

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)
Medication Administration Program (MAP)

MAP Policy Manual

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

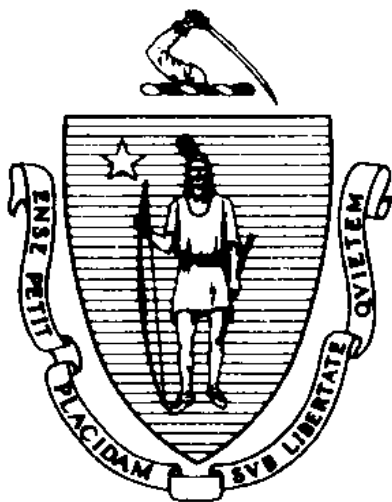


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01

SITE REGISTRATION REQUIREMENTS

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue	01-1 MAP Policy Manual as Required Reference Material
Policy Source	MAP Policy Manual
Issued Date:	9/01/10
Last Revision Date:	10/01/13

- 1 The Departments of Public Health, Mental Health, Developmental Services, and Children and Families have compiled all existing Medication Administration Program advisories and policies into one comprehensive document, the MAP Policy Manual.
 - a. For an explanation of terms frequently used within the MAP Policy Manual, see *Definition of Terms* on page 7.
- 2 The MAP Policy Manual is intended to provide Service Providers, trainers, staff and other interested parties with a single, topically organized source for MAP policies. As a condition of registration, each site registered with DPH must maintain a copy of this policy manual, as well as the current MAP Training Curriculum, as part of the required reference materials for MAP Certified staff.
- 3 A Program Site may elect to keep a virtual electronic copy provided:
 - a. latest version is readily accessible;
 - b. documentation is available that 'all' Certified staff know how to access it;
 - c. must be accessible twenty-four hours a day, seven days a week; and
 - d. must have a contingency plan in place in the event the site's computer is not functioning.

Definition of Terms

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 a person (adult or youth) supported by programs funded, operated, or licensed by or 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 receives medications 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 him/her to administer medications for MAP registered sites.
- 4 Licensed Staff: A nurse (RN, LPN) currently licensed in the state of Massachusetts, who is legally authorized to practice nursing.
- 5 Nurse Monitor: A Registered Nurse meeting the requirements for Medication Administration Program (MAP) Approved Trainer as set forth in MAP Policy 3-1, who provides additional MAP clinical monitoring to Department of Mental Health (DMH)/Department of Children and Families (DCF) youth programs.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue	01-2 Criteria for Site Registration with DPH
Policy Source	April 1997 MAP Advisory Supervisor's Training Manual
Issued Date:	04/97 5/15/98 Last Revision Date: 01/01/15

- 1 MAP DPH regulations are intended to address the medication administration needs of stable individuals who are living in DMH/DCF and adult DDS licensed, funded, or operated community residential programs that are their primary residences and/or are participating in day programs and short-term respite programs.
 - a. MAP does not apply to medication administration during school hours for residential schools. It only applies to the administration of medication in the residences listed above. (Refer to DPH Regulations 105 CMR 210.000 for medication administration during school hours).
- 2 These community residential programs, day programs, and short-term respite programs may register with DPH for the purpose of authorizing non-licensed employees to administer or assist in the administration of medications (105 CMR 700.000 and 105 CMR 700.004(C)(1)(i)).
- 3 Those programs listed above that meet the criteria for site registration must apply for a Massachusetts Controlled Substance Registration (MCSR) from DPH (*see Policy No. 01-3 on page 10*). The MCSR allows for the storage of medications at the site registered.
- 4 All sites are registered under the corporate name (name of Service Provider) not the program, (e.g., registered as Parabold Family Center, not April House). The MCSR is issued to the licensed corporate provider, at the geographic site, at which the medication is stored. For example, if there is a three family house with three staffed apartments (one on each floor) and all three apartments store medications, then all three apartments must obtain separate MCSRs. DPH issues three MCSRs, one for each apartment, not one MCSR covering the entire house. The name of the Service Provider will appear on all three MCSRs.
- 5 The original MCSR must be kept at the site with a copy of the MCSR kept at the Service Provider's administrative office, or vice versa.
- 6 Staff will need the MCSR number in order to complete a Medication Occurrence Report (MOR). This number (MAP plus five (5) digits) is recorded in the section of the MOR that requests the "DPH Registration Number" (*see Policy No. 09-7 on page 102*). In addition, the MCSR number is needed when requesting information from DPH. The MCSR number should be included in all correspondence.
- 7 The MCSR is valid for one year. Renewal forms must be submitted to DPH one month before the MCSR expires. The application or renewal process should take approximately four to six weeks. The previous MCSR will remain in effect until the renewal MCSR is received as long as the site has applied for renewal prior to the expiration date of the current MCSR. If you do not receive the MCSR within eight weeks, please contact DPH (*see Policy No. 17-1 on page 193*).
- 8 The MCSR applications for renewal and MCSRs are mailed to the Licensed Corporate Provider's administrative address, not the site address.

- a. The licensed Corporate Provider should keep the DPH advised of current mailing address, phone number, and contact person for the site.
- 9 MCSRs are not transferable. The MCSR issued to a site must be returned to DPH if:
- a. medications are no longer stored at that site;
 - b. registered site no longer houses DMH/DCF/DDS individuals;
 - c. the individuals are all self-administering; or,
 - d. the corporate provider changes.
 - i. If a site closes or changes ownership, the site is required to immediately return the MCSR to DPH with a written letter stating that the site is closed and the date of closure.
 - ii. If the site changes ownership, the new corporate provider must apply for a new registration in advance of the effective date of such change.
- 10 If a registered site plans to relocate, a written letter should be sent to the DPH, prior to the move, stating the change of address. The letter should include the date the new site will open and the date that the old site will close. The corporate provider for the relocated site must apply for a new registration in advance of the effective date of the change in address. DPH will make the necessary changes and issue an updated MCSR for the new location.
- a. The MCSR for the prior site must be returned to DPH immediately.
- 11 All new, renewal or amended information, require an application form (*see Policy No. 01-3 on page 10*).

**MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL**

Policy No. & Issue 01-3 Application for Controlled Substance Registration

Policy Source DPH Form

Issued Date: 10/06/97

Last Revision Date: 9/01/10

*APPLICATION FOR MASSACHUSETTS CONTROLLED SUBSTANCE REGISTRATION
(MCSR) FORMS MAY BE DOWNLOADED FROM THE DPH WEBSITE (see Policy No. 17-1
on page 193 for website access information).*

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MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 01-4 Administration to Youth

Policy Source April 1997 MAP Advisory

Issued Date: 04/97

Last Revision Date: 10/01/13

- 1 DPH regulations at 105 CMR 700.003 do not set the criteria for medication administration to individuals under the age of 18 years of age.
- 2 Direct care staff may be trained and Certified under MAP to administer medications to individuals (both adults and youth) in programs supported by the Department of Mental Health and/or the Department of Children and Families.
- 3 Direct care staff are not trained nor Certified under MAP to administer medications to individuals under the age of 18 years in programs supported by the Department of Developmental Services.

02

STAFF CERTIFICATION

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**MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL**

Policy No. & Issue 02-1 Certification Process and Guidelines

Policy Source April 1997 MAP Advisory

Issued Date: 04/97

Last Revision Date: 01/01/15

- 1 MAP Certification is valid for use only in adult DDS community programs; youth and adult DMH community programs; and youth and adult DCF community programs that possess a current and valid Massachusetts Controlled Substances Registration (MCSR) from the Department of Public Health.
- 2 Direct care staff, including licensed nurses working in positions that do not require a nursing license, must be Certified in MAP in order to administer medications in DMH, DCF, or DDS community programs.
- 3 Staff must be at least eighteen years of age to be Certified to administer medications.
- 4 Staff may not administer medications until they pass a D&S Diversified Technologies administered Computer-Based (Knowledge) Certification Test and MAP Skills (Transcription, Medication Administration Demonstration) Tests.
- 5 D&S Diversified Technologies conducts all initial MAP Certification Testing.
- 6 Upon completion of an approved MAP Certification Training Class and attaining a successful Pretest score, staff may be eligible to be tested by D&S Diversified Technologies.
 - a. Staff are eligible to take a Computer-Based (Knowledge) Test (CBT).
 - b. Staff may be reassessed up to three (3) times.
 - i. Staff are allowed up to three failures consisting of any combination of the 3 components (Knowledge Test, Transcription Test, Medication Administration Demonstration) of the MAP Certification Test.
 - c. After three failures, staff must complete the full MAP Certification Training again or complete remedial training given by the current MAP Trainer of record on the D&S database.
 - i. After completion of the additional training, staff may be eligible to retest through D&S Diversified Technologies
 1. Staff are again tested on all 3 components (Knowledge Test, Transcription Test, and Medication Administration Demonstration) of the MAP Certification Test.
- 7 Staff have one year from the date of successful completion of the MAP Certification Training to attempt to pass the MAP Certification Test.
 - i. If the staff does not pass the MAP Certification Test within one year, he/she must again complete the full MAP Certification Training.
- 8 MAP Certification is effective on the date that the test results are posted on the D&S Diversified Technologies website indicating that the staff passed the MAP Certification Test.
- 9 MAP Certification is valid for two years from the last day of the month in which the test was passed. For example, if a staff person passes the MAP Certification Test on 1/12/15 and

another staff person passes the test on 1/28/15; the expiration date in both cases is 1/31/17.

10 Once MAP Certification expires, staff have one year to recertify before he/she must complete the full MAP Certification Training and retake both the Computer-Based (Knowledge) and Skills (Transcription, Medication Administration Demonstration) Tests.

i. During this period of time, staff may not administer medications.

11 It is the responsibility of both the Service Provider and the MAP Certified staff to track the MAP Certification period and to assure MAP Certification remains current and valid.

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MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 02-2 Acceptable Proof of MAP Certification for Staff

Policy Source February 1998 DMH Memo

Issued Date: 2/28/98

Last Revision Date: 10/01/13

- 1 Only the following two documents are acceptable proof of Certification to administer medications:
 - a. a copy of the Certification printout from the D&S Diversified Technologies website confirming that the staff person has passed the MAP Certification test; or
 - i. This can be found on the D&S Diversified Technologies MAP Registry Database (*see Policy No. 17-1 on page 193 for website address*).
 - b. a signed copy of a successfully completed MAP Recertification Competency Evaluation Form.
 - i. A copy of the MAP Certification printout must replace this form as soon as it is received.
- 2 A staff person's MAP Certification status may be verified at any time by checking the D&S Diversified Technologies MAP Registry Database (*see Policy No. 17-1 on page 193 for website address*).
- 3 Community programs are required to maintain acceptable proof of MAP Certification.
- 4 Copies of MAP Certification printouts must be kept either at the Service Provider's administrative office or at the site to which the staff person is assigned.
 - a. If copies of MAP Certification printouts are kept on-site, then a master list of all MAP Certifications dates of expiration must be maintained at the Service Provider's administrative office.
 - b. If copies of MAP Certification printouts are kept at the Service Provider's administrative office, then a master list of all MAP Certifications with dates of expiration must be kept at each site.
 - c. Sites should be prepared to provide copies of MAP Certification printouts within 10 days of a request made by DPH, DMH, DCF, or DDS.
- 5 Master lists may be in written, printed, electronic, or any other readily retrievable format.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 02-3 Revocation of Certification

Policy Source April 1997 MAP Advisory

Issued Date: 04/97

Last Revision Date: 12/01/11

- 1 A person's Certification may be revoked in accordance with regulations of the Department of Mental Health at 104 CMR 28.06(9) (d) and (e) and the Department of Developmental Services at 115 CMR 5.15(6) (a) and (b). A Certification may be withdrawn or rejected if the Department 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 the health, safety and welfare of community program residents; or
 - d. is unfit to perform the duties for which the Certification was granted.
- 2 The Service Provider shall be responsible for notification of their MAP regional/area Coordinator(s) regarding any actions involving employees in these areas.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 02-4 MAP Testing Application

Policy Source DMR/DDS Forms

D&SDT Form

Issued Date: 04/97 8/01/00

Last Revision Date: 12/01/11

APPLICATIONS FOR MAP TESTING MAY BE DOWNLOADED FROM THE D&S DIVERSIFIED TECHNOLOGIES WEBSITE (see Policy No. 17-1 on page 193 for website access information).

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MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 02-5 MAP Pre-testing

Policy Source MAP Policy Manual

Issued Date: 9/30/03

Last Revision Date: 10/01/13

- 1 Staff are required to pass a Standardized Knowledge Pretest, a Transcription Skills Pretest, and a Medication Administration Demonstration Pretest before he/she can apply to take MAP Certification Testing.
 - a. Staff must complete MAP Certification Training taught by an Approved MAP Trainer.
 - b. Upon completion of the MAP Certification Training, an Approved MAP Trainer, or a Designated Test Administrator, will administer the D&S Diversified Technologies issued Pretests.
 - i. A Designated Test Administrator is a person who has been authorized to administer the Pretests by an Approved MAP Trainer.
 - c. Upon successfully passing the Pretests, staff may be scheduled to take the D&S Diversified Technologies MAP Certification Test.
 - i. Staff must achieve a score of 80% or better on the Standardized Knowledge Pretest; complete an error-free Transcription Skills Pretest; and complete Medication Administration Demonstration Pretest with a passing score of at least 10 (out of 12) demonstrated tasks acceptably performed.
 1. If the staff person does not pass the Pretests, he/she may take the Pretests again until they pass.
 2. Additional training may be provided, if that is available, to the staff person.
 - d. Pretest Answer Sheets are to be maintained by the Service Provider and be available for review by the DMH/DCF Area or DDS Regional MAP Coordinator upon request.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 02-6 Recertification Process

Policy Source Recertification Evaluation Manual

Issued Date: 12/01/03

Last Revision Date: 12/01/11

- 1 The MAP Recertification Process should be completed in one of two ways:
 - a. by the D&S Diversified Technologies Recertification Testing process to include demonstrated competence in medication administration via the use of a standardized skills test (*see Procedure for MAP Recertification through D&S Diversified Technologies on page 21*);or
 - b. by the Approved MAP Trainer Recertification Evaluation process at an actual program site or as a 'role play' at a site designated by the Provider Agency to include a skills evaluation by an Approved MAP Trainer, using the *MAP Recertification Competency Evaluation Form on page 25*. The results of the evaluation are forwarded to an agency-designated supervisory staff person for review and signature. (*See Procedure for MAP Recertification through Provider Agency on page 22*).

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 02-7 Recertification Guidelines

Policy Source Recertification Evaluation Manual

Issued Date: 12/01/03

Last Revision Date: 01/01/15

- 1 A Certified staff is eligible to Recertify if he/she is in good standing on the MAP Registry.
- 2 To become Recertified, staff must pass the Recertification evaluation or skills test.
 - a. The Recertification Process allows staff becoming Recertified to test up to 90 days before the expiration of his/her current Certification.
 - i. Once the MAP Certificate expires, the staff person may no longer administer medications.
 - ii. The expiration date of the Recertification is two years from the last day of the month in which the Recertification was issued.
- 3 If the Certified staff person takes the MAP Recertification Test through the D&S Diversified Technologies, he/she may continue to administer medications until the results are posted on the D&S Diversified Technologies website.
 - a. Employers are required to check the D&S Diversified Technologies website for test results no later than the second business day after the test.
 - b. If the MAP Recertification Test results show that the staff has failed, the person is no longer considered to be MAP Certified and must immediately stop administering medications even if his/her current Certificate has not yet expired.
 - i. The staff is not permitted to administer medications again until he/she retakes and passes the MAP Recertification Test and the passing results are verified on the D&S Diversified Technologies website.
- 4 If the staff person passes the MAP Recertification Evaluation Process through the Service Provider, he/she may continue to administer medications uninterrupted. If the staff person fails, he/she cannot administer medications until he/she passes a subsequent Recertification Evaluation.
- 5 Staff may be reassessed for Recertification by either process (D&S Diversified Technologies Recertification or Approved MAP Trainer Recertification) up to three (3) times.
 - a. If the staff does not pass the Recertification Process after three attempts, he/she must complete the full MAP Certification Training. Following the MAP Certification Training, staff must successfully pass MAP Certification Testing through D&S Diversified Technologies.

PROCEDURE FOR MAP RECERTIFICATION THROUGH D&S DIVERSIFIED TECHNOLOGIES

Application Process

- 1 Prior to being tested for Recertification by the D&S Diversified Technologies, the staff person must complete the *Medication Administration Program Testing Application Form* (see Policy No. 02-4 on page 17).
 - a. Applications can be submitted via online registration or as a paper application.
- 2 Upon D&S Diversified Technologies acceptance of the application;
 - a. The staff person will be scheduled for a Recertification Skills Test.
 - i. Candidates have the ability to view their scheduled test (including a link to a current test site map and directions) online.
 1. Candidates who registered using a paper application will be mailed (or emailed as an RTF file email attachment) a notification letter.

At the D&S Diversified Technologies Site

- 1 The candidate must arrive at the test site 15 minutes before the times listed on the Notification.
 - a. If the candidate arrives late for the testing, he/she will not be tested.
- 2 When listed, the candidate must attend both Recertification test times scheduled on the Notification. At the test site, the candidate will be tested on demonstrated competence in medication administration via the use of a standardized skills test.
- 3 The candidate must bring two forms of identification to the testing site.
 - a. One form must be a current and clear photo ID.
 - i. The only acceptable forms of a photo I.D. are the following: a valid current US driver's license, a valid current US passport, or a US government issued signed, non-expired photo I.D. issued by the military or the MA Registry of Motor Vehicles. No other Photo I.D. will be accepted.
 - b. Examples of a second ID are: Debit / Credit Card, Utility Bill, etc.
 - c. If the candidate does not bring two forms of identification, he/she will not be tested and will have to reschedule.

Following the D&S Diversified Technologies Test

- 1 Upon completion of the Recertification test, the test results will be available on line through the D&S Diversified Technologies website.
- 2 If the candidate missed or canceled the test, he/she should request a new test date.
 - a. Candidates will be informed on their notification letter of the phone number that they should call to reschedule their test event.

PROCEDURE FOR MAP RECERTIFICATION THROUGH PROVIDER AGENCY

- 1 The staff person seeking Recertification will be evaluated by an Approved MAP Trainer at an actual program site or as a 'role play' at a location designated by the Service Provider Agency.
 - a. An Approved MAP Trainer, using the *MAP Recertification Competency Evaluation Form*, [see *MAP Recertification Evaluation Guide* on page 25 for assistance in form completion], will determine if the staff person is eligible or not eligible to be Recertified.
- 2 After the staff person has concluded the Recertification Evaluation, the Approved MAP Trainer will indicate on the fulfilled *MAP Recertification Competency Evaluation Form* whether the staff person is "Eligible" or "Not Eligible" for Recertification and sign the form.
- 3 Once completed by the Approved MAP Trainer, the completed and signed *MAP Recertification Competency Evaluation Form* should be forwarded to the agency-designated supervisory staff person who:
 - a. reviews the evaluation form to determine if the staff person has been deemed "Eligible" or "Not Eligible"; and
 - i. For a staff person deemed "Eligible", the designated supervisor must indicate whether the staff person is "Recommended" or "Not Recommended" for Recertification.
 1. In the event an "Eligible" staff person is "Not Recommended" for Recertification by the supervisory staff person, the *MAP Recertification Competency Evaluation Form* should be forwarded to a DMH/DCF Area or DDS Regional MAP Coordinator.
 - ii. For a staff person deemed "Not Eligible" the designated supervisor must indicate that the staff person is no longer authorized to administer medications.
- 4 In the event a staff person is no longer authorized to administer medications because the person has been deemed "Not Eligible" for Recertification by the Approved MAP Trainer, the *MAP Recertification Competency Evaluation Form* is kept on file by the provider agency and a copy forwarded to D&S Diversified Technology.
 - a. following the review, must sign and date the form.
- 5 For a staff person who is deemed both "Eligible" and "Recommended" for Recertification, his/her completed and signed *MAP Competency Evaluation Form* are filed in the staff's personnel file.
- 6 The Approved MAP Trainer will update the MAP Registry on the D&S Diversified Technology website to indicate Recertification and current staff demographics.
 - a. A printout indicating the new Certification date will then be available to download from the D&S Diversified Technology website.

MAP Recertification Evaluation Guide
Examiner's Guide for Use with the MAP
Recertification Competency Evaluation Form

- 1 **Identifying Information:** Either the staff applying for Recertification or the Approved MAP trainer may complete this section.
- 2 **Check off List:** This section is to be completed by the Approved MAP Trainer administering the skills exam. Check "Yes" if the staff person demonstrates the skill correctly. Check "No" if the staff does not demonstrate the skill correctly. Comments regarding the individual's performance in regards to a specific skill may be written on the corresponding line under "Comments". Additional comments may be added to the back of form.
 1. **Staff identifies the correct medication sheet(s):** When the staff is told by the Approved MAP Trainer the identity of the individual to whom they will administer medications (actual or role-play), the staff is able to locate the correct medication administration sheet(s) for that individual.
 2. **Staff identifies correct medication(s):** When the staff is told by the Approved MAP Trainer the time of the medication they will be administering to the identified individual; staff is able to review the medication sheet to determine the medication to be given and is able to retrieve the correct medication from storage unit.
 3. **Staff identifies the correct Health Care Provider (HCP) order(s):** Staff is able to identify the correct HCP order that matches the medication retrieved.
 4. **Staff compares the HCP order to pharmacy label:** Staff compares the HCP order to the pharmacy label and verifies that they (five rights) agree.
 5. **Staff compares the pharmacy label to the medication sheet:** Staff compares the pharmacy label on the medication container to the corresponding entry on the medication sheet and verifies that they (five rights) agree.
 6. **Staff prepares the correct dose(s):** Staff pours the correct dose of medication and correctly prepares the medication for proper administration (i.e., it may need to be crushed, dissolved, or diluted).
 7. **Staff compares the pharmacy label to the medication sheet again:** Once the medication(s) are poured and prepared, the staff compares the pharmacy label on the appropriate medication container with the corresponding entry on the medication sheet to once again verify that they (five rights) agree.
 8. **Staff correctly administers medication(s):** Staff identifies the correct individual, explains to that individual what medications are being administered, provides that individual with appropriate agent for administration (water, juice, pudding, tissues for eye drops, etc.), and verifies that medication was successfully ingested or applied (administered via the right route) and safely disposes of medication administration supplies.
 9. **Staff looks again, then correctly documents administration:** Staff looks again to ensure what was just administered is correct. Staff also correctly places their initials in the box corresponding with the date and time of administration. Staff also includes any and all additional documentation that may be indicated as in the administration of a PRN or a countable medication.
 10. **Staff stores and manages medications in a secure manner:** Throughout the administration process, the staff demonstrates an understanding that medications must be maintained in a manner that keeps the individuals in that

setting safe from accidental or intentional ingestion of those medications. For example, medications are kept with the staff at all times when the storage unit is open and staff secures medications under a lock whenever it is appropriate.

11. **Staff accurately discontinues one HCP order and transcribes another on the medication sheet:** The staff is given a HCP order that includes a discontinuation of a current medication and pharmacy label (mock) of the newly prescribed medication. The staff is asked to transcribe that order onto a medication sheet. The order for the new medication must be one that is time-limited, in other words, it has a “start” and “stop” date. The staff must demonstrate that they understand all of the components of the HCP order and label and how they correspond to the components on the medication sheet, (i.e., “dose”, “amount”, “strength”, and “special instructions”).

- 3 **Eligibility:** In order to be deemed “Eligible” for Recertification, the staff person 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 his/her name on the line at the bottom of the MAP Recertification Competency Evaluation Form checklist section.
 - b. A staff person who is deemed “Not Eligible” for Recertification may no longer administer medications until they are reassessed and pass a skills test, evaluation or Certification exam.
 - c. The form is then forwarded to the supervisory staff person.

Medication Administration Program (MAP) Recertification Competency Evaluation Form

Name: _____ Date of Birth: _____
 Provider Agency: _____
 Date of Evaluation: _____

In order to receive a passing score on this test, staff must receive a "Yes" on every item.

MAP Trainer Recertification Check Off List: (To be completed by Approved MAP Trainer only.)	Comments: (Continue on reverse side if necessary.)
1. Staff identifies the correct medication sheet(s):	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
2. Staff identifies the correct medication(s):	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
3. Staff identifies the correct HCP order(s):	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
4. Staff compares the HCP order to the pharmacy label:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
5. Staff compares the pharmacy label to the medication sheet:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
6. Staff prepares correct dose:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
7. Staff compares the pharmacy label to the medication sheet again:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
8. Staff correctly administers medication(s):	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
9. Staff looks again, then correctly documents administration:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
10. Staff stores and manages medications in a secure manner:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
11. Staff accurately discontinues one HCP order and transcribes another on the medication sheet:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____

Based on this evaluation, the above-named staff person is ☐ **Eligible** ☐ **Not Eligible for Recertification.**

Approved MAP Trainer (Print Name)	Approved MAP Trainer Signature
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For Supervisory Sign Off Only.
 I verify that I have reviewed this form and (check one box only)

☐ recommend the above-named staff person. ☐ do not recommend the above-named staff person.

OR

☐ acknowledge that the above-named staff person is not eligible to administer medication under the MAP as a result of this evaluation.

Signature

Title

Date

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03

TRAINING AND CURRICULUM

**MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL**

Policy No. & Issue 03-1 Trainer Requirements

Policy Source MAP Training Policy

Issued Date: 10/15/97

Last Revision Date: 10/01/13

- 1 Regulations at 105 CMR 700.003(F)(2)(a) require that a trainer be a registered nurse, nurse practitioner, physician assistant, registered pharmacist or licensed physician who meets the applicable requirements for a trainer.
 - a. The established requirements for a trainer are:
 - i. currently licensed as a registered nurse, nurse practitioner, physician assistant, registered pharmacist, or physician in Massachusetts.
 - ii. at least two years of experience in his/her profession.
 - iii. completion of the DPH approved "Train the Trainer" Program.
 1. The "Train the Trainer" program will be offered by DPH/DMH/DCF/DDS at regularly scheduled intervals.
 - b. To maintain his/her approval status, trainers must:
 - i. remain current regarding all DPH approved training and testing materials, advisories, policies and other changes through meetings scheduled with a MAP Coordinator, and as determined by DPH.
 - ii. teach at least one MAP Certification Training every year.
- 2 To maintain his/her approval status, exclusively as a Recertification Trainer, Recert trainers must:
 - a. remain current regarding all DPH approved training and testing materials, advisories, policies and other changes through meetings scheduled with a MAP Coordinator, and as determined by DPH.
 - b. teach/test at least one MAP Recertification Training/Test every six months.
- 3 Trainers not attending scheduled MAP Trainer meetings, or not completing the required trainings yearly, may be notified that their approval status has been revoked.
 - a. Trainers who have not met the requirements to remain current may contact their DMH/DCF Area or DDS Regional MAP Coordinator for instruction/guidance in how to regain approved MAP Trainer status.
- 4 MAP Trainers must provide a resume and proof of current licensure upon request.
- 5 It is the responsibility of the Service Provider to assure that the trainer of their staff is an approved trainer. Applications for staff Certification and recertification testing will not be accepted from trainers who have not met the criteria.
 - a. Service Providers may contact their central office to confirm a trainer's approval.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 03-2 Training Direct Care Staff

Policy Source MAP Training Policy

Issued Date: 10/15/97

Last Revision Date: 10/01/13

- 1 Regulation at 105 CMR 700.003(F)(2), 115 CMR 5.15(6)(a) and 104 CMR 28.06(9)(b) require all training programs to meet specifications jointly established by DPH, DMH, DCF, and DDS.
 - a. As stated in the DPH approved training materials, training programs must not be less than 16 hours in length, including classroom instruction, testing, and the practicum. Trainers must comply with this specification.
- 2 The Medication Administration Program's training program is specific to DMH/DDS/DCF registered MAP programs only.
 - a. MAP trainers may only train staff who will be administering medications in registered DDS adult settings; DMH adult and/or youth settings; or DCF adult and/or youth settings.
- 3 All trainers must use the most recent DPH approved curriculum.
 - a. Recommendations for changes to the curriculum by a trainer may be submitted to DMH, DCF, and/or DDS.
- 4 Staff training and Certification is transferable between DMH, DDS, and DCF programs only and is valid only in adult DDS registered MAP programs and youth and adult DMH/DCF registered MAP programs.
- 5 Because Certification is transferable between all DDS adult community residential programs and DMH/DCF adult and youth residential programs, all required portions of the training manual must be taught.
 - a. No part of the training may be eliminated or modified due to a trainer's or Service Provider's preferences, personal beliefs or any other reasons.
 - b. Failure to teach the entire training would lead to inconsistencies in training and qualifications.
 - i. If DMH/DDS/DCF or Service Provider policies prohibit or discourage use of any portion of the training, (e.g., staff may not administer via a specific route) then staff should be instructed on the specific rules on site. Nevertheless, that portion of the training must be provided as part of the basic training.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 03-3 Additional Training for Vital Signs

Policy Source MAP Training Policy

Issued Date: 10/15/97

Last Revision Date: 01/01/15

- 1 To administer medications that require the monitoring of vital signs for administration, Certified staff must be proficient in this skill.
 - a. Training for vital signs is not offered in the initial MAP training; therefore, additional training must be provided to those Certified staff whose responsibilities include monitoring of vital signs for medication administration (*see Policy No. 08-1 on page 62*).
 - i. Regulation at 105 CMR 700.003(F)(1)(b) states "...that ensure that only properly trained and certified personnel administer medication."
 - ii. Regulation at 105 CMR 700.003(F)(2) states that these personnel must have successfully completed "a training program that meets the specifications for a training curriculum ... established jointly by the Department of Public Health and the Department of Mental Health, Department of Developmental Services, or Department of Children and Families".
- 2 A Health Care Provider, Registered Nurse (RN), Licensed Practical Nurse (LPN), Pharmacist, Paramedic, or Emergency Medical Technician (EMT) must conduct the vital signs trainings.
 - a. Training should include, at a minimum:
 - i. How to take vital signs, including 'hands on' use of the equipment (e.g., sphygmomanometer (i.e., blood pressure meter) thermometer, etc.);
 - ii. Certified staff responsibilities regarding medication administration if Vital Signs are not within parameters as defined by authorized prescriber; and,
 - iii. Proper documentation of Vital Signs, including date and time Vital Signs were taken.
- 3 Service Providers are responsible for:
 - a. obtaining instructions from Health Care Provider regarding the need for monitoring of vital signs for medication administration;
 - b. obtaining specific, written parameters for vital signs, if appropriate;
 - c. training their staff to take vital signs; and
 - d. maintaining a current list of trained and competent staff that includes the name(s), address(es), and telephone number(s) of the trainer(s).
 - i. This list should be maintained both at the site and at the provider's main office.
 - ii. The instructions for how to operate the specific equipment used in a program must be attached to the attendance list.

04

ROLE OF NURSING

Archived

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 04-1 Role of Nursing in MAP

Policy Source 1997 BoRN Advisory

Issued Date: 2/16/94 5/14/97

Last Revision Date: 9/11/13

Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice

Title: The Role of the Licensed Nurse as Trainer or Consultant for the Department of Public Health Medication Administration Program
(formerly Nursing Practice Related to Medication Administration)

Advisory Ruling Number: 9401

Authority: The Massachusetts Board of Registration in Nursing issues this Advisory Ruling on Nursing practice pursuant to Massachusetts General Laws (MGL) chapter 30A, section 8 and chapter 112, section 80B.

Date Issued: February 16, 1994

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

Scope of Practice: Registered Nurse, Licensed Practical Nurse

Purpose:

To guide the practice of the Registered Nurse who is employed specifically to provide training and consultation within the context of the MA Department of Public Health (DPH) Medication Administration Program (MAP). To guide the practice of the Licensed Practical Nurse 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 that is 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) or Department of Children and Families (DCF) with the exception of programs funded under Title XIX of the Social Security Act. This advisory ruling is not applicable to programs that are not funded, operated or licensed by DMH, DCF and/or DDS.

Such practice must be in compliance M.G.L. c. 112, s. 80B, M.G.L. c. 94C; 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*; 244 CMR 3.02 Responsibilities and Functions – Registered Nurse; 244 CMR 3.04 Responsibilities and

Functions – Practical Nurse; 244 CMR 9.03(5) Adherence to Standards of Nursing Practice; 244 CMR 9.03(9) Responsibility and Accountability; 244 CMR 9.03 (10) Acts within the Scope of Practice; 244 CMR 9.03 (11) Performance of Techniques and Procedures; 244 CMR 9.03 (12) Competency; 244 CMR 9.03 (14) Asepsis and Infection Control; 244 CMR 9.03(35) Security of Controlled Substances; 244 CMR 9.03(38) Administration of Drugs; 244 CMR 9.03(39) Documentation of Controlled Substances; and 244 CMR 9.03(44) Documentation.

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. The nurse must only assume those duties and responsibilities within the scope of practice for which necessary knowledge, skills, and abilities have been acquired and maintained.

It is the Board's current position that the licensed nurse, when providing training and consultation within the MAP:

- Meets applicable requirements for a trainer established jointly by the DPH and the DMH, DDS or DCF in order to instruct the didactic and practice components of the standardized 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, ordering, procuring, documenting, destroying and storing of medications pursuant to established policies and procedures;
- 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;
- May recommend action consistent with approved DPH policies such as a physician, clinic, or emergency room visit, or other intervention associated with an occurrence involving medication administration that is inconsistent with a duly authorized prescriber's prescription or anticipated outcome. It is not within the scope of practice of the Registered Nurse or Licensed Practical Nurse to order implementation of such recommendations (e.g., order lab work, order hospitalization, change a medication order); and
- Does 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. The licensed nurse is responsible and accountable for his or her nursing judgments, actions, and competence related to teaching unlicensed staff.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 04-2 Role of Nurse Monitor

Policy Source MAP Policy Manual

Issued Date: 10/01/13

Last Revision Date: 01/01/15

Role of Nurse Monitor in DMH/DCF *Caring Together* Programs

Definition: A Registered Nurse, meeting the requirements for Medication Administration Program (MAP) Approved Trainer as set forth in MAP Policy 3-1, who provides the functions listed below to Department of Mental Health (DMH)/Department of Children and Families (DCF) *Caring Together* programs.

Goal: To provide additional clinical monitoring to MAP in order to address the distinct needs and challenges presented in administering medication(s) to minors.

- 1 Provides ongoing Quality Assurance by monitoring a MAP site's medication administration system to ensure compliance with DPH, DMH and DCF regulations, licensing requirements and MAP policies .This is accomplished by conducting reviews of medication administration practices at regular intervals that include but are not limited to:
 - a. observing Certified staff administering medication to verify that they are following correct MAP policies, procedures and protocols (see also #3 below);
 - b. verifying that the authorized prescriber's orders are on site, current and properly transcribed;
 - c. verifying that medications dispensed by the pharmacy correspond with those medications prescribed by the authorized prescriber;
 - d. verifying that all medication is being administered in accordance with the authorized prescriber's written order;
 - e. verifying that medication is being properly procured and stored;
 - f. verifying that the program site has a current Massachusetts Controlled Substance Registration (MCSR) on-site and appropriate documentation of all Certified staff administering medication at the site;
 - g. reviewing documentation of medications being administered at the site to ensure that proper clinical protocols are in place and are being observed, e.g., monitoring vital signs, blood glucose monitoring, and appropriate authorized prescriber notification; and,
 - h. reviewing Medication Occurrence Reports (MORs) to determine areas where further training or other intervention may be needed.
- 2 Assesses issues and the technical functions related to medication administration that may be unique to individuals served at a particular site e.g., side effects, liquid medications, vital signs, blood glucose monitoring, allergies and takes steps to ensure that Certified staff are properly informed, educated and/or competent with regard to such issues.
- 3 Observes, no less than once every 12 months (*see also #1(a) above*); all Certified staff employed at the site prepare and administer medication in a manner consistent with all MAP policies, procedures and protocols. Such observation can be either a classroom-type (mock)

demonstration or an actual administration on site. The observation shall be documented on a form developed by the agency that contains the following information: Certified staff name, Certification number, date of observation, Nurse Monitor signature. The form shall be kept on file at the program site.

- 4 Ensures timely submission and follow-up of Medication Occurrence Reports (MORs).
- 5 Communicates with State MAP Coordinators regarding findings relative to Technical Assistance reviews performed at the site.
- 6 Assesses Certified staff medication administration competence in adherence to procedures and protocols outlined in the current Approved MAP Curriculum and MAP Policy Manual.
- 7 Works collaboratively with program supervisory staff to identify and address, individually and collectively, medication administration related remedial training needs for Certified staff.
- 8 Assures that current versions of the MAP Policy Manual and the MAP Curriculum are readily available at all programs.
- 9 Reports deficient practice by Certified staff in accordance with MAP Policies 02-3 and 04-1.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 04-3 Role of Nurses (Registered Nurses and Licensed Practical Nurses) in the Medication Administration Program *Advisory Ruling

Policy Source MAP Policy Manual

Issued Date: 06/18/14

Last Revision Date: 01/01/15

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, 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 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 program that has MAP Certified staff administering medications in a direct authorization model that nurse must become MAP Certified in order to oversee the administration of medications. The nurse cannot practice as a nurse and Site Supervisor at that program 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 his/her 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).

05

CONSULTANTS

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 05-1 Role of Consultants in MAP

Policy Source MAP Consultant Policy

Issued Date: 04/97

Last Revision Date: 01/01/15

- 1 For the purposes of the Medication Administration Program (MAP), the consultant is a professional; knowledgeable and skilled in medication administration systems, who provides technical assistance and advice to Certified staff.
 - a. The professional consultant must be a registered nurse, registered pharmacist or authorized prescriber (e.g., physician, dentist, nurse practitioner, physician assistant, etc.).
- 2 MAP Consultants provide advice, assistance and recommendations, and answer questions on medications and on issues regarding medication administration systems. This may include, but is not limited to:
 - a. interpreting a Health Care Provider order for the staff;
 - b. providing information on a medication's indications for use and side effects; and
 - c. recommending appropriate actions to follow a Medication Occurrence (error involving the wrong medication, individual, dose, time, or route of administration).
- 3 The information that the consultant supplies to the Certified staff is broad-based, general information that does not require, but does not preclude, direct observation, information on the individual's medical history, or direct follow-up.
- 4 MAP Consultants function within their scope of practice (e.g., a registered nurse could clarify for staff a Health Care Provider's medication order but only an authorized prescriber could order lab work).
 - a. If the consultant believes that he/she has insufficient information and/or knowledge to make a recommendation concerning a particular occurrence, then the consultant should recommend that the Certified staff contact the authorized prescriber, dispensing pharmacist, or another MAP consultant who is better able to provide information to the staff.
- 5 MAP is a direct authorization model under which Certified staff function in accordance with the orders of an authorized prescriber.
 - a. Consultants do not control, supervise, or monitor Certified staff's medication practices.
 - b. The Service Provider, not the consultant, is responsible for the direct care of the individual, including medication administration by the Certified staff.

- 6 In addition to the requirement that Certified staff have 24-hour access to a consultant, MAP policies require that consultants be contacted immediately for every Medication Occurrence. This ensures a Certified staff will have:
 - a. access to the technical assistance they need to interpret the Health Care Provider's order;
 - b. information on appropriate actions following an occurrence; and
 - c. guidance regarding the Medication Occurrence Reporting process should they require it.
 - i. Consultants, while required to provide technical assistance in these matters, are not expected to file Medication Occurrence Reports with DPH/DMH/DDS/DCF.
- 7 In the case of a Medication Occurrence, (*see Policy No. 09-1 on page 93*), the DPH registrant (the Service Provider), has the responsibility to:
 - a. determine whether or not an occurrence has happened;
 - b. determine what, if any, action(s) will be taken by direct care staff to care for the individual;
 - c. document on the MOR form that a consultant has been contacted; and
 - d. report to DPH/DMH/DDS/DCF within the established time frames.
- 8 Consultants should make independent arrangements with the program(s) they serve.
 - a. A letter of agreement between the program and the consultant(s) that describes the consultant's role and responsibilities is strongly recommended.
 - b. The Service Provider should have a list available for Certified staff of designated MAP Consultants for the site.
 - i. A MAP Consultant must be available to direct care staff twenty-four (24) hours a day, seven (7) days per week.
 - ii. It is recommended that the MAP Consultant(s) designated has/have knowledge of MAP and the program site.

06

MEDICATION ADMINISTRATION

Archived

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 06-1 Administration of Parenteral/Injectable medications & Medications via G-tube/J-tube

Policy Source April 1997 MAP Advisory

Issued Date: 04/97

Last Revision Date: 9/01/10

- 1 Administration of injectables to individuals who are not self-administering must be done by a licensed professional, with the exception of #2 below.
- 2 MAP Certified staff must have completed a specialized training program approved by DPH (see *Policy No. 14-1 on page 145*) before they may administer medications via G-Tubes/J-tubes and/or parenteral/injectable medications, including both insulin and epinephrine.
 - a. Specialized training programs have been approved for MAP Certified staff in the administration of epinephrine via an auto-injector device, (see *Policy No. 14-2 on page 146*), and medications via G/J tube, (see *Policy No. 14-4 on page 153*).
 - b. At this time, there is no approved program to train Certified staff to administer parenteral/injectable medications, (with the exception of epinephrine via an auto-injector device).
 - c. At this time, there is no approved program to train Certified staff to administer insulin.
 - i. This does not, however, preclude Certified staff from monitoring those individuals who self-administer their insulin as long as syringes are either filled by the individual or pre-filled by licensed professionals or the manufacturer.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 06-2 PRN Medications
Policy Source April 1997 MAP Advisory
Issued Date: 04/97

Last Revision Date: 01/01/15

- 1 Health Care Provider orders for all PRN medications must have specific target signs/symptoms and instruction(s) for their use (e.g., Tylenol 325 mg by mouth every 4 hours as needed for a fever above 101.)
 - a. Program sites should obtain guidance from the Health Care Provider regarding instructions to be followed if PRN medications are administered (e.g., Not to exceed three doses in twenty-four hours. Notify Health Care Provider if temperature is above 101 degrees Fahrenheit).
- 2 If PRN orders are unclear, the Health Care Provider must be contacted.
- 3 Certified staff may administer PRN medications only according to the authorized prescriber's order and not according to any assessments or medical decisions/judgments independently made by them or other direct care staff.
 - a. For instance, in the example listed in number one above, the order for Tylenol could not be given for a headache.
- 4 Administration of PRN medications requires additional documentation on an individual's progress note, on a medication comment sheet, or on the reverse side of the medication administration sheet.
 - a. Documentation of a PRN medication should include:
 - i. the PRN medication administered;
 - ii. who administered the medication;
 - iii. the date and time it was given;
 - iv. the reason for its use; and
 - v. information about the medication's effectiveness.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 06-3 Pre-filled Syringes

Policy Source December 1994 MAP Advisory

Issued Date: 12/94

Last Revision Date: 10/01/13

- 1 Pre-filling syringes is allowed when performed by Registered Pharmacists.
- 2 There are conditions that must be adhered to when receiving pre-filled syringes from the pharmacy:
 - a. all syringes with an attached needle, including pre-filled syringes, must be stored in a locked area. If the syringe contains a countable medication it must be kept on count and double locked (*see Policy No. 10-12 on page 123*).
 - b. Pre-filled syringes must be labeled (at a minimum) with the individual's name, medication name with strength, route of administration, and directions for use.
 - i. Such label must be affixed to the container for the syringe or the syringe itself, as appropriate.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 06-4 Pre-pouring/Pre-packaging of Medications

Policy Source April 1997 MAP Advisory

Issued Date: 04/97

Last Revision Date: 9/01/10

- 1 Regulations of the Department of Public Health at 105 CMR 700.003(F)(3) require all programs to maintain adequate storage, security and handling of medications.
- 2 Certified staff are not permitted to pre-pour or pre-package medications, [except as directed under the LOA policy (*see Policy No. 11-1 on page 125*)] or to administer medications poured or pre-poured by another person including Certified Staff or Licensed Professionals.
 - a. Medication must never be prepared at any time except immediately prior to the administration of that medication.
 - i. When a medication is “pre-poured” by staff, the identity and integrity of that medication can no longer be guaranteed.
 - b. Included among these prohibited activities (pre-pouring or pre-packaging medication) is the setting up of medication ‘pill-organizers’ and the pre-pouring of medications for training purposes.
 - i. This does not preclude staff from monitoring individuals who set up their own ‘pill-organizers’ in accordance with *Policy No. 07-3 on page 50*.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 06-5 Medication Administration Times

Policy Source 1997 DMH Memorandum

Issued Date: 8/14/97

Last Revision Date: 9/01/10

- 1 Programs must have a Medication Policy and Procedure describing the administration times for once a day (i.e., every day or daily) medications. Health Care Provider Orders should specify the time of day daily medications should be given.
 - a. For daily medications, programs should seek clarification from the Health Care Provider to indicate what “time of day” (i.e., morning, evening, bedtime, etc.) the daily medication should be given (e.g., Colace 100 mg by mouth every day in the morning).
- 2 Health Care Provider’s Orders are not required to have exact administration times; however, he/she may choose to specify this information.
 - a. Orders stating the frequency as two times a day, three times a day, etc. are acceptable.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 06-6 Over-the-Counter Medications and Preparations

Policy Source March 1996 Training Manual

Issued Date: 9/01/98

Last Revision Date: 10/1/13

- 1 All Over-the Counter medications (OTCs) and preparations require a Health Care Provider's order.
 - a. Over-the-Counter (OTC) medications and preparations have fewer regulatory controls than prescription medications, but they may have significant medical impact especially when an individual is taking prescription medications along with OTC medications.
- 2 All Over-the-Counter medications (OTCs) and preparations require labeling to be managed in one of the two following ways:
 - a. *OTC Method A:* A label is applied by the pharmacy as prescription medications are labeled; or
 - b. *OTC Method B:* A licensed professional must verify the contents of the OTC medication or preparation (if not labeled by the pharmacy). Verification is accomplished by:
 - i. ensuring that the OTC medication or preparation is in the original manufacturer's container with the original manufacturer's label affixed;
 - ii. ensuring that the contents of the container reflects the Health Care Provider's order;
 - iii. comparing the manufacturer's label to the Health Care Provider order and verifying the contents by initialing the container;
 - iv. placing the name of individual(s) on the container (If more than one individual has an order for the same OTC medication of the same strength, the name of each individual may be placed on the same container after verification);
 - v. placing the date of verification on the container, and;
 - vi. noting the verification on the Health Care Provider's order.
 1. Using OTC Method B requires verification of the contents by the licensed professional be performed every time a new container and/or updated HCP order of the medication or preparation is obtained.
- 3 Programs that utilize *OTC Method B* must:
 - a. have a policy developed by the Service Provider regarding the administration of OTCs without pharmacy or Health Care Provider labels; and
 - i. MAP Policies and Trainings do not instruct staff to administer medications and preparations without pharmacy or HCP labels.
 - b. ensure that all Certified staff are trained to administer medications and preparations from a container without a pharmacy label.
 - (a) Training, provided by the Service Provider, must be documented. Documentation must include the date of the training, name(s) of staff trained, and the name, address, and telephone number of the trainer(s).

- 4 The following applies to all OTC medications and preparations (regardless of whether OTC Method A or OTC Method B is used):
- a. Certified staff must document the administration of OTC medications and preparations in the same manner that prescription medications are documented;
 - b. OTC medications when in its original manufacturer's package is in an amount that is usual and customary (i.e., an average size container);
 - c. OTC medications and preparations must be stored in the same manner as the prescription medications; and
 - d. an OTC medication and preparation that is not administered according to the Health Care Provider's order is a Medication Occurrence and must be reported to DMH/DCF/DDS/DPH per the requirements of the Medication Occurrence Reporting System.

07

SELF-ADMINISTRATION

Archived

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue	07-1 Definition & Criteria for Self-Administration of Medications
Policy Source	December 1994 MAP Advisory Supervisor's Training Manual
Issued Date:	12/94 5/15/98 Last Revision Date: 10/01/13

- 1 DPH, DMH, DCF, and DDS each support the concept of individual self-administration of medications whenever feasible. Nothing in the MAP regulations should be viewed as an impediment to an individual's transition to self-administration. If an existing policy inhibits the goal of self-administration, it should be brought to the attention of the DPH for review.
- 2 While different programs may, for the purposes of case management, use various terms to denote stages of an individual's transition to self-administration, for the purposes of compliance with MAP regulations an individual is self-administering, by definition, only when the medication is under the complete control of the individual with no more than minimal assistance from program staff.
 - a. For individuals who are not self-administering or in transition and do not meet the above criteria, MAP Certified or licensed staff will be responsible for documenting medication usage and ensuring its security.
- 3 Verbal reminders to individuals who are self-administering are permissible by regulation. For individuals who are self-administering, staff may:
 - a. verbally remind them to take their medication
 - i. Reminding and prompting an individual to take their medication does not, in and of itself, require licensed or Certified staff. However, some staff training is recommended.
 - b. do a periodic inventory of their medications.
- 4 Criteria for Self-Administration.
 - a. In order to be considered self-administering an individual must demonstrate an ability to take medications independently. This is evidenced by:
 - i. an ability to store his/her medication so that it is inaccessible to others;
 - ii. an understanding of the type of medication, its purpose and for what symptoms or condition it is being prescribed;
 - iii. knowledge of the frequency of doses (verbal reminders may be used); and
 - iv. a familiarity with the most common side effects of the medication, if any.
- 5 Individuals who self-administer:
 - a. do not store their medications with those of individuals who are not self-administering, unless it is required to protect the safety of the other individuals;
 - b. do not need to document their medication self-administration; and
 - c. do not have Medication Occurrence Reports (MORs) filed on their behalf.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 07-2 Learning to Self-Administer

Policy Source April 1997 MAP Advisory

Issued Date: 04/97

Last Revision Date: 9/01/10

- 1 DMH/DDS regulations at (104 CMR 28.00, 115 CMR 6.00) regarding community residential programs require a clinical team to develop a teaching plan for individuals who are learning to self-administer in the IAP and/or ISP that includes goals to be achieved within a specified time frame and a plan of action for obtaining medications consistent with MAP regulations.
 - a. For individuals in programs funded, operated, or licensed by DMH:
 1. If DMH regulations have determined that an IAP medication need area is not required for a specific individual, programs must still ensure that the individual receives a medication management assessment and training to obtain or enhance self-administration skills.
- 2 For the purposes of DPH regulations for MAP, individuals who are learning to self-administer are considered to be not self-administering and DPH regulations at 105 CMR 700.000 apply.
 - a. The LOA policy (*see Policy No. 11-1 on page 125*) may not be used to cover the pre-pouring of medications for the purpose of training individuals in self-administration or for any other reason other than the actual unscheduled LOA.
- 3 At any point, an individual for whom there is concern that he/she may be unable to safely self-administer should go back to an earlier time in the training process.
- 4 Following an event whereby an individual has demonstrated an inability to reliably engage in self-administration or the self-administration transition training process, a reevaluation by the prescribing Health Care Provider is required.
 - a. The reevaluation should determine if the individual continues to meet the criteria for self-administration or the self-administration transition process. If the individual meets the criteria for the self-administration transition process, the prescribing Health Care Provider should also indicate what stage of the learning to self-administer progression is supported.
 - i. To assist in the process, it may be beneficial to have a skilled clinician (e.g., Registered Nurse) perform a Self-Administration Assessment with the individual and review the findings with the HCP.
 - b. Pending the reevaluation by the prescribing Health Care Provider; MAP Certified or licensed staff will be required to administer medication.
- 5 It is recommended that individuals transferring to a different setting be reevaluated by the prescribing Health Care Provider to determine the needed supports, oversight required, and the training development plan for the individual to follow prior to, during, and following the transition process.
 - a. To assist in the process, a Self-Administration Assessment performed by a skilled clinician (e.g., Registered Nurse) with the individual may be completed and the findings reviewed with the Health Care Provider.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 07-3 Appropriate Use of Pill-Organizers

Policy Source 1997 DMH Memorandum

Issued Date: 8/14/97

Last Revision Date: 9/01/10

- 1 Repackaging of medication by the individual is permissible if the individual is learning to self-administer according to a documented Individualized Action Plan (IAP) or Individual Service Plan (ISP) developed by the clinical treatment team.
 - a. If the individual is repackaging medications, the IAP/ISP must include specific steps and a time frame within which an individual will meet his/her goals.
 - b. Based upon an individual's skill assessment, documentation from the prescribing Health Care Provider(s) indicating approval for self-administration of medications for the period identified in the IAP/ISP training plan may be required. This documentation must include the number of days an individual may hold his/her medications.
 - i. The number of days an individual is allowed to package medication must be the same as the number of days the individual is allowed to hold and administer the medications.
 - c. The 'pill-organizer' must be clearly labeled to include:
 - i. individual's name;
 - ii. prescriber's name;
 - iii. medication name;
 - iv. dosage;
 - v. administration instructions; and
 - vi. cautionary statements, if any.
 - d. Individuals must be provided with written medication information sheets.
 - e. Programs should document the individual's packaging and transfer of medications on an observation sheet (i.e., Medication Administration Record) and/or progress note.
 - i. Documentation should indicate that medication was repackaged by the individual, date medication was packaged/transferred by the individual, initials of the Certified staff supervising individual repackaging, and name, dosage, and quantity of medication packaged/transferred.
 - f. Programs may have staff sign initials on observation sheet indicating 'pill-organizer' was returned by individual; empty to indicate individual took their medication.
- 2 Repackaging of PRN medication by the individual is permissible if the individual is learning to self-administer according to a documented Individualized Action Plan (IAP) or Individual Service Plan (ISP) developed by the clinical treatment team provided:
 - a. the individual demonstrates an understanding of the type of medication, including its purpose, the recommended hours between doses, the maximum number of doses daily and for what signs/symptoms it is being prescribed;
 - i. Individuals must be provided with written medication information sheets.
 - b. there is a valid Health Care Provider order for the 'as needed' medication specifying the target signs and/or symptoms the medication is ordered for;

- c. the 'as needed' medication is packaged separately in the 'pill-organizer' from scheduled medications;
 - i. The number of packaged doses of any PRN medication should be based upon an individual's skill assessment and documentation from the prescribing Health Care Provider describing the amount of 'as needed' medication the individual may hold.
 - 1. The individual packaging may hold no more than a maximum of seven doses of any PRN medication.
- d. programs document the packaging and transfer of medications to the individual on an observation sheet (i.e., Medication Administration Record) and/or progress note; and
 - i. Documentation should indicate that PRN medication was packaged by the individual; date medication was packaged/transferred by the individual, initials of the Certified/licensed staff supervising individual repackaging, and name, dosage, and quantity of medication packaged/transferred.
- e. There is a mechanism in place (e.g., individual notifies program that they have taken a PRN medication and its effect) for documentation of the effectiveness of the medication and total number of 'as needed' doses taken by the individual.
 - i. Information documented should be communicated to the individual's Health Care Provider.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 07-4 Skill Assessment

Policy Source Supervisor's Training Manual

Issued Date: 5/15/98

Last Revision Date: 9/01/10

- 1 In preparation for the IAP/ISP a health skills assessment will be completed for all individuals.
- 2 If the health skills assessment indicates that the individual could benefit from learning to self-administer, a team to include familiar staff, a nurse consultant (if available), and the individual will participate in specifically assessing the individual's ability to self-administer.
 - a. A Self-Administration Assessment form should be completed. This assessment is the basis for developing a medication skills teaching plan (see Policy No. 07-5 on page 56)
 - i. See sample form on the following page.
 1. Providers may use the sample form or choose from a number of Self-Administration Assessment forms available throughout the state.

Observation Tool For Self-Administration

Individual's Name: _____ Date of Observation: _____

Place Number of Response on line provided.

A _____

Cognitive Skills

- 0 Unable to follow directions.
- 1 Follows simple directions with 1 step prompting and encouragement.
- 2 Follows complex directions with 2 step prompting and encouragement.
- 3 Independent with complex directions.

B _____

Fine Motor Coordination

- 0 No functional use of hand.
- 1 Functional use of hands but has interfering factors (e.g., tremors)
- 2 Has use of hand but no pincer grasp (i.e., hold an object between thumb and forefinger).
- 3 Able to pick up and/or manipulate small objects.

C _____

Feeding

- 0 Unable to feed self.
- 1 Requires assistance at each meal.
- 2 Requires verbal prompting and encouragement.
- 3 Fully independent.

D _____

Behaviors

- 0 Chronically unstable or displays pica behavior (i.e., craving to ingest any material not fit for food).
- 1 Episodes of unstable behavior.
- 2 Stable with support staff.
- 3 Reacts typically to daily life events.

E _____

Vision

- 0 Totally blind with no compensation from other senses.
- 1 Legally blind with residual sight or augments vision with other senses.
- 2 Slight impairment (effects on abilities is minimal).
- 3 Normal vision with/without glasses.

F _____

Communication

- 0 Unable to communicate basic wants and needs.
- 1 Effective communication is limited by constraints (emotional, physical, or intellectual).
- 2 Communicates but requires clarification.
- 3 Communicates clearly.

G _____

Colors

- 0 Unable to recognize differences in color.
- 1 Able to match colors with samples.
- 2 Inconsistently identifies colors.
- 3 Consistently identifies and states colors.

Observation Tool For Self-Administration

Page Two

Individual's Name: _____

Date of
Observation: _____

Place Number of Response on line provided.

H _____

Shapes

- 0 Unable to recognize differences in shapes.
- 1 Able to match shapes with samples.
- 2 Inconsistently identifies shapes.
- 3 Consistently identifies shapes.

I _____

Numbers

- 0 Has no concept of the meaning of numbers.
- 1 Inconsistent awareness of number concepts.
- 2 Understands number concepts and identifies numerals.
- 3 Understands number concepts and identifies and writes numerals.

J _____

Time

- 0 Has no apparent concept of time.
- 1 Inconsistent awareness of time.
- 2 Ability to tell time by major daily events.
- 3 Ability to tell time by clock or watch.

K _____

Letters/Name

- 0 Cannot identify any letters.
- 1 Identifies isolated letters.
- 2 Recognizes written name.
- 3 Writes name.

L _____

Medication

- 0 Requires special techniques/total assistance to take medications.
- 1 Refuses medications frequently.
- 2 Takes medication with encouragement.
- 3 Always takes medication well.

M _____

Medication Recognition

- 0 Unable to name or identify current medications.
- 1 Able to say names of current medications, but not able to identify specific pill bottle or medication card.
- 2 Able to identify medication by name, pill bottle, and dosage with minimal prompting.
- 3 Able to identify medications by name, pill bottle, dosage, and reason for taking without prompting.

N _____

Side effects

- 0 Unable to identify/understand possible side effects of current medications.
- 1 Can identify one side effect, but not how to respond to side effect.
- 2 Identifies one or more side effects to specific medications and how to respond to side effects after training.
- 3 Identifies side effects to specific medications and how to respond to side effects after training.

Page Three

Individual's Name: _____

Date of
Observation: _____

Place Number of Response on line provided.

O _____

Ability to reorder

- 0 Unable to identify when it is time to reorder.
- 1 Does not reorder medications or seek assistance to reorder until after medication supply is depleted.
- 2 Seeks assistance to reorder medication before medication supply is depleted. Can reorder by phone with staff assistance.
- 3 Calls and reorders medications independently before medication supply is depleted.

Total score _____

Add up the number responses (Lines A-O) for the total Score.

Average
Score

Divide result of Total Score by 15 for the Average Score.

If Average Score is: Less than 1.7 Individual is not appropriate to learn to self-administer at this time.
 Greater than 1.7 Individual is appropriate to learn to self-administer to the full extent of his/her ability.

Based on this Observation Evaluation Tool, I have determined that the Individual named below **appears to be appropriate** to learn to self-administer medications.

Staff Person's Printed
Name _____

Individual's Printed
Name _____

Staff Person's
Signature _____

Date _____

Based on this Observation Evaluation Tool, I have determined that the individual named below **does not appear to be appropriate** to learn to self-administer medications at this time because:

Staff Person's Printed
Name _____

Individual's Printed
Name _____

Staff Person's
Signature _____

Date _____

As the above named individual's Health Care Provider, I concur that this individual demonstrated the ability to self-administer.

Health Care Provider
Printed Name _____

HCP's Phone Number _____

HCP's Signature _____

Date _____

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 07-5 Development of a Teaching Plan

Policy Source Supervisor's Training Manual

Issued Date: 5/15/98

Last Revision Date: 9/01/10

- 1 The Assessment of Self-Administration Skills is the basis for developing a medication skills teaching plan.
 - a. It is recommended that the Health Care Provider also be included in the decision to begin teaching self-administration skills.
 - i. This may require the Health Care Provider 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 the correct medication as prescribed.
 1. The individual's Health Care Provider will prescribe the correct medication and monitor its effectiveness.
- 2 The training plan will be individualized and will be documented in the IAP or ISP.
 - a. For individuals: in programs funded, operated, or licensed by DMH:
 1. If DMH regulations have determined that an IAP medication need area is not required for a specific individual, programs must still ensure that the individual receives a medication management assessment and training to obtain or enhance self-administration skills.
- 3 Documentation must include specific steps and a time frame within which the individual will meet his/her goals.
 - a. In accordance with the IAP/ISP systems, there will be quarterly reviews.
- 4 Staff may not pre-pour medication for individuals who are learning to self-administer.
 - a. Individuals may, under the supervision of Certified or Licensed staff, pour their own medication into appropriately marked 'pill-organizers' (see *Policy No. 07-3 on page 50*).
 - i. If use of a 'pill-organizer' is to be part of the individual's self-administration plan, it should be one of the first steps that he/she learns.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 07-6 Documentation

Policy Source Supervisor's Training Manual

Issued Date: 5/15/98

Last Revision Date: 9/01/10

- 1 Pending individuals meeting the criteria for self-administering status, staff should witness the individual preparing and taking medication.
 - a. If a 'pill-organizer' is used in the process of learning to self-administer, staff should document the packaging by the individual of his/her medications on an observation sheet and/or progress note.
 - i. Documentation should indicate that medication was packaged by the individual, date medication was packaged, initials of the Certified staff supervising the individual repackaging and name, dosage and quantity of medication packaged.
 1. A Medication and Treatment sheet may be used for this purpose if it clearly states that staff is observing the individual in the preparation and self-administration of his/her medication.
 - (a) Certified staff may not sign off on the Medication and Treatment sheet that a medication has been administered unless staff actually administers an individual's medication.
 - (b) Certified staff may, however, sign that he/she has observed an individual take the appropriate medications.
 - b. If programs wish to monitor and document the inventory of a 'pill-organizer', if used by the individual in the process of learning to self-administer, Certified/licensed staff may do so by placing his/her initials in the appropriate space on an observation sheet or by making a notation in a medication progress note or in the clinical progress note.
 - c. Some individuals may find a daily calendar or check-off sheet helpful in keeping track of their own medications. This can also serve as documentation during the training process.
- 2 The progress of the training program will be documented on a data collection sheet and in quarterly review notes.
- 3 The Service Coordinator/Case Manager and Program Director, in consultation with the individual's Health Care Provider, will decide when an individual is reliably self-administering as described in the IAP/ISP.
 - a. A 6-month training period with close supervision is recommended with weekly pill counts for another 3 months.
 - i. After this time, the individual's self-administering status should be reviewed at least in 3-month intervals.
 - b. An individual's completion will be recorded on the Self-Administration Assessment form (see Policy No. 07-4 on page 52 for a sample assessment form: *Observation Tool for Self-Administration*).
- 4 It is recommended that a written plan be completed for all individuals who are self-administering, detailing needed supports, oversight required, and the plan to follow if the individual, for some reason, becomes unable to safely self-administer.

- a. Following an event whereby an individual has demonstrated an inability to reliably engage in self-administration or the self-administration transition training process, a reevaluation by the prescribing Health Care Provider is required.
 - i. The reevaluation should determine if the individual continues to meet the criteria for self-administration or the self-administration transition process. If the individual meets the criteria for the self-administration transition process, the prescribing Health Care Provider should also indicate what stage of the learning to self-administer progression is supported.
 - (a) To assist in the process, it may be beneficial to have a skilled clinician (e.g., Registered Nurse) perform a Self-Administration Assessment with the individual and review the findings with the HCP.
 - ii. Pending the reevaluation by the prescribing Health Care Provider, MAP Certified or licensed staff will be required to administer medication.

5 Documentation of Self-Administration Teaching would include the following:

- a. Assessment of self-administration skills.
- b. IAP/ISP goals or teaching plan and data sheets.
 - i. For individuals in programs funded, operated, or licensed by DMH:
 - 1. If DMH regulations have determined that an IAP medication need area is not required for a specific individual, programs must still ensure that the individual receives a medication management assessment and training to obtain or enhance self-administration skills.
- c. Appropriate documentation, by Certified or licensed staff, in a medication and/or clinical progress note, on an observation sheet, or a Medication and Treatment sheet that clearly identifies the specific role of the staff in the process of teaching the individual to self-administer.
 - i. Documentation by the individual on a calendar, is acceptable—(the medication names, dosage, and times should be written accurately by a staff member if individual needs support in this area).
- d. Documentation of the supports needed for the individual to continue to be self-administering including:
 - i. the plan for monitoring accuracy of self-administration; and
 - ii. a plan to follow if the individual becomes unable to safely self-administer.

Self-administration Teaching Plan

Individual's

Name: _____ Date: _____

Goal:

Self-administration: (Specify what this will mean for this individual.)

Medication Administration skills to be addressed:

(Take from Observation Tool.)

Learning Objective(s):

Teaching Plan/Documentation:

Self-administration Support Plan

Name: _____ Date: _____

☐ **Assessment of Self-administration Skills Completed**

Individual must demonstrate competence in all areas in order to be considered self-administering.

Supports Needed:

- ☐ Takes pills from pill bottles
- ☐ Medication 'pill-organizer'
- ☐ Medication Chart (Individual places check mark on chart or calendar when medication is taken.)
- ☐ Prompts needed
- ☐ In person when: _____
- ☐ Aids, Timer, Watch, etc.: _____
- ☐ Other: _____

How is Self-administration of Medication Monitored?

- ☐ Observe each time medication is taken
- ☐ Check medication 'pill-organizer'
- ☐ Periodic pill count
- ☐ Review of individual's medication chart or calendar
- ☐ Other: _____

What system will be used if the individual is unable to accurately self-administer for a period of time?

- ☐ Staff will administer medication from labeled bottles or blister pack cards
- ☐ Medication 'pill-organizer' will be checked (Note how often) _____
- ☐ Other: _____

Describe plan to help individual regain independence in self-administration:

Individual's Signature

Date

Case Manager's Signature

Date

Program Director's Signature

Date

08

ANCILLARY PRACTICES

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 08-1 Vital Signs
Policy Source MAP Policy Manual
Issued Date: 9/01/98

Last Revision Date: 01/01/15

- 1 To administer medications that require the monitoring of vital signs for administration, Certified staff must be proficient in this skill (*see Policy No. 03-3 on page 29*).
 - a. A Health Care Provider, Registered Nurse (RN), Licensed Practical Nurse (LPN), Pharmacist, Paramedic, or Emergency Medical Technician (EMT) must conduct the vital signs trainings.
 - i. If vital sign monitoring is required in relation to the administration of medication for a health condition, staff must be Certified and must be proficient in this skill.
- 2 Service Providers must develop a policy addressing vital signs, as vital signs may be required for the administration of a medication. The policy must:
 - a. assure that written instructions, if needed, are obtained from the Health Care Provider regarding the need for monitoring of vital signs;
 - i. Routine consultation by Service Providers with an individual's Health Care Provider regarding medication administration and the possibility for the need to monitor vital signs provides for continuous quality of care that ensures safe and effective medication administration.
 - ii. In the event that vital signs are required, Service Providers are required to have a policy/procedure that outlines who will be responsible for obtaining vital signs.
 1. If Certified staff will have the responsibility for obtaining vital signs, he/she must be proficient in this skill.
 - (a) Regulations of the Department of Public Health at 105 CMR 700.003(F)(1)(b) state "The program shall establish, maintain, and operate in accordance with policies that ensure that only properly trained and certified personnel administer medication."
 2. The policy outlined for the training of Certified staff should:
 - (a) state whether the training offered by the Service Provider will be individual specific, program specific, or general in nature;
 - (b) list the equipment to be used by staff to monitor vital signs, (e.g., blood pressure cuff, thermometer, stethoscope); and
 - (i) the instructions for how to operate the specific equipment used in a program must be part of the training content.
 - (c) specify the appropriate documentation of staff training. Documentation must include the date of the training, name(s) of staff trained, and the name, address, and telephone number of the trainer(s).
 - (i) the instructions for how to operate the specific equipment used in a program must be attached to the attendance list.
 - b. have a system/process developed to ensure that written instructions are obtained, when needed;
 - i. The method(s) developed by the Service Provider must clearly state whether vital signs are or are not required for medication administration.

1. This may be achieved by adding a statement to the Health Care Provider consult form. (e.g., "Please document if you wish to have vital signs taken before the administration of any of these medications.")
- ii. The method(s) developed must require that specific, written parameters be obtained from the Health Care Provider if vital signs are required for medication administration.
 1. This may be achieved by adding a question to the Health Care Provider consult form. (e.g., "If vital signs are required, what parameters do you wish?")
- c. require proper documentation of vital signs on the Medication and Treatment sheet, (i.e., include documenting vital signs in a separate block on the Medication and Treatment sheet above or below the documentation for the administration of the medication that requires vital sign monitoring);
- d. include instructions for follow-up with the Health Care Provider when vital signs are outside of the established parameters, the failure to obtain vital signs, etc.; and
- e. require documentation of the notification of the Health Care Provider and any follow-up instructions/orders received.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 08-2 Allergies

Policy Source 1997 DMH Memorandum

Issued Date: 8/14/97

Last Revision Date: 9/01/10

- 1 All allergies must be listed on the following:
 - a. Health Care Provider order form;
 - b. Medication and Treatment sheet (all pages, every month);
 - c. Health Care Provider consult form;
 - d. Emergency Information sheet; and
 - e. all other appropriate forms.
- 2 Unless the form(s) cataloged above is/are being photocopied, it is recommended that the allergy list be formatted to assist in readily identifying the allergies, (e.g., documented using the font color red, highlighting the list, etc.).

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 08-3 Blood Glucose Monitoring

Policy Source 1998 DMH Letter

Issued Date: 2/24/98

Last Revision Date: 10/01/13

- 1 If blood glucose monitoring is required in relation to the administration of medication for a health condition, staff must be Certified and must be proficient in this skill.
- 2 DMH/DDS/DCF community residential programs that conduct blood glucose monitoring* must adhere to the following:
 - a. assure that written instructions are obtained from the Health Care Provider regarding the need for monitoring of blood glucose;
 - i. In the event that blood glucose monitoring is required, Service Providers are required to have a policy/procedure that outlines who will be responsible for attaining blood glucose monitoring.
 1. If Certified staff will have the responsibility for blood glucose monitoring, he/she must be proficient in this skill.
 - (a) Certified staff, who are trained in the monitoring of blood glucose, may perform “finger-stick” blood glucose monitoring (e.g., Accu-Chek, One Touch Ultra, etc.), to individuals who are disease stable and in accordance with a Health Care Provider’s order.
 2. The policy outlined for the training of Certified staff should:
 - (a) indicate that the training include individual(s) specific monitoring (e.g., glucose check protocols, instructions for the use of the individual’s glucometer, etc.);
 - (b) list the equipment to be used by staff for glucose monitoring;
 - (c) follow the glucometer manufacturer’s requirements for the performing of the test; and
 - (d) specify the appropriate documentation of staff training. Documentation must include the date of the training, name(s) of staff trained, and the name, address, and telephone number of the trainer(s).
 - b. include instructions for follow-up with the Health Care Provider when blood glucose levels are outside of the established parameters;
 - i. when parameters are indicated, they must be specific, written parameters that are obtained from the Health Care Provider. This may be achieved by adding a question to the Health Care Provider consult form, (e.g., “What upper and lower blood glucose level parameters do you wish?”);
 - c. require documentation of the blood glucose result; and
 - d. require documentation of the notification of the Health Care Provider and any follow-up instructions/orders received.

* 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, if required. The Clinical Laboratory Program contact information is

available through the Massachusetts portal (see *Policy No. 17-1 on page 193 for website access information*).

- 3 If Certified staff will be performing the assignment of blood glucose monitoring, he/she must receive instruction for blood glucose monitoring, from a licensed nurse, pharmacist, or Health Care Provider; in the equipment and procedure involved.
 - a. Staff training must include, at a minimum:
 - i. overview of blood glucose monitoring;
 - ii. rationale for blood glucose monitoring (including individual specific);
 - iii. signs and symptoms of high and low blood sugar;
 - iv. demonstration of the correct technique for blood glucose monitoring;
 - v. safe glucose monitoring procedures;
 - vi. importance of gloves, clean technique and proper hand washing;
 - vii. following individual health care protocols, if applicable;
 - viii. an emergency procedure guideline to follow, including but not limited to calling 911 and notification of the individual's Health Care Provider;
 - ix. overview of equipment (individual specific glucose monitoring/meter device, finger-pricking device, tests strips, etc.);
 - x. obtaining and care of the equipment;
 - xi. an understanding of the manufacturer's requirements for the performing of the test;
 - xii. proper disposal of used finger-stick devices (lancets); and
 - xiii. overview of storage requirements.
 - b. Any changes, in the Health Care Provider's order for glucose monitoring, requires a review.
 - c. A copy of the manufacturer's requirements for the glucometer being used for the individual's glucose monitoring must be available for staff reference.
 - d. Training and competency must be appropriately documented and maintained at the Service Provider's main office and on site.
 - i. Documentation must include the date of the training, name(s) of staff trained, and the name, address, and telephone number of the trainer(s).
 1. A Service Provider may use a nurse under their employ for this training.
 - (a) If the Service Provider does not employ a nurse, they may use a nurse from a Visiting Nurse Association, Home Health Agency, or staff at the Health Care Provider's office.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 08-4 Oxygen Therapy

Policy Source MAP Policy Manual

Issued Date: 9/01/10

Last Revision Date: 10/01/13

- 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.
- 2 Oxygen therapy may be administered in the individual's home setting.
 - a. Oxygen therapy is the administration of oxygen at concentrations greater than that of room air and is used to treat or prevent hypoxemia (not enough oxygen in the blood).
- 3 DMH/DDS/DCF community residential programs that implement oxygen administration must adhere to the following:
 - a. assure that there is a Health Care Provider order regarding the need for administration of oxygen including any specific, written parameters and instructions for follow-up when oxygen needs are outside of the established parameters;
 - i. In the event that oxygen administration is required, Service Providers are required to have a policy/procedure that outlines who will be responsible for providing oxygen administration.
 1. If Certified staff will have the responsibility for Oxygen administration, according to the Service Provider's policy, he/she must be proficient in this skill and be trained in Vital Signs.
 - (a) Certified staff, who are trained in oxygen administration, may administer supplemental oxygen to individuals in accordance with a Health Care Provider's order.
 - b. specify the appropriate documentation of staff training. Documentation must include the date of the training, name(s) of staff trained, and the name, address and telephone number of the trainer(s);
 - c. require proper documentation of the oxygen administration and;
 - d. require documentation of the notification of the Health Care Provider and any follow-up instructions/orders received.
- 4 If Certified staff will be administering oxygen, he/she must complete Vital Signs Training with demonstrated competence on a regular basis and received instruction in supplemental oxygen administration including the equipment and procedure involved.
 - a. staff training in supplemental oxygen administration must include, at a minimum:
 - i. overview of oxygen;
 - ii. rationale of supplemental oxygen administration (including individual specific);
 - iii. demonstration of the correct technique for proper oxygen administration;
 - iv. signs and symptoms of inadequate oxygenation;
 - v. following individual health protocols, if applicable;
 - vi. oxygen safety;
 - vii. safe oxygen handling procedures;
 - viii. adverse effects of oxygen therapy;

- ix. importance of clean technique and proper hand washing;
- x. oxygen delivery system overview including: oxygen delivery source (e.g., oxygen concentrator); oxygen delivery equipment (e.g., pressure regulator, gauge, flow meter); and delivery device (e.g., nasal cannula);
- xi. use of a Pulse Oximeter (if oxygen saturation monitoring is ordered by the Health Care Provider).
- xii. an emergency procedure guideline to follow, including but not limited to calling 911 and notification of the individual's Health Care Provider;
- xiii. obtaining and care of the equipment, and;
- xiv. overview of storage requirements.
- b. Any change, in the Health Care Provider's order for supplemental oxygen administration, requires a review.
- c. Training and competency must be appropriately documented and maintained at the Service Provider's main office and on site.
 - i. Documentation must include the date of the training, name(s) of staff trained, and the name, address, and telephone number of the trainer(s).
 - 1. A Service Provider may use a nurse under their employ for this training.
 - (a) If the Service Provider does not employ a nurse, they may use a nurse from a Visiting Nurse Association, Home Health Agency, or staff at the Health Care Provider's office.
 - 2. The Health Care Provider or a Respiratory Therapist may provide this training to staff.
 - (a) The company supplying the equipment can also provide training to staff.

Oxygen Therapy Training Guidelines

	Training Components of Equipment and Procedure	Comments
1.	Knows where to locate the agency policy/procedure that outlines who will be responsible for providing oxygen administration.	
2.	Knows that only licensed personnel (nurses) and MAP Certified Staff may administer oxygen.	
3.	Knows he/she must complete Vital Signs training and retraining on a regular basis.	
4.	Knows that oxygen is a medication.	
5.	Knows to follow all procedures for preparation of medications for administration according to MAP regulations and policies.	
6.	Knows that oxygen therapy is the administration of oxygen at concentrations greater than that of room air.	
7.	Knows oxygen therapy is used to treat or prevent hypoxemia.	
8.	Knows hypoxemia is not enough oxygen in the blood.	
9.	Knows the signs and symptoms of inadequate oxygenation.	
10.	Knows what s/he would do if there are signs and symptoms of inadequate oxygenation observed.	
11.	Knows where to locate and how to follow health protocols, if applicable of any individual receiving oxygen therapy.	
12.	Knows the importance of clean technique and proper hand washing.	
13.	Knows the individual specific purpose of supplemental oxygen administration.	
14.	Knows there must be a Health Care Provider order regarding the need for administration of oxygen including specific, written parameters and instructions for follow-up when oxygen needs are outside of the established parameters.	
15.	Knows there are various types of oxygen delivery methods.	
16.	Knows the individual specific oxygen delivery method.	
17.	Knows there are various types of oxygen equipment.	
18.	Knows the individual specific oxygen equipment in use.	
19.	Knows safe oxygen handling procedures.	
20.	Knows how to operate oxygen equipment.	
21.	Knows oxygen administration must be documented on a medication sheet.	
22.	Knows adverse effects of oxygen therapy.	
23.	Knows when a call to the Health Care Provider is necessary.	
24.	Knows when a 911 call is necessary.	
25.	Knows after Emergency Response personnel arrive and individual is cared for; notifies HCP, and follows all emergency procedures per the provider's policy.	
26.	Knows proper maintenance of oxygen equipment.	
27.	Knows oxygen reordering system.	
28.	Knows oxygen storage requirements.	

Based on this guideline used for training, I, as Trainer, have determined that the Certified Staff Person named below is competent to administer oxygen to the Individual named below.

Staff Person's Printed
Name _____

Trainer's Printed Name _____

Staff Person's
Signature _____

Trainer's Signature _____

Date _____

Trainer's Phone
Number _____

Individual's Printed
Name _____

Date _____

Maintain a copy of this document in training records at the program site.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 08-5 High Alert Medication-Warfarin sodium Therapy

Policy Source MAP Policy Manual

Issued Date: 01/01/15

Last Revision Date: 01/01/15

- 1 Warfarin sodium is a Scheduled VI (M.G.L. Chapter 94C §2 and 3) controlled substance and all MAP regulations and policies apply when Warfarin sodium is administered.
- 2 Certified staff, including relief staff, may administer Warfarin sodium therapy at the DPH MAP registered site provided:
 - a. There is a Service Provider policy/procedure for Warfarin sodium administration in place; and
 - i. The policy must include administrative procedures to be followed when there is a medical emergency related to the administration of Warfarin sodium.
 1. The 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 administration of Warfarin sodium).
 - b. The Certified staff have been trained in and are aware of Warfarin sodium therapy.
 - i. The Service Provider must have documented evidence of each Certified staff's training for Warfarin sodium administration. Documentation must include the date of the training, name(s) of staff trained, and the name, current contact information, address and telephone number, of the trainer(s).
- 3 The DMH/DDS/DCF community residential programs that implement Warfarin sodium administration must adhere to the following requirements:
 - a. There is an order by a Health Care Provider regarding the individual's need for Warfarin sodium that includes:
 - i. the specific medical condition or diagnosis that is the indication for Warfarin sodium; and
 - ii. a written specific international normalized ratio (INR) target range/goal for the individual.
 - b. There is documentation of the notification of the Health Care Provider(s) when there is a change in the individual's condition and any follow-up instructions/orders received.
 - c. Warfarin sodium dosages received from an Anticoagulation Management Service have been ordered by a Health Care Provider.
- 4 DMH/DDS/DCF community residential programs that implement Warfarin sodium administration must follow procedures for safe administration of Warfarin sodium including but not limited to:
 - a. When transcribing Warfarin sodium onto the medication sheet, the next date for the upcoming INR lab draw must be indicated on the medication sheet.
 - b. Adherence to the Service Provider's policy/procedure for Warfarin sodium administration.
 - i. A 'Warfarin Sodium Tracking System' must be generated (e.g., adding Warfarin sodium to the Countable Controlled Substance Count; or, establishing a Warfarin sodium accounting documentation procedure; or, establishing a Warfarin sodium Blister Packing Monitoring System, etc.).

1. If the tracking system includes adding the Warfarin sodium to the 'Count', 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 page.
 - ii. If a second Certified or licensed staff is available during the Warfarin sodium administration time, the second staff must also review and verify the Warfarin sodium order with the pharmacy label and the medication sheet before the Warfarin sodium is administered.
 1. The second Certified or licensed staff who reviews and verifies the accuracy of the medication administration must document that the 'verification was completed' by signing off on the medication sheet as well.
 - (a) The Certified or licensed staff, who will be administering the Warfarin sodium, must observe, and remain with, the second Certified or licensed staff during the verification process.
 2. If a second staff person is not available, the medication may still be administered.
 - iii. Each individual prescribed Warfarin sodium must have an individualized Warfarin sodium therapy protocol specifying any details of the HCP order, treatment or management that is not covered by the agency policy.
 - c. Whenever the Health Care Provider changes an individual's Warfarin sodium orders (e.g., dose change, holding medication dosage, etc.):
 - i. The change must be communicated to all staff (verbally or in writing);
 - ii. A narrative note must be written in the individual's chart;
 - iii. If indicated, the Warfarin sodium medication containers must be marked by the approved MAP method to indicate a change in the order. Licensed or Certified staff are never to write, or mark directly, on the labeled medication package. Approved methods to indicate a change in directions for administration include:
 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 Health Care Provider order and that the individual's medication order must be checked.
 2. 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.
 - iv. The pharmacy contacted to verify that the Health Care Provider has notified the Pharmacist of the currently prescribed dosage.
5. When the dosage of Warfarin sodium is not stabilized and there will be frequent dosage changes, it is acceptable for the Health Care Provider to provide the pharmacy with a prescription that does not include a specific dosage amount.
 - a. For example, the prescription for the pharmacy label would include: 1. the individual's name; 2. the medication name (i.e., Warfarin sodium); 3. the strength (e.g., 2 mg); 4. the route (i.e., by mouth); 5. the frequency (i.e., daily in the evening) and 6. No specific dosage directions (i.e., 'as directed by current Health Care Provider order').
6. Certified staff administering Warfarin sodium must complete Warfarin Sodium Therapy Training, conducted by an RN, NP, PA, RPh, or MD; with demonstrated understanding of the safe administration of Warfarin sodium on a regular basis.
 - a. Certified staff who have not administered Warfarin sodium in the previous twelve months or have not demonstrated understanding of the safe Warfarin sodium must take a supplemental Warfarin sodium retraining.

- i. An LPN, who is able to demonstrate initial and continued competence, may provide subsequent retraining for Warfarin sodium competency reviews.
- b. staff training in Warfarin sodium therapy must include, but not be limited to:
 - i. overview of Warfarin sodium and anticoagulant therapy;
 - ii. goal and rationale for Warfarin sodium administration (including individual specific);
 - iii. overview of blood testing monitoring including Prothrombin time (PT) and International Normalized Ratio (INR);
 - iv. INR target ranges (including individual specific);
 - v. an understanding of rationale for frequent Warfarin sodium dosage changes;
 - vi. an understanding of importance of consistent administration of Warfarin sodium(i.e., administered once a day at the same time each day);
 - vii. probable signs and symptoms associated with high and low INR results;
 - viii. overview of Warfarin sodium interactions (e.g., medications, foods, beverages, herbal, over-the-counter medications, spices, etc.);
 - ix. overview of Warfarin sodium telephone orders;
 - x. safe Warfarin sodium administration measures;
 - xi. following individual specific health care protocols, if applicable;
 - xii. demonstration of the correct technique to document Warfarin sodium transcription, telephone HCP orders, and administration of medication;
 - xiii. an understanding of when to contact the Health Care Provider or the MAP Consultant;
 - xiv. adverse effects of Warfarin sodium therapy;
 - xv. an understanding of injury prevention including caution with sharp objects, using soft-bristle toothbrush and waxed dental floss, electric razor, etc.; and
 - xvi. an emergency procedure guideline to follow, including but not limited to calling 911 and notification of the individual's Health Care Provider.
- c. As with all MAP Competency Training, the training and proof of understanding must be appropriately documented and maintained at the Service Provider's main office and on site.

Evaluation Tool for Warfarin Sodium Therapy

Staff Name: _____

Date: _____

Warfarin Sodium Therapy Training Guidelines

	Training Components of Equipment and Procedure	Comments
1.	Knows where to locate the agency policy/procedure that outlines when an individual is receiving Warfarin sodium therapy, the procedure to follow, and who will be responsible for providing Warfarin sodium administration.	
2.	Knows that only licensed personnel (nurses) and MAP Certified Staff may administer Warfarin sodium.	
3.	Knows that the generic named product 'Warfarin sodium' (also known by the common brand name COUMADIN®) is an anticoagulant used to prevent harmful blood clots from forming or growing larger, and knows that using an anticoagulant causes the blood to take longer to form a clot.	
4.	Knows the difference between 'beneficial' blood clots, (which prevent or stop bleeding) and 'harmful' blood clots, (which can cause a stroke, heart attack, deep vein thrombosis, or pulmonary embolism).	
5.	Knows when administering Warfarin sodium to follow all procedures for preparation of medications for administration; according to MAP regulations and policies.	
6.	Knows that the goal of Warfarin sodium therapy is to decrease the clotting tendency of blood and not to prevent clotting completely.	
7.	Knows Warfarin sodium is administered once a day at the same time each day.	
8.	Knows regular blood testing monitoring for the Prothrombin time (PT) and the International Normalized Ratio (INR) are required to ensure an adequate yet safe dose of Warfarin sodium.	
9.	Knows if the INR is too low that blood clots will not be prevented; but if the INR is too high, there may be an increase tendency for bleeding.	
10.	Knows that unlike most medications that are prescribed as a fixed dose, Warfarin sodium dosing is adjusted to the INR blood test results and the Warfarin sodium dosage usually changes over time.	
11.	Knows the Warfarin sodium dosage must be individualized and is based upon individual's medical condition, laboratory tests (e.g., PT, INR) and individual's response to treatment.	
12.	Knows that certain conditions may affect Warfarin sodium dosage (e.g., infections, diarrhea, indwelling catheter, uncontrolled high blood pressure, fever, etc.) and to consult with the Health Care Provider when there is a change in individual's condition.	
13.	Knows that Warfarin sodium tablets are supplied in different strengths, shapes, and pill colors.	
14.	Knows that unlike most medications, Warfarin sodium is supplied as a color-coded pill based upon the strength of the tablet; as each Warfarin sodium tablet color represents a specific strength.	
15.	Knows some medications may interact with Warfarin sodium and to consult with the Health Care Provider when a medication is started or stopped.	
16.	Knows some foods (particularly leafy vegetables with large amounts of vitamin K) may interact with Warfarin sodium and to consult with the Health Care Provider regarding individual's dietary needs.	
17.	Knows that Warfarin sodium interacts with Vitamin K in the body and knows the need to keep individual's Vitamin K intake consistent from day-to-day.	
18.	Knows excessive use of alcohol may affect the metabolism of Warfarin sodium and knows to consult with the Health Care Provider regarding individual's alcohol usage.	
19.	Knows some herbs and spices (e.g., ginger and garlic) may interact with Warfarin sodium and to consult the Health Care Provider regarding individual's dietary needs.	

REQUIRED

20.	Knows the individual's specific diet plan and knows it is important for individual to eat a consistent balanced diet while being treated with Warfarin sodium.	
21.	Knows that an individual receiving Warfarin sodium is at risk for bleeding. Knows ways to lower the chance of injury (e.g., use great caution with sharp objects, use an electric razor for shaving, use a soft-bristle toothbrush and waxed dental floss, etc.).	
22.	Knows the effects of Warfarin sodium can be reversed with prescribed treatment (e.g., administration of Vitamin K) and knows to seek medical attention for individual when warranted.	
23.	Knows that Certified staff are not permitted to split the Warfarin sodium tablets and knows if splitting of pill is required to achieve the prescribed dosage that the tablet splitting must be done by the pharmacy.	
24.	Knows if PT/INR self-testing is managed at the program setting, it is not to be done by Certified staff.	
25.	Knows Warfarin sodium administration must be documented on a medication sheet.	
26.	Knows adverse effects of Warfarin sodium therapy.	
27.	Knows when a phone call to the Health Care Provider is necessary.	
28.	Knows when a 911 phone call and/or Poison Control is necessary.	
29.	Knows after Emergency Response personnel arrive and individual is cared for; to notify appropriate persons, and follow all emergency procedures per the provider's policy.	
30.	Knows procedure for obtaining Warfarin sodium HCP orders, as well as HCP telephone orders.	
31.	Knows Warfarin sodium ordering and reordering system.	
32.	Knows Warfarin sodium storage requirements (if put on Count).	
33.	Knows the INR target range (goal) for individual and why individual is receiving Warfarin sodium.	
34.	Knows to contact a MAP Consultant for any questions or concerns regarding Warfarin sodium.	

Based on this guideline used for training, I, as Trainer, have determined that the Certified Staff Person named below has the knowledge to administer Warfarin sodium.

Staff Person's Printed
Name _____

Trainer's Printed Name _____

Staff Person's
Signature _____

Trainer's Signature _____

Date _____

Trainer's Phone
Number _____

[illegible]

SAMPLE HEALTH CARE PROVIDER ORDERS
Warfarin Sodium

Individual:		Address:	
Date of Birth:		Phone Number:	
Allergies:			
INR Target Range/Goal:			
Medical condition being treated:			

******CURRENT MEDICATION LIST ATTACHED** ☐

Warfarin Sodium Dosing Instructions:

*****Please fill in milligram dosage prescribed for each day of the week in the DOSE BLOCK below:**

WEEKDAY	DATE(S)	DOSE	INSTRUCTIONS
Sunday			By mouth once daily in the evening
Monday			By mouth once daily in the evening
Tuesday			By mouth once daily in the evening
Wednesday			By mouth once daily in the evening
Thursday			By mouth once daily in the evening
Friday			By mouth once daily in the evening
Saturday			By mouth once daily in the evening

Warfarin sodium Order Start Date:	
Warfarin sodium Order Stop Date:	
Next Lab Draw Date/Time:	

Special Instructions/Comments:	
For Questions call:	

Health Care Provider Name (PRINT):	Signature:	Date:	Time:
POSTED:		VERIFIED:	
DATE:	TIME:	DATE:	TIME:

OPTIONAL

**SAMPLE HEALTH CARE PROVIDER TELEPHONE/FAX ORDERS
Warfarin Sodium**

Individual:		Date of Birth	
Address:		Phone Number:	
INR Target Range/Goal		Fax Number:	
Allergies:			

Warfarin Sodium Dosing Instructions:

*****Staff receiving telephone order: fill in milligram dosage prescribed for each day of the week in the DOSE BLOCK below. ***Also, 'read back' the order/instructions to HCP.**

WEEKDAY	DATE(S)	DOSE	INSTRUCTIONS
Sunday			By mouth once daily in the evening
Monday			By mouth once daily in the evening
Tuesday			By mouth once daily in the evening
Wednesday			By mouth once daily in the evening
Thursday			By mouth once daily in the evening
Friday			By mouth once daily in the evening
Saturday			By mouth once daily in the evening

Warfarin Sodium Order Start Date:	
Warfarin Sodium Order Stop Date:	
Next Lab Draw Date/Time:	
Special Instructions:	

Health Care Provider Name (PRINT):	Staff Receiving Order:	Date:	Time:
POSTED:		VERIFIED:	
DATE:	TIME:	DATE:	TIME:

*****HCP, please sign below.....MAP Policy requires HCP Confirmation Signature within 72 hours.**

Health Care Provider Co-Signature:	Date:	Time:
POSTED:		VERIFIED:
DATE:	TIME:	DATE:

Sample Warfarin Sodium Chronological Event Sheet

Individual:				Health Care Provider:			
Date of Birth:				INR Target Range/Goal:			
Allergies:							
Medical condition being treated:							
Date	Time	INR	Warfarin sodium/Coumadin Dose	Next Lab Date	Comments/Notes	Signature	

Month/Year:

Sample Warfarin Sodium Medication Sheet

Allergies:

		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date	Generic	Warfarin sodium																															
	Brand	Coumadin																															
	Dose																																
	Strength																																
Stop Date	Amount																																
	Frequency	Every Evening	4 PM																														
	Route	By Mouth	2nd																														
	Next PT/INR Date	MM/DD/YR	Check																														

Special Instructions/Precautions: Watch for bleeding

Reason: Prevents blood clots from forming or growing larger

THIS MEDICATION SHEET TO BE USED FOR COUMADIN ORDERS ONLY

Name:	CODES	Initials	Signature	Initials	Signature
	DP-Day Program				
	H-Hospital				
	S-School				
	P-Packaged				
Site:	W-Work				
	LOA-Leave of Absence				
1 st check	Date/Time	2 nd check	Date/Time		

Month/Year:

Sample Warfarin Sodium Medication Sheet

Allergies:

		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Start:	Generic:	Warfarin sodium																																
	Brand	Coumadin																																
	Strength:		4 PM																															
Stop:	Amount:		Dose:	2 nd check																														
	Frequency	Every Evening	Special Instructions/Precautions:																			Reason:												
	Route:	By Mouth	Watch for bleeding																			Prevents blood clots from forming or growing larger												

		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Start:		PT																																
	PT/ INR BLOODWORK	INR																																
	NEXT PT/ INR BLOODWORK	Next lab date																																
Stop:		Special Instructions/Precautions:																			Reason:													
		Record lab results above																			Prescribed Coumadin													
		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Start:	Generic:																																	
	Brand																																	
	Strength:																																	
Stop:	Amount:		Dose:																															
	Frequency		Special Instructions/Precautions:																			Reason:												
	Route:																																	

THIS MEDICATION SHEET TO BE USED FOR COUMADIN ORDERS ONLY

Name:	CODES	Initials	Signature	Initials	Signature		
	DP-Day Program						
	H-Hospital						
	S-School						
	P-Packaged						
Site:	W-Work						
	LOA-Leave of Absence						
1 st check		Date/Time		2 nd check		Date/Time	

Month/Year:

Sample Warfarin Sodium Medication Sheet

Allergies:

		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Start:	Generic:	Warfarin sodium																																
	Brand	Coumadin																																
	Strength:		4 PM	X		X		X		X		X		X		X		X		X		X		X		X		X		X		X		
Stop:	Amount:		Dose:	2 nd check																														
	Frequency	Every other Evening	Special Instructions/Precautions: Watch for bleeding Alternate dose with Coumadin ____mg on _____																				Reason: Prevents blood clots from forming or growing larger											
	Route:	By Mouth																																

		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Start:	Generic:	Warfarin sodium																																
	Brand	Coumadin																																
	Strength:		4 PM		X		X		X		X		X		X		X		X		X		X		X		X		X		X			
Stop:	Amount:		Dose:	2 nd check																														
	Frequency	Every other Evening	Special Instructions/Precautions: Watch for bleeding Alternate dose with Coumadin ____mg on _____																				Reason: Prevents blood clots from forming or growing larger											
	Route:	By Mouth																																

		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start:		PT																															
	PT/ INR BLOODWORK	INR																															
	NEXT PT/ INR BLOODWORK	Next lab date																															
Stop:		Special Instructions/Precautions: Record lab results above																				Reason: Prescribed Coumadin											

THIS MEDICATION SHEET TO BE USED FOR COUMADIN ORDERS ONLY

Name:	CODES	Initials	Signature	Initials	Signature
	DP-Day Program				
	H-Hospital				
Site:	S-School				
	P-Packaged				
	W-Work				
	LOA-Leave of Absence				
1 st check	Date/Time	2 nd check	Date/Time		

Month/Year:

Sample Medication Sheet

Allergies:

			Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Start:	Generic:																																		
	Brand																																		
	Strength:																																		
Stop:	Amount:	Dose:																																	
	Frequency		<u>Special Instructions/Precautions:</u>																				<u>Reason:</u>												
	Route:																																		
			Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Start:	Generic:																																		
	Brand																																		
	Strength:																																		
Stop:	Amount:	Dose:																																	
	Frequency		<u>Special Instructions/Precautions:</u>																				<u>Reason:</u>												
	Route:																																		
			Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Start:	Generic:																																		
	Brand																																		
	Strength:																																		
Stop:	Amount:	Dose:																																	
	Frequency		<u>Special Instructions/Precautions:</u>																				<u>Reason:</u>												
	Route:																																		
Name:			CODES		Initials		Signature		Initials		Signature																								
			DP-Day Program																																
			H-Hospital																																
Site:			S-School																																
			P-Packaged																																
			W-Work																																
			LOA-Leave of Absence																																
1 st check			Date/Time				2 nd check				Date/Time																								

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 08-6 High Alert Medication-Clozapine Therapy

Policy Source MAP Policy Manual

Issued Date: 01/01/15

Last Revision Date: 01/01/15

- 1 Clozapine is a Scheduled VI (M.G.L. Chapter 94C §2 and 3) controlled substance and all MAP regulations and policies apply when Clozapine is administered.
- 2 Certified staff, including relief staff, may administer Clozapine therapy at the DPH MAP registered site provided:
 - a. There is a Service Provider policy/procedure for Clozapine administration in place; and
 - i. The policy must include administrative procedures to be followed when there is a medical emergency related to the administration of Clozapine.
 1. The 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 administration of Clozapine).
 - ii. procedures for safe administration of Clozapine, including but not limited to:
 1. When transcribing Clozapine onto the medication sheet, the next date for the upcoming White Blood Cell (WBC) count and Absolute Neutrophil Count (ANC) lab draw must be indicated on the medication sheet.
 - (a) The laboratory test could also be ordered as a Complete Blood Count with differential (CBC with diff).
 2. At any time when there is a change in the Health Care Provider Clozapine orders (dose change, holding medication dosage, etc.):
 - (a) the change must be communicated to all staff verbally or in writing; and
 - (b) a narrative note must be written in the individual's chart
 - b. The Certified staff have been trained in and are aware of Clozapine therapy.
 - i. The Service Provider must have documented evidence of each Certified staff's training for Clozapine administration. Documentation must include the date of the training, name(s) of staff trained, and the name, address and telephone number of the trainer(s) and maintained at the Service Provider's main office and on site.
 1. As a prerequisite to administering Clozapine, Certified staff must also have successfully completed Vital Signs Training.
- 3 DMH/DDS/DCF community residential programs that implement Clozapine administration must adhere to the following requirements:
 - a. There is an order from a Health Care Provider (authorized prescriber) regarding the individual's need for Clozapine that includes:
 - i. the specific medical condition or diagnosis that is the indication for Clozapine; and
 - ii. individualized instructions to follow when Clozapine dosage is not administered (omitted)
 1. individualized instructions must also specify directives to follow when the Clozapine dosage is missed for 2 days or more (i.e., the authorized prescriber must be contacted).

- 4 Certified staff administering Clozapine must complete Clozapine Therapy Training, conducted by an RN, NP, PA, RPh, or MD; with demonstrated understanding of the safe administration of Clozapine on a regular basis.
 - a. Certified staff who have not administered Clozapine in the previous twelve months or have not demonstrated understanding of safe Clozapine administration must take a supplemental Clozapine Therapy retraining.
 - i. An LPN, who is able to demonstrate initial and continued competence, may provide subsequent retraining for Clozapine Therapy competency reviews.
 - b. Staff training in Clozapine Therapy must include, but not be limited to:
 - i. overview of Clozapine and antipsychotic therapy;
 - ii. rationale for Clozapine administration (including individual specific);
 - iii. overview of importance of frequent blood testing monitoring of White Blood Cell (WBC) Count and Absolute Neutrophil Count (ANC) and its importance to safe administration;
 - iv. an understanding that the pharmacy must have current and acceptable ANC and WBC counts to dispense the Clozapine;
 - v. following an individualized clozapine administration protocol which includes at a minimum:
 - (a) an understanding of when to contact the Health Care Provider and/or the MAP Consultant;
 - (b) adverse effects of Clozapine therapy; and
 - (c) the emergency procedure to follow, including but not limited to calling 911 and notification of the individual's Health Care Provider.

Evaluation Tool for Clozapine Therapy

Staff Name: _____

Date: _____

Clozapine Therapy Training Guidelines

	Training Components of Equipment and Procedure	Comments
1.	Knows where to locate the agency policy/procedure that outlines when an individual is receiving Clozapine therapy, the procedure to follow, and who will be responsible for providing Clozapine administration.	
2.	Knows that only licensed personnel (nurses) and MAP Certified Staff may administer Clozapine.	
3.	Knows that the generic named product 'Clozapine' (also known by the common brand name CLOZARIL®) can be used for the management of individuals diagnosed with schizophrenia and/or schizoaffective disorder.	
4.	Knows there is significant risk of a potentially life threatening blood disorder (agranulocytosis) associated with the use of Clozapine. Knows that this potentially life threatening blood disorder, if caught early, can be reversed.	
5.	Knows regular blood testing monitoring for the White Blood Cell (WBC) count and the Absolute Neutrophil Count (ANC) is required for the pharmacy to dispense Clozapine.	
6.	Knows the pharmacy must be supplied with a current blood work (ANC and WBC count) result (drawn within 7 days, irrespective of monitoring frequency) prior to dispensing Clozapine. If lab draw date is more than 7 days old, the Clozapine cannot be dispensed by the pharmacy.	
7.	Knows if the ANC and WBC counts are older than 7 days (from when the Clozapine prescription is to be filled), another blood draw must be done.	
8.	Knows that initial Clozapine therapy requires frequent lab draws (typically weekly- for 6 months, then biweekly- for 6 months, and then every 4 weeks- after 12 months of continuous therapy without any interruptions).	
9.	Knows that in the event that an individual is discontinued from Clozapine therapy, weekly blood work must be obtained for a minimum of 4 weeks.	
10.	Knows that the Health Care Provider can prescribe the Clozapine (including refills) but the pharmacist cannot dispense the Clozapine without the current acceptable ANC and WBC counts.	
11.	Knows that the pharmacy will only dispense enough Clozapine tablets until individual's next blood test.	
12.	Knows to report any signs or symptoms of infection (e.g., fever, weakness, lethargy, or sore throat) to the Health Care Provider.	
13.	Knows individuals diagnosed with schizophrenia or schizoaffective disorder may exhibit suicidal behavior, which refers to actions by the individual that put him/her at risk for death or serious harm.	
14.	Knows that Clozapine therapy education should be provided (both initial and continuous) for an individual learning to self-administer Clozapine.	
15.	Knows adverse effects of Clozapine therapy.	
16.	Knows when a phone call to the Health Care Provider is necessary.	
17.	Knows when a 911 phone call is necessary.	
18.	Knows after Emergency Response personnel arrive and individual is cared for; to notify appropriate persons, and follow all emergency procedures per the provider's policy.	
19.	Knows procedure for obtaining Clozapine HCP orders, as well as Clozapine HCP telephone orders.	
20.	Knows that the next lab draw date for WBC (White Blood Count) and ANC (Absolute Neutrophil Count) must be on the medication administration record. ***Sometimes, this laboratory test will be ordered as a CBC with diff (Complete Blood Count with differential).	

Maintain a copy of this document in training records at the program site.

REQUIRED

21.	Knows Clozapine ordering and reordering system.	
22.	Knows if a dose of Clozapine is missed to contact the MAP Consultant and if the Clozapine dose is missed for more than 2 days to not administer the next dose of Clozapine without first contacting the prescribing Health Care Provider.	

Based on this guideline used for training, I, as Trainer, have determined that the Certified Staff Person named below has the knowledge to administer Clozapine.

Staff Person's Printed
Name _____

Trainer's Printed Name _____

Staff Person's
Signature _____

Trainer's Signature _____

Date _____

Trainer's Phone
Number _____

Month/Year:

Sample Clozapine Medication Sheet

Allergies:

		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start:	Generic:	Clozapine																															
	Brand	Clozaril																															
	Strength:																																
Stop:	Amount:		Dose:																														
	Frequency		Special Instructions/Precautions: Watch for signs of infection (e.g., elevated temperature, weakness, sore throat, etc.). Notify HCP when signs of infection are observed.																				Reason: Helps to prevent hallucinations										
	Route:	By Mouth																															

		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start:																																	
	BLOODWORK NEXT WBC / ANC BLOODWORK																																
		Next lab date																															
Stop:																																	
			Special Instructions/Precautions: Ensure that the pharmacy has received copies of lab work results.																				Reason: Prescribed Clozapine										
		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start:	Generic:																																
	Brand																																
	Strength:																																
Stop:	Amount:		Dose:																														
	Frequency		Special Instructions/Precautions:																				Reason:										
	Route:																																

Name:	CODES	Initials	Signature	Initials	Signature
	DP-Day Program				
	H-Hospital				
	S-School				
Site:	P-Packaged				
	W-Work				
	LOA-Leave of Absence				
1 st check	Date/Time	2 nd check	Date/Time		

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 08-7 High Alert Medication-
Combination drug product buprenorphine hydrochloride and
naloxone (brand name Suboxone®)

Policy Source MAP Policy Manual

Issued Date: 01/01/15

Last Revision Date: 01/01/15

- 1 The combination drug product buprenorphine hydrochloride and naloxone (buprenorphine/naloxone) is a Schedule III controlled substance and all MAP regulations and policies apply when administered.
- 2 Certified staff may administer buprenorphine/naloxone at the DPH MAP registered site provided:
 - a. The buprenorphine/naloxone has been prescribed by a medical doctor (not a nurse practitioner or other authorized prescriber). The pharmacist can only dispense buprenorphine/naloxone when it is prescribed by a medical doctor who is specially trained and registered, known as a DATA (Drug Addiction Treatment Act) waived prescriber.
 - i. Assure that the physician's order indicates the need for administration of buprenorphine/naloxone:
 1. This should specify narcotic treatment, opioid replacement therapy or other similar term as the purpose for buprenorphine/naloxone.
 - (a) If the medication is prescribed for 'pain management', it cannot be administered by Certified staff.
 - b. A copy of the individual's Medication List; that includes the current dosage of all prescribed medication, accompanies the individual to all Health Care Provider (e.g., Primary Care Physician, Psychiatrist, Dentist, etc.) encounters; and
 - i. Whenever a Health Care Provider prescribes a new medication or the dosage of a previously prescribed medication is changed, the physician who prescribed the buprenorphine/naloxone must be consulted.
 1. The site must maintain documented verification that the physician who prescribed the buprenorphine/naloxone was consulted.
 - (a) Drug Interactions are a leading cause of morbidity (i.e., disease) and mortality (i.e., death). This finding extends to medications used in the treatment of substance use disorders (e.g., buprenorphine/naloxone) and pharmacotherapies utilized for treatment of medical or mental illnesses, as well as for abused substances.
 - c. Certified staff have been trained and are aware of buprenorphine/naloxone.
 - i. The Service Provider must have documented evidence of Certified staff training. Documentation must include the date of the training, name(s) of trained staff and the name and current contact information (address and telephone number) of the trainer(s).

- 3 Certified staff cannot administer single entity buprenorphine drug products in place of the combination drug product buprenorphine/naloxone without the prescribing physician's documentation of the individual's intolerance to naloxone.
 - a. Single entity buprenorphine drug products can be used for detoxification and should only be administered by a treatment facility, never in a MAP setting (see US Food and Drug Administration website/ <http://www.fda.gov/> for additional information).

Archived

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 08-8 High Alert Medications-Medications Requiring Additional Monitoring of An Individual

Policy Source MAP Policy Manual

Issued Date: 01/01/15

Last Revision Date: 01/01/15

- 1 When a Health Care Provider, MAP Consultant, and/or Administrative MAP Advisor (i.e., DDS MAP Coordinator, DMH/DCF MAP Coordinator, 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 the safe administration, (including the additional monitoring of the individual), of that medication.
 - 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.

09

MEDICATION OCCURRENCES

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 09-1 Definition of Medication Occurrence

Policy Source October 1996 MAP Advisory

Issued Date: 10/96

Last Revision Date: 01/01/15

- 1 For the purpose of reporting, a Medication Occurrence is defined as an a breach of one of the five “R’s”, namely Right individual, Right medication, Right time, Right dose, and Right route.
 - a. There are five types of reportable occurrences: wrong individual, wrong medication (which includes administering a medication without an order), wrong time (which includes a forgotten dose or administering a medication without complying with parameters), wrong dose and wrong route. (Refer to the Training Curriculum, for additional information).
 - i. “The five wrongs” are listed on the Medication Occurrence Reporting form.
 - ii. The Medication Occurrence Report allows for six reportable selections of which ‘Omission’ is listed as well as those ‘wrongs’ described above.
- 2 The definition of “right time” is further clarified to include medications administered “within the appropriate time frame”.
 - a. This permits a consultant designated by the program to help determine if an occurrence has taken place by using the health care provider’s order as his/her guide and to recommend an intervention if needed.
- 3 The definition of “right time” is additionally clarified to include medications administered “within the Health Care Provider’s established parameters”.
 - a. For example, a medication is ordered to be given if the systolic (top number) blood pressure is 110 or above and staff obtain a blood pressure reading of 130/60. Certified staff should administer the medication because the established parameters have been met.
- 4 The determination of whether an occurrence has taken place is the responsibility of the program in conjunction with the consultant, and is based upon the health care provider order, not solely upon the program or site’s medication schedule.
 - a. For example, a medication ordered two times a day (BID) is not necessarily a reportable occurrence if it is given at 8 AM and 8 PM rather than at the times of 8 AM and 5 PM scheduled by site staff.
- 5 Events that are not within the staff’s control (such as medications missed due to an individual’s refusal/absence); that lead to a Medication Occurrence does not require reporting via a MOR.
 - a. Service Providers should have internal reporting procedures (e.g., incident reports, data tracking forms, etc.) for refusals and similar events in order to maintain appropriate care and quality assurance standards.
 - i. This is in addition to informing the Health Care Provider of a medication refusal, and/or following the Health Care Provider guidelines for refusal events.

- b. Actions of a Health Care Provider or the actions of a Pharmacist that lead to a Medication Occurrence do require reporting; (see *Policy No.10-9 on page 117 and Policy No.17-1 on page 193*).

Archived

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 09-2 Use of MAP Consultant

Policy Source April 1997 MAP Advisory

October 1996 MAP Advisory

Issued Date: 10/96 04/97

Last Revision Date: 01/01/15

- 1 A MAP Consultant must be contacted immediately for every Medication Occurrence.
- 2 A MAP Consultant is defined as a registered nurse, registered pharmacist or authorized prescriber.
 - a. An authorized prescriber is a physician, dentist, podiatrist, nurse practitioner, physician assistant or other person who is registered to prescribe controlled substances in the course of their professional practice.
- 3 A MAP Consultant must be available to Certified staff twenty-four (24) hours a day, seven (7) days per week.
 - a. The Service Provider must provide a list of designated MAP Consultants for the site and make it available for Certified staff.
 - i. It is recommended that the MAP Consultant(s) designated have a knowledge of MAP and the program site and that there be a formal written agreement for the service.
- 4 MAP Consultants shall:
 - a. provide staff with the technical assistance they require to interpret the health care provider order;
 - b. recommend appropriate action(s) to follow a Medication Occurrence, including medical intervention if necessary; and
 - c. provide the staff with guidance regarding the reporting process should they require it.
- 5 The DPH registrant (the Service Provider) has the responsibility to determine whether or not there has been an occurrence; to determine what, if any, action(s) will be taken by staff to care for the individual; and to report to DPH/DMH/DCF/DDS within the established time frames.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue	09-3 Requirements for Reporting Medication Occurrences
Policy Source	October 1996 MAP Advisory
Issued Date:	10/96
	Last Revision Date: 10/01/13

- 1 A Medication Occurrence Report (MOR) must be submitted for any reportable Medication Occurrence.
- 2 Those Occurrences that are followed by a medical intervention, illness, injury and/or death are reportable directly to DPH via the MOR Hotline Event process (*see Policy No. 17-1 on page 193 for contact information*) within twenty-four (24) hours of the discovery of the Occurrence.
 - a. When the Medication Occurrence is followed by medical intervention, illness, injury and/or death (a 'Hotline Event'), the completion of the DPH Medication Occurrence Report Form must be done (*see Policy No. 09-7 on page 102*).
 - i. If a Medication Occurrence is determined to be a Hotline Event for an individual supported by the Department of Developmental Services, the Department of Mental Health, or the Department of Children and Families the completed DPH Medication Occurrence Report Form must be faxed to the Department of Public Health. A copy should also be forwarded to the appropriate MAP Coordinator.
 1. This is in addition to the DDS Home and Community Information System (HCSIS) Medication Occurrence Report.
- 3 There need not necessarily be a demonstrated causal relationship between the Occurrence and the medical intervention, illness, injury or death in order for an Occurrence to be reportable to DPH.
 - a. Submission of an MOR does not constitute an admission that a medication error caused or contributed to the event.
 - b. A Medication Occurrence Report should be submitted regardless of the ultimate outcome of the event.
- 4 Copies of all MORs, including those separately reported to DPH via the Hotline Event process, must be forwarded within seven (7) days (or within twenty-four hours for 'hotline event') to the appropriate DMH/DCF Area or DDS Regional MAP Coordinator.
 - a. The original MOR must remain at the program site.
 - i. A system must be developed by the Service Provider to ensure the original MOR is maintained at the program site.
- 5 The Home and Community Services Information System (HCSIS) is a web-based service used by the Department of Developmental Services that allows Service Providers to file reports (such as clinical and informational documents). Documentation of a Medication Occurrence Report (MOR), for the Department of Developmental Services (DDS), is done via HCSIS.
 - a. When the DDS Home and Community Information System (HCSIS) reporting system is utilized, the HCSIS paper form must be maintained at the program site.

- i. If the Medication Occurrence information is directly data entered into HCSIS (no paper form is used) and the information regarding the MOR can be electronically retrieved from the program, it is not necessary to print a paper copy of the data entered.
 - ii. If the Medication Occurrence information is directly data entered into HCSIS and the information regarding the MOR can not be electronically retrieved at the program site, it is necessary to have a printed copy of the MOR on site.
 - iii. If the original Medication Occurrence information is completed on a paper document version of the HCSIS MOR form and entered later into the electronic system, the original paper MOR must be maintained at the program site.
 - b. If a Medication Occurrence is determined to be a Hotline Event, the original completed DPH MOR (a copy of which should have been faxed to the Department of Public Health) should be maintained at the program site. This is in addition to the HCSIS report.
- 6 It is strongly recommended that Service Providers maintain their own internal reporting procedures to identify and address medication related issues, concerns or problems as part of a system of providing appropriate care and quality assurance standards.
- 7 DPH will inform DMH/DCF/DDS of those Medication Occurrences reported directly to DPH via the Hotline Event process.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 09-4 Medical Intervention

Policy Source April 1997 MAP Advisory

Issued Date: 04/97

Last Revision Date: 9/01/10

- 1 Medical Intervention(s) are actions taken following a Medication Occurrence that includes medical care provided to the individual. Any event that requires medical intervention, regardless of the outcome of the medical intervention, must be reported as a Hotline Event.
 - a. Examples of Medical Interventions are: Lab work, EKG/ECG (Electrocardiogram), CT (Computed tomography) scan, a visit to or treatment by the health care provider, clinic visit, hospitalization, emergency room, etc.
 - i. Recommended Action by the MAP Consultant, which requires Medical Intervention, should be marked as 'yes' in the Hotline Events *Section D* of the DPH Medication Occurrence Report (MOR) form and MAP Consultant's Recommended Action *Section E* (see *Policy No. 09-7 on page 102*).
 1. The Medication Occurrence Report should include documentation of the Recommended Action, for Medical Intervention, by the MAP Consultant.
- 2 Medical Intervention(s) does not include contacting the consultant nor does it include adjustments made to the medication regimen.
 - a. An example of a recommended action by the Health Care Provider or Pharmacist that is not considered medical intervention would be: 'skipping the missed dose and administering next dose as scheduled' or 'vital sign monitoring by Certified staff'.
 - i. Recommended Action by the MAP Consultant, which does not require Medical Intervention, should be marked as 'no' in the MAP Consultant's Recommended Action *Section E* of the DPH Medication Occurrence Report form (see *Policy No. 09-7 on page 102*).

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue	09-5 DPH Medication Occurrence Reporting (MOR) Form
Policy Source	October 1996 MAP Advisory
Issued Date:	10/96
Last Revision Date:	9/01/10

- 1 The DPH Medication Occurrence Reporting form (MOR) (*see Policy No. 09-7 on page 102*) requests information in a manner that reduces the paperwork burden on Service Providers and facilitates tracking and review by state agencies.
 - a. The form is user friendly requiring no narrative statement from direct care staff and minimal narrative notes from the supervisor.
 - b. The form is designed to:
 - i. facilitate appropriate reporting;
 - ii. allow for the collection of relevant information; and
 - iii. improve the ability to track and respond to Medication Occurrences.
 - c. Direct care staff completing the form do not need to sign their name nor identify the staff person involved in the occurrence.
 - d. The responsibility lies with the supervisor to review the occurrence, check off contributing factors (if any), comment, document action taken (e.g., staff retraining) to minimize future occurrences and forward a copy of the MOR to the appropriate agency within the assigned time frames.
- 2 Original completed DPH Medication Occurrence Report forms should remain at the site.
- 3 A Medication Occurrence Report is only used for an Occurrence involving a Certified staff administering medications.
 - a. Medication Occurrence Reports do not need to be completed on behalf of individuals, who are self-administering or when medications are administered by licensed staff.
 - i. It is recommended that Service Providers have an internal reporting system for Medication Occurrences involving licensed staff or individuals who are self-administering.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 09-6 Instructions for Completion of DPH Medication Occurrence Report (MOR) form

Policy Source October 1996 MAP Advisory

Issued Date: 10/96

Last Revision Date: 10/01/13

- 1 The DPH Medication Occurrence Report (MOR) form must be complete.
 - a. Fill in all areas before the MOR is faxed to DPH and/or forwarded to DDS or DMH/DCF.
 - i. Incomplete forms will be returned.
 1. The reverse side (side two) is not required to be faxed to DPH if the narrative regarding the occurrence can be completed within *Section F* of the document.
 - ii. Keep original MORs at the site.
- 2 Complete the Medication Occurrence Report (MOR) after the individual's immediate needs for care or medical intervention have been met.
 - a. If unsure whether an event is reportable, staff should clarify this with the consultant when the consultant is contacted.
- 3 The top section of the MOR requests basic information that permits DPH/DMH/DCF/DDS to identify the agency, site, and individual.
 - a. Include the site's telephone number with area code and the site's DPH (5 digit) registration number. These numbers will be used by DPH/DMH/DCF/DDS as identifiers for tracking purposes.
- 4 To complete *Section A*, select the type of occurrence that has taken place. Only one type of occurrence should be selected.
 - a. If unsure what type of occurrence should be selected, staff should clarify this with the consultant when the consultant is contacted.
- 5 To complete *Section B*, document the medications involved in the occurrence.
 - a. List the name of the medication ordered by the health care provider next to 'As Ordered', as well as the dosage, frequency/time, and route.
 - b. List the exact medication, dose, frequency/time, and route by which the medication was actually given to the individual next to 'As Given'.
 - c. *Section B* allows room for three medications to be listed. If more than three medications were noted in the occurrence, list the additional medications on the reverse side (side two) of the MOR using the 'As Ordered/As Given' format.
- 6 To complete *Section C*, select the title of the MAP Consultant contacted. Document the consultant's name (e.g., 'Fred Jones R.Ph., not CVS'), date and time contacted.
 - a. If more than one MAP Consultant was contacted, that information may be documented, as well.
- 7 To complete *Section D*, select the appropriate 'yes'/'no' answer to designate if, medical intervention, illness, injury and/or death (a Hotline Event) followed the occurrence.

- a. If 'yes' was selected, check all the applicable boxes that apply (medical intervention, illness, injury, and/or death).
 - i. Notify DPH and the DDS or DMH/DCF MAP Coordinator within 24 hours of the discovery of a Medication Occurrence followed by a Hotline Event.
 1. Notification to DPH may be by telephone and/or fax of the MOR form (faxing is encouraged whenever possible). A copy of the MOR form should also be forwarded to the appropriate MAP Coordinator.
 - b. If no medical intervention, illness, injury or death followed the occurrence, 'no' would be the appropriate selection.
 1. 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.
- 8 To complete *Section E*, select the appropriate 'yes'/'no' answer to designate if medical intervention was the recommended action given by the MAP Consultant listed in Section C.
- a. If medical intervention was recommended, (a Hotline Event) select all the applicable boxes. Medical Intervention(s) are actions taken following a Medication Occurrence that includes medical care provided to the individual by a clinician.
 - i. For the purpose of reporting, medical interventions include, but are not limited to, treatment in an emergency room, clinic or other health care facility; treatment by a Health Care Provider; and/or, Lab work, EKG/ECG, CT scan, or other tests.
 1. If the medical intervention recommended is not listed on the form, select 'Other', and document the medical intervention(s) recommended in the space provided.
- 9 The supervisor should then review the MOR and complete *Section F*.
- a. To complete *Section F*, the Supervisor should review the factors involved in the occurrence.
 - i. A listing is provided in *Section F* of the most common factors that contribute to Medication Occurrences. The site supervisor should review the factors involved in the occurrence and select all those that apply.
 - ii. If no contributing factors listed on the form are involved, then '7' 'none' should be selected.
 - iii. The supervisor may comment, as he/she deems necessary and appropriate in the narrative section.
 1. Additional space is available on the reverse side (side two) *Section F-1*.
 - iv. After completion of the Review/Follow up, the supervisor must enter his/her printed name, his/her job title, his/her contact phone number, his/her e-mail address, and the date the form was completed.
- 10 A completed copy of the MOR should be forwarded to the DMH/DCF Area or DDS Regional MAP Coordinator within seven (7) days (or within twenty-four hours for 'hotline events').
- a. Contact information for the DMH/DCF or DDS MAP Coordinator(s) is provided on the reverse side (side two) of the MOR.
- 11 The original Medication Occurrence Report should remain at the program site.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 09-7 Approved MOR Form

Policy Source October 1996 MAP Advisory

Issued Date: 10/96

Last Revision Date: 01/01/15

- 1 The DPH MOR form should be used for all DMH or DCF program site(s) medication occurrences.
- 2 The DPH MOR form should be used for all DDS program site(s) 'hotline' medication occurrences submitted to DPH.
 - a. DDS program sites should use the HCSIS MOR reporting process to report all MORs (see *Policy No. 09-3 on page 96*).

SEE FORM ON FOLLOWING PAGE.

Department of Public Health Medication Administration Program
MEDICATION OCCURRENCE REPORT (side one)

Agency Name		Date of Discovery	
Individual's Name		Time of Discovery	
Site Address (street)		Date(s) of Occurrence	
City/Town Zip Code		Time(s) of Occurrence	
Site Telephone No.		DPH Registration No.	MAP

A) Type Of Occurrence (As per regulation, contact MAP Consultant)

1 <input type="checkbox"/> Wrong Individual 2 <input type="checkbox"/> Wrong Dose 3 <input type="checkbox"/> Wrong Route	4 <input type="checkbox"/> Wrong Medication (includes medication given without an order) 5 <input type="checkbox"/> Wrong Time (includes medication not given in appropriate timeframe) <input type="checkbox"/> Omission (subgroup of 'wrong time'--medication not given or forgotten)
--	---

B) Medication(s) Involved

	Medication Name	Dosage	Frequency/Time	Route
As Ordered:				
As Given:				
As Ordered:				
As Given:				
As Ordered:				
As Given:				

C) MAP Consultant Contacted (Check all that apply)

Type	Name	Date Contacted	Time Contacted
<input type="checkbox"/> Registered Nurse			
<input type="checkbox"/> Registered Pharmacist			
<input type="checkbox"/> Health Care Provider			

D) Hotline Events

Did any of the events below follow the occurrence? ☐ Yes ☐ No

If yes, check all that apply below, and within 24 hours of discovery fax this form to DPH (617) 753-8046 or call to notify DPH at (617) 983-6782 and notify your DMH/DCF or DDS MAP Coordinator.

For All Occurrences, forward reports to your DMH/DCF or DDS MAP Coordinator within 7 days.

<input type="checkbox"/> Medical Intervention (see Section E below)	<input type="checkbox"/> Illness	<input type="checkbox"/> Injury	<input type="checkbox"/> Death
---	----------------------------------	---------------------------------	--------------------------------

E) MAP Consultant's Recommended Action

Medical Intervention ☐ Yes ☐ No If Yes, Check all that apply.

<input type="checkbox"/> Health Care Provider Visit	<input type="checkbox"/> Lab Work or Other Tests	<input type="checkbox"/> Clinic Visit
<input type="checkbox"/> Emergency Room Visit	<input type="checkbox"/> Hospitalization	
<input type="checkbox"/> Other: Please describe		

F) Supervisory Review/Follow-up

Contributing Factors: Check all that apply. If none apply, check none (8)

1 <input type="checkbox"/> Failure to Properly Document Administration 2 <input type="checkbox"/> Medication not Available (Explain Below) 3 <input type="checkbox"/> Medication Administered by Non-Certified Staff (includes instances of expired or revoked Certification) 4 <input type="checkbox"/> Failure to Accurately Take or Receive a Telephone Order	5 <input type="checkbox"/> Medication Had Been Discontinued 6 <input type="checkbox"/> Improperly Labeled by Pharmacy 7 <input type="checkbox"/> Failure to Accurately Record and/or Transcribe an Order 8 <input type="checkbox"/> None
---	--

Narrative: (If additional space is required, continue in box F-1)

Print Name	Print Title	Date
Contact phone number	E-mail address	

MEDICATION OCCURRENCE REPORT FORM (side two)

Agency Name		Date of Discovery	
Individual's Name		Time of Discovery	
Site Address (street)		Date(s) of Occurrence	
City/Town Zip Code		Time(s) of Occurrence	
Site Telephone No.		DPH Registration No.	

F-1) Supervisory Review/Follow-up [continued from section F)]

Use this section if needed for additional narrative.

Contacts			
DMH/DCF Area MAP Coordinators	Contact Information	DDS Regional MAP Coordinators	Contact Information
Western Mass Area Office Northampton State Hospital P.O. Box 389 Northampton, MA 01061	Telephone Number: (413) 587-6269 Fax Number: (413) 587-6258	DDS Central West Regional Office 140 High St., Suite 301 Springfield, MA. 01105	Telephone Number: (413) 205-0914 Fax Number: (413) 205-1608
Department of Mental Health Central Mass Area Farmhouse 361 Plantation Street Worcester, MA 01605	Telephone Number: (774) 420-3142 Fax Number: (774) 420-3163	Metro Region DDS-Medication Administration 411 Waverly Oaks Road Suite 304 Waltham, MA 02452	Telephone Number: (781) 314-7506 Fax Number: (781) 398-0333
Southeast Area Office Learoyd Building P.O. Box 4007 Taunton MA 02780	Telephone Number: (508) 977-3456 Fax Number: (508) 977-3231	Northeast Region DDS Northeast Region P.O. Box A Hathorne, MA 01937	Telephone Number: (978) 774-5000 ext. 354 Fax Number: (978) 739-0425
Metro Boston Area Office 85 E. Newton Street Boston, MA 02118	Telephone Number: (617) 626-9269 Fax Number: (617) 626-9216	Southeast Region Southeast Area Office DDS 68 North Main Street Carver, MA 02330	Telephone Number: (508) 866-8877 Fax Number: (617) 727-7822
Northeast-Suburban Area Department of Mental Health 40 Industrial Park Road Plymouth MA 02360	Telephone Number: (508)732-3029 Fax Number: (508)746-3224		

10

MEDICATION SECURITY AND RECORD KEEPING

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue	10-1 Administrative Policies and Procedures
Policy Source	December 1994 MAP Advisory
Issued Date:	12/94
	Last Revision Date: 01/01/15

- 1 All program sites shall have on file a master list of all Certified staff members' Certifications with dates of expiration and/or copies of Certification printouts.
- 2 All program sites must have on file up-to-date individual-specific medication records.
- 3 Each site must also have a copy of the following:
 - a. The agency's list of approved MAP Consultants;
 - b. Written listing of all Emergency Contact Numbers including, at a minimum, universal emergency number, poison control, all MAP Consultants (e.g., pharmacist consultant);
 - c. Current medication specific resource material (e.g., Drug Reference Guide or Drug Handbook) containing, at minimum, information on the specific medications being administered on site;
 - d. Agency specific policies and procedures related to access of MAP Consultants (twenty-four hours a day, seven days a week);
 - e. Agency specific policies and procedures for medical emergencies related to medication administration;
 - f. Agency specific pertinent medication specific policies (when applicable), e.g., Warfarin sodium; OTC Method B; Clozapine; Medications Requiring Additional Monitoring of An Individual; Buprenorphine/Naloxone, etc.;
 - g. Approved/current Medication Occurrence Reporting forms;
 - h. Approved/current Disposal Record forms;
 - i. Agency specific LOA policies;
 - j. Agency specific policies on Vital Signs;
 - k. Agency specific written policies for obtaining properly labeled medication containers, when a medication is given at two or more locations;
 - l. Agency specific policies for identifying and educating staff or family members/caregiver responsible for off-site medication administration;
 - m. Policies on agency specific medication administration times; and
 - n. Agency specific policies on access to the medication storage area.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 10-2 Medication Security

Policy Source 1995 DDS Memorandum

December 1994 MAP Advisory

Issued Date: 12/94

9/12/95

Last Revision Date: 9/01/10

- 1 Each program site must have a specific area dedicated to the storage of all Schedule II-VI prescription medications and OTC medications.
 - a. Schedule II-VI are prescription controlled medications.
 - i. Schedule II-V are also countable controlled medications.
- 2 Each program site must have procedures that limit the day-to-day access to this area to the staff authorized to administer medications during each shift and that limit possession of the key to the medication area to the authorized staff on that shift.
- 3 Each program site must have procedures that provide only one duplicate key to the medication area should exist and that the key should be in the possession of agency administrative staff.
- 4 The key should be personally given to the staff person assigned to administer medications on the incoming shift or replaced in the locked area after completion of the shift/assignment, if there is no incoming shift staff.
 - a. To limit the number of medication keys, the key should be stored in a locked area within the house accessible to designated staff only.
- 5 The staff person administering medications should keep the key on person during the assigned shift. If they need to leave the residence, it should be placed in a secure place.
 - a. To limit the number of medication keys, the key should be stored in a locked area within the house accessible to designated staff only.
- 6 Each individual program should have available a back-up key that is kept in a separate locked location. The knowledge of this location shall be restricted to the Program Director and Residential Supervisor.
- 7 If at any time the medication key is lost or misplaced the appropriate administrative staff must be notified immediately.
- 8 Each program site must utilize a bound medication count book for recording Schedule II-V medication administration.
 - a. The Countable Controlled Substance Book must have pages which are consecutively numbered and an index that gives the name of each countable medication and lists the page on which the count is recorded, count pages and shift count verification pages.
 - i. The book must have preprinted page numbers.
 - ii. The pages can not be removed.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 10-3 Schedules II-V

Policy Source 1995 DDS Memorandum

December 1994 MAP Advisory

Issued Date: 12/94

9/12/95

Last Revision Date: 9/01/10

- 1 Medication counts are to be conducted whenever control of the medication key is passed (i.e., at the start and end of each shift/assignment).
- 2 DPH recognizes that there are some situations where two licensed and/or Certified staff are not available at every change of shift. In those instances, it is recommended that the single licensed/Certified staff person coming on or off shift/assignment conduct a count and sign the medication count book. At the first opportunity for a two-person count, the count must be conducted.
 - a. Under no circumstances should a two-person count be conducted less than once every twenty-four hours.
- 3 All Schedule II-V medications must be doubled locked (i.e., locked box within a locked cabinet).
- 4 In addition to contacting the Program Supervisor and/or on-call manager, any discrepancy noted in the count should be reported to the Department of Public Health on the next day after the discovery of the discrepancy (*see Policy No. 10-7 on page 115, and Policy No. 17-1 on page 193*).
- 5 The Countable Controlled Substance 'count sheets' must be maintained in a bound (i.e., the pages can not be removed) book within the medication administration area. (These books may be obtained from a commercial manufacturer.)
 - a. The Countable Controlled Substance Book must have preprinted consecutively numbered pages and an index that gives the name of each countable medication and lists the page on which the count is recorded; count pages and shift count verification pages.
- 6 All Schedule II-V medications should be marked as such by the pharmacy.
 - a. The Pharmacy must inscribe an identifier on the pharmacy label (e.g., 'C', 'N', etc.) indicating that the medication is a countable controlled substance.
 - i. All countable controlled medications must be logged into the Countable Controlled Substance Book when received from the pharmacy.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 10-4 Storage and Labeling of Medications

Policy Source 1995 DDS Memorandum

Issued Date: 9/12/95

Last Revision Date: 01/01/15

- 1 Prescription and nonprescription (OTC/Over-the-Counter) medications for all individuals who are not self-administering shall be labeled and stored in a locked container or area, which is devoted strictly to medication storage, supplies, and records relevant to medication administration. (Policy books or other supplies are not to be stored in the area.)
 - a. A controlled substance (prescription medication) should have a label affixed to the medication container (e.g., medication bottle or blister pack) that indicates:
 - i. the name of the individual;
 - ii. the name of the controlled substance (medication) including the IC (i.e., interchange) name, if any;
 - (a) The IC name of the medication should be listed when the pharmacy dispenses a generic substitution or a less expensive brand name drug product for the prescribed medication.
 - iii. the strength and amount;
 - iv. the frequency;
 - v. the route of administration;
 - vi. the name of the prescribing health care provider;
 - vii. directions for use;
 - viii. cautionary statements, if any;
 - ix. total quantity of medication dispensed (e.g., if the medication was dispensed as tablets or capsules, the number of same in the container);
 - x. the date of filling;
 - xi. the lot number;
 - xii. the pharmacy name, address, telephone number and serial/prescription number;
 - xiii. the expiration date; and
 - xiv. the filling pharmacist's initials.
- 2 Only MAP Certified or licensed staff who are assigned the duty of administering medications may have access to the medication storage areas.
- 3 The program must maintain a record of when a prescription is filled and the quantity of medication dispensed by the pharmacy. Medication dispensed by the pharmacy, for use in a DPH MAP Registered site, must be received from the pharmacy only by MAP Certified or licensed staff.
- 4 Pharmacy receipts should be kept at the site for a minimum of 90 days.
- 5 A supply of OTC medication, in its original manufacturer's package and in an amount that is usual and customary (i.e., an average size container), may be maintained at a program (see *Policy No. 06-6 on page 45*).
- 6 Any illegible, worn, or missing labels should be referred to the pharmacy for replacement or issuance of new medication.

- 7 Prescription medication requiring refrigeration must be stored in a locked container within the on-site refrigerator, or in a separate (locked) refrigerator dedicated to medication storage.
- 8 Topical (external) and internal medications are to be stored separately (i.e., different shelf or in separate containers).
- 9 Except as cited in MAP Policy No. 11-2, staff shall not repack or re-label any medications when medication is given at two different locations (*see Policy No. 11-2 on page 127*).
- 10 If the individual receives medication at two different sites, a separate labeled prescription bottle or bubble pack will be obtained from the pharmacy for use at each separate site. The documentation for administration will remain the same at both sites. The residential program will remain responsible for notifying the off-site program of any medication changes and for supplying the necessary forms (e.g., copy of Health Care Provider order, medication administration record, drug information sheets, etc.).
 - a. The program shall not store on site more than a thirty-seven (37) day supply of prescription medication except when the prescription plan utilized by the individual requires that they purchase an amount of medication in excess of thirty-seven (37) days at one time.
 - i. Documentation of such a prescription plan requirement must be kept in the individual's record at the program where the medications are stored.
- 11 Sample medication may be received from a Health Care Provider and administered to an individual only when:
 - a. The amount of the sample doses received from the Health Care Provider is no more than 'a one-time' 30 day amount;
 - i. Larger supplies of Schedule VI sample medications, (up to 90 days), may be dispensed as part of a manufacturer's indigent drug program.
 - ii. If after using the sample medication, the Health Care Provider wants to continue its use, a prescription for the medication must be obtained for the medication and the medication must be dispensed by the pharmacy.
 - b. The sample medication must be received in the original manufacture's packaging along with the original manufacture's insert (medication information sheet) packaged by the manufacturer;
 - i. The sample medication (in its original packaging) may be put 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 Health care Provider should label the medication (as the medication was not dispensed by the pharmacist). The label must include:
 - 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 statement; and
 - viii. Date the medication will expire.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 10-5 Disposal

Policy Source April 1997 MAP Advisory

Issued Date: 04/97

Last Revision Date: 10/01/13

- 1 All unused or discontinued medications must be destroyed on site or at the Service Provider's office. Medications are not permitted to be returned to the pharmacy for disposal.
- 2 According to regulations at 105 CMR 700.003(F)(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 requires that disposal occur in the presence of two Certified/licensed staff; of which one of the two is supervisory staff.
 - a. If a supervisor is unavailable when an individual refuses a prepared medication, or a pill is inadvertently dropped then two Certified staff may render these medications unusable in accordance with acceptable DPH disposal practices.
- 3 Whenever medications are destroyed, regardless of the quantity, the DPH approved *Controlled Substance Disposal Record* must be used (see Policy No. 10-6 on page 113).
- 4 Disposal must render the medications unusable and must be in accordance with acceptable DPH disposal practices.
- 5 Unless prohibited by local ordinance, acceptable practices for medication disposal include, but are not limited to the following actions:
 - a. Any specific disposal instructions on the medication information sheet, or drug label, should be followed.
 - i. Certain medication labeling specifically instructs that unused or expired medication be flushed (flushing should be restricted to those medications so labeled).
 1. Some countable controlled substances (such as oxycodone, fentanyl patch) carry instructions for flushing to reduce the danger of unintentional use.
 - b. If not instructed otherwise, medications should be rendered unusable and disposed of in the trash. There is no single method for rendering medications unusable. The following is one of a number of possible methods. The medication should be:
 - i. taken out of its original container;
 - ii. crushed and/or dissolved in water;
 - iii. put into a sealable bag and mixed with an unpalatable substance, (such as liquid soap, used coffee grounds, or kitty litter); and
 - iv. mixture should then be put into an impermeable, non-descript container, (e.g., detergent bottle), and placed in the trash.
 - c. Following medication disposal, remove and obliterate all identifying personal information (prescription label) from the medication container.
- 6 Medications returned to the program site, whether from LOAs, or other sources, must be destroyed as per DPH regulation. They cannot be reused by the program.
 - a. When a medication had been previously transferred to a health-care facility (hospital or rehabilitation center) by the program site because the medication was not accessible on

the health-care facility's drug formulary; the medication may be returned and used by the program site, following the individual's stay at the facility, provided that:

- i. there is a current Health Care Provider's order for the medication;
- ii. the medication has an appropriate label (there are no hand printed changes on the label);
- iii. the directions have not changed;
- iv. 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 e.g., blister pack, unit dose, tamper-resistant cassette) container; and
- v. a dated medication-release document has been signed by a licensed/Certified staff, from both the health-care facility and program site, stating the name and amount of the medication being transferred.

7 The DPH approved disposal form must be used for all Schedule II through VI medication disposals.

- a. the disposal form may also be used for all OTC medication disposals.

**MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL**

Policy No. & Issue 10-6 Disposal Form
Policy Source April 1997 MAP Advisory
Issued Date: 04/97

Last Revision Date: 10/01/13

SEE FORM ON THE FOLLOWING PAGE

Archived

Controlled Substance Disposal Record Form

Agency:

Program Site:

DPH Registration #:

Item #:		Date:		Item #:		Date:	
Individual's Name:		Date Last Filled:		Individual's Name:		Date Last Filled:	
Medication:		Strength:		Medication:		Strength:	
Amount Disposed:		Reason:		Amount Disposed:		Reason:	
Countable Controlled Substance	Page Number:	Rx Number:		Countable Controlled Substance	Page Number:	Rx Number:	
Book Number:		Pharmacy:		Book Number:		Pharmacy:	
Signatures:		Supervisor:		Signatures:		Supervisor:	
Staff:				Staff:			

Item #:		Date:		Item #:		Date:	
Individual's Name:		Date Last Filled:		Individual's Name:		Date Last Filled:	
Medication:		Strength:		Medication:		Strength:	
Amount Disposed:		Reason:		Amount Disposed:		Reason:	
Countable Controlled Substance	Page Number:	Rx Number:		Countable Controlled Substance	Page Number:	Rx Number:	
Book Number:		Pharmacy:		Book Number:		Pharmacy:	
Signatures:		Supervisor:		Signatures:		Supervisor:	
Staff:				Staff:			

Item #:		Date:		Item #:		Date:	
Individual's Name:		Date Last Filled:		Individual's Name:		Date Last Filled:	
Medication:		Strength:		Medication:		Strength:	
Amount Disposed:		Reason:		Amount Disposed:		Reason:	
Countable Controlled Substance	Page Number:	Rx Number:		Countable Controlled Substance	Page Number:	Rx Number:	
Book Number:		Pharmacy:		Book Number:		Pharmacy:	
Signatures:		Supervisor:		Signatures:		Supervisor:	
Staff:				Staff:			

Destruction of all prescription medications in Schedules II - VI that are either outdated, spoiled or have not been administered due to a change in the prescription or a stop order shall be documented on the DPH approved disposal record. According to regulations at 105CMR 700.003(f)(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 policy requires disposal to occur in the presence of two Certified or licensed staff of which one of the two is supervisory staff. If a supervisor is unavailable when an individual refuses a prepared medication, or a pill is inadvertently dropped then two Certified staff may render these medications unusable in accordance with acceptable DPH disposal practices. Failure to maintain complete and accurate records of drug destruction could result in revocation of your Controlled Substance Registration. Disposal must render the medication unusable and must be in accordance with acceptable DPH disposal practices. Unless prohibited by local ordinance, acceptable practices include, but are not limited to, flushing (flushing should be restricted to those medications so labeled), crushing the medication and/or dissolving in water put into a sealable bag and mixing with an unpalatable substance (such as liquid soap, used coffee grounds, kitty litter). Mixture should then be put into an impermeable, non-descript container, (e.g., detergent bottle) and placed in trash. Medications are not permitted to be returned to the pharmacy for destruction. Medications returned to the program site (e.g., LOAs) must be destroyed as per DPH regulation. They cannot be reused by the program.

10/01/13

Page # _____

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 10-7 Drug Loss

Policy Source DPH Policy

Issued Date: 9/01/98

Last Revision Date: 9/01/10

- 1 In the Commonwealth of Massachusetts, controlled substances include all prescription medications (Schedules II-VI). However, regulations require that only those prescription medications in Schedules II-V, (known as Countables: e.g., narcotics, stimulants) be reconciled (*see Policy No. 10-2 on page 107 and Policy No. 10-3 on page 108*).
- 2 To comply with state regulations, drug losses for all prescription medications or written prescriptions (Schedules II-VI) must be reported to DPH.
- 3 Because medication losses are not Medication Occurrences, they are not to be called into the DPH Medication Occurrence Hotline, nor should a Medication Occurrence Report (MOR) be filed.
 - a. Medication losses must be reported to the Drug Control Program (DCP) at DPH by the first business day after discovery [105 CMR 700.003(F)(1)(e)].
 - b. A Drug Incident Report Form, available on the DPH website under DCP, must be completed and faxed to the DCP (*see Policy No. 17-1 on page 193 for DCP contact information and DPH website information*).

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 10-8 Packaging of Prescription Medications

Policy Source April 1997 MAP Advisory

Issued Date: 04/97

Last Revision Date: 10/01/13

- 1 Department of Public Health policy requires that all Schedule II-V (Countable Substances) medications shall be dispensed to, and maintained by the community program, in “Blister” packs, “Bingo” cards, tamper-resistant cassettes, tamper-resistant packaged syringes, unit dose bottles/packaging, or other similar tamper-resistant packages. [105 CMR 700.005(A)]
 - a. Schedule II-V Controlled Substances, (including medication dispensed in a liquid format), must be received from the dispensing pharmacist in tamper resistant-packaging.
- 2 The current MAP Inspection form utilized by DPH requires that: all countable controlled substances are received directly from the pharmacy in a properly labeled, tamper-resistant container, as defined above and that if found in violation, the program shall correct the violation “Immediately”. [Immediately being defined as ‘by the next business day’]
- 3 Multiple medications may not be packaged in one “window”, “bubble”, “cartridge”, or other section of the above-described tamper-resistant packages. [105 CMR 700.005(A)]
 - a. Each type of medication should be in its own package and clearly labeled.
 - b. Varying strengths of the same medication should be in its own package and clearly labeled.
 - c. Each individual dose should be in its own “window”, “bubble”, “cartridge”, or other section.
- 4 Splitting, cutting, or breaking of a tablet, pill or capsule is prohibited. All medication must be dispensed by the pharmacy in such a manner that it is ready for administration. For Schedules II-V, this means that the dosage ordered (e.g., a half tablet) should be packaged as such in the tamper-resistant packages described above.
- 5 A pharmacist can prepare medications in ‘pill-organizers’.
 - a. A pharmacist prepared ‘pill-organizer’ may be used by individuals who meet the criteria for self-administration of medications (see *07 Self-Administering on page 47*).

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 10-9 Pharmacy Errors

Policy Source MAP Policy Manual

Issued Date: 1/01/05

Last Revision Date: 9/01/10

- 1 Pharmacy errors identified by staff are required to be reported to the Board of Registration in Pharmacy (see *Policy No. 17-1 on page 193 for contact information*).
 - a. Medication errors identified as solely being caused by pharmacy personnel, (meaning Certified staff followed all MAP medication administration practices [the five Rights] and Certified staff could not have reasonably discovered the error) do not require the completion of a Medication Occurrence Report (MOR).
- 2 The reporting of a pharmacy error requires completion of a Board of Pharmacy Complaint Form. This form may be found at: www.mass.gov/dph/boards or obtained directly from the Board of Pharmacy.
- 3 If there are any questions about the reporting of pharmacy errors, contact the Board of Pharmacy directly (see *Policy No. 17-1 on page 193*).

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 10-10 Transfer/Transport of Medication

Policy Source MAP Policy Manual

Issued Date: 9/01/10

Last Revision Date: 10/01/13

- 1 Regulations of the Department of Public Health at 105 CMR 700.003(F)(3) requires all programs to maintain adequate storage, security and handling of medications.
 - a. Any time medications are the responsibility of a MAP program; the medications must be secured and transported by a Certified/licensed person.
- 2 Medications may be transferred:
 - a. from a health-care facility (hospital, nursing home, crisis stabilization unit, or rehabilitation center) to a DPH MAP registered site;
 - b. from one DPH MAP registered site to another DPH MAP registered site;
 - c. from a DPH MAP registered site to a day program;
 - d. from an individual's family home to a DPH MAP registered temporary respite site; or
 - e. from an individual's family home to a DPH MAP registered site.
- 3 Medication may be transferred from a health care facility (hospital, nursing home, crisis stabilization unit, or rehabilitation center) to a DPH MAP registered site provided:
 - a. there is a current signed Health Care Provider's order for the medication;
 - b. the medication has an appropriate label (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 e.g., blister pack, unit dose, tamper-resistant cassette) container; and
 - e. a dated medication-release document has been signed by a licensed/Certified staff, from both the health care facility and the DPH MAP registered site; listing the inventory of all the medications, including the amount transferred, between the health care facility and the DPH MAP registered site.
- 4 Medication may be transferred from one DPH MAP registered MAP site to another DPH MAP registered site provided:
 - a. there is a current signed Health Care Provider's order for the medication;
 - b. the medication has an appropriate label (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 e.g., blister pack, unit dose, tamper-resistant cassette) container; and
 - e. a dated medication-release document has been signed by a licensed/Certified staff, from both the preceding DPH MAP registered site and the subsequent DPH MAP registered site; listing the inventory of all the medications, including the amount transferred, between sites.
- 5 Medication may be transferred from a DPH MAP registered site to a day program provided:

- a. there is a current signed Health Care Provider's order for the medication;
 - b. the medication has an appropriate label (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 e.g., blister pack, unit dose, tamper-resistant cassette) container; and
 - e. a dated medication-release document has been signed by a licensed/Certified staff, from both the DPH MAP registered site and the day program; listing the inventory of all the medications, including the amount transferred, between the DPH MAP registered site and the day program.
- 6 Medications may be transferred from an individual's family home to a DPH MAP registered temporary respite site provided:
- a. there is a current signed Health Care Provider's order for the medication;
 - b. the medication has an appropriate label (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 e.g., blister pack, unit dose, tamper-resistant cassette) container; and
 - e. a dated medication-release document has been signed by a designated family member and a licensed/Certified staff, from the DPH MAP registered respite site; listing the inventory of all the medications, including the amount transferred, between the home and the DPH MAP registered temporary respite site.
 - i. A dated medication-release document should also be completed when the individual leaves the DPH MAP registered temporary respite site. The document should be signed by a licensed/Certified staff, from the DPH MAP registered temporary respite site and a designated family member; listing the inventory of all the medications, including the amount transferred, between the DPH MAP registered temporary respite site and the individual's family home.
- 7 Medications for individuals in the process of moving from the individual's family home to a DPH MAP registered site may be transferred provided:
- a. there is a current signed Health Care Provider's order for the medication;
 - b. the medication has an appropriate label (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 e.g., blister pack, unit dose, tamper-resistant cassette) container; and
 - e. a dated medication-release document has been signed by a designated family member and a licensed/Certified staff, from the DPH MAP registered site; listing the inventory of all the medications, including the amount transferred, between the home and the DPH MAP registered site.
- 8 Medications for individuals living in their family home may be transferred to a DPH MAP registered day program site provided:
- a. there is a current signed Health Care Provider's order for the medication;
 - b. the medication has an appropriate label (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 e.g., blister pack, unit dose, tamper-resistant cassette) container; and
- e. a dated medication-release document has been signed by a designated family member and a licensed/Certified staff, from the DPH MAP registered day program site; listing the inventory of all the medications, including the amount transferred, between the home and the DPH MAP registered day program site.

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MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 10-11 Administering Medication to Individuals living in the
Community (off registered-site/“backpacking”) Setting

Policy Source MAP Policy Manual

Issued Date: 9/01/10

Last Revision Date: 9/01/10

- 1 Regulations of the Department of Public Health at 105 CMR 700.003(F)(3) requires all programs to maintain adequate storage, security and handling of medications.
- 2 Medications may be administered to individuals living in a non-registered community address (off-site) that are supported by a program’s MAP registered site provided:
 - a. the agency responsible for the registered site has a policy which specifies the practice to follow when medications are administered to individuals in the community (off-site) setting;
 - i. The policy should include administrative procedures to be followed when there is a medical emergency relating to medication.
 1. The policy should include a list of program staff and MAP Consultants to be contacted, which is up to date, readily available to Certified/licensed staff, and clearly indicates who is to be contacted.
 - b. the Certified/licensed staff is trained in how the medication is to be administered to the individual(s) in the community (off-site) setting;
 - i. The Service Provider should maintain a current list of trained staff. This list should be available both at the program site and at the Service Provider’s main office.
 - ii. The Certified/licensed staff should have a copy of their current Certificate/license, as well as, documentation verifying the staff person is able to administer medications to individuals in community (off-site) setting.
 1. Documentation should be available (on hand) for the staff person assigned to administer medication in the community (off-site) setting.
 - c. medication is packaged and labeled by a pharmacist;
 - i. Program staff should not repack or relabel prescription medications, which are taken or applied at any location.
 1. Certified staff are not permitted to pre-pour or pre-package medications, [except as directed under the LOA policy (*see Policy No. 11-1 on page 125*)] or to administer medications poured or pre-poured by another person including Certified Staff or Licensed Professionals.
 - d. medication is transported by the licensed/Certified staff in a locked portable carrying container (e.g., locked backpack);
 - i. Schedule II-V (countable controlled) medications should be double locked (*see Policy No. 10-3 on page 108*).
 - ii. Medication counts are to be conducted:
 1. when a countable controlled substance is transferred from the registered site’s medication storage area and placed into the portable carrying container for transport to the individual, and
 2. when the countable controlled substance is transferred from the portable carrying container to the registered site’s medication storage area [after returning to the registered site from the individual’s community (off-site) residence].

- iii. Medications should not be stored at the community (off-site) setting unless that site has been registered with the DPH (see *Policy No. 01-2 on page 8*).
- e. all necessary documentation, including Health Care Provider's orders, medication and treatment records, and pharmacy labels are accurate and available to the licensed/Certified staff;
- f. all MAP procedures for medication administration are followed; and
 - i. Medication must never be prepared at any time except immediately prior to the administration of that medication.
 - 1. When a medication is "pre-poured" by staff, the integrity of that medication can no longer be guaranteed.
 - 2. Included among these prohibited activities is the setting up of medication 'pill-organizers' and the pre-pouring of medications for training purposes.
 - (a) This does not preclude staff from monitoring individuals who set up their own 'pill-organizer' (see *Policy No. 07-3 on page 50*).
- g. following return from the community (off-site) setting to the MAP registered site all medications must be removed from the portable carrying container (e.g., backpack) and stored within the MAP registered site's medication storage area.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 10-12 Syringe Security

Policy Source MAP Policy Manual

Issued Date: 9/01/10

Last Revision Date: 9/01/10

- 1 Syringes with an attached needle, including pre-filled syringes (*see Policy No. 06-3 on page 42*) must be stored in a secure/locked area.
 - a. Labeled pre-filled syringes containing a countable controlled substance (Schedules II-V) must be double locked and the program site must maintain a documented accounting of these pre-filled syringes (*see policy 10-3 on page 108*).
 - i. The documented accounting must be reconciled whenever control of the medication key is passed.
 - ii. Pre-filled syringes must be labeled (at a minimum) with the individual's name, medication name with strength, route of administration, and directions for use.
 1. Such label must be affixed to the container for the syringe or the syringe itself, as appropriate.
 - b. Non-filled (empty) syringes, with or without an attached needle, are not required to be kept on 'count'.
 - c. Whenever possible, the amount of syringes in the locked storage container is limited to a thirty-seven day supply (*see Policy No. 10-4 on page 109*);
 - d. Syringes for individuals who are self-administering (*see Policy No. 07-1 on page 48*) parenteral medications, (with written authorization and in accordance with the written instructions of the prescribing Health Care Provider), must be stored in a locked container or locked area accessible by the individual.

11

LEAVE OF ABSENCE

Archived

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue	11-1 Leave of Absence (LOA) Policy
Policy Source	December 1994 MAP Advisory April 1997 MAP Advisory
	1997 DMH Memorandum
Issued Date:	12/94 04/97 8/14/97 Last Revision Date: 9/01/10

- 1 Leaves of absence often require that an individual receive only a portion of the originally dispensed medication.
 - a. While the 'split packaging' of individual's medications is not encouraged, there are certain circumstances where it is permissible.
 - i. The DPH recommends that whenever possible a pharmacist should be responsible for 'split packaging' prescription medications.
 - ii. If an individual routinely requires medication administration at more than one location (e.g., at his/her residence and day program, day-hab, or at a relative's home on weekends) the pharmacist should be asked to split the medication into two tamper-resistant (i.e., packaged by/received from the pharmacy in such a manner that prevents the contents from being altered e.g., blister pack, unit dose, tamper-resistant cassette) containers; one for the day program, day-hab, or home consumption and one for the residence. Note:
 1. If the individual will be receiving prescribed medication while attending a 'Day Program', one of the 'split packaged' medication may be transferred from the registered site to the Day Program. The Day Program must have Certified or licensed staff and possess a Controlled Substances Registration.
 - (a) A dated medication-release document listing the inventory of all the medication and amount transferred between the sites must be signed by the Certified or licensed staff transferring the medication and the Certified or licensed staff receiving the medication. A copy of the document should be retained at both locations.
 2. If the individual will be receiving prescribed medication while attending a 'Day Habilitation' (day-hab), one of the 'split packaged' medication may be transferred from the registered site to the licensed nursing personnel at the Day Habilitation.
 - (a) A dated medication-release document listing the inventory of all the medication and amount transferred between the sites must be signed by the Certified or licensed staff transferring the medication and the licensed staff receiving the medication. A copy of the document should be retained at both locations.
 - (b) Day Habilitation regulations do not permit medications to be administered by Certified staff.
 3. If the individual will be receiving prescribed medications while at a relative's home, one of the 'split packaged' medication may be transferred from the registered site to the responsible family member/caregiver.
 - (a) A dated LOA form listing the inventory of all the medication and amount given to the family member/caregiver must be signed by the Certified or licensed staff transferring the medication and the responsible family member/caregiver receiving the medication. A copy of the document should be given to the family member/care giver and one should be retained by the site.

- (b) For home visits, the responsible family member/caregiver should receive some training on administration of medications and potential side effects from the Certified or licensed staff accountable for transferring the medication (see *Policy No. 11-3 on page 129*).
- iii. If an individual will be away from their residence for a period of up to 72 hours; will not be under the staff's direct supervision; and the pharmacist is unable to prepare the medications, Certified or licensed staff may prepare the medications for the LOA (see *Policy No. 11-3 on page 129*).
- iv. If an individual will be away from the residence or day program with a Certified staff, and a medication needs to be administered during the absence, medications can be packaged and administered following the LOA packaging policy.
- v. All routine absences of less than 72 hours and all extended absences of greater than 72 hours require preparation of the medications by a pharmacist.
- b. Under no other circumstances does DPH permit the packaging of medications by Certified or licensed staff.
 - i. Unless an individual is learning to self-administer and meets all of the criteria and requirements noted in section '07 *Self Administration*' of this manual, he/she is not permitted to package his/her own medication.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue	11-2 Preparation of Medications for LOA		
Policy Source	December 1994 MAP Advisory	April 1997 MAP Advisory	
Issued Date:	12/23/94	04/97	Last Revision Date: 9/01/10

- 1 Whenever possible, a tamper-resistant (i.e. packaged by/received from the pharmacy in such a manner that prevents the contents from being altered e.g., blister pack, unit dose, tamper-resistant cassette) container should be used;
 - a. A separate container must be used for each type of LOA medication.
 - i. Packaging in tamper-resistant containers are not required for LOA Schedules II-V medications, however, as with all medications, only the exact number of doses necessary for the LOA may be packaged.
- 1 Medications for all routine absences of less than 72 hours and all extended absences (planned or unplanned) of greater than 72 hours must be prepared by a pharmacist.
- 2 For unplanned absences of less than 72 hours, medications may be prepared by Certified or licensed staff.
 - a. The Certified or Licensed staff who will be administering the medication or transferring the LOA medication to the responsible family member/caregiver should prepare the medication and must follow the following procedure:
 - i. use an appropriate sized container so that the required information can be put directly on the container (ask the pharmacist for a supply of containers and blank labels without the pharmacy name and/or directions);
 1. A separate container must be used for each type of LOA medication.
 - ii. the amount of medication needed for the LOA should be determined and transferred from the original card or container directly into the LOA container; and
 - iii. the LOA container should be marked with all the necessary information. This information should be taken directly from the original medication card or container and must include at least the following, in accordance with M.G.L. Chapter 94C sec.22,:
 1. individual's name;
 2. name and strength of medication;
 3. directions for usage (clearly stated; including specific doses and dosing times);
 4. prescribing health care provider's name;
 5. date of dispensing;
 6. any necessary cautionary statements (e.g., take with food.); and
 7. amount of medication in the LOA container.
- 3 Individuals are not permitted to repackage medications under the LOA Policy.
 - a. The LOA Policy may not be used to cover the pre-pouring of medications for the purpose of training individuals in self-administration (*see Policy No. 07-2 on page 49*).
- 4 Unused oral LOA medications cannot be returned to the program for reuse. Certified and/or licensed staff must dispose of these medications as per DPH regulation (*see Policy No. 10-5 on page 111*).

- 5 Medications may be administered to individuals accompanied by MAP Certified staff for a planned LOA vacation provided:
- a. the program has a policy which specifies the practice to follow when medications are administered to individuals during the staffed LOA vacation;
 - i. The policy should include administrative procedures to be followed when there is a medical emergency relating to medication.
 - 1. the policy must include the need for an up to date listing of program staff and MAP Consultants readily available to Certified/licensed staff
 - (a) the list should clearly indicate who is to be contacted.
 - ii. The medications are packaged for the individual(s) by the pharmacy,
 - 1. Licensed/Certified staff should take the medications prepared by the pharmacy, in a locked box, along with copies of the Health Care Provider's orders, medication administration documentation sheet(s), and medication information sheet(s) to the vacation location.
 - b. all policies regarding drug security are observed.
 - c. the Certified/licensed staff is trained in how the medication is to be administered to the individual(s) during the staffed LOA vacation (off-site) setting;
 - i. The Service Provider should maintain a current list of trained staff. This list should be available both at the program site and at the Service Provider's main office.
 - ii. The Certified/licensed staff should have available (on-hand) a copy of their current Certificate/license, as well as, documentation verifying the staff person is able to administer medications to individuals during the staffed LOA vacation location.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue	11-3 Documentation of LOA		
Policy Sources	December 1994 MAP Advisory	April 1997 MAP Advisory	
	1997 DMH Memorandum	1995 DDS Memorandum	
Issued Date:	12/23/94	04/97	Last Revision Date: 9/01/10
	8/14/97	9/12/95	

- 1 When LOA medication is sent with an individual, it must be noted as “LOA” on the individual’s medication and treatment sheet.
- 2 All Schedule II-V medications sent on the LOA must be accounted for in the Countable Controlled Substances medication count book.
- 3 Any LOA oral medication brought back to the site by the individual cannot be used. This medication must be destroyed and documented in the approved manner.
- 4 The individual and his/her responsible party must be provided with written instructions for the LOA medications and with copies of the medication information sheet(s). This should be noted in the individual’s record.
 - a. Included in the list of instructions is: who, what, where and how to call for technical assistance; preparation and other instructions; and special circumstances, if any, for omission of the medication.
 - b. The above information is to be reviewed with all parties who will be administering medication
 - i. If this is not possible, then staff should review the information with at least one person who will be administering medication.
 - c. The signed LOA form should be kept in the individual’s health folder/record.
 - i. Following the review of the LOA medication with the individual’s family member or responsible party, both the Certified/licensed staff providing the LOA medication and instructions and the individual’s responsible party receiving the LOA medication and instructions should sign the form indicating that the medications have been transferred and accepted.

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REFILLING PRESCRIPTIONS

Archived

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 12-1 Refilling Prescriptions Guidelines

Policy Source April 1997 MAP Advisory

Issued Date: 04/97

Last Revision Date: 9/01/10

- 1 In MAP, prescription(s) should be refilled one week before the medication(s) runs out. If this timeline is not permitted due to insurance coverage, the Service Provider will need to follow the prescription plan guidelines for the refilling of prescriptions to ensure a sufficient medication supply.
- 2 The Service Provider should have refilling prescription procedures in place for staff to follow.
 - a. Procedures should include the ordering/reordering and receiving (staff pick up/pharmacy delivery) of medications.

13

HEALTH CARE PROVIDERS ORDERS

Archived

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue **13-1 Transcription, Posting and Verifying of Health Care
Provider's Orders**

Policy Source **MAP Policy Manual**

Issued Date: **9/01/98**

Last Revision Date: **01/01/15**

- 1 All transcriptions of Health Care Provider's orders must be posted and verified. This must be done by two licensed and/or Certified staff. The following established guidelines must be followed in transcribing a Health Care Provider's Orders:
 - a. One Certified or licensed staff must transcribe (copy/record) and post the Health Care Provider's order.
 - i. The Certified or licensed staff person who transcribes and 'posts' the order(s) must place a check mark in red, green or other readily distinguished color next to the order being transcribed. (The color should be designated by the Service Provider and is to be consistent throughout their sites.). This must be done for each and every order transcribed.
 - ii. When all orders have been transcribed from the Health Care Provider's order form to the Medication and Treatment Sheet, the Certified or licensed staff must write "Posted", the date, the time and their name on the order form in the color designated by the Service Provider.
 - b. A second Certified or licensed staff must review the orders that were transcribed by the first staff person.
 - i. The Certified or licensed staff person who reviews and 'verifies' the order(s) must place a check mark in green, red or other readily distinguished color next to the check mark made by the staff who posted the order. (The color should be designated by the Service Provider and is consistent throughout their sites).
 - ii. After reviewing the orders that were transcribed for accuracy, the second Certified or licensed staff must write "Verified", the date, the time and their name on the Health Care Provider order form in the color designated by the Service Provider.
 1. If a second staff person is not scheduled when the orders are transcribed, then the next Certified or licensed person on duty must follow the verification procedure described above and must review and verify the orders making the appropriate notation on the order form.
- 2 The Certified or licensed staff person who transcribes the order initially may, if a second staff person is unavailable, administer the ordered medications before verification is completed. However, the next Certified or licensed person on duty must verify the orders immediately upon arrival at the site and prior to administration of the medication(s).
- 3 All Certified and licensed staff must compare any change in a medication order with the Health Care Provider's order before administering the medication.

- 4 When a Health Care Provider changes (e.g., dose or frequency adjustment of a medication) or discontinues a medication, Certified staff should indicate the change or discontinuance in the following manner:
 - a. In the margin (next to the order the Health Care Provider has changed or discontinued) document:
 - i. Discontinued (i.e., D/C);
 - ii. Certified staff's initials; and
 - iii. Date
 1. Example:

Previous Health Care Provider order

Name: xxxxxxx Allergies: xxxxxx

	Previous Drug	Dosage	Frequency	Route of Administration	Special Instructions	Reason for medication
D/C AA 1/30/yr	xxxxxxx	xxxxxxx	xxxxxxx	xxxxxxx	xxxxxx	xxxxxxx

Health Care Provider Signature: xxxxxxxxxxxx

- b. Apart from documenting the discontinuance or change to a medication order (In accordance with instructions of the Health Care Provider) in the above manner, Certified staff should not alter any information recorded on the previous Health Care Provider order.
- 5 Any Health Care Provider's order that is unclear or confusing must be brought to the attention of the Health Care Provider. The Health Care Provider must explain the order to the staff before the order is transcribed and the medication is administered.
- 6 Written clarification must be obtained from the Health Care Provider within seventy-two hours of the telephone verification.
- 7 Service Providers must have a procedure for assuring that the Health Care Providers' orders are reviewed on a regular basis and consistent with all medications being administered.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 13-2 Documentation of Health Care Provider Orders

Policy Source 1995 DDS Memorandum

Issued Date: 9/12/95

Last Revision Date: 01/01/15

- 1 All medication orders must be written on a Health Care Provider's order form.
 - a. Prescriptions may not be substituted for Health Care Provider order forms.
 - b. Only an authorized prescriber, registered with the state of Massachusetts to prescribe, can order medication.
 - i. Prescription medication ordered for administration by Certified staff must not be experimental and must be currently approved by the US Food and Drug Administration for marketing in the United States.
 - c. Each Health Care Provider Order must specify, at a minimum, the following:
 - i. name of the individual;
 - ii. allergies;
 - iii. date of the order, including the year;
 - iv. name of the drug;
 - v. dosage;
 - vi. route of administration;
 - vii. the number of day(s) the individual can package and hold medication(s) (if the individual is currently in a self-administration training plan);
 - viii. the period of time medication is to be administered (if medication is to be ordered for a set period of time);
 1. All pre-test medication orders must specify the period of time of pre-test administration (i.e., one hour before EEG).
 - ix. frequency and duration of administration; and
 - x. Health Care Provider's signature.
 1. Electronic Health Care Provider signatures are acceptable by the Departments.
 2. An electronic signature is an image of the provider's signature.
 - d. It is suggested that Health Care Provider orders also include the time the order was written.
- 2 All orders for medication shall be noted on a medication and treatment form which contains at least the following information:
 - a. name of the individual;
 - b. documented historical allergies of the individual;
 - c. name and dosage of medication;
 - d. the time(s) the medication should be administered;
 - e. by what route the medication is given (oral, optic, rectal, etc.);
 - f. acceptable codes (e.g., LOA, P, etc.);
 - g. reason for medication being administered;
 - h. start and stop dates (if the medication is ordered for a set number of days)
 - i. documentation of specific parameters (if applicable); and

- i. for example: documentation of blood pressure readings if prescribed antihypertensive medication; documentation of bowel movement data if prescribed PRN laxatives medication, etc.
 - j. any special instructions for administration.
- 3 Any change in the medication order shall be considered a new order and documented as such on a medication and treatment form.
- 4 All medications whether prescription or nonprescription (OTC / Over the counter) shall be treated equally, specifically:
 - a. all medication needs a Health Care Provider's order; and
 - b. all medication is documented on a medication treatment form.
- 5 At any time when there is a change in orders (new drug, dose change, time change, etc.):
 - a. the change should be communicated to all staff verbally;
 - b. a progress note should be written in the individual's chart;
 - c. if indicated, pharmacy labels on the actual medication containers should be flagged by the approved method; 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 indicates that there is a new Health Care Provider order and that the individual's record should be checked.
 - 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. Staff are never to write or mark directly on the medication package.
 - d. the pharmacy contacted regarding the order change.
- 6 Monthly orders (computer generated or hand written) should undergo a quality check (i.e., All orders should be compared to the previous month to ensure accuracy.).
- 7 The medication and treatment form should also be compared with the Health Care Provider's orders and the pharmacy labels. (Health Care Provider's orders, medication/treatment forms, and pharmacy labels must all agree or medication may not be administered until orders are clarified).
 - a. Monthly medication/treatment administration records (computer generated or hand written) should undergo a quality check (i.e., all entries should be compared to the Health Care Provider's orders and the previous month's records to ensure accuracy).
 - i. Accuracy checks require a two (Certified and/or licensed) staff review.
- 8 If, for any reason, the medication is not administered as ordered, the reason must be recorded on the medication treatment form.
 - a. Blank spaces are not acceptable.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue	13-3 Telephone Orders
Policy Source	December 1994 MAP Advisory 1995 DDS Memorandum
Issued Date:	12/23/94 9/12/95 Last Revision Date: 9/01/10

- 1 Medication changes by telephone are allowed, however, the Departments strongly urge the use of fax orders in place of telephone orders.
- 2 When a Health Care Provider furnishes a telephone order to a residence, or when a telephone medication change is called in, Certified/licensed staff should document the order. Documentation should also be completed on the individual's medication and treatment record.
 - a. A change in medication orders does not necessarily require that the existing medication be destroyed. There are situations in which the existing medication can be used, either in higher or lower dosage or in frequency of administration.
 - i. Staff should contact the prescriber, the Service Provider's consultant, or the pharmacy to confirm whether or not the existing medication can be used or must be destroyed.
 - ii. In addition, the staff person responsible for administering the medication should note clearly and distinctly on the medication package that there is a new Health Care Provider order and that the individual's record should be checked by flagging the medication container label.
 1. 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 indicates that there is a new Health Care Provider order and that the individual's record should be checked.
 - (a) A brightly colored sticker may be used in place of a 'directions change' sticker.
 - (b) 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.
 - (c) Staff are never to write or mark directly on the medication package label.
- 3 A telephone order should be treated as a new order and must be transcribed as such.
 - a. The Health Care Provider, in most cases, will call the pharmacy to notify them of the change in order (new drug, dosage change, change of route, etc.).
 - i. Additional documentation will be necessary if this takes place.
 - b. The new Health Care Provider order should also be documented in the individual's progress notes.
- 4 The following are criteria for telephone orders:
 - a. The Certified/licensed staff who obtains the order, via the telephone, will be responsible for transcribing the order.
 - b. The Certified/licensed staff who obtains the order, via the telephone, must reiterate (read back) the order received to the prescribing Health Care Provider.
 - c. The new medication must be obtained from the pharmacy at the earliest opportune time.

- d. A Health Care Provider's telephone order form must be filled out which contains, at least, the following information:
 - i. identifying site information;
 - 1. address of residence.
 - 2. telephone and fax numbers.
 - ii. identifying individual information;
 - 1. individual's name.
 - 2. any documented historical allergies.
 - iii. identifying Health Care Provider information;
 - 1. name of prescribing Health Care Provider.
 - 2. contact information (telephone/fax number).
 - iv. actual order(s) and/or other instructions;
 - 1. If the individual is currently in a self-administration training program, the number of day(s) the individual can package and hold the new medication(s) must be obtained.
 - 2. date of discontinuance (if applicable).
 - v. signature of staff obtaining the order; and
 - vi. date and time order received.
 - e. All telephone orders must be posted and verified.
 - i. In the interests of safety, the Service Provider should ensure that all telephone orders are verified at the earliest opportune time.
- 5 After the order is obtained, and all information is gathered, the original form must be given to, mailed out, or faxed to the Health Care Provider for his/her signature. (All telephone orders must be signed by the prescriber within 72 hours.)
- a. A copy will remain in the individual's record until the original signed Health Care Provider's copy is obtained.
 - b. Once the signed Health Care Provider's original telephone order is returned the residence, it must be posted and verified.
 - i. Following this, the previous unsigned copy may be discarded.
- 6 If at anytime there is a concern or question about the order or the process, the protocol for technical assistance should be initiated.
- 7 A telephone order taken by Certified staff must be verified by a licensed nurse before that nurse may administer the medication.
- a. As evidence, the licensed nurse may use a pharmacy labeled medication container that complies with regulatory needs.
 - i. This label is to be compared with the Health Care Provider's order for accuracy.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 13-4 Exhausting Current Supply of Medication

Policy Source 1997 DMH Memorandum

Issued Date: 4/25/97

Last Revision Date: 9/01/10

- 1 When the prescribing Health Care Provider orders a change in a current medication, the program should attempt to obtain the medication ordered from the pharmacy.
- 2 At times, due to pharmacy requirements and cost interests, it is acceptable to exhaust the current supply of the medication when a change in dosage (or a change in the time of administration) occurs.
 - a. Verify with the pharmacist that the existing supply of medication may be exhausted in reference to the new changed prescription.
 - i. If the current supply of medication can not be exhausted, the medication as ordered by the Health Care Provider should be obtained from the pharmacy.
- 3 Exhausting the current supply of medication can be done, provided all of the following four(4) criteria apply:
 - a. The prescribing Health Care Provider supplies a new written order to the program. (See *Policy No. 13-3 2a.ii on page 137*);
 - b. The pill, capsule, or other vehicle is in a form that allows for “easy administration” of the new changed order (i.e., the new dosage is an even multiple (up or down) of the strength of the medication on hand, as cutting or splitting of medication is not permitted);
 - i. For example: The Health Care Provider order for two(2) 10 mg. capsules of a medication now given two times a day could easily be administered if there was an increase to three(3) 10 mg. capsules three times a day or a decrease to one(1) 10 mg capsule two times a day.
 1. However, it would not be possible, or allowable; to use the existing supply of medication in the previous example if the order was changed to one (1) 5 mg capsule two times a day since cutting or splitting of the 10 mg capsule would be required.
 - c. The medication container label has been flagged by the approved method to alert the 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 indicates that there is a new Health Care Provider order and that the individual’s record should be checked.
 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. Staff are never to write or mark directly on the medication package.

- d. The medication administration sheet reflects the change by:
 - i. indicating the previous order has been discontinued with a stop of the old dosage and/or change in the time of administration; and
 - ii. a new entry is transcribed to replicate the new changed order.

Archived

**MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL**

Policy No. & Issue 13-5 Health Care Provider's Orders via FAX

Policy Source MAP Policy Manual

Issued Date: 9/01/98

Last Revision Date: 9/01/10

- 1 Faxed Health Care Provider's orders are legal orders and, therefore, are acceptable by the Departments.
- 2 Electronic Health Care Provider signatures are acceptable by the Departments.
 - a. An electronic signature is an image of the provider's signature.

Archived

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue	13-6 Renewal of Health Care Provider's Orders
Policy Source	MAP Policy Manual DMH Licensing and Operational Standards
Issued Date:	9/01/98 Last Revision Date: 10/01/13

- 1 Health Care Provider orders, including standing orders are valid for one year.
- 2 Each individual supported by the Department of Mental Health, who receives psychotropic medications, shall be seen at clinically appropriate intervals, but at least every three months, by the Health Care Provider prescribing the psychotropic medications to assess:
 - a. the appropriateness of the current medication dosage;
 - b. the mixture of medications;
 - c. any side effects;
 - d. the reason for use of the medication; and
 - e. the effectiveness of the medications.
- 3 Health Care Provider medication orders must be reconciled during every transition of care (e.g., transferred to/from a health-care facility, hospital, nursing home, crisis stabilization unit,, rehabilitation center, etc.)
 - a. Medication reconciliation is the process of comparing the individual's medication orders to all of the medications the individual had previously been taking, and if applicable formulating a newly reconciled medication listing.
 - b. Medication reconciliation should be done at every transition of care (prior to discharge/transfer).

Discharge Orders/Medication Reconciliation (sample guide)

Medication Reconciliation is the process of comparing an individual's new medication orders to all of the medication orders that were in place prior to the new orders. This must be done during every transition of care (e.g., transferred to/from a health-care facility, hospital, nursing home, crisis stabilization unit or rehabilitation center, etc.).

Discharge (new) orders from a Health Care Facility supersede (take the place of) prior existing orders. Any discrepancies identified must be immediately brought to the attention of the prescribing Health Care Provider (HCP). Document that the prescribing HCP has been informed.

Checklist

1 Before the individual is discharged from the Health Care Facility:

- ☐ Obtain all HCP orders that were in place prior to the admission (from the individual's home).
- ☐ Obtain the new HCP medication orders being prescribed (using the Health Care Facility discharge orders).
- ☐ Compare the medications on the two sets of HCP orders (new and prior); bear in mind the 5 rights. Pay particular attention to dose and/or frequency changes for medications that appear on both sets of orders.
- ☐ If there are discrepancies between the two sets of orders; review these with the HCP prior to discharge.
- ☐ Be sure to obtain signed, dated, HCP orders. If there is more than one page of HCP orders, each page must be signed and dated by the HCP. Electronic Health Care Provider signatures are acceptable by the Departments. An electronic signature is an image of the provider's signature.
- ☐ Obtain any new prescriptions or ensure that the pharmacy has been notified by the HCP of any new medication prescriptions.

2 Once the individual has returned home:

- ☐ Notify the Primary Care Physician (PCP), and any other prescribing HCP, that the individual had a transfer of care.
- ☐ Notify the PCP, and any other prescribing HCP, of any new or changed medication / treatment orders or previously ordered medications omitted from the Health Care Facility discharge orders.
- ☐ Obtain from the PCP and any other prescribing HCP, orders to resume any previously scheduled medications/treatments that they want reordered (and are not on the new Health Care Facility discharge orders).
- ☐ Obtain any newly prescribed medication from the pharmacy.
- ☐ Transcribe, Post, and Verify Health Care Facility Discharge Orders and newly reordered medications.
- ☐ Communicate the changes to others involved in supporting individual (e.g., coworkers, supervisor, day program staff, family members, etc.) according to agency policy.

14

SPECIALIZED TRAINING PROGRAM

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 14-1 Specialized Training Programs

Policy Source MAP Training Policy

Issued Date: 10/15/97

Last Revision Date: 01/01/15

- 1 All trainers must be qualified trainers.
 - a. Criteria for qualifications are identified in each specific specialized training policy.
- 2 All trainers must use the DPH approved specialized training documents.
 - a. No deviation from the protocols and procedures set forth in the training documents is permitted.
- 3 The regulation found at 105 CMR 700.003(F)(5)(e) requires staff to have successfully completed a specialized training program prior to administering “parenteral drugs generally intended for self-administration, or drugs administered via a gastrostomy/jejunostomy tube”. Such training programs must be approved by the Department of Public Health and the Departments of Mental Health and/or Developmental Services.
- 4 With the exception of epinephrine administration via pre-filled auto-injector device(s), (see *Policy No. 14-2 on page 146*) at present, there are no approved specialized training programs for parenteral drugs.

**MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL**

Policy No. & Issue	14-2 Epinephrine Administration via Auto-injector Device(s)
Policy Source	MAP Policy Manual
Issued Date:	9/01/98
Last Revision Date:	10/01/13

See forms and instructions on following pages.

Archived

Process for Initiating Epinephrine Administration via Auto-injector Device(s) Curriculum for MAP Certified Staff

- 1 All MAP regulations and policies apply to the use of curriculum for MAP Certified staff.
- 2 MAP Certified staff are to be trained in the use of epinephrine administration via pre-filled auto-injector devices(s) annually. Certified staff should be approved separately for each individual at risk of anaphylactic shock, that they work with, who may require epinephrine via pre-filled auto-injector.
- 3 A Health Care Provider, Registered Nurse (RN), Pharmacist, Physician Assistant (PA), Paramedic, or Emergency Medical Technician (EMT) must conduct the specialized training in administration of epinephrine via pre-filled auto-injector device.
 - a. An LPN, who is able to demonstrate initial and continued competence, may provide subsequent annual Epinephrine Administration via Auto-injector device competency reviews.
- 4 Any epinephrine administration via pre-filled auto-injector device curriculum utilized by a Service Provider to train MAP Certified staff must contain the following DPH approved essential components.
 - a. General synopsis of the use of epinephrine via a pre-filled auto-injector including:
 - i. overview of epinephrine;
 - ii. purpose of the administration of epinephrine via pre-filled auto-injector device;
 - iii. overview of anaphylactic reaction; and
 - iv. demonstration of the correct technique used to administer epinephrine via the pre-filled auto-injector.
 - b. General synopsis of how the use of epinephrine administration via pre-filled auto-injector device relates to the Medication Administration Program (MAP).
 - c. Individual-specific training regarding administration of epinephrine via pre-filled auto-injector including:
 - i. reviewing the signs and symptoms of the individual's allergic response to certain stimuli;
 - ii. when to administer epinephrine specific to the individual's Health Care Provider's order; and
 - iii. following individual-specific health protocols, if applicable.
 - d. An emergency procedure guideline to follow once epinephrine is administered, including but not limited to calling 911 and notification of the individual's Health Care Provider.
 - e. What to do in case of accidental injection to a person.
 - f. Overview of storage requirements.
 - g. System for checking the expiration date regularly and replacing the pre-filled auto-injector when it becomes outdated.
 - h. Review of proper disposal.
 - i. Use of standardized *Competency Evaluation Tool for Epinephrine Administration via Auto-injector Device*.
- 5 The individual-specific Competency Tool must be signed by both the qualified trainer and the trainee. A signed completed copy of which must be maintained at the program.
 - a. Staff qualifications to administer epinephrine via pre-filled auto-injector devise(s):

- i. has current MAP Certification in good standing as determined by the Service Provider;
 - ii. has current CPR and First Aid certification;
 - iii. has completed vital signs training with demonstrated competency on a regular basis;
 - (a) It is recommended that Certified staff who are not monitoring vital signs on a routine basis be provided a refresher review annually.
 - iv. has successfully completed individual-specific training to administer epinephrine via pre-filled auto-injector device conducted by an acknowledged trainer; and
 - v. has successfully demonstrated competence in the process of administration of epinephrine via pre-filled auto-injector device (defined as 100% accuracy) utilizing the approved *Competency Evaluation Tool for Epinephrine Administration via Auto Injector Device*.
- 6 Demonstration of the epinephrine administration by the MAP Certified staff must be done as many times as is necessary to assure competency with the administration. In addition, a written test may be used by the trainer. The determination of competency is solely the decision of the trainer.
- 7 Individual-specific training and demonstrated competence, using the *Competency Evaluation Tool*, must be repeated at least yearly for each qualified MAP Certified staff.
- a. An LPN, who is able to demonstrate initial and continued competence, may provide subsequent annual Epinephrine Administration via Auto-injector device competency reviews.
- 8 Any changes, in the Health Care Provider order for epinephrine use, require a review. This review, according to the Service Provider's policy, must be done prior to allowing administration of epinephrine via pre-filled auto-injector device by approved staff.
- 9 A complete set of written materials used to train staff must be maintained at the program.

Competency Evaluation Tool for Epinephrine Administration via Auto Injector Device

Staff Name: _____

Individual's Name: _____

Date: _____

	Pass (P), Fail (F), N/A	Comments	General Knowledge
1.			Knows that only licensed personnel (nurses) and MAP Certified staff, who have successfully completed specialized training in medication administration of epinephrine via pre-filled auto-injector device training, may administer the epinephrine medication.
2.			Knows that another competency evaluation including a return demonstration with 100% accuracy must be completed annually.
3.			Knows that all MAP regulations must be followed when administering epinephrine via pre-filled auto-injector device.
4.			Knows what an auto-injector device is and knows why this individual has a Health Care Provider order for one.
5.			Knows to compare the Health Care Provider order with the label and the medication sheet at the beginning of the shift.
6.			Knows to check the epinephrine pre-filled auto-injector device expiration date at the beginning of the shift.
7.			Knows the epinephrine solution should be clear and colorless.
8.			Knows if the epinephrine solution is brown it is not to be used and another device obtained.
9.			Knows what an anaphylactic reaction is.
10.			Knows the symptoms of an anaphylactic reaction.
11.			Knows what effect epinephrine has on the body.
12.			Knows the most common effects of epinephrine felt by the individual after the injection.
13.			Knows why 911 is immediately called following epinephrine administration and the importance of informing emergency personnel that epinephrine was administered.
14.			Knows that epinephrine wears off in about 10 to 20 minutes after it is administered.
15.			Knows the Health Care Provider must be notified.
16.			States other emergency procedure guidelines per agency policy.
17.			States what s/he would do if there were an accidental administration of epinephrine via pre-filled auto-injector.
18.			Knows storage requirements of the pre-filled epinephrine via auto-injector device; that it is locked, and kept at room temperature away from heat and sunlight.
19.			Knows disposal requirements specific to the used auto-injector device(s).

	Pass (P), Fail (F), N/A	Comments	Procedure for Return Demonstration of Administration of Epinephrine via Auto-Injector Device:
1.			Follows all procedures for preparation of medications for administration according to MAP regulations and policies.
2.			Informs individual what is being done.
3.			Forms a fist around the pre-filled auto-injector with the tip [usually it is an orange tip] facing down and pulls off the safety cap. (Knows to NEVER put fingers over the tip)
4.			Places the pre-filled auto-injector device at a 90-degree angle on the outer thigh. (Knows it is not necessary to remove clothing since the auto-injector device is designed to work through clothing.).
5.			With a quick motion, pushes the pre-filled auto-injector firmly against the outer thigh. (Holds in place and slowly counts to 10 before removing needle.)
6.			Knows even though a small amount of liquid remains inside the auto-injector after use, the device cannot be used again.
7.			Calls 911 immediately for transportation to emergency room.
8.			After ER personnel arrive and individual is cared for, notifies HCP, and follows all emergency procedures per the provider's policy.
9.			Properly disposes of the used auto-injector.
10.			Documents administration according to MAP regulations and policies.

Based on this Competency Evaluation Tool, I, as Trainer, have determined that the Certified Staff Person named below is competent to administer epinephrine via auto-injector device to the Individual named below.	
Staff Person's Printed Name _____	Individual's Printed Name _____
Staff Person's Signature _____	Date _____
Trainer's Printed Name _____	Trainer's Phone Number _____
Trainer's Signature _____	Date _____

Epinephrine Auto Injector (EpiPen) Disposal Guidelines

- 1 *Used EpiPens* (EpiPens that have been used for its intended purpose and contain only Epinephrine residue):
 - a. MAP Certified/licensed staff should dispose of used EpiPens in a 'Sharps Container'.
- 2 *Unused/Expired EpiPens* (EpiPens that have not had its contents administered):
 - a. MAP sites should check with the supplier or manufacturer of the EpiPen (supplied for the individual) to verify the proper classification of its active ingredient. The active ingredient will impact the disposal requirements for unused EpiPens.
 - 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 base: It is a component of the hazardous waste listing.
 2. Epinephrine salt (Epinephrine Hydrochloride): It is not a component of the hazardous waste listing.
 - c. MAP Certified/licensed staff should dispose of unused/expired EpiPens 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 EpiPen in a 'Sharps Container'.
 - (a) The unused EpiPen should be disposed of in its intact original syringe (Epinephrine medication still within it).
 - (b) The contents (Epinephrine medication) should not be squeezed/squirted out of the syringe.
 2. The staff that disposed of the EpiPen should document the disposal on the 'Countable Controlled Substance Record'.
 - 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 EpiPen in a rigid plastic container marked 'Hazardous Waste' and labeled 'Expired EpiPens for Disposal'.
 - (a) The unused EpiPen should be disposed of in its intact original syringe (Epinephrine medication still within it).
 - (b) The contents (Epinephrine medication) should not be squeezed/squirted out of the syringe.
 2. The staff that disposed of the EpiPen should document the disposal on the 'Controlled Substance Disposal Record Form'.
 3. Whenever EpiPens are not being added to the 'Expired EpiPens for Disposal' hazardous waste container, the container should be kept closed (with a tight fitting cover).
 4. The registered site should keep the 'Expired EpiPens 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'.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 14-3 Administration Via Gastrostomy/Jejunostomy Tube
Policy Source MAP Policy Manual
Issued Date: 9/01/10 **Last Revision Date:** 9/01/10

- 1 Medication may be administered to clinically appropriate individuals via a Gastrostomy or Jejunostomy tube by trained MAP Certified staff (*see Policy No. 14-4 on page 153 along with its applicable forms and instructions*).
 - a. *Policy No. 14-4* addresses the administration of medication via gastrostomy or jejunostomy tube(s) only.
 - i. Although not under the jurisdiction of the Medication Administration Program, Certified staff are permitted to administer prescribed formula and/or water via a Gastrostomy or Jejunostomy Tube to clinically appropriate individuals (using the bolus, continuous, or intermittent method).
 1. Competency Tools for Bolus and Continuous feedings are included in *Policy No. 14-4* for providers to use if desired.
 - (a) As this procedure is not under the jurisdiction of MAP, these Tools are optional.
 - b. Certified staff must receive individual-specific specialized training to administer medications and water flushes via a Gastrostomy or Jejunostomy Tube.
 - i. Competency Tools for General knowledge, Water Flushes, and Medication Administration are required to be completed.
 1. Certified staff must be approved separately for each individual with whom he/she works.
 - (a) The Required Competency Tools must be completed for each individual, deemed appropriate for this practice, to whom the Certified staff will be administering medications.

**MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL**

Policy No. & Issue 14-4 Medication Administration Via Gastrostomy/Jejunostomy
Tube

Policy Source MAP Policy Manual

Issued Date: 7/01/03

Last Revision Date: 01/01/15

See forms and instructions on following pages.

Archived

Process for Initiating Medication/Tube Feeding via G/J Tube Curriculum for MAP Certified Staff

- 1 Using the Massachusetts Department of Developmental Services Registration Form, Provider will register the individual who has a G/J tube.
- 2 If the Provider wants to train MAP Certified staff to administer medications via G/J tube, they must submit to DDS written documentation from a licensed Health Care Provider (e.g., Physician, Nurse Practitioner), or Registered Nurse that it is appropriate to train MAP Certified staff to administer medications via the G/J tube to this particular individual.
- 3 Provider must include an evaluation of the staffing pattern in the individual's residence. The G/J tube registration form mentioned in #1 above can be utilized for this purpose.
- 4 Once it is determined that an individual with a G/J tube is a clinically appropriate candidate to have medications administered by MAP Certified staff, any change in their health status would require that a licensed Health Care Provider or Registered Nurse once again evaluate the individual. Evaluation is to determine if it is still prudent for MAP Certified staff to administer medications to the individual via G/J tube.
- 5 MAP Certified staff, who are to be trained to administer medications via G/J tube, will be approved separately for each individual, that that they work with. Each individual must have been deemed appropriate for this practice.
- 6 Specialized training, in administration of medications via G/J tube, must be done by an RN.
- 7 Any G/J tube curriculum utilized by a provider to train MAP Certified staff in the administration of medications via a G/J tube must contain the following DPH approved essential components:
 - a. general overview of how G/J tube medication administration relates to MAP;
 - b. purpose of G/J tubes;
 - c. overview of various kinds of G/J tubes;
 - d. overview of different methods of tube feedings (bolus, continuous, intermittent);
 - e. importance of clean technique and proper hand washing;
 - f. maintenance of G/J tube;
 - g. positioning issues with G/J tubes as well as specific positioning instructions for each individual;
 - h. overview of problems associated with a G/J tube including what to do if a G/J tube becomes dislodged, or a G/J tube occludes (Additionally, an overview of possible untoward effects experienced by the individual including diarrhea, respiratory difficulty, vomiting, and insertion site is observed to be red or has drainage.);
 - i. any individual specific protocol(s) to manage potential problems;
 - j. how to prepare different forms of medication for administration via G/J tube;
 - k. safe management and storage of formula and equipment including protocol regarding length of time a specific formula may hang for a specific individual and reuse of equipment; and
 - l. an individual specific training regarding all of the above including an on-site, individual-specific, demonstration.
- 8 The standardized competency evaluation tool should be used.

- 9 A complete set of written materials used to train staff must be maintained at the program.
- 10 Staff must be qualified to administer medications to an individual with a G/J tube.
- a. Staff qualifications include:
 - i. has current MAP Certification in good standing as determined by the agency;
 - ii. has current CPR and First Aid certification;
 - iii. has completed vital signs training with demonstrated competence on a regular basis;
 - iv. has successfully completed individual specific training to administer medications via G/J tube done by an RN following accepted MAP procedures for the administration of medication; and
 - v. has successfully completed a medication administration via G/J tube training with an RN and has successfully demonstrated competency in this skill. This demonstrated competency evaluation must be repeated at least every two years (i.e., at least every twenty-four months) or if the health status of the individual changes in such a manner that the RN deems it is necessary.
- 11 MAP Certified staff who are G/J tube approved are not allowed to administer medications via G/J tube without a competency review by an RN if six or more months have elapsed since that staff person administered feedings or medications to that individual via a G/J tube. In State operated community programs this will be monitored by an RN as part of the MAP oversight review process.
- 12 MAP Certified staff responsible for a Medication Occurrence involving the administration of a medication via G/J tube would be required to have at least a verbal review of the occurrence with the licensed health care professional responsible for clinical oversight of the G/J tube. The occurrence must also be reported utilizing the MOR system according to MAP policy.
- 13 Changes in medication orders would need to be reviewed, according to the Service Provider's policy, by the licensed health care professional responsible for clinical oversight of the G/J tube prior to allowing G/J tube approved staff to administer the medication. Additional training would be provided as appropriate.
- 14 If there is no nurse assigned to the program, a licensed Health Care Provider should evaluate the individual in regards to skin integrity, tube placement, new orders, etc. and document such findings in the individual's record. This should be done on a regular basis, as determined by the Health Care Provider, but at least once every three months.

Massachusetts Department of Developmental Services Gastrostomy / Jejunostomy Registration Form

Date: _____	DPH MAP Registration No. _____
Region: _____	Area/Facility: _____
Class Org.: _____	
Site Address: _____	
Provider Agency _____	

Name of Individual with G/J Tube: _____

Date of Birth: _____ Soc. Sec. No.: _____

Type of Tube: ☐ Gastrostomy
☐ Jejunostomy

Date of Placement of G/J Tube
(approximate if necessary): _____

Reason for Replacement of G/J Tube:

- ☐ Dysphagia
☐ Chronic Aspiration
☐ Nutrition Concerns
☐ Hydration Concerns
☐ Other: _____
☐ Unknown

Does this person:

- ☐ Receive feedings via their G/J tube?
☐ Receive hydration via their G/J tube?
☐ Receive medications via G/J tube?
☐ Have medications administered via G/J tube by licensed person only?
☐ Have medications administered via G/J tube by MAP Certified Staff?

I have evaluated this individual and have determined that it is appropriate at this time for MAP Certified, non-licensed staff to be trained to administer medications via their:

(Initial One) _____ Gastrostomy Tube

_____ Jejunostomy Tube

Printed Name of
RN or NP or
Physician _____

Phone Number _____

Signature of RN or
NP or Physician _____

Date _____

FAX TO: SHARON OXX@ 617-624-7578

Competency Evaluation Tool for Gastrostomy (G) or Jejunostomy (J) Tube Medication Administration

Staff Name: _____

Individual's Name: _____

Date: _____

	Pass (P), Fail (F), N/A	Comments	General Knowledge
1.			Knows that only licensed personnel (nurses) and MAP Certified staff, who have successfully completed specialized G or J tube medication administration training, may administer medications through the G or J tube.
2.			Knows that another competency evaluation will need to be completed if a MAP Certified staff person who has successfully completed specialized training in G or J tube medication administration does not administer medications via G/J tube to an individual for a period of time exceeding six months.
3.			Knows that all MAP regulations must be followed when administering medications via G or J tube.
4.			Knows what gastrostomy and jejunostomy tubes are and why this individual has one.
5.			Knows a brand of formula should never be changed without a Health Care Provider's order.
6.			Is aware that there are 3 different methods of tube feedings. (Bolus, Continuous, and Intermittent)
7.			Knows that a method of tube feeding, rate and time may not be changed without a Health Care Provider's order.
8.			Knows that individuals with tube feedings need to be weighed as directed by RN, NP, or Physician.
9.			Knows why water flushes are needed.
10.			Knows that good hand washing and cleanliness of G/J-tube equipment is essential in safe administration of tube feedings and medications.
11.			Knows the importance of elevated position of individual's upper body during feedings, flushes, and medication administration.
12.			Able to state what s/he should do if the feeding tube became dislodged or appears to have moved in or out of its intended position within the first 8 weeks of original placement of the tube. (When tract not yet well established.)
13.			Able to state what s/he should do if the tube became dislodged or appears to have moved in or out of its intended position, after the first 8 weeks of original placement of the tube. (When tract is well established.)
14.			Knows the importance of preventing the tube from being pulled.
15.			Able to state what s/he should do if the individual vomits while feeding is being administered.
16.			Able to state what s/he should do if the individual had breathing difficulty.
17.			Able to state what s/he should do if the individual had diarrhea.
18.			Able to identify some the causes of vomiting or diarrhea.
19.			Able to state what s/he should do if stoma site is observed to be red, swollen or has purulent (yellowish or greenish fluid produced by infection) drainage.
20.			States what s/he would do and look for if pump alarm says the tube is blocked or that there is an occlusion.

	Pass (P), Fail (F), N/A	Comments	Procedure for Medication Administration:
1.			Follows all procedures for preparation of medications for administration according to MAP regulations and policies.
2.			Washes hands.
3.			Assembles necessary equipment and enough water for pre and post med flushes.
4.			Prepares medications according to MAP. Shakes suspensions vigorously before pouring, and crushes pills finely before mixing with water or other liquid.
5.			Informs individual what is being done.
6.			Checks G/J tube placement if part of individual's G/J tube protocol.
7.			Positions individual in correct position.
8.			Clamps/pinches G/J tube before unplugging or disconnecting feeding.
9.			Removes plug or disconnects feeding.
10.			Places plug or hangs feeding bag tubing so that they remain free from contamination.
11.			Inserts the tip of syringe barrel (which has been separated from plunger) into the G/J tube, while continuing to pinch off the tube.
12.			Pours 20 ml (or other instructed amount of water) into syringe and allows it to flow into stomach/intestine. (For J-tube may have to replace plunger back into barrel and push in gently for each water flush and medication.)
13.			Pinches off G/J tube just prior to syringe being completely emptied.
14.			Pours medications into barrel of syringe with 5 ml to 10 ml of water in-between each type of medication.
15.			Ends medication administration with 20 ml (or instructed amount) water flush.
16.			Reinserts plug or resumes feeding.
17.			Documents administration according to MAP regulations and policies.

Based on this Competency Evaluation Tool, I as RN Trainer have determined that the Certified Staff Person named below is competent to administer medications via G/J tube to the individual named below.

Staff Person's Printed Name _____

Individual's Printed Name _____

Staff Person's Signature _____

Date _____

RN's Printed Name _____

RN's Phone Number _____

RN's Signature _____

Date _____

Competency Evaluation Tool for Gastrostomy (G) or Jejunostomy (J) Tube Water Flushes

Staff Name: _____

Individual's Name: _____

Date: _____

	Pass (P), Fail (F), N/A	Comments	Procedure for Water Flushes:
1.			Checks Health Care Provider's orders.
2.			Washes hands.
3.			Gathers equipment.
4.			Informs individual of what is being done.
5.			Checks placement of tube if part of individual's G/J tube protocol.
6.			Positions individual in correct position.
7.			Clamps/pinches G/J-tube before unplugging or disconnecting feeding.
8.			Removes plug or disconnects feeding.
9.			Places plug or hangs feeding bag tubing so that they remain free of contamination.
10.			While G/J-tube is still clamped/pinched, inserts tip of syringe (which has been separated from plunger) into G/J tube.
11.			Pours prescribed amount of water into barrel of syringe, unclamps the tube, and allows water to slowly enter stomach /intestine by gravity. (For J-tube, may have to replace plunger back into barrel and push water in gently.)
12.			Clamps tube when syringe has just completely emptied.
13.			Inserts plug or reconnects tube to pump tubing.
14.			If indicated—rechecks setting on pump, turns pump on, and unclamps tube.
15.			Documents that flush has been given according to MAP regulations and policies.

Based on this Competency Evaluation Tool, I as RN Trainer have determined that the Certified Staff Person named below is competent to administer water flushes via G/J tube to the individual named below.

Staff Person's Printed Name _____

Individual's Printed Name _____

Staff Person's Signature _____

Date _____

RN's Printed Name _____

RN's Phone Number _____

RN's Signature _____

Date _____

Competency Evaluation Tool for Gastrostomy (G) Tube Bolus Feeding

Staff Name: _____

Individual's Name: _____

Date: _____

	Pass (P), Fail (F), N/A	Comments	Procedure for Bolus Feeding:
1.			Checks Health Care Provider's orders.
2.			Washes hands.
3.			Gathers equipment—Correct amount of formula, water, 60 ml catheter tip syringe (with barrel separated from plunger), and clean towel.
4.			Informs individual of what is being done.
5.			Positions individual in correct position.
6.			Pinches G-tube before unplugging tube. Removes plug and places plug so that it remains free of contamination.
7.			Inserts tip of syringe into tube.
8.			Pours prescribed amount of water into barrel of syringe; unpinches the tube; allows water to slowly enter stomach by gravity and pinches the tube just prior to syringe being completely emptied.
9.			Slowly pours formula into barrel of syringe; unpinches the tube to allow the formula to enter the stomach; continuously refills the barrel before it completely empties, (to prevent air from entering), until all of prescribed amount of formula has been poured into the syringe.
10.			Pinches G-tube just prior to syringe being completely emptied.
11.			Pours prescribed amount of water into syringe, unpinches tube, and allows water to enter stomach (to flush tube).
12.			Pinches G-tube when syringe has just completely emptied of water.
13.			Reinserts plug prior to unpinching tube.
14.			Documents that feeding has been given.
15.			Ensures that individual sits up for at least 60 minutes after feeding is complete.

Based on this Competency Evaluation Tool, I as RN Trainer have determined that the Certified Staff Person named below is competent to administer G-tube bolus feedings to the individual named below.

Staff Person's Printed Name _____

Individual's Printed Name _____

Staff Person's Signature _____

Date _____

RN's Printed Name _____

RN's Phone Number _____

RN's Signature _____

Date _____

Competency Evaluation Tool for Gastrostomy (G) or Jejunostomy (J) Tube Continuous Feeding and Discontinuation of Feeding

Staff Name: _____

Individual's Name: _____

Date: _____

	Pass (P), Fail (F), N/A	Comments	Procedure for Continuous Feedings:
1.			Checks Health Care Provider's orders.
2.			Washes hands.
3.			Gathers equipment and 20 ml (or other amount if specifically prescribed) water for flush.
4.			Inform individual of what is being done.
5.			Positions individual in correct position.
6.			Marks label on bag or bottle with current date and time.
7.			Fills feeding bag with no more than 4 hours worth of formula unless otherwise directed by RN, NP, or Health Care Provider.
8.			Primes tubing before connecting bag to pump.
9.			Clamps feeding bag tubing (of both old and new feeding bags) prior to removing old feeding bag from pump.
10.			Connects new feeding bag tubing to pump and sets desired rate on pump.
11.			Clamps/pinches G/J-tube before unplugging or disconnecting tubing.
12.			Removes plug or disconnects feeding. (If using plug, places plug so that it remain free of contamination.)
13.			Separates barrel from plunger of syringe.
14.			While G/J tube is still clamped or pinched, places tip of syringe into G/J tube and pours 20 ml (or other amount if specifically prescribed) water into barrel of syringe.
15.			Unclamps tube and allows water to slowly enter stomach/intestine by gravity. (For J-tube, may have to replace plunger back into barrel and push water in gently.)
16.			Clamps/pinches tube just prior to syringe being completely emptied.
17.			Connects tube to clean feeding bag tubing and unclamps tube.
18.			Rechecks setting on the pump and turns pump on.
19.			Documents that feeding has been hung, the rate of feeding, and how individual is tolerating procedure.

	Pass (P), Fail (F), N/A	Comments	Procedure for Discontinuous Feeding:
1.			Verifies by looking at Health Care Provider's orders and MAR sheet that it is time to stop the feeding.
2.			Washes hands.
3.			Gathers equipment and 20 ml (or other amount if specifically prescribed) water flush.
4.			Informs individual what is being done.
5.			Turns off pump.
6.			Clamps or pinches G/J tube.
7.			Clamps or pinches feeding bag tube.
8.			Disconnects tube from feeding bag tubing. (If feeding bag is to be used again, ensures tubing does not get contaminated.)
9.			While G/J-tube is still clamped/pinched, places tip of syringe (which has been separated from plunger) into tube.
10.			Pours 20 ml (or other amount if specifically prescribed) of water into syringe; unclamps tube and allows water to flow into stomach/intestine by gravity. (For J-tube, may have to replace plunger back into barrel and push water in gently.)
11.			Clamps/pinches tube just prior to syringe being completely emptied.
12.			Inserts plug.
13.			Unclamps G/J tube.
14.			Checks G/J tube placement by measuring tube.
15.			Documents according to MAP regulations and policies.

Based on this Competency Evaluation Tool, I as RN Trainer have determined that the Certified Staff Person named below is competent to administer continuous feedings via G/J and discontinuous feedings via G/J tube to the individual named below.

Staff Person's Printed Name _____

Individual's Printed Name _____

Staff Person's Signature _____

Date _____

RN's Printed Name _____

RN's Phone Number _____

RN's Signature _____

Date _____

15

**DPH
CLINICAL PRACTICE
REVIEW
AND
INSPECTION**

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 15-1 Clinical Practice Review and Inspection

Policy Source DPH Policy

Issued Date: 10/27/97

Last Revision Date: 9/01/10

- 1 For the purpose of evaluating the Medication Administration Program for its safety and effectiveness, DPH Drug Control Program (DCP) conducts both inspections and clinical practice reviews.
 - a. The outcomes of these evaluations facilitate the determination of the areas of strength and weakness. This in turn allows the Departments to:
 - i. develop policy;
 - ii. revise the curriculum, training and testing; and
 - iii. address specific concerns raised by the inspections/reviews.
- 2 The DPH Inspection conducted by the DCP Inspector is specific to the security and accountability of controlled substances (prescription medications).
 - a. The inspection of a site usually takes one to two hours.
- 3 The DPH Clinical Practice Review conducted by the DCP Clinical Reviewer for MAP addresses clinical issues specific to medication administration, practices, and systems as defined by 105 CMR 700.000 et seq.
 - a. The review may be done at the Service Provider's main office and/or the registered site(s).
 - i. The review at each site varies depending on its size and the complexity of the individual(s)' care.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 15-2 Clinical Review

Policy Source MAP Policy Manual

Issued Date: 8/01/00

Last Revision Date: 10/01/13

- 1 The steps of the Department of Public Health's Drug Control Program (DCP) 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 Service Provider's administrative office and/or the registered site(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 DMH, DCF or DDS.
 - e. The Service Provider is required to submit a plan of correction within 10 days to DPH and the appropriate licensing/certifying agency (i.e., DMH, DCF or DDS).
 - f. DMH, DCF or DDS, in consultation with DPH, conducts follow-up as indicated on the plan of correction.

SPECIALIZED SERVICES

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MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 16-1 Hospice: Protocol for Instituting

Policy Source MAP Policy Manual

Issued Date: 5/01/07

Last Revision Date: 10/01/13

- 1 In order to institute hospice services and the ensuing policies at a MAP site, the following protocols and supports must first be put into place.
 - a. The program/provider must notify the DMH/DCF Area/DDS Regional MAP Coordinator that hospice services are being initiated at the program site.
 - b. The Service Provider must identify a Hospice Point Person.
 - i. Hospice Point Person (HPP) to act as a liaison or “Gate Keeper” between DDS/DMH/DCF, residential and day program staff, school, family and the Hospice Services.
 1. It is recommended that the HPP be a residential supervisor/program director or nurse employed by the program site/service provider.
 - ii. Responsibilities of the HPP:
 1. establishing a hospice record-keeping process for the program; which would include:
 - (a) Communication forms;
 - (b) Medication administration records;
 - (c) Health Care Provider (HCP) order forms;
 - (d) individual health and information record;
 - (e) consent status; and
 - (f) end-of-life wishes.

(See Policy No. 16-4 on page 178 Sample Hospice Record Keeping Forms)
 2. arranging orientation to hospice services for both program staff, as well as, the hospice provider;
 3. arranging orientation of program staff to hospice record-keeping process and all mandatory forms (Supporting documentation of said orientation to be maintained at the program site and to include the name of the trainer, date of orientation, and staff signatures indicating attendance.);
 4. arranging for ongoing review of Reference Sheet for Calling Hospice Nursing (see *Policy No. 16-3 on page 172*) and medication progress notes; and
 5. establishing and maintaining open lines of communication between all members of the individual’s team including hospice staff.
 - c. The Service Provider must ensure that orientation to Hospice Services and the Medication Administration Program has been accomplished.
 - i. Orientation to hospice services. Orientation by hospice staff for DMH/DCF/DDS program staff must include, at a minimum:
 1. hospice services available;
 2. eligibility criteria for hospice;
 3. primary hospice nurse role including:
 - (a) how to contact;
 - (b) when to contact; and
 - (c) hospice home visits.

4. role of Home Health Aides provided by hospice;
 5. obtaining hospice medications and orders;
 6. Emergency Starter Kit/ Hospice Comfort Care Box;
 7. documentation;
 8. procuring equipment;
 9. spiritual needs;
 10. social services; and
 11. education/ support services available for:
 - (a) individual;
 - (b) peers;
 - (c) roommates;
 - (d) staff; and
 - (e) family.
- ii. Orientation to Medication Administration Program. Orientation by DDS/DMH/DCF program staff for hospice staff must include, at a minimum:
1. Hospice Point Person (HPP) role and contact information;
 2. overview of how DDS/DMH/DCF programs operate;
 3. overview of MAP including specific hospice MAP policies/procedures;
 4. review of Emergency Fact Sheet;
 5. review of staffing pattern for residence;
 6. hospice record keeping mandated by MAP policies;
 7. guardianship status/health care proxy status;
 8. the individual's wishes for end of life care;
 9. DNR status; and
 10. program specific information.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 16-2 Hospice: Exceptions to Other MAP Policies

Policy Source MAP Policy Manual

Issued Date: 5/01/07

Last Revision Date: 10/01/13

- 1 The following MAP policy exceptions exist for a DDS/DMH/DCF MAP registered site that is supporting an individual who is receiving services from hospice.
 - a. A hospice-oriented MAP Certified staff person may accept a PRN order from the Health Care Provider (HCP) that does not give specific doses as long as:
 - i. An *Individualized Hospice PRN Medication Observation Protocol Form* (see Policy 16-3 on page 172) has been completed and has been signed by the Health Care Provider.
 1. For example, a hospice-oriented MAP Certified staff person may accept the following PRN order: MSIR (Morphine Sulfate Immediate Release) oral concentrate solution 5 mg/0.25 ml. Give 5 mg-30 mg by mouth every 4 hours PRN for discomfort according to the "*Individualized Hospice PRN Medication Observation Protocol*".
(See Policy 16-3 on page 172 for further instructions)
 - (a) In accordance with other DPH policies relative to the management of MSIR oral concentrate, only unit dose packaging for MSIR oral concentrate is allowed to be stored at MAP sites.
 - b. MAP Certified staff may accept a Health Care Provider order relayed to them by a hospice nurse.
 - i. Such orders should be faxed whenever possible. Those orders must still be signed by the prescribing Health Care Provider within 72 hours.
 - c. The sealed hospice emergency starter kit or the sealed hospice comfort care box may be reconciled as one sealed item.
 - i. When the "Hospice Comfort Care Box" or "Emergency Starter Kit" is brought into the home in anticipation of increased need for medication supports, it is sealed or locked. Several of the medications in the box may be Countables. Until the box is opened for use, the program simply needs to document that the box is present and remains sealed or locked. (See attached sample "*Sealed Hospice Emergency Starter Kit Count Sheet*" on page 171) Once the "box" or "kit" is unsealed, each countable medication within the box must be added to the index in the "Count Book" and the medications entered onto individual count sheets in the "Count Book".
 - d. MAP Certified staff may care for an individual with a pre-filled automatic medication infusion device. However, MAP Certified staff may not operate the device including administration of a bolus or calibration of the device. MAP Certified staff may observe and report the condition of a pre-filled automatic medication infusion device and insertion site. Such observations would include but not be limited to noting if the infusion site is warm, painful, or the infusion device is dislodged. Such observations must be documented on the Medication Sheet or Progress Note and problems reported to the hospice nurse immediately. MAP Certified staff must receive training for such observations and reporting from the Hospice nurse. Documentation of such training must

be maintained at the program and must include the name of the trainer, date of training and signatures of staff present as proof of attendance.

- e. In recognition of the fact that orders can change frequently when an individual is receiving hospice services, labels on medications for an individual receiving hospice services may be allowed to state '*See Health Care Provider's orders for further instructions*'.

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Sealed Hospice Emergency Starter Kit Count Sheet

(Once Kit has been unsealed, indicate “No” in “Kit Sealed?” column and add Countables from the Kit to count book index and count sheet(s).)

[illegible]

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue **16-3 Hospice: Procedure for Telephone Clarification of PRN Orders with Dose Ranges**

Policy Source **MAP Policy Manual**

Issued Date: **5/01/07**

Last Revision Date: **9/01/10**

- 1 When an individual is receiving hospice services there will be regular on-going communication between the hospice-oriented MAP Certified staff and the hospice nurse.
 - a. Frequent communication between MAP Certified staff and the hospice nurse will facilitate team building and mutual respect and trust.
 - i. A vital part of this on-going communication will be the clarification of PRN medication dosages.
 1. Prior to making a change in the previously administered dose of a PRN medication with dose ranges, the hospice nurse must be consulted for clarification.
- 2 Prior to calling the hospice nurse, the hospice-oriented MAP Certified staff must:
 - a. review the *Individualized Hospice PRN Medication Observation Protocol* form (See form on page 174);
 - b. complete the *Reference Sheet for Calling Hospice Nurse* form (See form on page 175); and
 - c. have the medication progress notes, the Health Care Provider (HCP) orders, and the individual's medication administration sheet at hand for additional reference.
- 3 Once the hospice-oriented MAP Certified staff person has completed the above they must:
 - a. contact the hospice nurse;
 - b. identify who they are, the program and the individual receiving hospice services;
 - c. give a brief description of the individual's current condition using the *Reference Sheet for Calling Hospice Nurse* form;
 - d. review the Health Care Provider (HCP) order;
 - e. review the *Individualized Hospice PRN Medication Observation Protocol* form;
 - f. inform the hospice nurse of their understanding of the HCP order, the individual's current status relative to the *Individualized Hospice PRN Medication Observation Protocol* and the dose they plan to administer;
 - g. clarify with the hospice nurse the Health Care Provider orders based on their observation of the individual; and
 - h. discuss follow-up recommendations with the hospice nurse.
- 4 The conversation between the hospice-oriented MAP Certified staff and the hospice nurse will be documented on the *Reference Sheet for Calling Hospice Nurse* form and must include the following information:
 - a. description of symptoms reported by the MAP Certified staff to the hospice nurse;
 - b. the hospice nurse's Health Care Provider order clarification; and
 - c. the mutually agreed upon follow-up action.
- 5 After administering the medication as agreed, the MAP Certified staff person will document the administration per MAP protocols/policy.

- 6 At the next on-site clinical assessment, the hospice nurse will specifically review all PRN medication administration documentation as well as other related documentation.

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Individualized Hospice PRN Medication Observation Protocol Form

Individual's Name: _____

Allergies: _____

HCP Order and Protocol

Medication: _____

Dose: _____

Frequency: _____

Route: _____

Reason: _____

As Evidenced By: _____

Vital Signs: ☐ Yes: ☐ No If Yes; list parameters and when to call HCP: _____

HCP Signature: _____

Date: _____

Posted: _____

Date: _____

Verified: _____

Date: _____

HCP Order and Protocol

Medication: _____

Dose: _____

Frequency: _____

Route: _____

Reason: _____

As Evidenced By: _____

Vital Signs: ☐ Yes: ☐ No If Yes; list parameters and when to call HCP: _____

HCP Signature: _____

Date: _____

Posted: _____

Date: _____

Verified: _____

Date: _____

Reference Sheet for Calling a Hospice Nurse

Fill in blanks 1 through 10 before calling Hospice Nurse

Date: _____ Time: _____

1. Name of Individual: _____
2. Name of Primary Hospice Nurse: _____
3. Pain Management: (May refer to *INDIVIDUALIZED HOSPICE PRN MEDICATION OBSERVATION PROTOCOL FORM*)
 a. Verbal complaints: _____
 b. Nonverbal signs of discomfort as evidenced by: _____
4. List name and time of all medications given, including routine meds: _____

5. If PRN pain medication was given, report its effect to the hospice nurse (this should also be documented on the back of the medication administration sheet along with the Certified staff's name).

Name of PRN Medication: _____ Dose: _____ At: _____ For: _____

6. How long was the individual comfortable for after last dose? _____
7. Current Symptoms:
 - a. Nausea/Vomiting: ☐ No ☐ Yes Evidenced By: _____
 - b. Anxious/Agitated: ☐ No ☐ Yes Evidenced By: _____
 - c. Respiratory Status: ☐ Gurgling ☐ Noisy ☐ Normal ☐ Fast ☐ Slow
 - d. Vital Signs (if part of *INDIVIDUALIZED HOSPICE PRN MEDICATION OBSERVATION PROTOCOL*)

Temperature _____ Pulse _____ Respiratory Rate _____ Blood Pressure _____

8. Is the individual receiving oxygen? ☐ No ☐ Yes If yes, how many liters/minute? _____
9. When was their last bowel movement? _____
10. Has their overall general appearance changed? Are they more sluggish or drowsy, non-responsive?
 Describe: _____

Documentation of conversation between hospice nurse and MAP Certified staff person:

1. Description of symptoms reported by the MAP Certified staff: _____
2. The hospice nurse's HCP order clarification: _____
3. The mutually agreed upon follow up action:: _____

Hospice Nurse Contacted: _____
 MAP Certified Staff Person: _____

Reviewed by: _____ Point Person _____ Date _____

Sample Reference Sheet for Calling a Hospice Nurse

Fill in blanks 1 through 10 before calling Hospice Nurse

Date: 4/10/YR

Time: 9:00 PM

1. Name of Individual: Jane Doe
2. Name of Primary Hospice Nurse: Susan Carol RN
3. Pain Management (May refer to *INDIVIDUALIZED HOSPICE PRN MEDICATION OBSERVATION PROTOCOL FORM*)
 - a. Verbal complaints: "I Hurt, I Hurt"
 - b. Nonverbal signs of discomfort as evidenced by: Holding stomach, rolling from side to side, crying
4. List name and time of all medications given, including routine meds: Colace 100 mg at 8 pm, Morphine sulfate oral concentrate 5 mg at 5 pm

5. If PRN pain medication was given, report its effect to the hospice nurse (this should also be documented on the back of the medication administration sheet along with the Certified staff's name).

Name of PRN

Medication: Morphine sulfate oral concentrate Dose: 5 mg At: 5 pm For: Abdominal pain

6. How long was the individual comfortable for after last dose? 3 hours
7. Current Symptoms:
 - a. Nausea/Vomiting: ☒ No ☐ Yes Evidenced By: _____
 - b. Anxious/Agitated: ☐ No ☒ Yes Evidenced By: Grabbing at staff, trying to get out of bed
 - c. Respiratory Status: ☐ Gurgling ☐ Noisy ☐ Normal ☒ Fast ☐ Slow
 - d. Vital Signs (if part of *INDIVIDUALIZED HOSPICE PRN MEDICATION OBSERVATION PROTOCOL*)

Temperature _____ Pulse _____ Respiratory Rate 26 Blood Pressure _____

8. Is the individual receiving oxygen? ☒ No ☐ Yes If yes, how many liters/minute? _____
9. When was their last bowel movement? 4/10/YR
10. Has their overall general appearance changed? Are they more sluggish or drowsy, non-responsive?
Describe: More restless, sweating

Documentation of conversation between hospice nurse and MAP Certified staff person:

1. Description of symptoms reported by the MAP Certified staff: Rolling in bed side to side saying "I hurt" and holding stomach, crying, alert, sweaty, pain medication (Morphine sulfate, 5mg) usually works for 4 hours but not this time. Tried to make more comfortable. Can have up to 30 mg every 4 hours per Doctor's orders.
2. The hospice nurse's HCP order clarification: Hospice nurse agreed dose range in order is 5 mg—30 mg every 4 hours PRN for abdominal pain.
3. The mutually agreed upon follow up action: MAP Certified staff will administer 10 mg every 4 hours for pain from now on and report effectiveness to hospice nurse in two hours.

Hospice Nurse Contacted: Sarah Jones, RN

MAP Certified Staff Person: Carol Smith

Reviewed by: Carl Steven Program Director
Point Person

June 11, YR
Date

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**MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL**

Policy No. & Issue 16-4 Hospice Sample Record Keeping Forms

Policy Source MAP Policy Manual

Issued Date: 5/01/07

Last Revision Date: 9/01/10

PLEASE SEE ATTACHED SAMPLE RECORD KEEPING FORMS.

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**MEDICATION SHEETS ARE
NOW LOCATED IN
INDIVIDUAL'S HOSPICE
NOTEBOOK**

Individual Information

Health Care Provider's Orders

Medication Sheets

Residence Staff Notes

Hospice Staff Notes

**Phone Contact Reference Sheets
Completed**

Medication Information

Resource Information

DDS/DNR Policy/Information

Care and Comfort Form

Blank Forms

MAP Hospice Policies

Individual Information

Health Care Provider's Orders

Medication Sheets

Residence Staff Notes

Hospice Staff Notes

**Phone Contact Reference Sheets
Completed**

Medication Information

Resource Information

DDS/DNR Policy/Information

Care and Comfort Form

Blank forms

MAP Hospice Policies

Admission to Hospice Check Off List

Individual's

Name: _____

Date of Admission to

Hospice: _____

☐ Orientation to Hospice

Staff:

Hospice

Personnel:

☐ Hospice Intake Addendum Form

☐ Assign Point Person

☐ Notify Area/Regional MAP Coordinator

☐ Notify Area Office Nurse (if not already involved)

☐ Receipt of Hospice Notebook

☐ Receipt of Starter Kit (if applicable)

☐ Transfer of all Medication Sheets and Health Care Provider's Orders from current medication book to Hospice Notebook

☐ Post and Verify all new orders

☐ Comfort and Care/ DNR Verification Forms (if applicable)

Residential
Program

☐ Original Verification Form

Day Program

☐ Copy of Form***

School

☐ Copy of Form***

Transportation
Service

☐ Copy of Form***

Family

☐ Copy of Form***

***May also use optional original bracelet

Contacts

Name of Individual: _____

Primary HCP: _____ Phone Number: _____
 Fax Number: _____

Hospice Agency: _____ Phone Number: _____

Primary Hospice Nurse: _____ Phone Number: _____
 Pager Number: _____

Point Person for Communicating with Hospice: _____ Phone Number: _____
 Pager Number: _____

Alternate Individual when Point Person is not available: _____ Phone Number: _____
 Pager Number: _____

Agency Nurse: _____ Phone Number: _____
 (if applicable) Pager Number: _____

Sample Hospice Intake Addendum

Individual's Name: _____		Likes to be called: _____	
Birth Date: _____		Soc. Sec. No.: _____	
Address: _____			
Telephone Number: _____		Religion: _____	
Health Insurance: (Type and Numbers)		Primary: _____ Secondary: _____	
Agency Responsible for Care: _____		<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, List Name of Agency: _____ Agency Point Person: _____ Agency Telephone Number: _____	
Nursing Support: _____		<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, List Name of Agency: _____	
Day Program: _____		Type of Day Program: _____	
Nursing Support: _____		Day Program Contact Person: _____	
<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, List Name of Agency: _____			
DDS Area Office: _____		DDS/Area Office Nurse: _____	
Service Coordinator: _____		Telephone Number: _____	
Consent Status: _____		<input type="checkbox"/> Can Give Own Consent <input type="checkbox"/> Consent from Guardian Guardian Name: _____ Telephone Number: _____ <input type="checkbox"/> Unable to give Own Consent and No Guardian	
Resuscitation Status: _____		<input type="checkbox"/> DNR If DNR, is Comfort Care form available? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> Full Resuscitation	
Health Care Proxy: _____		<input type="checkbox"/> No Proxy Name: _____ Telephone Number: _____ <input type="checkbox"/> Yes	
Emergency Contacts Name: _____		Allergies _____	
Telephone Number: _____		Medications: _____	
Name: _____		Food/Environmental: _____	
Telephone Number: _____		Type of Reaction: _____	
Medications: _____		<input type="checkbox"/> Medication Sheet/Record Attached Current Medical Problems and Diagnoses: _____ <input type="checkbox"/> List Attached	
Pharmacy Name: _____			
Pharmacy Address: _____			
Telephone Number: _____			

OPTIONAL

Communication:	<input type="checkbox"/> Able to Communicate	<input type="checkbox"/> Communication Difficulties/ Uses Verbalizations	<input type="checkbox"/> Communication Difficulties/ Uses Gestures	<input type="checkbox"/> Not able to Communicate Needs			
	<input type="checkbox"/> Unable to use Call Bell	<input type="checkbox"/> Only Speaks/ Understands Foreign Language	<input type="checkbox"/> Unknown				
Vision:	<input type="checkbox"/> Normal	<input type="checkbox"/> Low Vision	<input type="checkbox"/> Blind	<input type="checkbox"/> Wears Glasses			
	<input type="checkbox"/> Unknown						
Hearing:	<input type="checkbox"/> Normal	<input type="checkbox"/> Hard of Hearing	<input type="checkbox"/> Deaf	<input type="checkbox"/> Hearing Aid			
	<input type="checkbox"/> Unknown						
Supportive Devices:	<input type="checkbox"/> Padded Side Rails	<input type="checkbox"/> Splints	<input type="checkbox"/> Braces	<input type="checkbox"/> Helmet			
	<input type="checkbox"/> Other: _____		<input type="checkbox"/> Unknown	<input type="checkbox"/> None			
Toileting Ability:	<input type="checkbox"/> Continent	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Incontinent	<input type="checkbox"/> Catheterized			
	<input type="checkbox"/> Other: _____		<input type="checkbox"/> Unknown				
Medication Administration:	<input type="checkbox"/> Independent/Self-Administers	<input type="checkbox"/> Medicated by Staff	<input type="checkbox"/> Other				
Dining/Eating:	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Totally Dependent	<input type="checkbox"/> Fed Through Tube			
	<input type="checkbox"/> Other		<input type="checkbox"/> Unknown				
Diet Texture:	<input type="checkbox"/> Regular	<input type="checkbox"/> Chopped	<input type="checkbox"/> Ground	<input type="checkbox"/> Puree			
	<input type="checkbox"/> Thicken Liquid	<input type="checkbox"/> Other					
Diet Type:							
Ambulation:	<input type="checkbox"/> Independent-Steady	<input type="checkbox"/> Independent-Unsteady	<input type="checkbox"/> Needs Assistance (1 person)	<input type="checkbox"/> Needs Assistance (2 people or more)			
	<input type="checkbox"/> Ambulation Aids-Walker	<input type="checkbox"/> Ambulation Aids-Cane	<input type="checkbox"/> Ambulation Aids-Crutches	<input type="checkbox"/> Ambulation Aids-Wheelchair			
	<input type="checkbox"/> Non-Ambulatory	<input type="checkbox"/> Other: _____		<input type="checkbox"/> Unknown			
Personal Hygiene:	<input type="checkbox"/> Independent	<input type="checkbox"/> Special Needs	<input type="checkbox"/> Other				
Oral Hygiene:	<input type="checkbox"/> Independent	<input type="checkbox"/> Special Needs	<input type="checkbox"/> Other				
Head of Bed Elevated?	<input type="checkbox"/> No	<input type="checkbox"/> Yes					
Special Needs:	<input type="checkbox"/> Behavior/Rituals: _____ <input type="checkbox"/> Likes: _____ <input type="checkbox"/> Dislikes: _____ <input type="checkbox"/> Special Communication Device/Method: _____						
Pain Response:	<input type="checkbox"/> Typical <input type="checkbox"/> Unique Please Explain: _____						
Health Care Providers							
Type/Specialty	Name	Street Address	City	State	Zip	Telephone Number	Fax Number
Primary Care							
Dental Care							
Eye Care							
Additional Information:							

Completed By: _____ Date: _____
 Relationship to the Individual: _____

Archived

Health Care Provider's Order Form

Name: _____ Birth Date: _____
 Address: _____ Telephone: _____
 Allergies: _____ Number: _____
 Pharmacy: _____

Name of Medication	Dose	Frequency and Duration	Route
Reason for Medication:			
Preparation and other Special Instructions:			
If vital signs are indicated, Please give parameters and when to notify Health Care Provider:			
If Accidentally Omitted:			

Name of Medication	Dose	Frequency and Duration	Route
Reason for Medication:			
Preparation and other Special Instructions:			
If vital signs are indicated, Please give parameters and when to notify Health Care Provider:			
If Accidentally Omitted:			

Name of Medication	Dose	Frequency and Duration	Route
Reason for Medication:			
Preparation and other Special Instructions:			
If vital signs are indicated, Please give parameters and when to notify Health Care Provider:			
If Accidentally Omitted:			

HCP Signature: _____ Date: _____
 Posted: _____
 Staff Signature: _____ Date: _____ Time: _____
 Verified: _____
 Staff Signature: _____ Date: _____ Time: _____

Health Care Provider's Order Form (2)

Name: _____ Birth Date: _____
 Address: _____ Telephone: _____
 Allergies: _____ Number: _____
 Pharmacy: _____

Name of Medication	Dose	Frequency and Duration	Route
Reason for Medication:			
Preparation and other Special Instructions:			
If vital signs are indicated, Please give parameters and when to notify Health Care Provider:			
If Accidentally Omitted:			

Name of Medication	Dose	Frequency and Duration	Route
Reason for Medication:			
Preparation and other Special Instructions:			
If vital signs are indicated, Please give parameters and when to notify Health Care Provider:			
If Accidentally Omitted:			

Name of Medication	Dose	Frequency and Duration	Route
Reason for Medication:			
Preparation and other Special Instructions:			
If vital signs are indicated, Please give parameters and when to notify Health Care Provider:			
If Accidentally Omitted:			

HCP Signature: _____ Date: _____
 Posted: _____
 Staff Signature: _____ Date: _____ Time: _____
 Verified: _____
 Staff Signature: _____ Date: _____ Time: _____

Archived

Clinical Progress Note

Name: _____

[illegible]

Hospice Medication Sheet

Name of Individual:

Month and Year:

Allergies:

		Day of Month (See entry Codes below *)																														
Generic:	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Brand:																																
Strength:	Dose:																															
Amount:	Route:																															
Frequency:																																
Start:	Stop:	Special Instructions/Precautions:															Reason for Medication:															
Generic:	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Brand:																																
Strength:	Dose:																															
Amount:	Route:																															
Frequency:																																
Start:	Stop:	Special Instructions/Precautions:															Reason for Medication:															
Generic:	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Brand:																																
Strength:	Dose:																															
Amount:	Route:																															
Frequency:																																
Start:	Stop:	Special Instructions/Precautions:															Reason for Medication:															
Site Address:	Initial	Signature										Initial	Signature										* Codes	Stands For								
																							LOA	Leave of Absence								
																							Circle Initial	Med Not Given								
																							DP	Day Program								
																							P	Packaging Observed								
																						H	Hospital									

Pain Review for Individual with Dementia or are Non-verbal

Individual's Name: _____

Date: _____ Time: _____

Assessed By: _____

Directions: Circle any behaviors that you observe in this individual. Indicate if this behavior has:
Increased (I), Decreased (D) or Remained the Same (S) since the individual was last observed.

Symptoms:	I	D	S
Agitation			
Restlessness			
Draws up legs			
Stretches			
Disrobes			
Repetitive Movements			
Wrenching Hands			
Rocking			
Rubbing a Body Area			
Tapping Feet			
Anxious			

Symptoms:	I	D	S
Guarding			
Self-bracing			
Splinting			
Guarding Limbs			
Scooting			
Rigidity			
Stays in One Position			
Gait Changes			
Refuses to Walk			
Refuses to Move			
Sliding			

Symptoms:	I	D	S
Facial Expression			
Wincing			
Grimacing			
Grating Teeth			
Face Muscles Tighten			
Blinks Rapidly			
Closes Eyes			
Wrinkles Brows			
Flushed Look			

Symptoms:	I	D	S
Verbalizations			
Complains of Pain (where and how strong)			
Yelling			
Moaning			
Groaning			
Swearing			
Whimpering			
Screaming Out			

Symptoms:	I	D	S
Aggression			
Striking out			
Pinching			
Hitting			
Biting			
Scratching			
Pulling on Staff arms, clothes, shoulders etc.			

Symptoms:	I	D	S
Resistance to Care			
Holds onto Bed Rails			
Grabs Staff			
Pushes Staff Away			
Refuses Care			
Refuses to Move			
Stiffens when being moved or touched			
Refuses to speak			

Symptoms:	I	D	S
Non-Sociable Behavior			
Refusing to Attend Activities			
Self-Imposing Isolation			
Refuses to Communicate in Social Situations			
Refuses to Eat in Dining Room			
Refuses to attend Outings			

Symptoms:	I	D	S
Other			
Sleeping Problems			
Difficulty Breathing			
Vital Sign Changes			
Perspires Heavily			
Decreased Eating			

Is individual receiving nutritional feedings via a G/J tube? ☐ No ☐ Yes

17

RESOURCES

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 17-1 Contacts
Policy Source MAP Policy Manual
Issued Date: 1/01/05

Last Revision Date: 10/01/13

The following are central state agency and other contacts for MAP.

State agency contact information is also available on agency websites through the Massachusetts portal at: www.mass.gov

Department of Public Health (DPH):

**Drug Control Program
Department of Public Health
99 Chauncy Street
Boston, MA 02111
Phone: (617) 983-6700
Fax: (617) 753-8046
MOR Hotline: (617) 983-6782
www.mass.gov/dph/dcp**

Department of Public Health (DPH):

**DPH Clinical Reviewer
Department of Public Health
99 Chauncy Street
Boston, MA 02111
Phone: (617) 753-7315
Fax: (617) 753-8046
www.mass.gov/dph/dcp**

Department of Mental Health (DMH):

**Statewide MAP Director
Department of Mental Health
25 Staniford Street
Boston, MA 02114
Phone: (617) 626-8070
Fax: (617) 626-8077
www.mass.gov/dmh**

Department of Developmental Services (DDS):

**Director of Health Services
Department of Developmental Services
500 Harrison Avenue
Boston, MA 02118
Phone: (617) 624-7792
Fax: (617) 624-7577
www.mass.gov/dds**

CLIA

**Clinical Laboratory Program
99 Chauncy Street
Boston, MA 02111
Phone: (617) 753-8438
Fax: (617)-753-8240
www.mass.gov/dph/clp**

Board of Registration in Medicine

**200 Harvard Mill Square, Suite 330
Wakefield, MA 01880
Phone: (781) 876-8200
Fax: (781) 876-8383
Consumer Hotline: (800) 377-0550
www.mass.gov/massmedboard**

Board of Registration in Nursing:

**239 Causeway Street, Suite 500, 5th Floor
Boston, Massachusetts 02114
Phone: (800)-414-0168 or (617)-973-0900
Fax: (617)-973-0984
www.mass.gov/dph/boards/rn**

Board of Registration in Pharmacy:

**239 Causeway Street, Suite 500, 5th Floor
Boston, MA 02114
Phone: (800) 414-0168
Fax: (617) 973-0983
Complaint Questions: (617) 973-0865
www.mass.gov/dph/boards/pharmacy**

Division of Health Professions Licensure

239 Causeway Street, Suite 500, 5th Floor
Boston, MA 02114
Phone: (800) 414-0168
www.mass.gov/dph/boards

D &S Diversified Technologies, LLP dba HEADMASTER, LLP (D&SDT):

333 Oakland Ave.
PO Box 418
Findlay, OH 45840
Toll Free: 1-(877)-851-2355
Fax: (419)-422-7395
Email: hdmastereast@hdmaster.com
www.hdmaster.com

Department of Children and Families

600 Washington Street
Boston, MA 02111
Phone: (617) 748-2000
<http://www.mass.gov/dcf>

Caring Together Website

<http://www.mass.gov/eohhs/gov/commissions-and-initiatives/caring-together/>

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 17-2 MAP Advisory Group

Policy Source MAP Policy Manual

Issued Date: 1/01/05

Last Revision Date: 10/01/13

- 1 Purpose: The Medication Administration Program Advisory Group advises the Departments of Public Health, Mental Health, Department of Children and Families, and Developmental Services on policy development for MAP.
- 2 Membership: The Advisory Group is comprised of representatives of state agencies, legislators, Service Providers, professional organizations, bargaining units, and other interested parties. Membership is open to anyone with an interest in MAP.
- 3 Meetings: Advisory Group meetings provide a forum for exchange of information, discussion of policy issues, development of recommendations for program improvement and review of policies. Drafts of policies and other documents are routinely circulated among members, at meetings and through mailings, to solicit comments prior to finalization and general dissemination.
- 4 Schedule of meetings: The Advisory Group meets as needed to address emerging policy issues in MAP. Announcements of meetings are sent to all members. Attendance at meetings is voluntary and is not necessary to obtain information or provide comments on MAP. Requests for information and offers of feedback and input are always welcome.
- 5 Contacts: For further information on the Advisory Group or to request to be added to the membership list, please contact the DPH MAP Clinical Reviewer. For general questions or comments on MAP, please get in touch with any of the appropriate designated personnel. To find these contacts please see *Policy No. 17-1 on page 193*.

MEDICATION ADMINISTRATION PROGRAM POLICY MANUAL

Policy No. & Issue 17-3 Publications
Policy Source MAP Policy Manual
Issued Date: 1/01/05

Last Revision Date: 9/01/10

The following MAP publications are available through the sources listed:

Publication:

Map Policy Manual

MAP Curriculum (MAP Training Manual)

The Medication Administration Program: An Introduction

Technical Assistance Tool

Source¹:

Area and Regional MAP Coordinators; State agency contacts; DPH/DCP Website

Area and Regional MAP Coordinators

Area and Regional MAP Coordinators; DPH/DCP Website

Area and Regional MAP Coordinators

¹ State Agency websites may be accessed through the Massachusetts portal at [www.mass.gov] (SEE POLICY NO. 17-1 ON PAGE 191)