

POLICY AND PROCEDURE ON HEALTH SERVICE COORDINATION

I. PURPOSE

The purpose of this policy is to promote the health and safety of persons served through establishing guidelines for the coordination and care of health-related services.

II. POLICY

This company is designated as a residential program and will implement procedures to ensure the continuity of care regarding health-related service needs as assigned in the *Support Plan (SP)* and/or *Support Plan Addendum*. These procedures will be implemented in a way that is consistent with the specific health needs of the person served and which follows the procedures stated in the *Policy and Procedure on Safe Medication Assistance and Administration*.

Decision making regarding the health services needs of the person served will be guided by person-centered philosophy and conservative medical practice. The company will defer to the judgment of the assigned nurse, nurse consultant, or other licensed health care professional regarding medical or health-related concerns. If the company does not have an assigned nurse or nurse consultant, the company will coordinate all health-related services with the licensed health care professionals of the persons served.

III. PROCEDURE

- A. If responsibility for meeting the person's health service needs has been assigned to the company in the *Support Plan (SP)* and/or *Support Plan Addendum*., the company must maintain documentation on how the person's health needs will be met, including a description of the procedures the company will follow in order to:
1. Provide medication setup, assistance, or administration according to MN Statutes, chapter 245D.
 2. Monitor health conditions according to written instructions from a licensed health care professional.
 3. Assist with or coordinate medical, dental, and other health service appointments.
 4. Use medical equipment, devices, or adaptive aides or technology safely and correctly according to written instructions from a licensed health care professional.
- A. Unless directed otherwise in the *Support Plan (SP)* and/or *Support Plan Addendum*., the company will ensure the prompt notification to the legal representative, if any, and the case manager of any changes to the person's mental and physical health needs that may affect the health service needs assigned to the company in the *Support Plan (SP)* and/or *Support Plan Addendum*. This notice will be made, and the date documented, when the change in mental and physical health needs of the person has been discovered by the company, unless the company has reason to know that the change has already been reported. . A copy of the Health/Medication Needs Change Report is to be used and is attached to this policy. (See Attachment A)
- B. In coordination with the person's health care providers, the company and person's legal representative will determine how each person's health condition(s) will be monitored.
- C. When a person served requires the use of medical equipment, devices, or adaptive aides or technology, the company will ensure the safe and correct use of the item and that staff are trained accordingly on its use and assistance to the person. These items will only be used according to the written instructions from a licensed health care professional.
- F. When a person served requires the use of medical equipment to sustain life or to monitor a medical condition that could become life-threatening without proper use of the medical equipment, staff will be specifically trained by a licensed health care professional or a manufacturer's representative including an observed skill assessment to demonstrate staff's ability to safely and correctly operate the equipment according to the treatment orders and manufacturer's instructions. Equipment includes, but is not limited to ventilators, feeding tubes, and endotracheal tubes.



Health/Medication Needs Change Notice

(Attachment A)

Marshall County Group Homes, Inc. must report any changes in the person's physical/Mental health needs and Medication/Treatment needs when assigned in the support plan or support plan addendum.

Consumer's Name(print): _____ Program: _____

Change in Mental/Physical Health (mark and document all that apply)

____ Mental Health

Document Change: _____

____ Physical Health

Document Change: _____

Change in Medication/Treatment (mark and document all that apply)

____ Medication

Name of Medication _____ Dosage: _____

Directions for Dosage: _____

Start Date: _____ End Date (if applicable): _____

Physician Signature (if applicable): _____ Date: _____

**If the physician signature is not obtained, please fill in the information below:
(Nursing to complete form if not completed by physician)**

Name/Title of person completing form (print): _____

How you obtained notification of change and documentation provided:

Nurse Signature: _____ Date: _____

Legal Representative Signature: _____ Date: _____

Case Manager: _____ Date notified: _____

Copy of form sent: ____ Email ____ Fax ____ Mail