

POLICY:

It is the policy of this agency to provide monitoring of the health status of individuals, maintain accurate records, and provide supports necessary for individuals to receive care promoting their health and well being.

PROCEDURE:

Documentation:

The program shall maintain records on each individual to aid physicians, medical professionals, and the program in understanding the individual's medical history and current treatment plan. Such documentation shall include a medical history, current medical conditions, and current, signed orders for all medications, treatments, therapies, special diets, adaptive equipment, and prosthetic devices.

All individual medical records shall be kept confidential, current, and organized in a manner that permits staff and medical persons to follow easily the individual's course of treatment.

A segregated, locked file shall be maintained for any individual's HIV information upon his/her request.

Individuals shall have a primary physician and provisions for a secondary physician or clinic in the event of an emergency.

Individuals shall be examined no less often than every two years. All visits to medical professionals shall be documented on a Physician Visit/Order form and filed in the individual's medical record.

Physician Telephone Order forms shall be used to document changes in existing orders made by the physician over the telephone. The completed form shall be sent to the physician for his/her signature. A copy of the completed form shall be retained to transcribe the order and this shall be matched to and filed with the signed copy upon return from the physician.

Individuals shall not have PRN orders for psychotropic medications.

Individuals shall have their health status monitored and timely action shall be taken in response to identified changes that could lead to deterioration or harm.

Medical Progress Notes shall be utilized to document all medical or medically related events and to follow medical issues to resolution.

A communication log shall be utilized in each residence to facilitate information exchange between staff and shall be retained for 30 days.

Individuals shall be assisted with ordered therapies and the use and maintenance of adaptive/prosthetic devices as needed.

The ISP shall contain an overview of the individual's medical history, current medical conditions, therapies, and any additional documentation identified to aid physicians, medical professionals, and the program in understanding the individual's medical history and current treatment plan.

Approved by: _____ Date: _____
Jon Cooper, Director