A. Preventable Health Services
    a. All applicable regulatory guidelines shall be adhered to on behalf of all Individuals to promote health and safety, including, but not limited to the following:
        i. Initial and annual physical examinations
        ii. Tuberculosis screening
        iii. Dental hygiene and treatment
        iv. Routine screenings, laboratory examinations and special studies as necessary
        v. Immunizations
        vi. Other health evaluations and care as recommended by physicians or other health care professionals
        vii.
    b. Reportable Diseases

        All Individuals diagnosed with a disease found on the PA Department of Health List of Reportable Diseases, shall be reported in EIM per Office of Developmental Programs (ODP) guidelines. See incident management guidelines for further guidance on reportable diseases.

B. Food Storage

a. All opened jars shall be refrigerated unless clearly marked nonperishable.
b. Food should not be refrigerated in aluminum cans but shall be transferred to a plastic container or pitcher.
c. All leftover food and drink items in the refrigerator must be covered, labeled, and dated.
d. Any uneaten food or drink already served to an Individual or Team Member shall be discarded.
e. Unserved leftovers shall be discarded after four days.
f. The refrigerator should be kept clean of spills and other debris. Each refrigerator must have a thermometer and the temperature shall be maintained at approximately 40 degrees Fahrenheit at all times. This shall be monitored at least monthly.
g. Foods must be thawed in refrigerator or microwave, not on counter top. Thawed meat or vegetables may not be returned to the freezer.
h. Stock foods shall be kept in an acceptable food storage location, free from weather fluctuations, chemicals and areas where insects and/or rodents may gain access. Newly purchased cans and boxes should be placed behind cans and boxes already on the shelf to avoid expiration of previously purchased items.
i. Cutting boards used in food preparation shall be disinfected after use.
j. All items stored in the freezer shall be properly sealed and kept at or below zero degrees Fahrenheit. There shall be a thermometer in each freezer, and shall be monitored at least monthly. Frozen raw meat should not be stored in the freezer longer than 6 months.
k. Raw meat shall be stored in the refrigerator no more than three consecutive days or longer than the date specified on packaging at time of purchase.

C. Team Member Health Training
   a. Team Members shall be trained in:
      i. Detecting signs of illness that warrant medical or nursing intervention,
      ii. Basic skills required to meet the health needs of the Individuals including personal hygiene practices and health maintenance.
      iii. First aid for accidents and illness, including CPR, First Aid, AED, Epi Pen and emergency response to choking.
      iv. Standard Precautions according to OSHA guidelines including disease prevention.
      v. Hepatitis and HIV/AIDS information.
   b. A responsible Team Member shall be on duty at all times who is immediately available to the Individuals to take reports or inquiries, symptoms of illness and emergencies.
   c. Training for all Team Members shall include:
      i. Regular training on health issues
      ii. Information of the risk of contracting Hepatitis B and the opportunity to receive the vaccine.
      iii. Prior to administering medication, Team Members must meet the requirements of The Pennsylvania Department of Human Services Medication Administration Training.
         1. Any Team Member who fails the Medication Training test has one opportunity, after remediation, to re-take the entire test.
         2. A Team Member who fails the test a second time, may be eligible to re-take the entire course, if recommended by the Program Manager who is monitoring his/her performance.
   d. Health and Hygiene
      i. Individuals requiring increased supervision shall have plans and/or Team Member support which are based on observed needs for improved personal hygiene.
      ii. An Infection Control Manual is available at each program that includes instruction on:
         1. Standard Precautions
         2. Hand washing and use of hand cleansing products
         3. Handling of potentially infectious materials

D. Procedure for Transfer to a Hospital
   a. Emergency Conditions
      i. Criteria for calling 911 (see also 911 Health Alert issued by ODP, location in First Aid Manual):
         1. A fast heart rate (more than 120-150 beats/minute) at rest, especially if associated with shortness of breath or feeling faint.
         2. Allergic reaction, especially if there is any difficulty breathing (anaphylactic shock)
         3. Bleeding from any wound **that won't stop**
         4. Bleeding from the mouth, nose, vagina or rectum **that won't stop**
         5. Broken bones visible through an open wound, or a broken limb.
         6. Chest or upper abdominal pain or pressure lasting two minutes or more
         7. Choking
         8. Confusion or sudden changes in mental status, unusual behavior, difficulty waking
         9. Coughing or vomiting blood
         10. Difficulty breathing, shortness of breath
         11. Drowning
         12. Drug overdose **or** poisoning (Call the Poison Center at 1-800-222-1222)
         13. **Extremely** hot or cold skin/body temperature
         14. Fainting, sudden dizziness, weakness
         15. Fall **with suspected injury and/or inability to assist Individual up from a fall**
         16. Motor vehicle accident with suspected **injury**
         17. Neck or back **injury**
         18. Severe headache
         19. Numbness, or weakness of any part of the body
         20. Seizures **that are new or uncontrolled**
         21. Severe burns
         22. **Severe or persistent** vomiting or diarrhea
         23. Severe or sudden pain
         24. Someone is unresponsive or unconscious
         25. Speech changes including slurred speech or difficulty speaking
         26. Sudden blindness or vision changes
         27. Suicidal or homicidal feelings or statements
         28. Unusual abdominal pain
      ii. Dial 911 for transport to hospital of choice as specified in the Individual's record.
      iii. Notify the DAP to inform them of the emergency and arrange for staffing. (Be sure that a med trained Team Member will be available to administer medications at the next med times).
      iv. Attend to Individual until ambulance arrives.
      v. Get Transfer Packet (Located in Med Book or special folder. If emergency

occurs within the community, the transfer packet will need to be brought from the program they are attending at the time of the medical emergency). This includes medical information as well as all medical cards. Medical cards should stay with the accompanying Team Member. Do not give to ambulance personnel. After copies are made at hospital, Team Members are responsible to return the cards to Transfer Packet.

vi. Individual's medication list and/or contents of Transfer Packet may be copied for ambulance personnel. Be prepared to answer the following questions:
    1. Name and age of Individual
    2. Time event occurred
    3. Signs and symptoms
    4. Changes leading up to the emergency
    5. Past medical history
    6. Allergies and current medications
    7. Diagnoses listed in the Transfer Packet
    8. Last food/liquid intake
    9. Last medication time, including names and doses of medications
    10. Name of Primary Care Physician
    11. Name of emergency contact
    12. Most recent weight
    13. Most recent bowel movement

vii. Whenever possible, a med trained Team Member should accompany the Individual to the hospital.

viii. The Team Member accompanying the Individual will stay with them until they are relieved by another Team Member, the Individual is admitted for inpatient care or the Individual is discharged from the Emergency Department.

ix. If the Individual is admitted to the hospital, they are now under the care of hospital staff. Friendship Community Team Members will maintain communication with hospital personnel during the hospital stay, but shall not provide care while Individual is in the care of hospital or other medical facility.

x. As soon as possible, DAP will contact the Program Manager and/or Program Coordinator. If applicable, contact the Nursing Team. The family will be contacted by the Program Coordinator or designee.

xi. Appropriate reporting form, as applicable, shall be completed for submission to the Point Person (Program Manager, Program Coordinator or DAP).

xii. The accompanying Team Member shall record a case note concerning the incident. The case note should include the following:
    1. Date and time of incident
    2. Location of incident (i.e., bedroom, bathroom, etc.)
    3. Condition that required attention
    4. List persons called and who called them
    5. Treatment given by Team Member and/or by emergency or

hospital personnel (i.e., oxygen, sutures, x-rays, diagnostic tests, intravenous lines, etc.)
6. If admitted, note the name of the hospital and room number
7. Write a brief note in the Team Member communication book.

b. Urgent, Non-Emergency Health Threatening Conditions
   i. Notify the DAP who may contact a nursing Team Member or Program Manager to determine whether physician should be called.
      1. Team Member shall call Individual's primary care physician if indicated by the DAP.
      2. If ambulance is required, after consultation with physician and DAP, Team Member will dial 911 for transport to hospital.
      3. Whenever possible, a med trained Team Member should accompany the Individual to the hospital. The Team Member accompanying the Individual shall stay with them until they are relieved by another Team Member or the Individual is discharged from the Emergency Department.
   ii. Get Transfer Packet (Located in Med Book or special folder. If emergency occurs during an outing, the transfer packet will need to be brought from the house). This includes medical information as well as all medical cards. Medical cards should stay with the accompanying Team Member. Do not give to ambulance personnel. After copies are made at hospital, Team Members are responsible to return the cards to Transfer Packet.
   iii. The DAP will give verbal report to:
      1. Program Manager and/or Coordinator who will then contact appropriate Team Members.
      2. Nursing Team Members as applicable.
   iv. Appropriate reporting form, as applicable, will be completed for submission to the Point Person (Program Manager, Program Coordinator or DAP).
   v. Accompanying Team Member will record a case note which includes the following:
      1. Date and time of incident
      2. Location of incident (bedroom, bathroom, etc.)
      3. Condition that required attention
      4. List persons called and who called them (911, DAP etc.)
      5. Treatment given by Team Member and/or by emergency or hospital personnel (i.e., oxygen, sutures, x-rays, diagnostic tests, intravenous lines, etc.)
      6. If admitted, note the name of the hospital and room number
      7. Write a brief note in the Team Member communication book.

E. Policy for Hospital Discharge of a Friendship Community Individual

a. Friendship Community serves many Individuals in a variety of settings. The organization is staffed primarily with unlicensed caregivers and does not operate as a medical care facility.

b. Friendship Community's goal is to provide person-centered services and supports designed to meet the range of needs which Adults with Intellectual Disabilities and Autism present. Currently, this range extends from those who need minimal assistance in life activities to those who have multiple physical and developmental challenges. Friendship Community seeks to comply with all applicable government regulations. We also strive to work cooperatively with government organizations in the provision of quality services to people with Intellectual Disabilities and Autism.

c. Friendship Community Team Members are trained to administer oral medications using the PA Department of Human Services Medication Administration Training Program. Team Members have also been trained to provide care for minor illnesses and treatments such as topical applications, eye and ear drops and other strictly limited, specified treatments.

d. In the best interest of our Individuals' continuity of care upon discharge, it is helpful to keep in mind that Friendship Community does not have:

i. 24-hour nursing coverage

ii. Team Members who are trained in the use of specialized equipment

iii. The ability to add specialty Team Members for special circumstances and therefore, we may be unable to work with the following health conditions:

1. 24- hour feeding pumps
2. Overnight nutrition administered by way of medical devices
3. Administering, flushing or monitoring IV therapy
4. Wound VAC
5. Suctioning of any kind
6. Tracheotomies
7. Mechanical ventilation

e. Consideration may be granted for the following health conditions if, after consultation in the hospital two business days prior to discharge, the Friendship Community team, determines that team training and support is possible to adequately care for the Individual:

1. Oxygen administration
2. Ostomies- (Ileostomies or Colostomies)
3. Certain types of feeding tubes
4. Indwelling catheters
5. Palliative care (end of life) including administration of narcotics
6. Advanced stages of Dementia/Alzheimer's disease
7. Injections (Long term) with exception of insulin pens
8. Insulin administration (via insulin pen)- requires the Individual and Team Members receive training from a certified Diabetes Educator before instituting this in the home. Team Members are not trained in the administration of sliding scale insulin.
9. Behavioral Health managed by PRN chemical restraint or continuing pervasive self-injurious or aggressive behavior. (Prior to discharge, hospital consultation must also include the Friendship Community Behavior Support Professional.)

f. These lists are not all inclusive. Because we are not a medical facility and do not have 24-hour nursing coverage, transfer from other institutions must be carefully coordinated to ensure adequate support for all Individual needs post-discharge.
g. Discharges shall be facilitated following a discharge planning team meeting, including hospital/rehabilitation facility staff, Program Manager, Program Coordinator and Nursing Consultant, at a minimum.
h. Discharge Order Requirements:
    i. Regulatory guidelines require prescriptions for medications, including OTC (over-the-counter), indicating medication name, dosage, route, frequency, and diagnosis for which the medication is prescribed.
    ii. A prescription is also required for all treatments and therapies.
    iii. DME (Durable Medical Equipment) assistive devices and medical equipment ordered for use in the home shall be on hand for discharge with instructions/training for use.
    iv. New treatments need to have been managed successfully during the hospital stay before being included in discharge orders.

F. Lifetime Medical History Summary

a. The purpose of this policy is to establish the need for Lifetime Medical History Summaries and to provide procedures for their creation and maintenance.
b. Each Individual shall have a Lifetime Medical History Summary compiled as part of the initial assessment and annually thereafter. The information contained in the Summary is intended to aid Team Members in understanding the Individual's medical history and for medical professionals in their treatment of the Individuals.
c. Guidelines
    i. The confidential Lifetime Medical History Summary provides a comprehensive historical medical overview of the person. Documentation of past medical/dental information including emergency room treatment/hospitalizations, psychological/social well-being, functional abilities and previous living arrangements are all integral parts of the document and shall include all other components as specified in regulatory guidelines, as applicable.
    ii. The Lifetime Medical History Summary shall be constructed from relevant past and present documentation by a trained medical professional, such as a nurse, a nurse practitioner or a physician.
        1. Non-medical Team Members may construct the history as long as the document is reviewed by a medical professional for accuracy and content, signed and dated prior to use.
    iii. The current Lifetime Medical History Summary shall be kept with the Transfer Packet in the event that emergency medical services are needed.
    iv. The current Lifetime Medical History Summary shall be made available to the Individual's Primary Care Physician (PCP), specialists and other related professionals.
    v. The Lifetime Medical History Summary shall be updated as needed and re-typed at least every three years, generally in conjunction with the Individual's annual physical exam date.

G. Substitute Health Care Decision Making
   a. Purpose
      i. Act 28 of Pennsylvania code establishes standards of care that must be provided to Individuals residing in licensed facilities and provides criminal and civil penalties in instances when those standards are not met. Act 28 covers all programs operated by Friendship Community.
      ii. ID Bulletin #00-98-08, issued by the Office of Mental Retardation (Term since changed to Intellectual Disabilities and Autism) on November 30, 1998, provides guidance on this issue. It also establishes that Individuals with developmental disabilities have the same right to medical treatment as do others in the community. This bulletin outlines policy that is intended to protect and safeguard those rights while at the same time allowing people to die with dignity when that time arises.
      iii. Much of this policy is modeled after ID Bulletin #00-98-08.
   b. Definitions
      i. Incompetent - The lack of sufficient capacity for a person to make or communicate decisions concerning him/herself. Even when an Individual has not been adjudicated incapacitated or incompetent, he/she may still be incompetent to make a particular health care decision. An Individual who is determined to be incapacitated or incompetent by a physician at any given point in time may have the capacity to make a decision at a later date, if there has been no court adjudication of incompetence. Only a court may modify or reverse determinations of incompetence or competence based on assessments from medical care providers only.
      ii. Do Not Resuscitate (DNR) Order - An order in the Individual's medical record that Cardiopulmonary Resuscitation (CPR) or other specified life sustaining measures or treatments should not be provided to the Individual.
      iii. Next of Kin - A close family member, as outlined on the Individual's Substitute Health Care Decision Making document.
      iv. Permanently Unconscious - A medical condition that has been diagnosed in accordance with currently accepted medical standards and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction with the environment. The term includes, without limitation, a persistent vegetative state or irreversible coma.
      v. Terminal Condition - An incurable or irreversible medical condition in an advanced state caused by injury, disease or physical illness which shall, in the opinion of the attending physician, to a reasonable degree of medical certainty, result in death regardless of the continued application of life sustaining treatment.
   c. Incompetent/Incapacitated
      i. Standards against which competence is measured include 1) the Individual's ability to manage finances, and 2) the Individual's ability to make decisions about daily living. In general, if a person with Intellectual Disability and/or Autism is living in a facility or in the community where

he/she requires services to help manage daily activities and financial affairs, he/she may not be considered competent.

1. An Individual who is incompetent/incapacitated cannot execute an Advance Directive for Health Care.
2. If an Individual is not competent to make a particular health care or end of life decision, another person must make that decision on the Individual's behalf. An Individual does not need to be adjudicated incompetent or incapacitated to lack competence to make a particular decision. Consent is implied in law for emergencies and there is no need to seek a substitute decision maker before providing emergency medical treatment.
3. A physician has the authority to determine whether or not an Individual is competent to make a particular health care or end of life decision in the absence of a court determination.

d. Substitute Decision Makers
    i. Responsibilities of Substitute Decision Makers
        1. To assure that Individuals with disabilities receive all appropriate medical care that non-disabled Individuals would receive, including end of life services.
        2. To place high value on preserving life of the Individual
        3. To attempt to make the same decision the Individual would be likely make for himself/herself
        4. To provide accommodations that allow the Individual to participate in all decisions which affect them to the extent of their ability to do so.
        5. To give consideration to all available information and input from other interested and involved parties.
        6. To make a decision that embodies a consensus of all interested/involved parties.
        7. Substitute decision makers are not required to authorize provision of treatment that is medically futile. A decision about futility of treatment should not be prejudiced by the nature of the Individual's disability or the notions of others about the Individual's perceived quality of life.

e. Choosing a Substitute Decision Maker
    i. Ideally, a substitute decision maker should be appointed prior to a medical need. This issue shall be discussed at annual planning meetings with family and/or Support Team involvement. The Individual shall give input regarding whom they desire to serve in this capacity. A clear understanding between Friendship Community, the Individual and the Individual's family or Substitute Health Care Decision Maker shall be established. The person who shall serve as the Substitute Health Care Decision Maker shall be clearly stated in the annual Individual Support Plan (ISP) and supporting documentation. This shall be reviewed annually and updated as necessary.

ii. If no family is available or willing to serve in this capacity, a Substitute Health Care Decision Maker should be chosen in the following order:
    1. A health care proxy (agent) or attorney in fact for health care decisions. If the Individual, while competent, has designated a person to make health care decisions on the Individual's behalf, that person the Individual chose should make health care decisions for the Individual.
    2. A guardian of the Individual's person. If a court has already appointed a person to make decisions on the Individual's behalf in accordance with Pennsylvania's guardianship statute, that person shall make health care decisions on the Individual's behalf. When there is intractable conflict between interested parties with respect to a particular health care or end of life decision, it is advisable to request a court to appoint a guardian. Medical treatment to preserve life should be provided until the conflict can be resolved.
    3. Next of kin: If no one has been designated by a court or by the Individual, the following next of kin in order of priority and as available and willing, should make health care decisions for the Individual (i.e. the spouse, an adult son or daughter, either parent, or an adult brother or sister).
    4. The facility director: In the absence of any other appointed decision maker or willing next of kin, the facility director becomes the decision maker pursuant to the Mental Health and Mental Retardation Act of 1966 (MH/ID Act). The facility director must act under the following guidelines
        a. The director must review the Individual's annual plan (ISP) and all relevant medical records, including the Lifetime Medical History.
        b. The facility director may authorize treatment only with the written agreement of two physicians not employed by the facility.
        c. The facility director must be informed of the Individual Support Team's consensus regarding the decision to be made.
        d. Even where another substitute decision maker is identified, the facility director shall continue to monitor the situation to ensure that the law is followed and that decisions are made with the best interest(s) of the Individual as the paramount concern.

iii. Substitute Health Care Decision Maker Limitations. There are limits on the authority of Substitute Health Care Decision Maker.

iv. Because Friendship Community is an Act 28 facility, treatment, care, goods and services may not be withheld in the absence of authorization from a Substitute Health Care Decision Maker.

v. No Substitute Health Care Decision Maker may execute an Advance Directive or name a health care proxy on behalf of an incompetent Individual.
vi. No Substitute Health Care Decision Maker may authorize a DNR Order or otherwise withhold life-sustaining care unless the Individual has a terminal condition or is permanently unconscious.
vii. Substitute Health Care Decision Makers may withhold treatment that would only extend the process of dying. Palliative care that may have the unintended effect of hastening the death of an Individual with a terminal condition may be allowed.
viii. A Substitute Health Care Decision Maker may authorize termination of life-sustaining treatment for an Individual who has a terminal condition or is permanently unconscious without a court order, providing the Individual's condition has been confirmed in writing by two physicians.

f. Advance Directives, DNRs and Terminal Conditions
   i. Advance Directives
      1. In most cases, people with Intellectual Disabilities would not be appropriate candidates for an Advance Directive.
      2. Friendship Community shall not accept an Advance Directive written on behalf of an Individual with Intellectual Disabilities. Pennsylvania's Advance Directive statute does not allow anyone to write an Advance Directive for anyone else.
      3. There is no law that requires people to have Advance Directives.
   ii. Do Not Resuscitate (DNR) Orders
      1. A DNR order can be written only by a physician and only when the attending physician certifies in writing that the person has a terminal condition or is permanently unconscious. The terminal condition or permanent unconsciousness must be confirmed by a second physician.
      2. A DNR order is related to the terminal illness. Other things may happen such as choking, short-term illness, and other injuries that are not related to the terminal illness and should be treated.
      3. CPR is not provided for a person who has a valid DNR order on file.
      4. Severe physical deformities, chronic conditions such as Alzheimer's, and/or other disease conditions such as cancer are not justifiable reasons for initiating a DNR order unless the person has been diagnosed as either end-stage terminal condition or permanently unconscious.
   iii. Terminal Condition
      1. In medicine, a terminal condition is one which has no cure, no hope of recovery, and death is likely to occur within six months or less. This is also the time frame used by organizations who provide palliative care (i.e. Hospice).
      2. The diagnosis of a terminal condition must be certified in writing by the attending physician and confirmed by a second physician.

Neither of these two physicians can be employed by the organization, nor be a family member of the Individual.

3. If an Individual is diagnosed with a terminal condition, support shall be given to Team Members as well as other Individuals. Hospice is a resource that is generally utilized for end of life situations.