.
            (a) the Certified staff has successfully completed the 'General *Knowledge' Epinephrine via Auto-Injector Device Training* within the previous twelve (12) months; and
            (b) they have demonstrated an understanding of safe Epinephrine administration.
      ii) 'Repeat training' is required when the Certified staff has not demonstrated an understanding of safe Epinephrine administration.
      iii) Supplemental training is required when:
         (1) there is any change in the HCP Order and/or Protocol; or
         (2) there is a change in the type of prescribed auto-injector device.
            (a) The supplemental training must be done prior to the Certified staff administering the Epinephrine (via the newly prescribed pre-filled auto-injector device).
   c) demonstrates proficiency in the skill of administering Epinephrine; and
   d) performs the administration of Epinephrine in accordance with the individual's HCP Order and/or Protocol.

7) Annual Epinephrine Training for Certified staff, including relief staff, must be conducted by a Health Care Provider, Registered Nurse, Registered Pharmacist, Physician Assistant, Paramedic, or Emergency Medical Technician, provided the Trainer has demonstrated initial and continued competency in the knowledge of safe administration of Epinephrine.

   a) A Licensed Practical Nurse (LPN), who is able to demonstrate initial and continued competence in the knowledge of safe administration of Epinephrine, may provide 'subsequent' Epinephrine Trainings.

8) The required annual '*General Knowledge' Epinephrine via Auto-Injector Device Training* must include, but is not limited to:

   a) overview of Epinephrine;
   b) overview of storage requirements;
   c) purpose of the administration of Epinephrine;
   d) overview of anaphylactic reaction and recognition of symptoms of severe allergic reaction;
   e) what to do in case of accidental injection to a person;
   f) emergency procedure guidelines;
   g) system for regularly checking the expiration date;
   h) system for replacing the pre-filled auto-injector device just prior to its expiration; and

i) acceptable disposal procedures.

9) The required annual '*Individual-Specific' Epinephrine via Auto-Injector Device Training* including an *Epinephrine via Auto-Injector Device 'Return-Demonstration'* must include, but is not limited to, a review of:

a) the individual's Epinephrine HCP Order and/or Protocol;
b) the individual's specific allergen(s) requiring Epinephrine administration;
c) procedures to reduce the risk of an allergen(s) exposure;
d) how to recognize the signs and symptoms of the individual's allergic response;
e) when to contact the HCP;
f) 'Individual-Specific' adverse effects of Epinephrine (if any);
g) emergency procedures, including calling 911;
h) the system for regularly checking the expiration date of the individual's Epinephrine;
i) the system for ensuring replacement of the individual's Epinephrine auto-injector device just prior to it becoming outdated;
j) auto-injector device-specific disposal procedures; and
k) how to administer the Epinephrine using the currently prescribed auto-injector device.
    i) The Certified staff must:
        (1) observe the Trainer demonstrate a mock Epinephrine administration via auto-injector 'TRAINER'(i.e., 'practice injector' that contains no active drug or needle); and
        (2) be observed by the Trainer, successfully completing a mock (via auto-injector 'TRAINER') return-demonstration of Epinephrine administration.
            (a) Demonstration of Epinephrine administration using the auto-injector 'TRAINER' by the Certified staff may be done as many times as is necessary to ensure competency.

10) Certified staff Training and Competency in Epinephrine via Auto-Injector Device documentation must be maintained at the MAP Registered site.

a) Required documentation of the Epinephrine via Auto-Injector Training must include, but is not limited to:
    i) name and contact information of the Trainer(s);
    ii) a complete set of training materials used to train Certified staff;
    iii) date of '*General Knowledge' Epinephrine via Auto-Injector Device Training* and names of Certified staff trained (i.e., attendance list); and
        (1) Trainers must use the required Competency Evaluation Tool form.
            (a) Use of the standardized *Competency Evaluation Tool for 'General Knowledge' of Epinephrine Administration via Auto-Injector Device* form is required *(See Policy Section 19 for Competency Tool).*
    iv) date of *'Individual-Specific' Epinephrine via Auto-Injector Device Training* and names of Certified staff trained (i.e., attendance list).
        (1) Trainers must use the required Competency Evaluation Tool forms.
            (a) Use of the standardized *Competency Evaluation Tool for 'Individual-Specific' Epinephrine via Auto-Injector Device* form and the *Competency Evaluation Tool for Epinephrine via Auto-Injector Device Return-Demonstration* form are required *(See Policy Section 19 for Competency Tools).*

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Competency Evaluation Tools for Epinephrine Administration via Auto-Injector Device

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CLICK HERE TO ACCESS THE REQUIRED *Competency Evaluation Tool for 'General Knowledge' of Epinephrine Administration via Auto-Injector Device* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE REQUIRED *Competency Evaluation Tool for Epinephrine via Auto-Injector Device 'Return Demonstration'* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE REQUIRED *Competency Evaluation Tool for 'Individual-Specific' Epinephrine via Auto Injector Device* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

Epinephrine Auto-Injector Disposal Guidelines

1) For *'Used Epinephrine Auto-Injectors'* (i.e., Epinephrine Auto-Injectors that have been used and contain only Epinephrine residue):

   a) MAP Registered sites should dispose of used Epinephrine Auto-Injectors in a 'Sharps Container'.

2) For *'Unused/Expired Epinephrine Auto-Injectors'* (i.e., Epinephrine Auto-Injectors that have not had its contents administered or the Epinephrine has expired):

   a) MAP Registered sites should check with the supplier or manufacturer of the Epinephrine Auto-Injector (that was dispensed from the pharmacy for the individual) to verify the proper classification of its active ingredient. The active ingredient will impact the disposal requirements for unused or expired Epinephrine Auto-Injectors.
   b) Epinephrine is listed as 'acutely hazardous waste' (PO42) under the Massachusetts Hazardous Waste Regulations (310 CMR 30.136). However, Epinephrine Hydrochloride is not considered part of the (PO42) Hazard listing.
      i) If the active ingredient is:
         (1) *Epinephrine salt* (Epinephrine Hydrochloride): It is not a component of the hazardous waste listing.
         (2) *Epinephrine base*: It is a component of the hazardous waste listing.
   c) Certified/licensed staff should dispose of unused/expired Epinephrine Auto-Injectors as follows:
      i) If the active ingredient is *Epinephrine salt*:
         (1) Two Certified/licensed staff (of which one of the two is supervisory) should dispose of the Epinephrine Auto-Injector in a rigid plastic 'Sharps Container'.
            (a) The unused Epinephrine Auto-Injector should be disposed of in its intact original syringe (Epinephrine medication still within it).
               (i) The contents (Epinephrine medication) should not be squeezed/squirted out of the syringe.
         (2) The two staff that disposed of the Epinephrine Auto-Injector must document the disposal on the '*Controlled Substance Disposal Record'* form'.
      ii) If the active ingredient is *Epinephrine base*:
         (1) Two Certified/licensed staff (of which one of the two is supervisory) should dispose of the Epinephrine Auto-Injector in a rigid plastic container marked 'Hazardous Waste' and labeled 'Expired Epinephrine Auto-Injectors for Disposal'.
            (a) When not in use, the rigid plastic container should be kept closed with a tight fitting cover.
            (b) The unused Epinephrine Auto-Injector should be disposed of in its intact original syringe (Epinephrine medication still within it).
               (i) The contents (Epinephrine medication) should not be squeezed/squirted out of the syringe.
            (c) The hazardous waste container may only be opened when disposing of a hazardous waste material (e.g., Auto-Injector filled with Epinephrine salt).
         (2) The two staff that disposed of the Epinephrine Auto-Injector must document the disposal on the '*Controlled Substance Disposal Record'* form*'*.
         (3) The MAP Registered site should keep the 'Expired Epinephrine Auto-Injectors for Disposal' hazardous waste container in a secure area until it can be disposed of at a 'Household Hazardous Waste Collection Event' or a 'Household Hazardous Waste Collection Center'.

Policy No. & Issue **19-4 Administration Via Gastrostomy (G) or Jejunostomy (J) Tube Route**
Policy Source **MAP Policy Manual**

1) The Service Provider must identify each individual, supported at the MAP Registered site, who has a Gastrostomy (G) or Jejunostomy (J) Tube. For each individual identified, the Service Provider must:
   a) complete the *Gastrostomy (G) or Jejunostomy (J) Tube Management Form* (*See Policy Section 19*);
      i) The Service Provider must also complete and include an evaluation of the staffing pattern at the individual's residence (i.e., MAP Registered site) to ensure adequate staffing.
   b) file and maintain the completed and signed *Gastrostomy (G) or Jejunostomy (J) Tube Management Form* in the Individual's Record; and
   c) identify a licensed professional (e.g., Health Care Provider, Visiting Nurse, Service Provider licensed nurse, etc.) who is responsible for the clinical oversight of the G or J Tube.

2) Each individual, supported at the MAP Registered site, who has a G or J Tube, should be recurrently assessed and evaluated by the licensed professional (e.g., Health Care Provider, Visiting Nurse, Service Provider licensed nurse, etc.) responsible for the clinical oversight of the G or J Tube. The evaluation and assessment should:
   a) include, but is not limited to; an assessment of the:
      i) integrity of the skin/stoma site;
      ii) tube placement; and
      iii) weight management.
   b) be done at clinically appropriate intervals as determined by the Health Care Provider, but no less than once every three (3) months; and
   c) ensure the findings are documented and filed in the Individual's Record.
      i) Any concerns assessed should be reported to the Health Care Provider.

3) 'Nutritional' Supplements (e.g., Ensure) are considered food items and are not under the jurisdiction of the Medication Administration Program (MAP).
   a) *Policy Section 19* includes Competency Tools for Bolus and Continuous feedings. As Nutritional Supplements are not under the jurisdiction of MAP, these Tools are 'Optional' and are provided exclusively for the select use of the Service Provider.

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Gastrostomy (G) or Jejunostomy (J) Tube Management Form

CLICK HERE TO ACCESS THE REQUIRED *Gastrostomy (G) or Jejunostomy (J) Tube Management Form* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

Policy No. & Issue **19-5 Medication Administration and Water Flushes via Gastrostomy (G) or Jejunostomy (J) Tubes**
Policy Source **MAP Policy Manual**

1) The Service Provider may elect to have proficient (i.e., experienced in the process of medication administration via the oral route) Certified staff (including proficient relief staff) be trained to administer medication and water flushes via a Gastrostomy (G) or Jejunostomy (J) Tube, provided:
   a) the individual is deemed 'stable and clinically appropriate' by the Health Care Provider (HCP) (*See Policy No. 19-4*);
      i) There must be documentation from the HCP specifically indicating that it is appropriate for non-licensed Certified staff to administer medication, to the intended individual, via the G or J Tube route.
         (1) Any change in the individual's health status requires a re-evaluation by the HCP to determine if it is still prudent for Certified staff to administer medication to the intended individual via the G or J Tube route.
   b) there is an HCP Order and/or Protocol for medication and water flushes to be administered to the individual via the G or J Tube route, including but not limited to:
      i) all required components of a valid HCP Order, including the route of medication administration (*See Policy No. 08-1);*
         (1) Changes in medication orders (that are administered via the G or J Tube route) must be reviewed by the licensed professional responsible for clinical oversight of the G or J Tube prior to the Trained Certified staff being permitted to administer the medication.
            (i) Additional training is to be provided, as applicable.
      ii) the specific medical condition or diagnosis that is the indication for the G or J Tube;
      iii) when to call 911 and/or the HCP; and
      iv) instructions for necessary follow-up (e.g., issues with the G or J Tube, integrity of skin/stoma site, etc.) with the HCP.
         (1) Each time the HCP is contacted regarding the G or J Tube, documentation (of the contact and recommendations given by the HCP) must be completed.

2) When an individual has a Health Care Provider (HCP) Order and/or Protocol for medications to be administered via the G or J Tube route, the Service Provider must have a 'Medication Administration via Gastrostomy (G) or Jejunostomy (J) Tube Policy' that includes procedures for Certified staff to follow. The procedures must include, but are not limited to:
   a) administrative procedures to be followed when there is a medical emergency related to the administration of medication via the G or J Tube route; and
      i) The 'Medication Administration via Gastrostomy (G) or Jejunostomy (J) Tube Policy' can reference the Service Provider's overall Policy that specifies the administrative procedures to be followed when there is a medical emergency relating to a medication (if the Policy would be applicable when there is a medical emergency related to medication administration via the G or J Tube route).

b) safe administration of a medication via the G or J Tube route, including who (i.e., licensed nurses and/or trained Certified staff) will be assigned the task of medication administration via the G or J Tube route.
   i) When Certified staff, including relief staff, will be responsible for medication administration via the G or J Tube route, they must be trained and proficient in the skill.

3) As a prerequisite for administering medication via the G or J Tube route, Certified staff, including relief staff, must have a current CPR certification, current First Aid certification, and have successfully completed Vital Signs Training with demonstrated proficiency on a regular basis (*See Policy No. 18-1).*

4) Certified staff, including relief staff, may administer medication via the G or J Tube route, in accordance with a valid HCP Order and/or Protocol, provided the Certified staff successfully:
   a) completes a '*General Knowledge' Medication Administration via the G or J Tube Route Training;*
   b) completes an '*Individual-Specific' Medication Administration via the G or J Tube Route Training;*
   c) demonstrates proficiency in the skill of administering medication via the G or J Tube route;
   d) performs the administration of medication via the G or J Tube route, in accordance with the individual's HCP Order; and
   e) demonstrates competency (observed by the Trainer) of medication administration via the individual's G or J Tube on a biennial basis.
      i) The demonstrated competency must be completed at least biennially (i.e., every two (2) years) or if the health status of the individual changes in such a manner that the Registered Nurse (RN) and/or HCP deems it necessary.
         (1) The demonstrated competency must be performed on the 'intended individual' and not as a mock demonstration.
         (2) For tracking purposes, it is recommended that the biennial demonstrated competency be completed following the Certified staff being Recertified (*See Policy Section 05).*

5) *Medication Administration and Water Flushes via the Gastrostomy (G) or Jejunostomy (J) Tube Route Training* for Certified staff, including relief staff, must be conducted by a Health Care Provider (HCP) or a Registered Nurse (RN).

   a) Certified staff, who have successfully completed *Medication Administration and Water Flushes via the Gastrostomy (G) or Jejunostomy (J) Tube Route Training,* but have not administered medications to the intended individual for six (6) months or more; must complete a Competency Review with an HCP or RN before administering medications to the intended individual.

6) 'General Knowledge' Training in Medication Administration and Water Flushes via the Gastrostomy (G) or Jejunostomy (J) Tube Route must include, but is not limited to:
   a) overview of how G or J Tube medication administration relates to MAP;
   b) knowing that only licensed nurses and trained proficient Certified staff may administer medication via the G or J Tube route;
   c) awareness that if a previously trained Certified staff does not administer medication to the intended individual via the G or J Tube route for a time period of six (6) months or more, a demonstrated competency retraining is required;
   d) hand hygiene and clean technique;
   e) purpose of a G or J Tube;
   f) various kinds of G or J Tubes;

g) maintenance of a G or J Tube;
h) methods of G or J Tube feedings;
i) importance of water flushes;
j) overview of problems associated with a G or J Tube, including who to notify if the G or J Tube becomes dislodged or clogged;
k) overview of untoward effects (e.g., diarrhea, respiratory difficulty, vomiting, etc.) the individual could experience; including who to notify, if observed;
l) overview of the management of the stoma site; including who to notify, if redness, drainage, or other untoward concern is noted;
m) how to prepare different forms/formulations/types of medication prior to administering a medication via the G or J Tube route;
n) safe management and storage of formula and equipment; and
o) what to do if the feeding pump sounds an alarm, including:
    i) if the feeding is completed; or
    ii) who to notify if the feeding is not completed.

7) 'Individual-Specific' Training in Medication Administration and Water Flushes via the intended individual's Gastrostomy (G) or Jejunostomy (J) Tube must include, but is not limited to:

a) the reason the intended individual has a G or J Tube;
b) review of the individual's HCP Orders and/or Protocol for prescribed medications, water flush order(s), nutritional supplement, etc.;
c) how to obtain and care for the individual's equipment (e.g., feeding pump, tubing, syringe, etc.);
d) overview of the workings of the individual's equipment (e.g., feeding pump, tubing, syringe, etc.);
e) reuse of equipment, as applicable;
f) positioning of the individual when receiving water flushes, medication, and nutritional supplement;
g) checking for placement (e.g., measuring tape),(if included in the HCP Order and/or Protocol);
h) the 'hang-time' (i.e., how long the opened container of formula may remain at room temperature) for the individual's specific nutritional supplement or feeding system (e.g., 'closed' feeding system or 'open' feeding system);
i) demonstration (by the Trainer) of the correct technique of medication administration and a water flush administration, followed by a return-demonstration by the Certified staff; and
j) knowing that a change in the individual's health status requires a review by the HCP.

8) Certified staff, who are responsible for a medication occurrence involving the administration of a medication via the G or J Tube route, are required to be retrained by an RN or HCP.

a) The medication occurrence must also be reported, as applicable (*See Policy No. 17-3*).

9) *Medication Administration and Water Flushes via the Gastrostomy (G) or Jejunostomy (J) Tube Route Training* for Certified staff, including relief staff, must be properly documented and maintained at the MAP Registered site.

a) Documentation of the Training must include, but is not limited to:
    i) name and contact information of the Trainer(s);
    ii) date of the training(s) and names of Certified staff trained (i.e., attendance list);
    iii) a complete set of training materials used to train Certified staff; and
    iv) completed Competency Evaluation Tool forms.
        (1) Trainers must use the required Competency Evaluation Tool forms, including:

(a) *Competency Evaluation Tool for General Knowledge of Medication Administration via a Gastrostomy (G) or Jejunostomy (J) Tube;*
   (i) The required General Knowledge (Medication) Competency Evaluation Tool may be used to document the training competency for multiple Certified staff (*See Policy Section 19 for Competency Evaluation Tools*).

(b) *Competency Evaluation Tool for Individual-Specific Medication Administration via a Gastrostomy (G) or Jejunostomy (J) Tube;*
   (i) The required Individual-Specific (Medication) Competency Evaluation Tool must be completed per individual. The Tool may be used to document the training competency for multiple Certified staff (*See Policy Section 19 for Competency Evaluation Tools*).

(c) *Competency Evaluation Tool for Return-Demonstration of Medication Administration via the Individual's Gastrostomy (G) or Jejunostomy (J) Tube; and*
   (i) The required Return-Demonstration (Medication) Competency Evaluation Tool must be completed per Certified staff per individual (*See Policy Section 19 for Competency Evaluation Tools*).

(d) *Competency Evaluation Tool for Return-Demonstration of Water Flush Administration via the Individual's Gastrostomy (G) or Jejunostomy (J) Tube.*
   (i) The required Return-Demonstration (Water Flush) Competency Evaluation Tool must be completed per Certified staff per individual (*See Policy Section 19 for Competency Evaluation Tools*).

MEDICATION ADMINISTRATION PROGRAM
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Competency Evaluation Tools for Gastrostomy (G) or Jejunostomy (J) Tube Training

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CLICK HERE TO ACCESS THE REQUIRED *Competency Evaluation Tool for 'General Knowledge' of Medication Administration via a Gastrostomy (G) or Jejunostomy (J) Tube* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE REQUIRED *Competency Evaluation Tool for 'Individual-Specific' Medication Administration via a Gastrostomy (G) or Jejunostomy (J) Tube* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE REQUIRED *Competency Evaluation Tool for Return-Demonstration of 'Medication Administration' via the Individual's Gastrostomy (G) or Jejunostomy (J) Tube* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE REQUIRED *Competency Evaluation Tool for Return-Demonstration of 'Water Flush' via the Individual's Gastrostomy (G) or Jejunostomy (J) Tube* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE OPTIONAL *Competency Evaluation Tool for Gastrostomy (G)Tube 'Bolus Feeding'* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE OPTIONAL *Competency Evaluation Tool for Gastrostomy (G) or Jejunostomy (J) Tube 'Continuous Feeding'* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE OPTIONAL *Competency Evaluation Tool for Gastrostomy (G) or Jejunostomy (J) Tube 'Completion of Feeding'* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

Policy No. & Issue **19-6 High Alert Medications-Medications Requiring Additional Monitoring of An Individual**
Policy Source **MAP Policy Manual**

1) When a Health Care Provider, MAP Consultant, and/or Administrative MAP Advisor (i.e., State Agency MAP Coordinator(s), DPH MAP Coordinator(s), DPH Clinical Reviewer) determines that a medication requires additional monitoring of the individual, the Service Provider must develop and enforce Policies and Procedures to ensure all Certified staff, including relief staff, who administer that medication are trained on its safe administration and monitoring.
   a) Certain medications require additional monitoring of the individual because the blood concentration of the medication that is safe and effective can easily become unsafe and cause life-threatening adverse effects. The additional monitoring provides clinical information that can be significant for Health Care Providers whose patients are receiving medications that have tightly controlled blood concentrations.

Policy No. & Issue **19-7 High Alert Medication-Warfarin Sodium (Coumadin)Therapy**
Policy Source **MAP Policy Manual**

1) Warfarin sodium (Coumadin) is a Schedule VI controlled substance (medication) and all MAP Regulations and Policies apply when Warfarin sodium is administered.

2) When an individual has a Health Care Provider (HCP) Order and/or Protocol for Warfarin sodium, the Service Provider must have a 'Warfarin Sodium Policy' that includes procedures for Certified staff to follow. The procedures must include, but are not limited to:
   a) administrative procedures to be followed when there is a medical emergency related to the administration of Warfarin sodium; and
      i) The 'Warfarin Sodium Policy' can reference the Service Provider's overall Policy that specifies the administrative procedures to be followed when there is a medical emergency relating to a medication (if the Policy would be applicable when there is a medical emergency related to Warfarin sodium).
   b) safe administration of Warfarin sodium, including:
      i) each individual with an HCP Order for Warfarin sodium has an individualized Warfarin sodium Therapy Protocol;
      ii) the date for the next (i.e., upcoming) International Normalized Ratio (INR) and Prothrombin time (PT) lab draw is on the Medication Administration Record (MAR);
         (1) Documentation must include that the laboratory testing was completed.
      iii) a 'Warfarin sodium Tracking System' is generated; and
      iv) a second Certified/licensed staff reviews and verifies the Warfarin sodium HCP Order, with the pharmacy label, and the MAR to ensure the accurate dosage has been prepared.
   c) Certified staff are appropriately trained.

3) Certified staff, including relief staff, may administer Warfarin sodium at the MAP Registered site provided there is an HCP Order and/or Protocol regarding the individual's need for Warfarin sodium. The HCP Order and/or Protocol should include, but is not limited to:
   a) all required components of a valid HCP Order (*See Policy No. 08-1*);
      i) Warfarin sodium dosages received from an Anticoagulation Management Service must be ordered by an HCP (authorized prescriber).
         (1) Any change in the HCP Order for Warfarin sodium Therapy administration requires a review.
      ii) When Warfarin sodium HCP Orders are received via Fax, Email, Telephone, or Telehealth, all MAP related procedures must be followed (*See Policy No. 08-2*).
   b) the specific medical condition or diagnosis that is the indication for Warfarin sodium;
   c) the frequency of PT and INR lab work draws;
      i) When PT/INR testing is managed at the MAP Registered site, it may not be obtained by Certified staff.
   d) a documented specific International Normalized Ratio (INR) Target Range/Goal for the intended individual;
   e) 'Individual-Specific' adverse effects to observe for, including when to call 911 and/or the HCP; and
   f) individualized instructions to follow when the Warfarin sodium dosage is not administered, as ordered (e.g., omitted).

4) Whenever there is a change to the individual's HCP Warfarin sodium Order (e.g., dose change, holding medication dosage, etc.):

a) the change is communicated to all staff (verbally and/or in writing);
b) the pharmacy is contacted to verify that the HCP has notified the Pharmacist of the currently prescribed dosage (if applicable);
c) the Warfarin sodium medication container(s) is marked by the approved MAP Method to indicate a change in the HCP Order, (if applicable); and
    i) The approved MAP Method (to indicate a change in directions for administration) includes:
        (1) A 'directions change' sticker or 'brightly colored sticker' must be affixed to the medication container in 'close proximity' to the pharmacy label. The sticker indicates that there is a new HCP Order and that the individual's Warfarin sodium medication order must be checked.
            (a) The 'directions change' sticker or brightly colored 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.
                (i) Certified/licensed staff must never apply the 'directions change' sticker directly on the pharmacy label.
    ii) Certified/licensed staff are not permitted to write, or mark directly, on the pharmacy label of the medication container.
d) a narrative note is written in the Individual's Record.

5) When an individual has a Health Care Provider Order for Warfarin sodium, the Service Provider must ensure that:

a) the individual has an individualized Warfarin sodium Therapy Protocol;
b) when transcribing Warfarin sodium onto the Medication Administration Record (MAR), the date for the next (i.e., upcoming) International Normalized Ratio (INR) and Prothrombin time (PT) lab draw must also be transcribed;
    i) Documentation of the date of the next lab draw should be positioned on the Medication Administration Record (MAR) in close proximity (e.g., above, below, or 'electronically linked') to the Warfarin sodium medication transcription.
        (1) Documentation must include that the laboratory testing was completed.
c) there is a 'Warfarin Sodium Tracking System' including either:
    i) adding Warfarin sodium to the *Countable Controlled Substance Book;*
        (1) When the tracking system includes adding the Warfarin sodium to the 'Count Book', each strength of Warfarin sodium must be entered on a separate line of the 'Index' in the *Countable Controlled Substance Book* and on a corresponding 'Count Sheet' page.
    ii) establishing a Warfarin sodium accounting documentation procedure; or
    iii) establishing a Warfarin sodium 'Blister Pack Monitoring System'.
d) a 'Verification Process' of the Warfarin sodium dosage is completed by a second Certified/licensed staff; and
    i) When a second Certified or licensed staff is working during the Warfarin sodium administration time, the second Certified/licensed staff must complete a 'Verification Process' by reviewing, comparing, and verifying the Warfarin sodium HCP Order, with the pharmacy label, and with the MAR.
    ii) The 'Verification Process' must be completed before the dosage of Warfarin sodium may be administered.
        (1) The second Certified/licensed staff, who completes the 'Verification Process', must document on the MAR that the verification was completed.
            (a) The Certified or licensed staff, who will be administering the Warfarin sodium, must remain with the second Certified/licensed staff to observe the 'Verification Process'.

iii) When a second Certified staff is not available to complete the 'Verification Process', the prescribed medication should still be administered.
(1) The code 'NSS', defined as 'No Second Staff', may be used on the MAR to indicate there was 'no second staff' available for the 'Verification Process'.

e) When there is a change in the individual's condition, the HCP is notified, documentation of the notification of the HCP is completed, and any HCP Orders/instructions followed.

6) As a prerequisite for administering Warfarin sodium, Certified staff, including relief staff, must have a current CPR certification, current First Aid certification and have successfully completed Vital Signs Training with demonstrated proficiency on a regular basis (*See Policy No. 18-1*).

7) Certified staff, including relief staff, may administer Warfarin sodium in accordance with a valid HCP Order and/or Protocol, provided the Certified staff successfully:

a) completes a '*General Knowledge' Warfarin sodium Therapy Training*;
b) completes an '*Individual-Specific' Warfarin sodium Therapy Training*;
c) demonstrates proficiency in the skill of administering Warfarin sodium; and
d) performs the administration of Warfarin sodium in accordance with the individual's HCP Order.

8) Initial Warfarin sodium Therapy Training for Certified staff, including relief staff, must be conducted by a Health Care Provider, Registered Pharmacist or Registered Nurse provided the Trainer has demonstrated initial and continued competency in the knowledge of safe administration of Warfarin sodium.

a) A Licensed Practical Nurse (LPN), who is able to demonstrate initial and continued competence in the knowledge of safe administration of Warfarin sodium, may provide subsequent Warfarin sodium retraining.

9) Certified staff, who have not administered Warfarin sodium in the previous twelve (12) months or have not demonstrated an understanding of safe Warfarin sodium administration, must successfully complete a supplemental Warfarin sodium Therapy Retraining.

a) A Health Care Provider, Registered Pharmacist, Registered Nurse or Licensed Practical Nurse may provide subsequent Warfarin sodium Therapy Retraining provided the Trainer has demonstrated initial and continued competency in the knowledge of safe administration of Warfarin sodium.

10) Required Warfarin sodium Therapy Training for Certified staff, including relief staff, must include both 'General Knowledge', and 'Individual-Specific' Training.

a) When supporting more than one individual with an HCP Order for Warfarin sodium, Certified staff, who have completed '*General Knowledge' Warfarin sodium Therapy Training* within the previous twelve (12) months are only required to receive '*Individual-Specific' Warfarin sodium Therapy Training* (for each of the individuals receiving Warfarin sodium that they support).

11) 'General Knowledge' of staff training in Warfarin sodium Therapy must include, but is not limited to:

a) overview of Warfarin sodium and anticoagulant therapy;
b) the difference between 'beneficial' blood clots and 'harmful' blood clots;
c) goal and rationale for Warfarin sodium administration;
d) emergency procedures to follow, including notification of the HCP, calling 911, etc.;
e) overview of importance of monitoring lab draws and results including Prothrombin time (PT) and International Normalized Ratio (INR);
f) overview of INR target ranges;

g) an understanding of the rationale for frequent Warfarin sodium dosage changes;
h) an understanding of the importance of consistent administration of Warfarin sodium (i.e., administered once a day at the same time each day);
i) probable signs and symptoms associated with high and low INR results;
j) overview of Warfarin sodium interactions (e.g., prescription medications, over-the-counter medications, dietary supplements, alcohol, foods, beverages, spices, etc.);
k) overview of Warfarin sodium Telephone HCP Orders and Telehealth HCP Orders;
l) safe Warfarin sodium administration procedures;
m) awareness that in MAP, a Warfarin sodium tablet may only be split by the pharmacy;
n) overview of the correct technique to document HCP Warfarin sodium Orders, Telephone HCP Orders, Telehealth HCP Orders, transcription, and administration of medication;
o) overview of Warfarin sodium and how it interacts with Vitamin K;
p) adverse effects of Warfarin sodium Therapy;
q) an understanding of injury prevention (e.g., caution with sharp objects, using soft-bristle toothbrush, waxed dental floss, electric razor, etc.); and
r) an understanding of how to maintain an adequate supply of Warfarin sodium at the MAP Registered site.

12) 'Individual-Specific' staff training in Warfarin sodium Therapy must include, but is not limited to, reviewing:

a) individual's HCP Order specific to Warfarin sodium;
b) individual's Warfarin sodium Protocol and any special instructions;
c) rationale/reason the individual's Warfarin sodium is prescribed;
d) adverse effects of Warfarin sodium Therapy for the intended individual;
e) how and where the PT/INR lab work is obtained (e.g., laboratory name/address, HCP office, VNA, etc.);
f) how the INR lab results are reported to the HCP (authorized prescriber);
g) how the new signed HCP Orders for Warfarin sodium dose changes are received;
h) how the pharmacy is notified of a Warfarin sodium dose change;
i) how the MAP Registered site obtains the Warfarin sodium medication from the pharmacy;
j) how changes in the Warfarin sodium HCP Orders are communicated to all staff (e.g., medication progress note, narrative note, flow sheet, etc.);
k) requirement that if a single dose of Warfarin sodium is missed or omitted, the MAP Consultant must be notified; and
l) when a telephone call to 911 and/or the HCP is necessary.

13) Certified staff Training and Competency must be appropriately documented and maintained at the MAP Registered site.

a) Documentation of Warfarin sodium Therapy Training must include, but is not limited to:
    i) name and contact information of the Trainer(s);
    ii) date of the training(s) and names of Certified staff trained (i.e., attendance list);
    iii) a complete set of training materials used to train Certified staff; and
    iv) completed Competency Evaluation Tool forms.
        (1) Trainers must use the required Competency Evaluation Tool forms including, the:
            (a) *Competency Evaluation Tool for General Knowledge of Warfarin Sodium (Coumadin) Therapy;* and
                (i) The required General Knowledge Competency Evaluation Tool may be used to document the training competency for multiple Certified staff (*See Policy Section 19 for Competency Evaluation Tool).*
            (b) *Competency Evaluation Tool for Individual-Specific Warfarin Sodium (Coumadin) Therapy.*

(i) The required Individual-Specific Competency Evaluation Tool must be completed per individual and may be used to document the training competency for multiple Certified staff (*See Policy Section 19 for Competency Evaluation Tool).*

MEDICATION ADMINISTRATION PROGRAM
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Competency Evaluation Tools and Forms for Warfarin Sodium (Coumadin) Therapy

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CLICK HERE TO ACCESS THE REQUIRED *Competency Evaluation Tool for 'General Knowledge' of Warfarin Sodium (Coumadin) Therapy* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE REQUIRED *Competency Evaluation Tool for 'Individual-Specific' Warfarin Sodium (Coumadin) Therapy* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE OPTIONAL *Narrative Notes* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE OPTIONAL *Health Care Provider Orders Warfarin Sodium* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE SAMPLE *Warfarin Sodium (Coumadin) Therapy Protocol* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE SAMPLE *Warfarin Sodium (Coumadin) Chronological Event Sheet* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE SAMPLE *Warfarin Sodium (Coumadin) Medication Sheet* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE SAMPLE *Warfarin Sodium (Coumadin) Medication Sheet-Alternating Doses* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

Policy No. & Issue **19-8 High Alert Medication-Clozapine (Clozaril) Therapy**
Policy Source **MAP Policy Manual**

1) Clozapine (Clozaril) is a Schedule VI controlled substance (medication) and all MAP Regulations and Policies apply when Clozapine is administered.

2) When an individual has a Health Care Provider (HCP) Order and/or Protocol for Clozapine, the Service Provider must have a Clozapine Policy that includes procedures for Certified staff to follow. The procedures must include, but are not limited to:

   a) administrative procedures to be followed when there is a medical emergency related to the administration of Clozapine;
      i) The Clozapine Policy can reference the Service Provider's overall Policy that specifies the administrative procedures to be followed when there is a medical emergency relating to a medication (if the Policy would be applicable when there is a medical emergency related to Clozapine).
   b) safe administration of Clozapine, including:
      i) each individual with an HCP Order for Clozapine must have an individualized Clozapine Protocol;
      ii) the date for the next (i.e., upcoming) Absolute Neutrophil Count (ANC) lab draw must be indicated on the Medication Administration Record (MAR); and
         (1) The laboratory test may be ordered as a Complete Blood Count with differential (CBC with diff).
            (a) Documentation must include that the laboratory testing was completed.
      iii) obtaining directives from the HCP (Authorized Prescriber) to follow when the Clozapine dosage is omitted for two (2) days or more.
   c) Certified staff are appropriately trained.

3) Certified staff, including relief staff, may administer Clozapine at the MAP Registered site provided there is an HCP Order and/or Protocol regarding the individual's need for Clozapine. The HCP Order and/or Protocol should include, but is not limited to:

   a) all required components of a valid HCP Order (*See Policy No. 08-1*);
      i) When Clozapine HCP Orders are received via Fax, Email, Telephone, or Telehealth, all MAP related procedures must be followed (*See Policy No. 08-2*).
      ii) Any change in the HCP Order for Clozapine Therapy administration requires a review.
   b) the specific medical condition or diagnosis that is the indication for Clozapine;
   c) the frequency of the Absolute Neutrophil Count (ANC) lab tests;
   d) individualized instructions to follow when the Clozapine dosage is not administered (omitted) for two (2) days or more;
   e) individual-specific adverse effects to observe for; and
   f) when to call 911 and/or the HCP.

4) At any time there is a change in the HCP Clozapine Orders (e.g., dosage change, holding medication dose, etc.) the change must be communicated to all staff and a narrative note must be documented in the Individual's Record.

5) When transcribing Clozapine onto the Medication Administration Record (MAR), the date for the next (i.e., upcoming) Absolute Neutrophil Count (ANC) lab draw must be indicated on the MAR.

   a) Documentation of the date of the next lab draw should be positioned on the MAR in close proximity (e.g., above, below, or 'electronically linked') to the Clozapine.

i) The laboratory test may be ordered as a Complete Blood Count with differential (CBC with diff).
(1) Documentation must include that the laboratory testing was completed.

6) As a prerequisite for administering Clozapine, Certified staff, including relief staff, must have a current CPR certification, current First Aid certification, and have successfully completed Vital Signs Training with demonstrated proficiency on a regular basis (*See Policy No. 18-1*).

7) Certified staff, including relief staff, may administer Clozapine in accordance with a valid HCP Order and/or Protocol, provided the Certified staff successfully:

a) completes a 'General Knowledge' Clozapine Therapy Training;
b) completes an 'Individual-Specific' Review of Clozapine Protocol;
c) demonstrates proficiency in the skill of administering Clozapine; and
d) performs the administration of Clozapine in accordance with the individual's HCP Order.

8) 'General Knowledge' Clozapine Training for Certified staff, including relief staff, must be conducted by a Health Care Provider, Registered Pharmacist, or Registered Nurse provided the Trainer has demonstrated initial and continued competence in the general knowledge of safe administration of Clozapine.

a) Trained Certified staff must demonstrate an understanding of safe administration of Clozapine on a regular basis.
i) When Certified staff have not administered Clozapine in the previous twelve (12) months or have not demonstrated an understanding of safe Clozapine administration, they must repeat Clozapine Therapy Training.
(1) A Licensed Practical Nurse, who is able to demonstrate initial and continued competence in the safe administration of Clozapine, may provide subsequent general knowledge retraining for Clozapine Therapy.

9) 'Individual-Specific' Review of the Clozapine Protocol for Certified staff, including relief staff, may be conducted by a Health Care Provider, Registered Pharmacist, Registered Nurse, Licensed Practical Nurse, or Site Supervisor, provided the Trainer has demonstrated initial and continued competence regarding the information on the individual's Clozapine Protocol.

a) Certified staff, who have completed the 'General Knowledge' Clozapine Therapy Training within the previous twelve (12) months, and have demonstrated an understanding of safe Clozapine administration, are only required to complete the 'Individual-Specific' Protocol Review for each of the individuals that they support.

10) '*General Knowledge' Clozapine Therapy Training* must include, but is not limited to:

a) overview of Clozapine and antipsychotic therapy;
b) rationale for Clozapine administration;
c) overview of importance of frequent blood test monitoring of Absolute Neutrophil Count (ANC) and its role in safe administration;
d) a general overview of the components of a Clozapine HCP Order and Clozapine Protocol.
e) an understanding that the pharmacy must have current and acceptable ANC results to dispense the Clozapine: and
f) an understanding of how to maintain an adequate supply of Clozapine at the MAP Registered site.

11) '*Individual-Specific' Review of the Clozapine Protocol* must include, but is not limited to, a review of:

a) the individual's current Clozapine Protocol;
b) the procedure to follow to ensure:

i) the individual's ANC lab work is attained; and
   (1) This includes a review of the location and contact information of the individual's preferred laboratory.
ii) the results of the ANC lab work is received by the consulting pharmacy.
   (1) This includes a review of the location and contact information of the individual's preferred pharmacy.

c) when to contact the HCP and/or the MAP Consultant; and
d) the Service Provider's Clozapine Emergency Policy to follow including but not limited to calling 911 and notification of the individual's HCP.

12) Certified staff Training and Competency must be appropriately documented and maintained at the MAP Registered site.

a) Documentation of Clozapine Therapy Training must include, but is not limited to:
   i) name and contact information of the Trainer(s);
   ii) date of the training(s) and names of Certified staff trained (i.e., attendance list);
   iii) a complete set of training materials used to train Certified staff; and
   iv) completed Competency Evaluation Tool forms.
      (1) Trainers must use the required Competency Evaluation Tool forms including, the:
         (a) *Competency Evaluation Tool for General Knowledge of Clozapine (Clozaril) Therapy; and*
         (b) *Competency Evaluation Tool for Individual-Specific Review of the Clozapine (Clozaril) Therapy Protocol.*

MEDICATION ADMINISTRATION PROGRAM
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Competency Evaluation Tools and Forms for Clozapine (Clozaril) Therapy

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CLICK HERE TO ACCESS THE REQUIRED *Competency Evaluation Tool for 'General Knowledge' of Clozapine (Clozaril) Therapy* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE REQUIRED *Competency Evaluation Tool for 'Individual Specific' of Clozapine (Clozaril) Therapy* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE SAMPLE *Clozapine (Clozaril) Protocol* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE SAMPLE *Clozapine Medication Sheet* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

1) Insulin is a Schedule VI controlled substance (medication), and all MAP Regulations and Policies apply when Insulin is administered.

2) When an individual has a Health Care Provider (HCP) Order and/or Protocol to administer Insulin via an Insulin Pen and Certified staff will be responsible for the administration of the Insulin, the Service Provider must have an 'Insulin Administration via Insulin Pen by MAP Certified Staff Policy' that includes procedures for Certified staff to follow. The procedures must include, but are not limited to:

    a. administrative procedures to be followed when there is a medical emergency related to the administration of Insulin;
        i. The 'Insulin Administration via Insulin Pen by MAP Certified Staff Policy' can reference the Service Provider's overall Policy that specifies the administrative procedures to be followed when there is a medical emergency relating to a medication (if the Policy would be applicable when there is a medical emergency related to Insulin).
    b. safe administration of Insulin procedures, including but not limited to, how to:
        i. Safely administer Insulin via an Insulin Pen; and
            1. The process requires two (2) Insulin trained Certified staff. If two (2) Insulin trained staff are not available, the medication may not be administered by one (1) Insulin trained staff.
                a. The Service Provider Policy must include:
                    i. the procedure to follow to maintain adequate staffing during timelines when Insulin is to be administered; and
                    ii. steps to take if staffing falls below minimum (i.e., less than two (2) Insulin trained MAP Certified staff).
        ii. Communicate any changes in the individual's HCP Insulin Order and/or Protocol, and/or the prescribed Insulin Pen device, with all Certified/licensed staff, and how to document the changes in the Individual's Record.
            1. If there is any change in the prescribed Insulin or Insulin Pen device, training for Certified staff must be completed by a qualified Trainer.
                a. The training must be completed prior to the Certified staff administering the prescribed Insulin via Insulin Pen.
    c. Certified staff are appropriately trained.
        i. The Service Provider for the MAP Registered site must ensure that any individual who has an HCP Order and/or Protocol requiring the administration of Insulin via an Insulin Pen, has a licensed nurse or, if a licensed nurse is not able to be secured, then two (2) 'Insulin Trained' Certified staff on-site during timelines when the Insulin is to be administered including scheduled and sliding scale (as needed) administration(s).

3) Certified staff may only administer Insulin that is ordered as a scheduled dose (i.e., 'long-acting' Insulin) and/or that is ordered in response to a Blood Glucose Monitoring (e.g., 'finger-stick') level, (i.e., 'sliding-scale').
    a. Certified staff may not calculate an Insulin dosage based on carbohydrate-counting (carb-counting), nor based on estimation of percentage of food intake.

4) Certified staff may only administer HCP Ordered Insulin via a pharmacy packaged and labeled Insulin Pen device in accordance with the HCP Insulin Order.
    a. The Insulin Pen may have the ability to select the HCP Ordered dosage through use of a 'dial'.
        i. Certified staff may not administer Insulin via any other method than an Insulin Pen (i.e., Certified staff may not 'draw-up a dose' with a syringe from a multi-dose vial, manage Automatic Delivery Insulin Pumps, etc.).

5) When Certified staff are responsible for the administration of Insulin via an Insulin Pen, the process requires two (2) 'Insulin Trained' Certified staff.
    a. The second Certified staff reviews and 'verifies' the Insulin HCP Order, with the pharmacy label, and the Medication Administration Record (MAR) to ensure the accurate dosage has been dialed by the Certified staff responsible for administration.
        i. The 'Verification Process' must be completed before the dosage of Insulin may be administered.
            1. The Certified staff, who will be administering the Insulin, must remain with the second Certified staff to observe the 'Verification Process'.

6) Certified staff, including relief staff, may administer Insulin via an Insulin Pen, provided there is an HCP Order and/or Protocol regarding the individual's requirement for Insulin. The HCP Order and/or Protocol must include, but is not limited to:
    a. All required components of a valid HCP Order (*See Policy No. 08-1*);
    b. The specific medical condition or diagnosis that is the indication for Insulin;
    c. The type of Insulin device (i.e., Insulin Pen);
    d. Blood Glucose Monitoring;
    e. What to do in the event of a high or low blood glucose level; and
    f. When to call 911 and/or the HCP.

7) When there is a change in the individual's condition, the HCP must be notified.
    a. Documentation must be completed including, the change in condition, notification of the HCP, any HCP Orders/instructions obtained, and actions taken.

8) As a prerequisite to taking the *Insulin Administration via Insulin Pen by MAP Certified Staff Training,* Certified staff, including relief staff, must have:

    a. their MAP Certification in 'good standing' with the state contracted testing vendor;
    b. current Massachusetts Certified Nurse Aide (CNA) certification;
    c. current CPR certification
    d. current First Aid certification;
    e. successfully completed Blood Glucose Monitoring Training *(See Policy No. 18-2);* and
    f. successfully completed Vital Signs Training *(See Policy No. 18-1)*.

9) Certified staff, including relief staff, may administer Insulin via an Insulin Pen in accordance with a valid HCP Order and/or Protocol, provided the Certified staff successfully:

a. Completes an annual 'General Knowledge' *Insulin Administration via Insulin Pen by MAP Certified Staff Training*;
    i. A 'repeat training' is required when the Certified staff has not demonstrated an understanding of safe Insulin via Insulin Pen administration.
b. Completes an annual 'Individual Specific' *Insulin Administration via Insulin Pen by MAP Certified Staff Training*;
    i. The Certified staff must complete individualized training, specific to 'each individual' that the Certified staff will be responsible for administering their insulin via an Insulin Pen.
    ii. 'Repeat training' is required when the Certified staff has not demonstrated an understanding of safe Insulin administration.
    iii. Supplemental training is required when:
        1. there is any change in the Insulin HCP Order and/or Protocol; or
        2. there is a change in the type of prescribed Insulin Pen device.
            a. The supplemental training must be completed prior to the Certified staff administering the prescribed Insulin and/or Insulin Pen device.
c. demonstrates proficiency in the skill of administering Insulin via Insulin Pen device; and
d. performs the administration of Insulin in accordance with the individual's HCP Order and/or Protocol.

10) 'General Knowledge' and 'Individual Specific', *Insulin Administration via Insulin Pen by MAP Certified Staff Training*, must be conducted by a Health Care Provider, Registered Nurse, or Registered Pharmacist, provided the Trainer has demonstrated initial and continued competency in the knowledge of safe administration of Insulin.

11) When supporting more than one individual with an HCP Order and/or Protocol for Insulin via Insulin Pen, Certified staff are only required to complete the 'General Knowledge' *Insulin Administration via Insulin Pen by MAP Certified Staff Training* once, provided:

    a. the Certified staff has successfully completed the 'General Knowledge' *Insulin Administration via Insulin Pen by MAP Certified Staff Training* within the previous twelve (12) months; and
    b. they have demonstrated an understanding of safe Insulin administration.

12) The required 'General Knowledge' *Insulin Administration via Insulin Pen by MAP Certified Staff Training* must include, but is not limited to:
    a. Overview of Diabetes;
    b. Normal ranges for Blood Glucose levels;
    c. Symptoms of Diabetes;
    d. Types of Diabetes (i.e., Type 1, Type 2, Gestational, and Other Types of Diabetes);
    e. Causes of Diabetes;
    f. How the body processes sugar (i.e., carbohydrates);
    g. Ketones (i.e., what are they, why do they occur, how to test for, etc.);
    h. Diabetic Ketoacidosis;
    i. How diet, exercise, stress, medication, and illness affect a blood glucose level;
    j. The importance of Blood Glucose Monitoring;
    k. The importance of documenting Blood Glucose Monitoring levels;
    l. Hemoglobin A1C and its importance;

m. Complications of Diabetes;
n. Medications used to treat Diabetes;
o. Overview of Insulin;
p. Types of Insulin (e.g., Rapid Acting, Short Acting, Intermediate Acting, Long Acting, etc.);
q. The effects of Insulin;
r. Goals of Medication Treatment;
s. Types of Insulin delivery devices (e.g., Pre-filled Insulin Pen, fillable syringe, Automatic Delivery Pump, etc.);
    i. Staff know that they are only allowed to administer Insulin via a pharmacy obtained and labeled prefilled Insulin Pen device.
t. The timing of Insulin administration in relation to food intake;
u. Signs and symptoms of Hypoglycemia;
v. Signs and symptoms of Hyperglycemia;
w. Adverse effects of Insulin Therapy;
x. What to do in the event of an accidental injection to a person;
y. Overview of Insulin storage requirements;
z. Infection Control; and
aa. Sharps Disposal Guidelines.

13) The required 'Individual Specific' *Insulin Administration via Insulin Pen by MAP Certified Staff Training* must include, but is not limited to:
    a. The individual's Insulin HCP Order and/or Protocol;
    b. The individual's specific diagnosis requiring Insulin administration;
    c. Prescribed Blood Glucose Monitoring;
    d. What to do in the event of a low blood glucose level;
    e. What to do in the event of a high blood glucose level;
    f. Emergency procedure/guidelines (e.g., calling 911, notification of the individual's HCP, etc.) to follow when warranted;
    g. The system for maintaining an adequate supply of Insulin;
    h. Overview of the individual's specific equipment (e.g., Insulin Pen, etc.);
    i. How to give a subcutaneous injection;
    j. The rotation of injection sites;
    k. Reporting changes (e.g., redness, swelling, drainage, etc.) in the individual's injection sites;
    l. How to administer the Insulin using the currently prescribed Insulin Pen device;
        i. The Certified staff must:
            1. observe the Trainer demonstrate a 'mock' Insulin administration via Insulin Pen "TRAINER" (i.e., 'practice pen' that contains no active drug or needle);
                a. To be completed at the 'initial' Individual-Specific training and as needed for re-training or supplemental training.
            2. be observed by the Trainer, successfully completing a mock return-demonstration (via Insulin Pen TRAINER) of Insulin administration; and
                a. To be completed at the 'initial' Individual-Specific training and as needed for re-training or supplemental training.
            3. be observed by the Trainer, successfully completing the Medication Administration Process and administering the prescribed Insulin via Insulin Pen to the individual during a 'Med Pass'.

a. To be completed as part of the 'initial' training and on an 'annual' basis.

m. How to change the needle on the Insulin Pen device;
n. How to re-cap the Insulin Pen;
o. Documentation of Insulin administration and injection site;
p. Insulin storage requirements; and
q. Sharps/empty pen disposal guidelines.

14) The Service Provider is responsible for notifying the applicable state agency MAP Coordinator prior to instituting the use of Insulin Trained MAP Certified staff to administer Insulin via Insulin Pen at the MAP Registered site, to ensure requirements are in place.
    a. To locate the applicable state agency MAP Coordinator's contact information, click **here**.

15) Certified staff Training and Competency in Insulin Administration via Insulin Pen documentation must be maintained at the MAP Registered site.
    a. Required documentation of the Insulin Administration via Insulin Pen Training must include:
        i. Name and contact information of the Trainer(s);
        ii. A complete set of training materials used to train Certified staff;
        iii. Date of 'General Knowledge' *Insulin Administration via Insulin Pen by MAP Certified Staff Training* and names of Certified staff trained; and
            1. Use of the standardized *Competency Evaluation Tool for '*General Knowledge' *Insulin Administration via Insulin Pen by MAP Certified Staff Training* form is required (*See following page for link to the* Competency Tool).
        iv. Date of 'Individual-Specific' *Insulin Administration via Insulin Pen by MAP Certified Staff Training* and names of Certified staff trained.
            1. Use of the standardized Competency Evaluation Tool(s) are required including the:
                a. 'Individual-Specific' *Insulin Administration via Insulin Pen by MAP Certified Staff Training* form (*See following page for the link to the* Competency Tool*)*;
                b. 'Initial' *Insulin Administration via Insulin Pen by MAP Certified Staff Training Return-Demonstration* form (*See following page for the link to the* Competency Tool); and
                c. 'Annual' *Insulin Administration via Insulin Pen by MAP Certified Staff Demonstration* form (*See following page for the link to the* Competency Tool).

MEDICATION ADMINISTRATION PROGRAM
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Competency Evaluation Tools for Insulin (via Insulin Pen) Therapy

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CLICK HERE TO ACCESS THE REQUIRED *Competency Evaluation Tool for 'General Knowledge' of Insulin (via Insulin Pen) Therapy* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE REQUIRED *Competency Evaluation Tool for 'Individual Specific' of Insulin (via Insulin Pen) Therapy* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE REQUIRED *Competency Evaluation Tool for 'Initial Return-Demonstration' of Insulin (via Insulin Pen) Therapy* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE REQUIRED *Competency Evaluation Tool for 'Annual Demonstration' of Insulin (via Insulin Pen) Therapy* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

1) All MAP Regulations and Policies apply when a Schedule VI Injectable Medication is administered.

2) When an individual has a Health Care Provider (HCP) Order and/or Protocol for a Schedule VI Injectable Medication and MAP Certified staff are responsible for the administration of the medication, the Service Provider must have a medication specific 'Schedule VI Injectable Medication by MAP Certified Staff Policy' that includes procedures for Certified staff to follow. The procedures must include, but are not limited to:

   a) any Schedule VI Injectable Medication, to be administered by a trained MAP Certified staff:

      i) must be packaged and labeled by the pharmacy in a pre-dosed pen device; and

      ii) may only be administered, per the HCP Order, by the subcutaneous route.

         (1) MAP Certified staff are not allowed to administer a Schedule VI Injectable Medication by any other parenteral route other than subcutaneous, with the exception of Epinephrine via Auto-Injector Device (*See Policy No. 19-3*).

   b) administrative procedures to be followed when there is a medical emergency related to the administration of the Schedule VI Injectable Medication;

      i) The 'Schedule VI Injectable Medication by MAP Certified Staff Policy' can reference the Service Provider's overall Policy that specifies the administrative procedures to be followed when there is a medical emergency relating to a medication (if the Policy would be applicable when there is a medical emergency related to the Schedule VI Injectable Medication).

   c) safe administration of the medication specific Schedule VI Injectable Medication, including how to:

      i) safely administer the Schedule VI Injectable Medication;

      ii) safely transport the Schedule VI Injectable Medication;

      iii) safely dispose of the Schedule VI Injectable Medication; and

      iv) communicate any changes in the individual's HCP Schedule VI Injectable Medication Order and/or Protocol with all Certified/licensed staff and how to document the changes in the Individual's Record.

         (1) If there is a change in the type of prescribed pen device for the Schedule VI Injectable Medication, a training for Certified staff must be completed by a qualified Trainer.

            (a) The medication specific *Schedule VI Injectable Medication Training* must be done prior to the Certified staff administering the Schedule VI Injectable Medication via the newly prescribed pen device.

   d) Certified staff are appropriately trained.

i) The Service Provider for the MAP Registered site must ensure that any MAP Certified staff responsible for the administration of a Schedule VI Injectable Medication is appropriately trained.

3) Certified staff, including relief staff, may administer a Schedule VI Injectable Medication, provided there is an HCP Order and/or Protocol regarding the individual's requirement for the medication. The HCP Order and/or Protocol should include, but is not limited to:

   a) all required components of a valid HCP Order (*See Policy No. 08-1);*

      i) Any change in the HCP Order and/or Protocol for the Schedule VI Injectable Medication requires a review.

   b) the specific medical condition or diagnosis that is the indication for the Schedule VI Injectable Medication;

   c) adverse effects to observe for; and

   d) when to call 911 and/or the HCP.

4) As a prerequisite for administering a Schedule VI Injectable Medication, Certified staff, including relief staff, must have a current CPR certification, current First Aid certification and have successfully completed Vital Signs Training with demonstrated proficiency on a regular basis (*See Policy No. 18-1*).

5) Certified staff, including relief staff, may administer a Schedule VI Injectable Medication in accordance with a valid HCP Order and/or Protocol, provided the Certified staff successfully:

   a) completes an annual medication specific '*General Knowledge' Schedule VI Injectable Medication via Pen Device Training*;

      i) When supporting more than one individual with an HCP Order and/or Protocol for the same Schedule VI Injectable Medication, Certified staff, are required to only complete the *General Knowledge' Schedule VI Injectable Medication via Pen Device Training* 'once' provided:

         (1) the Certified staff has successfully completed the '*General Knowledge' Schedule VI Injectable Medication via Pen Device Training* within the previous twelve (12) months; and

         (2) they have demonstrated an understanding of safe Schedule VI Injectable Medication administration.

      ii) A 'repeat training' is required when the Certified staff has not demonstrated an understanding of safe Schedule VI Injectable Medication via Pen Device administration.

   b) completes an annual 'Individual-Specific' *Schedule VI Injectable Medication via Pen Device Training* including a *Schedule VI Injectable Medication via Pen Device Training 'Return-Demonstration'*;

      i) A 'repeat training' is required when the Certified staff has not demonstrated an understanding of safe Schedule VI Injectable Medication via Pen Device administration.

      ii) Supplemental training is required when:

         (1) there is any change in the HCP Order and/or Protocol; or

         (2) there is a change in the type of prescribed pen device.

c) demonstrates proficiency in the skill of administering the Schedule VI Injectable Medication; and

d) performs the administration of the Schedule VI Injectable Medication in accordance with the individual's HCP Order and/or Protocol.

6) *Schedule VI Injectable Medication via Pen Device Training* for Certified staff, including relief staff, must be conducted by a Health Care Provider, Registered Pharmacist or Registered Nurse, provided the Trainer has demonstrated initial and continued competency in the knowledge of safe administration of the Schedule VI Injectable Medication.

a) A Licensed Practical Nurse (LPN), who is able to demonstrate initial and continued competence in the knowledge of safe administration of the Schedule VI Injectable Medication, may provide 'subsequent' Schedule VI Injectable Medication Trainings.

7) The required '*General Knowledge' Schedule VI Injectable Medication via Pen Device Training* must include, but is not limited to:

a) overview of the specific Schedule VI Injectable Medication;

b) overview of storage requirements;

c) purpose of the administration of the Schedule VI Injectable Medication;

d) what to do in case of accidental injection to a person;

e) emergency procedure guidelines; and

f) acceptable disposal procedures.

8) The required annual '*Individual-Specific' Schedule VI Injectable Medication via Pen Device Training* including a *Schedule VI Injectable Medication via Pen Device 'Return-Demonstration'* must include, but is not limited to, a review of:

a) the individual's Schedule VI Injectable Medication HCP Order and/or Protocol;

b) when to contact the HCP;

c) emergency procedures, including calling 911;

d) pen device-specific disposal procedures; and

e) how to administer the Schedule VI Injectable Medication using the currently prescribed pen device.

i) The Certified staff must:

(1) observe the Trainer demonstrate a mock Schedule VI Injectable Medication administration via pen device;

(2) be observed by the Trainer, successfully completing a mock return-demonstration of Schedule VI Injectable Medication administration;

(3) be observed by the Trainer, successfully completing an administration of the prescribed Schedule VI Injectable Medication (following the Medication Administration Process) to the individual at the scheduled time of administration.

9) Certified staff Training and Competency in medication specific Schedule VI Injectable Medication documentation must be maintained at the MAP Registered site.

a) Required documentation of the *Schedule VI Injectable Medication via Pen Device Training* must include, but is not limited to:

   i) name and contact information of the Trainer(s);

   ii) a complete set of training materials used to train Certified staff;

   iii) date of '*General Knowledge' Schedule VI Injectable Medication via Pen Device Training* and names of Certified staff trained (i.e., attendance list); and

   iv) date of *'Individual-Specific' Schedule VI Injectable Medication via Pen Device Training* and names of Certified staff trained (i.e., attendance list).

20

LEARNING TO SELF-ADMINISTER MEDICATION

Policy No. & Issue **20-1 Definition and Criteria for Self-Administration of Medication**
Policy Source **December 1994 MAP Advisory Supervisor's Training Manual**

1) Self-administration of medication, by definition, is only 'when the medication is under the complete control of the individual'.

2) An individual who self-administers their medication is able to demonstrate without assistance:
   a) an ability to obtain their own medication (e.g., from the pharmacy);
   b) an ability to store their medication so that it is inaccessible to others;
   c) an understanding of the type of medication, its purpose, and for what symptoms or condition it is prescribed;
   d) a knowledge of the frequency of doses;
   e) a familiarity with the most common side effects of the medication, if any;
   f) an ability to take their medication by the prescribed route; and
   g) when and how to dispose of expired/discontinued medication.

3) Individuals who self-administer:
   a) do not need the assistance of Certified staff;
   b) do not have medication occurrences filed on their behalf;
   c) do not need to document the self-administration of their medication;
   d) do not need to add 'Schedule II-V' (i.e., countable controlled substances) medication and 'high-risk Schedule VI' medication to a *Countable Controlled Substance Book*; and'
   e) do not need to store their medications with those of individuals who are not self-administering.
      i) If it is required that the individual's medication be stored in the MAP Registered site's medication storage area (to protect the safety of other individuals), it is permissible provided only the intended individual maintains the key to their locked container of medication.

Policy No. & Issue	**20-2 Definition and Criteria for Learning to Self-Administer Medication**
Policy Source	**December 1994 MAP Advisory Supervisor's Training Manual**

1) For the purposes of MAP, an individual is considered 'learning to self-administer' their medication if assistance is required from Certified/licensed staff with any of the following:
   a) obtaining their medication (e.g., from the pharmacy);
   b) storing their medication so that it is inaccessible to others;
   c) understanding the type of medication, its purpose, and for what symptoms or condition it is prescribed;
   d) having a knowledge of the frequency of doses;
   e) being familiar with the most common side effects of the medication, if any;
   f) taking their medication by the prescribed route; and
   g) knowing when and how to dispose of expired/discontinued medication.

2) For individuals who do not meet the criteria for self-administration (*See Policy No. 20-1*) and are 'learning to self-administer', Certified or licensed staff are responsible for medication administration and medication security.
   a) Individuals who are 'learning to self-administer' their medication are not to be considered self-administering.
      i) The Service Provider for the MAP Registered site must ensure that any individual who requires assistance with medication administration has trained Certified staff and/or licensed nurses on-site during times when the medications are to be administered.

Policy No. & Issue **20-3 Self-Administration of Medication Skills Determination/Assessment**
Policy Source **Supervisor's Training Manual**

1) When an individual could benefit from training and assistance in 'learning to self-administer' their medications, a 'Self-Administration of Medication Skills Determination/Assessment' should be completed.
   a) A team (e.g., familiar staff, a nurse consultant [if available], the individual, etc.) coordinates in determining the individual's ability to learn to self-administer their medication; including defining the specific supports required to meet the need(s) of the individual (who will be learning to self-administer their medication).
      i) To document a self-administration of medication skills determination/assessment, the Service Provider may either use the Self-Administration of Medication Skills Determination/Assessment form (*See Policy Section 20 for sample 'Observation Tool for Self-Administration of Medication Skills' form*) or use a Self-Administration of Medication Skills Determination/Assessment form created by the Service Provider.

2) The outcome of the 'Self-Administration of Medication Skills Determination/Assessment' is the basis for developing an 'Individualized Medication Plan' (e.g., Community Service Plan [CSP], Individual Treatment Plan [ITP], Individualized Service Plan [ISP], etc.), as applicable.

3) It is recommended that when an individual, (who has participated in a Self-Administration of Medication Determination/Assessment) moves (e.g., to another MAP Registered site), that they be reevaluated. The prescribing Health Care Provider (HCP), along with the team, will determine:
   a) additional needed supports (if any);
   b) oversight required; and
   c) the development of a teaching/support plan.
      i) The teaching/support plan should include the strategies needed for the individual to follow including:
         (1) prior to the transfer;
         (2) during the transfer; and
         (3) following the transfer.
      ii) To assist in the process, a self-administration of medication skills determination/assessment' may be completed and the findings reviewed with the HCP.

Observation Tool for Self-Administration of Medication Skills

CLICK HERE TO ACCESS THE SAMPLE *Observation Tool for Self-Administration of Medication Skills* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

Policy No. & Issue **20-4 Development of a Learning to Self-Administer Medication Teaching/Support Plan**
Policy Source **Supervisor's Training Manual**

1) The 'Self-Administration of Medication Skills Determination/Assessment' (*See Policy No. 20-3)* is the basis for developing a 'Self-Administration of Medication Teaching/Support Plan'.
   a) The Health Care Provider (HCP) must be included in the decision to begin teaching and assisting the individual in 'learning to self-administer' their medication.
      i) This may require the HCP be given an explanation of the methods used to teach and what kind of supervision and monitoring will be used to ensure that the individual receives their medication as prescribed.
         (1) The individual's HCP will continue to prescribe the individual's medication and monitor its effectiveness.

2) When State Agency regulations require a clinical team to develop a Learning to Self-Administer Teaching/Support Plan (e.g., Community Service Plan [CSP], Individual Treatment Plan [ITP], Individualized Service Plan [ISP], Individualized Medication Plan, etc.), it is recommended that the plan includes, but is not limited to:
   a) goals to be achieved;
   b) a specified time-frame for goal achievement; and
   c) a plan of action for obtaining medications.
      i) The plan of action for obtaining medications must be consistent with MAP Regulations, Policies, and Curriculum.

3) The Teaching/Support Plan (*See Section 20 'Learning to Self-Administer Medication Teaching/Support Plan' sample form)* should be individualized and documented in accordance with applicable State Agency requirements (e.g., CSP, ITP, ISP, etc.). In addition, there should be documented periodic reviews, as applicable.
   a) For individuals supported by a program funded, operated, or licensed 'by the Department of Mental Health' (DMH):
      i) If an individual's CSP does not include a Medication Self-Administration Training goal or objective, Service Providers must ensure the individual has an accompanying medication Teaching/Support Plan.

4) If use of a 'pill-organizer' is to be part of the individual's Self-Administration of Medication Teaching/Support Plan, it should be one of the first steps that the individual learns *(See Policy No. 20-5*).
   a) Certified/licensed staff may not pre-pour medication for individuals as part of the Teaching/Support Plan.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

Learning to Self-Administer Medication Teaching/Support Plan

CLICK HERE TO ACCESS THE SAMPLE *Learning to Self-Administer Medication Teaching/Support Plan* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

Policy No. & Issue **20-5 Learning to Self-Administer Medication and the Appropriate Use of Pill-Organizers**
Policy Source **1997 DMH Memorandum**

1) The use of a 'Pill-Organizer' is permitted when individuals are deemed that they are 'learning to self-administer their medication'.

2) If the use of a Pill-Organizer is part of the individual's Self-Administration of Medication Teaching/Support Plan, it should be one of the first steps of the learning process.
   a) Certified/licensed staff may not package medication into a Pill-Organizer, as part of an individual's teaching/support plan.

3) The Self-Administration of Medication Teaching/Support Plan (*See Policy No. 20-4*) may include the individual packaging their 'regularly scheduled' medication into a Pill-Organizer provided:
   a) the individual's 'Self-Administration of Medication Skills Determination/Assessment' indicates the individual's readiness;
   b) documentation from each of the individual's Authorized Prescribers (i.e., Health Care Provider(s) [HCP]) indicates approval (as applicable) for the individual to participate in a plan for 'learning to self-administer' any/all of their 'regularly scheduled' prescribed medication;
      i) The HCP Order must include the specific medication(s) and the number of days/doses the individual may package and hold their regularly scheduled medication.
         (1) Any changes in the individual's HCP Order regarding the number of days/doses the individual may package and hold must be documented (*See Policy No. 20-6*) and reviewed with all staff.
   c) Medication Information Sheets are provided to the individual;
   d) the Pill-Organizer is marked with the individual's name; and
   e) documentation is completed by the Certified staff to include their observation of the individual packaging of the regularly scheduled medication. Documentation may be done on an Observation Sheet (e.g., Medication Administration Record), as well as, a Medication Progress Note.

4) The Self-Administration of Medication Teaching/Support Plan (*See Policy No. 20-4*) may include the individual packaging their 'PRN' (i.e., as needed) medication into a Pill-Organizer provided:
   a) the individual's 'Self-Administration of Medication Skills Determination/Assessment' indicates the individual's readiness;
   b) documentation from each of the individual's Authorized Prescribers (i.e., Health Care Provider(s) [HCP]) indicates approval (as applicable) for the individual to participate in a plan for 'learning to self-administer' any or all of their 'PRN' (as needed) prescribed medication;
      i) The HCP Order must include the specific medication(s) and number of 'PRN' doses the individual may package and hold.
         (1) Any changes in the individual's HCP Order regarding the number of PRN doses the individual may package and hold must be documented (*See Policy No. 20-6*) and reviewed with all staff.
            (a) In MAP, the individual may package and hold 'no more' than seven (7) doses of any PRN medication.
   c) the PRN medication is packaged 'separately' in the Pill-Organizer from the 'regularly scheduled' medication;

i) If the individual is using a second Pill-Organizer to package the PRN medication, then the second Pill-Organizer must be marked with the individual's name.

d) Medication Information Sheets are provided to the individual;

e) the individual demonstrates an understanding of the type of PRN medication, including the reason for its use, the recommended time (e.g., hours) between doses, the maximum number of daily doses, and for what signs/symptoms it is being prescribed;

f) documentation is completed by the Certified staff to include their observation of the individual packaging of the PRN medication. Documentation may be done on an Observation Sheet (e.g., Medication Administration Record), as well as, a Medication Progress Note; and

i) The documentation on the Medication Progress Note should include when the PRN dose(s) was taken by the individual and its effectiveness.

(1) There must be a mechanism in place (e.g., individual notifies the MAP Registered site that they have taken a PRN medication and its effect) to ensure that documentation of the ingestion of the PRN medication and the effectiveness of the medication is completed.

g) information documented about the 'PRN' medication is communicated to the individual's HCP (as applicable).

5) When the Pill-Organizer is returned by the individual at the designated time, Certified staff must document the contents of the Pill-Organizer as either: 'empty' (i.e., no medication remains in the Pill-Organizer) or 'not empty' (i.e., medication remains in the Pill-Organizer).

a) If the Pill-Organizer is returned with remaining medication, Certified staff should report and document which day(s) and time(s) the remaining medication was intended to be taken (*See Policy No. 20-6*).

i) Any remaining medication in the Pill-Organizer must be reported, (as applicable).

(1) Any unused medication must be disposed per MAP Policy.

ii) Documentation must include any recommendations given by the HCP.

Policy No. & Issue **20-6 Documentation of the Learning to Self-Administer Medication Process**
Policy Source **Supervisor's Training Manual**

1) Documentation of the Learning to Self-Administer Medication Process includes, but is not limited to:
   a) completed Self-Administration of Medication Skills Determination/Assessment (*See Policy Section 20 for sample 'Observation Tool for Self-Administration of Medication Skills'*);
   b) Health Care Provider (HCP) Order(s) for the individual to learn to self-administer their medication;
      i) The HCP Order should include how many days/doses the individual may package and hold their 'regularly scheduled' and/or 'PRN' medication (*See Policy No. 20-5*).
         (1) An HCP Order is required from each prescribing HCP, (as applicable).
   c) Self-Administration of Medication Teaching/Support Plan (*See Policy Section 20 for Sample 'Self-Administration of Medication Teaching/Support Plan');*
      i) The Teaching/Support Plan must clearly identify the specific role of the Certified staff in the process of assisting the individual to self-administer their medication.
      ii) When a 'Pill-Organizer' is used by the individual in the process of learning to self-administer, the Certified staff should document the individual's packaging on an Observation Sheet (e.g., Medication Administration Record [MAR] and Medication Progress Note) (*See Policy No. 20-5*).
         (1) When an MAR is used for this purpose, it must clearly indicate that Certified staff is observing the individual packaging their medication under the supervision of Certified staff.
         (2) When documenting on the MAR, the Certified staff observing the packaging should use the code 'P' (i.e., Packaged) in the applicable date and time section on the medication grid(s).
            (a) When the code 'P' is used, additional documentation (e.g., Medication Progress Note) is required.
               (i) Medication Progress Note documentation should indicate that the medication was packaged by the individual; including, the name of medication, the dosage, the quantity of medication packaged, the date medication was packaged, and the signature of the Certified staff observing the individual packaging the medication.
      iii) The Teaching/Support Plan must clearly identify how the individual will participate in the process of learning to self-administer their medication.
         (1) When a Tracking Tool is part of the individual's Teaching/Support Plan, documentation by the individual on a calendar is acceptable.
            (a) The medication name(s), dosage(s) and time(s) may be written accurately on the Tracking Tool by a Certified staff (if the individual needs support in this area).
      iv) Documentation of the Training/Support Process may be accomplished by a State Agency's specific assessment/planning process (e.g., Community Service Plan [CSP], Individual Treatment Plan [ITP], Individualized Service Plan [ISP], etc.).
         (1) A six (6) month training period with close supervision is recommended followed by periodic pill counts for another three (3) months.

2) The individual's team, in consultation with the individual's HCP, will decide when an individual is reliably self-administering their medication.

a) Before an individual may be deemed self-administering of their medication, Certified staff should witness and document the individual preparing and taking their medication.

3) After an individual has been deemed self-administering of their medication, ongoing oversight and/or documentation to be completed, if any, is the responsibility of the Service Provider.

Policy No. & Issue	**20-7 Ongoing Supports for Individuals Learning to Self-Administer their Medication**
Policy Source	**Supervisor Training Manual**

1) If an individual has maximized their capabilities and continues to require ongoing supports within the Learning to Self-Administer Medication Process, the individual may remain indefinitely in the Learning to Self-Administer Phase of the process (as they are unable to meet the definition/criteria for self-administration of their medication) (*See Policy No. 20-1*).
   a) The Learning to Self-Administer Phase of the Learning to Self-Administer Medication Process should be supported with goals identified in an Individualized Medication Plan.
      i) An Individualized Medication Plan can be documented as an Independent Training Plan or as part of the Individualized Service Plan (ISP), Community Service Plan (CSP), Individual Treatment Plan (ITP), etc.
   b) Individuals who are learning to self-administer their medication are not to be considered self-administering.
      i) DPH and State Agencies support the concept of an individual's self-administration of medication whenever feasible. If an existing Policy inhibits the goal of self-administration, it should be brought to the attention of the DPH for review.

Policy No. & Issue **20-8 Change in Individual's Status Warranting a Reevaluation**
Policy Source **Supervisor Training Manual**

1) A Reevaluation of medication skills is required following an event (e.g., after hospitalization for major illness, etc.) or change in status (e.g., alteration in vision, etc.), whereby an individual has demonstrated, or potentially could demonstrate an inability to reliably engage in the 'Self-Administration' of their medication or in the 'Learning to Self-Administer Medication Process'.
   a) The Reevaluation should determine if the individual continues to meet the criteria for 'Self-Administration' or the 'Learning to Self-Administer Medication Process'.
      i) To assist in the Reevaluation, it may be beneficial to have a skilled clinician perform a Self-Administration of Medication Determination/Assessment with the individual and review the findings with the Health Care Provider (HCP).
         (1) Pending the Reevaluation, MAP Certified or licensed staff may be required to administer medication.

21

DPH CLINICAL REVIEW AND INSPECTIONS

Policy No. & Issue **21-1 DPH Clinical Reviews and Inspections**
Policy Source **DPH Policy**

1) For the purpose of evaluating the Medication Administration Program (MAP) for safety and effectiveness, the DPH Drug Control Program (DCP) conducts both Clinical Reviews and Inspections.
   a) The outcomes of these evaluations facilitate the determination of the areas of strength and weakness. This in turn allows the DPH and the State Agencies to:
      i) develop Policy;
      ii) revise the Curriculum, Training and Testing; and
      iii) address specific concerns raised by the Reviews/Inspections.
2) The DPH Clinical Review conducted by the DCP Clinical Reviewer and/or the DCP MAP Coordinator(s) addresses clinical issues specific to medication administration, practices, and systems as defined by 105 CMR 700.000 *et seq*.
3) The DPH Inspection conducted by the DCP Inspector(s) is specific to the security and accountability of Schedule II-VI controlled substances (prescription medications).

Policy No. & Issue **21-2 DPH Clinical Review Process**
Policy Source **MAP Policy Manual**

1) The steps of the Department of Public Health's Clinical Review Process for the Medication Administration Program may be summarized as follows:
   a) Service Providers are notified by DPH of the date and time scheduled for a Clinical Review.
   b) The Clinical Review Process is conducted at the MAP Registered site(s) and/or the Service Provider's administrative office(s), selected by DPH.
   c) Following the Clinical Review, findings are reviewed with the Service Provider.
   d) A copy of the Clinical Review findings is subsequently forwarded by DPH to the Service Provider and the applicable State Agency.
   e) The Service Provider is required to submit a Plan of Correction within ten (10) days to DPH and the applicable State Agency.
   f) The applicable State Agency, in consultation with DPH, conducts follow-up when appropriate.

22

HOSPICE CARE SERVICES

Policy No. & Issue **22-1 Hospice Care Services: Protocol for Instituting**
Policy Source **MAP Policy Manual**

1) Individuals who are receiving Hospice Care Services may be supported at a MAP Registered site.

2) When Hospice Care Services are being initiated at a MAP Registered site, the Service Provider must:
   a) notify the applicable MAP Coordinator regarding Hospice Care Services;
   b) identify a Hospice Point Person (HPP) employed by the Service Provider (e.g., Site Supervisor, Program Director, Nurse, etc.);
      i) If the HPP will not be available, an alternate HPP, employed by the Service Provider, should be identified.
   c) ensure that MAP Registered site residential staff receive 'Hospice Care Services Orientation' Training; and
   d) ensure that Hospice Care Services personnel are oriented to the Medication Administration Program (MAP).

3) When Hospice Care Services are initiated at a MAP Registered site, an HPP must be identified. The Responsibilities of the HPP include, but are not limited to:
   a) acting as a Liaison or 'Gate Keeper' (specific to the Hospice Care) between the MAP Registered site and the (as applicable):
      i) Residential staff;
      ii) Day Program staff;
      iii) School staff;
      iv) Family and/or Guardian;
      v) Support System (e.g., individual's friends, Clergy, Case Manager, etc.);
      vi) Visiting Resources (e.g., Oxygen Supply Company, etc.); and
      vii) Hospice Care Services.
   b) establishing the Hospice Care Record Keeping System *(See Policy No. 22-3)* for the MAP Registered site, to consist of the:
      i) Individual's Health and Information Record;
      ii) Health Care Provider (HCP) Orders;
      iii) Medication Administration Records (MAR[s]);
      iv) Communication documents (e.g., Medication Progress Notes, Narrative Notes, Clinical Progress Notes, etc.);
      v) Consent Status information; and
      vi) End-of-Life Wishes for Care documents (e.g., Medical Orders for Life-Sustaining Treatment [MOLST], Comfort Care [CC]/Do Not Resuscitate [DNR], etc.).
   c) arranging for training in:
      i) 'Hospice Care Services Orientation' for the MAP Registered site residential staff;
      ii) the 'Hospice Care Services Record Keeping System' and all Hospice-Related documents;
      iii) the criteria for 'When to Call Hospice Nursing'; and
      iv) 'Orientation to the Medication Administration Program (MAP)' for the Hospice Care Services personnel.
   d) ensuring that there is a system for:

i) ongoing review of the 'Communication Documentation' (e.g., Medication Progress Notes, Narrative Notes, Clinical Progress Notes, etc.); and
ii) establishing and maintaining open lines of communication between all of the individual's Care Team Members including Hospice Care Services personnel.

4) When Hospice Care Services are initiated at a MAP Registered site; both the staff working at the site, and the personnel who will be providing the Hospice Care Services, must receive an Orientation.

a) 'Hospice Care Services Orientation' Training, for the MAP Registered site residential staff, should be provided by the Hospice Care Services personnel. The 'Hospice Care Services Orientation' Training should include, but is not limited to:
i) the Hospice Care Services available;
ii) the eligibility criteria for Hospice Care;
iii) the role of the Primary Hospice Care Nurse, along with:
(1) how to contact;
(2) when to contact; and
(3) the hospice home visits.
iv) the role of Home Health Aides provided by Hospice Care Services;
v) information on obtaining Hospice Medications and Health Care Provider Orders;
vi) information regarding the Hospice Palliative Care Emergency Kit (E-Kit);
vii) documentation;
viii) procuring equipment;
ix) Spiritual Needs;
x) Social Services; and
xi) Education/Support Services available for the:
(1) individual;
(2) individual's peers and friends;
(3) individual's roommates;
(4) MAP Residential site staff; and
(5) individual's family.

b) 'Orientation to Medication Administration Program (MAP)', for the Hospice Care Services personnel, should be provided by the MAP Registered site residential staff. The 'Orientation to MAP' should include, but is not limited to the:
i) HPP role and their contact information;
ii) overview of how the MAP Registered site operates;
iii) overview of MAP, including specific Hospice Care MAP Policies/Procedures;
iv) 'Hospice Record Keeping System' in accordance with MAP Policy;
v) review of the staffing pattern for the MAP Registered site;
vi) MAP Registered site specific information;
vii) individual's Guardianship Status and Health Care Proxy Status;
viii) review of the individual's Emergency Fact Sheet; and
ix) individual's End-of-Life Wishes for Care.

5) Documentation of the completion of the 'Hospice Care Services Orientation' Training and the 'Orientation to MAP', includes but is not limited to the:

a) Trainer name(s) and contact information;
b) name(s) of staff/personnel trained/oriented; and
c) date(s) of training/orientation.

i) Documentation of the Training/Orientation should be maintained at the MAP Registered site.

Policy No. & Issue **22-2 Hospice Care Services: MAP Policies Exemptions**
Policy Source **MAP Policy Manual**

1) When supporting an individual, who is receiving Hospice Care Services, the Medication Administration Program (MAP) Residential site is permitted an exemption from MAP Policy. The exemptions include:
   a) The sealed 'Hospice Palliative Care Emergency Kit' (that contains a small supply of medication that may be used for an individual receiving Hospice Care Services) is permitted to be initially reconciled in the *Countable Controlled Substance Book* as 'one' sealed item.
      i) The sealed 'Hospice Palliative Care Emergency Kit' (E-Kit) must be secured under a double key-lock (*See Policy Section 12*).

2) When the sealed E-Kit is brought into the MAP Registered site in anticipation of the increased need for medication supports, it may contain 'Schedule II-V' (i.e., countable controlled substances) medication or 'high-risk Schedule VI' medication.
   a) Until the E-Kit is opened for use:
      i) the presence of the 'sealed E-Kit' should be documented as 'one sealed item' in the *Countable Controlled Substance Book.*
   b) Once the E-Kit is unsealed (opened):
      i) each 'Schedule II-V' (i.e., countable controlled substances) medication and 'high-risk Schedule VI' medication within the E-Kit must be added to a separate 'Index' line in the *Countable Controlled Substance Book;* and
      ii) each 'Schedule II-V' (i.e., countable controlled substances) medication and 'high-risk Schedule VI' medication must be entered onto a separate Count Sheet page in the *Countable Controlled Substance Book*.
         (1) All 'Schedule II-V' (i.e., countable controlled substances) medication and 'high-risk Schedule VI' medication must be received from the pharmacy in tamper-resistant packaging *(See Policy No. 10-1*).

3) Certified staff are permitted to support and care for an individual, who is receiving Hospice Care Services, and has been prescribed a 'Pre-filled Automatic Medication Infusion Device' provided:
   a) the Certified staff do not operate the device including administration of a bolus or calibration of the device;
   b) there is an Individualized 'Pre-filled Automatic Medication Infusion Device Protocol' in place. The Individual's Protocol should include, but is not limited to:
      i) what to observe (including subjective and objective information);
      ii) who to contact regarding observations; and
      iii) how to document observations and actions taken.
         (1) Certified staff may observe and report the condition of the Infusion Device and the insertion site per the Individual's Protocol.
   c) the Certified staff have received *Pre-filled Automatic Medication Infusion Device Protocol Training* (including observing, reporting, etc.) from the Hospice Care Services personnel.
      i) Documentation of the completion of the *Pre-filled Automatic Medication Infusion Device Protocol Training*, includes but is not limited to the:
         (1) Trainer name(s) and contact information;
         (2) date(s) of training; and
         (3) name(s) of Certified staff trained.

(a) Documentation of the Training should be maintained at the MAP Registered site.

CLICK HERE TO ACCESS THE OPTIONAL *Hospice Notebook Cover* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE OPTIONAL *Hospice Notebook Tabs* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE SAMPLE *Admission to Hospice Care Services Checklist* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE SAMPLE *Hospice Contacts List* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE SAMPLE *Hospice Intake Addendum* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE SAMPLE *Hospice Progress/Narrative Notes* ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

CLICK HERE TO ACCESS THE SAMPLE *Hospice Pain Review for an Individual Who is Non-Verbal* FORM ON THE MASS.GOV MAP PAGE www.mass.gov/dph/map

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RESOURCES

Policy No. & Issue **23-1 Contacts**
Policy Source **MAP Policy Manual**

1) For guidance and technical assistance with any MAP Policy, you may contact your Area/Regional/Statewide MAP Coordinator. Click here for the MAP State Agency Contact List including DPH Clinical Reviewer, DPH MAP Coordinator, MAP Directors and MAP Coordinators.

2) For the DCP MAP Website, click here.

DPH, State Agencies, and Other Contacts for MAP

DPH and State Agencies contact information is also available on the agency website through the Massachusetts portal at:

www.mass.gov

Department of Public Health (DPH)

www.mass.gov/dph/map

Drug Control Program (DCP):

www.mass.gov/dph/dcp

Massachusetts Medication Administration Program Training Resources and Support:

www.mapmass.com

State Contracted Testing Vendor:

D&S Diversified Technologies, LLP dba HEADMASTER, LLP (D&S DT):

Click here for MAP Testing Information

Click here for Massachusetts MAP (Certification) Registry, or ma.tmuniverse.com

Department of Mental Health (DMH):

www.mass.gov/dmh

Department of Developmental Services (DDS):

www.mass.gov/dds

Department of Children and Families (DCF):

www.mass.gov/dcf

MassAbility:

www.mass.gov/orgs/massability

Clinical Laboratory Improvement Amendment (CLIA) Certificate of Waiver Clinical Laboratory Program:

www.mass.gov/dph/clp

Board of Registration in Medicine (BORIM):

www.mass.gov/massmedboard

Board of Registration in Nursing (BORN):

www.mass.gov/dph/boards/rn

Board of Registration in Pharmacy (BORP):

www.mass.gov/orgs/board-of-registration-in-pharmacy