MINUTES FROM NDP MAS NURSE/MATT RN QUARTERLY MEETING

Thursday, February 17, 2022

Per Carter English, AL Pharmacy Director-

- AL Medicaid Alert: COVID-19 OTC and "At-Home" Tests for Pharmacy Billing (See attachment)

Per Beverly Jackson, NDP Coordinator:

- MAS Nurse Manual progression is going well. NDP Advisory Committee is meeting weekly.

- ABN MAC Challenges vs MACE Program. MAC Training is specific to agency where trained. Does not transfer to MACE Program.

- Form Changes/Revisions. Revised Forms will be uploaded to NDP Website -
  - **NDP Form 1 DD Certification Form:**
    - Mirrors ADMH Operational Guidelines/ Factor 5 – Best Possible Health
  - **NDP Form 2 Delegation Form:**
    - Box for "Date Delegation Started" added to page 1
    - Verified competency of MAC Worker for MAS Nurse Supervision added to page 2
  - **NDP Form 5 Self-Medication Assessment Form:**
    - Added Self-Medication to title of form
    - Goals added to Nurse's Notes section at bottom of form
  - **NDP Form 8 MAS RN Assessment Form**
    - Added O2 Sat and FSBS (if applicable) to Vital Signs Section
    - Added Fall Assessment Completed under AIMS Completed
    - Added Level of Nursing/Medical Care Section (page 8)
    - This form may be used as a template but if you choose to use your own Nursing Assessment, it must mirror every component of this assessment.

- Managing Stock Meds – See attached memorandum regarding OTC Stock Medications. Memorandum will be updated/revised and uploaded to the NDP Website

- MATT RN Training will be held March 29th and 30th, 2022

- See attached agenda related to Training Dates for ***Becoming An Approved Delegating Nurse (Initial Training)*** and ***MAS Nurse Update Training*** conducted by Beverly Jackson, NDP Coordinator. Training is conducted via ZOOM.

- All training conducted by Beverly Jackson require registration on the Relias' website: www.admh.academy.reliaslearning.com

Next Meeting Date: ***Thursday, May 19, 2022***

Attachments:

- Meeting Agenda
- AL Medicaid Alert: COVID-19 OTC and "At-Home" Tests for Pharmacy Billing
- NDP Form 1
- NDP Form 2
- NDP Form 5
- NDP Form 8
- Memo related OTC Meds

HAPPY FRIDAY, EVERYONE!!!!!!!!!!!!

Angela W. Marks, RNIII, MATT RN *Date: February 18, 2022*
Regional Nurse, ADMH - Region 3

MAS/MATT MEETING AGENDA
February 17, 2022

- Welcome - sign in/Please enter your name in the chat box. This will serve as our roster.
- MAS/MATT Meeting Schedule -10am-

- What's Happening in Pharmacy
    a. Carter English, ADMH Pharmacist
- Manual update progress
- ABN MAC Challenge
- Form Changes:
    a. DD Certification form
    b. NDP 2 Delegation Form
    c. NDP 5 Self Medication Assessment
    d. NDP 8 Comprehensive Assessment
    e. ~~NDP 15 MAC Delegation Revocation Form~~
- Managing stock medications- Sheree
- MATT Training
    a. March 29 & 30
- Training Dates – MUST REGISTER ON RELIAS ZOOM
    a. Becoming a Certified Delegating Nurse (Initial Training)
        i. March 8 & 9
        ii. April 5 & 6
        iii. May 10 & 11
        iv. June 14 & 15
        v. July 12 & 13
        vi. August 6 & 7
    b. MAS UPDATE 2021
        i. Feb 22
        ii. March 15
        iii. April 19
        iv. May 3
        v. June 2
        vi. July 14
        vii. August 16
- **Next MAS/MATT meeting**
    a. MAY 20 add to your calendar –
- How do I register for training?

www.admh.academy.reliaslearning.com

If you have a problem with Relias, I cannot fix it you must call them.1.800.381.2321

Alerts

COVID-19 OTC and "At-Home" Tests for Pharmacy Billing

1/20/2022

PDF Version (https://medicaid.alabama.gov/documents/1.0_ALERTS/1.0_2022/1.0_ALERT_COVID-19_OTC_At_Home_Tests_Pharmacy_Billing_1-20-22.pdf)

TO: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes

RE: COVID-19 OTC and "At-Home" Tests for Pharmacy Billing

Effective January 1, 2022, Alabama Medicaid will cover FDA-authorized COVID-19 diagnostic and screening tests with "at-home" sample collection for reimbursement with no cost sharing for eligible beneficiaries. "At home" tests include FDA-authorized point of care and over-the-counter (OTC) tests.

Policy:

- Covered "at-home" test kits must be authorized by the FDA for use in both symptomatic and asymptomatic patients and allow for self-collection without medical observation.

- A prescription by a Medicaid-enrolled prescriber or the standing order by the Alabama State Health Officer, Dr. Scott Harris, is required. Please see the standing order on the ADPH website here: https://www.alabamapublichealth.gov/covid19/assets/cov-testkit-standingorder.pdf (https://www.alabamapublichealth.gov/covid19/assets/cov-testkit-standingorder.pdf).

- A maximum of 4 tests per month per eligible recipient (each kit may contain two tests for serial testing), will be covered. Maximum unit overrides will be available for medical necessity through the routine pharmacy override process (Kepro).

- Pharmacies may bill using the National Drug Codes (NDCs) provided which have been derived by using the Universal Product Code (UPC). Pharmacies may utilize the Medicaid online drug look-up tool to determine coverage and see pricing information. The online drug-look up can be found here: https://www.medicaid.alabamaservices.org/alportal/NDC%20Look%20Up/tabId/5/Default.aspx (https://www.medicaid.alabamaservices.org/alportal/NDC%20Look%20Up/tabId/5/Default.aspx).

- Reimbursement for tests are based on Medicaid policy (Section 27.2.5, Reimbursement for Covered Drugs and Services, of the Provider Billing Manual). Questions related to reimbursement rates should be directed to the AAC Vendor, Myers & Stauffer at (800) 591-1183.

Questions related to this ALERT can be addressed by calling the Alabama Medicaid Pharmacy Department at (334) 242-5050.

News (https://medicaid.alabama.gov/news.aspx)

- COVID-19 Update from Alabama Medicaid (https://medicaid.alabama.gov/news_detail.aspx?ID=13729)
- Nurse-Family Partnership Program (https://medicaid.alabama.gov/news_detail.aspx?ID=15695)
- BIRMINGHAM MEDICAID DISTRICT OFFICE TO RELOCATE DECEMBER 1, 2021 (https://medicaid.alabama.gov/news_detail.aspx?ID=15685)
- Alabama Medicaid Agency Awarded Mobile Crisis Intervention Grant (https://medicaid.alabama.gov/news_detail.aspx?ID=15626)
- Alabama Medicaid Seeks Public Comment on Home and Community-Based Settings Final Rule (https://medicaid.alabama.gov/news_detail.aspx?ID=15625)
- Governor Kay Ivey announces New Partnership for 'Reach Out and Read' Program (https://medicaid.alabama.gov/news_detail.aspx?ID=15509)
- Alabama MES Strategy Overview (https://medicaid.alabama.gov/news_detail.aspx?ID=15425)
- Annual Public Forum set for Input on Progress of Alabama Medicaid Plan First Section 1115 Demonstration Waiver (https://medicaid.alabama.gov/news_detail.aspx?ID=15422)
- Change to the Alabama Medicaid 1095-B Form Process (https://medicaid.alabama.gov/news_detail.aspx?ID=15405)
- Alabama Department of Public Health, Medicaid Agency, Attorney General Issue Warning on Scams Claiming to Offer COVID-19 Testing and Vaccines (https://medicaid.alabama.gov/news_detail.aspx?ID=14268)

ALERTs (https://medicaid.alabama.gov/alerts.aspx)

- COVID-19 Emergency Expiration Date Extended to March 31, 2022 (https://medicaid.alabama.gov/alert_detail.aspx?ID=15751)
- Fiscal Year (FY) 2023 (October 1, 2022-September 30, 2023) Patient-Centered Medical Home (PCMH) Attestation (https://medicaid.alabama.gov/alert_detail.aspx?ID=15736)
- COVID-19 Emergency Expiration Date Extended to February 28, 2022 (https://medicaid.alabama.gov/alert_detail.aspx?ID=15732)
- COVID-19 OTC and "At-Home" Tests for Pharmacy Billing (https://medicaid.alabama.gov/alert_detail.aspx?ID=15725)

- Information on Billing for Administration of COVID-19 Vaccines (for Non-Pharmacy Providers) (https://medicaid.alabama.gov/alert_detail.aspx?ID=15719)
- COVID-19 Emergency Expiration Date Extended to January 31, 2022 (https://medicaid.alabama.gov/alert_detail.aspx?ID=15705)
- Coming Soon: Upcoming Changes to CARC Code 45 (https://medicaid.alabama.gov/alert_detail.aspx?ID=15698)
- Preferred Drug List (PDL) and Pharmacy Quarterly Update (https://medicaid.alabama.gov/alert_detail.aspx?ID=15688)
- New Chatbot Feature Available to Assist Providers with Questions (https://medicaid.alabama.gov/alert_detail.aspx?ID=15687)
- COVID-19 Monoclonal Antibody Infusion (https://medicaid.alabama.gov/alert_detail.aspx?ID=15682)

Factor Five *(note: this Factor requires 100% compliance)*

Best Possible Health 580-5-30-.10 (6)	*Y/N*	**Supporting Information**
A. Individuals have supports to manage their own health care. 1. Are individuals given the opportunity to choose health care providers as desired? 2. Are individuals provided understandable information about their current and past health conditions, medications, and treatments, including the purpose, intended outcomes, side effects, or other risks and alternatives? (OG 6.3.f.A(3)) 3. Do individuals have access to all their health care records? (OG 6.3.f.A(4)) 4. Are the individual's preferences and ability to self-administer medications and treatments assessed at least annually in compliance with the Nurse Delegation Program? (OG 6.3.f.A(5)) 5. Are supports available to assist individuals with medications and treatments if necessary? (OG 6.3.f.A(6)) 6. If the individual self-administers medications, have all the following criteria been established and documented in accordance with the Nurse Delegation Program? *Probes:* Has the individual been: (OG 6.3.f.E(12)) **a.** provided information and effectively communicated understanding regarding the purpose, dosage, time, and possible side effects of the medications? **b.** instructed, and effectively communicated understanding of what to do and who to call if he/she misses a dose, takes extra medication, or experiences an adverse reaction? **c.** educated, and effectively communicated understanding, in maintenance of his/ her medication history and in recording information needed by the physician to determine medication and dosage effectiveness? (OG 6.3.f.A(3)) ***6.*** Has the individual demonstrated a competent self-administration of medication? (OG 6.3.f.E(12c)) ***7.*** Is self-medication discussed during the annual person-centered plan meetings? Are concerns addressed and documented? OG 6.3.f.E (14) 8. Does staff support self-administration of medication through periodic monitoring of administration and documentation of continued proficiency by the individual? OG 6.3.f.E (15) 9. Are individuals supported to become knowledgeable about how to access emergency medical care and to access it as needed? (OG 6.3.f.A(7))		

Best Possible Health 580-5-30-.10 (6)	*Y/N*	**Supporting Information**
B. Individuals access quality health care. 1. [If the individual began receiving services within the last year], was the individual's initial physical examination conducted by a licensed physician or CNP within 365 days prior to admission? (OG 6.3.f.B(1)) 2. Has the individual had an annual physical and have the medical needs been reviewed within 90 days prior to or at the time of the PCP? (OG 6.3.f.B(2)) 3. Are individuals assisted in obtaining preventive and routine health services, including physical examinations, immunizations, and screenings, consistent with their age and risk factors as recommended by their personal physician? (OG 6.3.f.B(3)) 4. Are preventive health care strategies/interventions contained in the Person-Centered Plan based on the individual's current health status and age implemented carried out according to the Centers for Disease Control recommendations regarding preventive/screening practices? Emphasis will be placed on age-specific screening tests. - OG6.3.f.B(3) 5. Does each individual newly admitted have a TB skin test with documented results, or written evidence that the test was completed previously, or the test is medically contraindicated? (OG 6.3.f.B(4)) 6. Does each individual have annual TB skin test as medically indicated? If the skin test yields a questionable result, does the organization follow-up with the physician? (OG 6.3.f.B(4)) 7. Are individuals who require supports for mobility provided assistance and supports to prevent skin breakdown. (OG 6.3.f.B(5)) 8. Do individuals have therapeutic and adaptive equipment that fits and is in good repair. (OG 6.3.f.B(5))		
Best Possible Health (OG 6.3.f.)	*Y/N*	**Supporting Information**
C. Health needs are addressed in a timely manner. 1. Does the organization have a process for ensuring an individual who develops a medical problem, either an emergency or acute health care change, is assessed [by a qualified health care practitioner] in a timely manner? (OG 6.3.f.C(1)) 2. Is the individual with an emergency or acute health problem provided treatment/care and monitoring in accordance with good standards of nursing or medical care to resolve the problem effectively? (OG 6.3.f.C(1)) 3. Does the organization have systems in place that ensure ongoing communication between individuals' health care support staff, and outside health care staff to promote continuity of care? (OG 6.3.f.C(2)) 4. Are actions taken to address health needs documented? (OG 6.3.f.C(3))		

5. When available, do individuals' medical records document hospital summaries that include the discharge diagnosis, current health status, follow-up instructions and any restrictions or limitations of recent hospitalizations? Does the organization document its efforts to obtain hospital summaries? (OG 6.3.f.C(4)) 6. Do individuals' records document acute health changes to provide a clear picture of the course of the illness or injury, treatment provided, and the individual's status from the time of identification through resolution? (OG 6.3.f.C(5)) 7. Are individuals' person-centered plans, including health care and supports, modified in a timely manner based upon acute health changes? (OG 6.3.f.C(6)) ***Factor** Five **(note: this Factor requires 100% compliance)***		
Best Possible Health 580-5-30-.10 (6)	Y/N	Supporting Information
D. Staff immediately recognize and respond to medical emergencies. *Probes:* 1. Do direct support staff (non-licensed medical personnel) receive training to recognize and 2. Is medical equipment ordered by a physician to respond in a potential emergency for pre- existing (known) conditions available, well maintained, clean and functional? (OG 6.3.f.D(2)) 3. Is medication ordered by a physician to respond in a potential emergency available in the appropriate dose, quantity, and form? (OG 6.3.f.D(3)) 4. Are first aid kits available and appropriately stocked for the provision of initial care for an illness or injury? (OG 6.3.f.D(4)) respond to individuals experiencing medical emergencies? (OG 6.3.f.D(1))		
Best Possible Health (OG 6.3.f.) *This indicator NA for agencies not administering meds*	Y/N	Supporting Information
E. Individuals receive medications and treatments safely and effectively. 1. Does the organization implement policies and procedures approved by their Board of Directors requiring full compliance with the Alabama Board of Nursing's Regulation 610-X- 7-.06, Alabama Department of Mental Health Residential Community Programs and the Nurse Delegation Program? (OG 6.3.f.E(1)) 2. Is the unit dose or individual prescription system used for all prescription drugs? (OG 6.3.f.E(2)) 3. Are all medications labeled and stored in accordance with criteria herein? (OG 6.3.f.E(3)) 4. Are medications, both prescription and non-prescription, administered and recorded according to valid orders and in compliance with the Alabama Board of Nursing's		

Regulation 610-X-7-.06, Alabama Department of Mental Health Residential Community Programs, and the Nurse Delegation Program. (OG 6.3.f.E(4)) 5. Are prescription medications used only by the individual for whom they are prescribed? (OG 6.3.f.E(5)) *6.* Is each prescription medication identifiable up to the point of administration? Identifiable means it is clearly labeled with the name of the individual, name of the medication, and the specific dosage. Do prescription medication labels state the expiration date? Do names of medications on labels match the Medication Administration Record. (OG 6.3.f.E(6)) 7. Are medication errors and reactions recorded and reported in accordance with the organization's written policy, the Community IPMS guidelines, and the Nurse Delegation Program? (OG 6.3.f.E(7)) 8. Does the organization document corrective action taken in response to medication errors? (OG 6.3.f.E(8)) 9. Does the organization ensure a nurse, pharmacist, or physician dispose discontinued and outdated medications promptly and safely? Is the disposal of discontinued/outdated medications witnessed and documented in accordance with policy? (OG 6.3.f.E(9)) Probes: a. Medications are stored under lock and key. b. All narcotic medications, Schedule 2, 3, 4, and 5 are stored under double lock and key. c. Medications are stored separately from non-medical items. d. Medications are stored under proper conditions of temperature, light, humidity, sanitation, and ventilation. e. Internal and external medications are clearly labeled as such and stored separately from each other. f. The organization as a system to document ongoing accountability for all prescription medication through an inventory process. 10. Does each individual administered medication receive supervision by the prescribing physician including regular evaluation of the individual's response to the medication? (OG 6.3.f.E(10))		

NDP 2
2-2022

MANDATORY FORM

DELEGATION FORM

Facility _____ MAC Worker _____

BY SIGNING THIS FORM, I ACKNOWLEDGE COMPLETION OF ALABAMA BOARD OF NURSING APPROVED MAC I AND MAC II TRAINING. I WILLINGLY ACCEPT THE RESPONSIBILITY TO ASSIST WITH MEDICATION ADMINISTRATION AND OTHER DELEGATED NURSING TASKS.

MAC Workers Signature _____ **Date** _____

Date MAC I Completed _____

DATE MAC II COMPLETED (Date Competency of Delegated Nursing Tasks Verified by MAS Nurse OR Date of completion of 8 hour of MAC II training)	**DATE DELEGATION SUSPENDED** (Note Reason for Suspension of Delegated Nursing Tasks On Back)	**DATE DELEGATION STARTS**	**DELEGATING MAS RN/LPN SIGNATURE AND DATE**

By signing this form, I acknowledge I am a MAS Nurse with current certification AND I accept/acknowledge the current MAC Certification of the person named above. I agree to provide supervision of the unlicensed assistive person (MAC Worker) named above.

NDP 2
2-2022

MANDATORY FORM

DELEGATION FORM

FACILITY _____ **MAC Worker** _____

OTHER DELEGATING NURSES:

By signing this form, I acknowledge I am a MAS Nurse with current certification. I have verified the MAC Worker noted above is competent regarding the 7 rights of med administration, med error reporting documentation on the MAR, MAC Call Log and Controlled Substance accountability procedures. I agree to provide supervision of the unlicensed assistive person (MAC Worker) named above.

THE NEW MAS NURSE MUST DOCUMENT ON THE SKILLS VERIFICATION FORM, "*COMPETENCY VERIFICATION ON (Date) BY (Name of MAS) accepted. The New MAS Nurse must sign, date and initial the skills check sheet.*

DELEGATING MAS RN/LPN SIGNATURE	DATE ALL DELEGATED NURSING TASKS VERIFIED	INTIALS

DATE	MAS RN/LPN COMMENTS/NOTES	INITIALS

SELF-MEDICATION ADMINISTRATION ASSESSMENT FORM

Location: _____ **Date of Determination:** _____

Name: _____ **Case#_:** _____

Self-Med Administration Criteria	YES	NO
1. The person can effectively verbalize understanding of the **purpose** for the medication(s)		
2. The person can effectively verbalize common possible **side effects**, including: i. What to do if dose is missed ii. What to do if extra does(s) taken iii. What to do if adverse reactions occur		
3. The person can **recognize** the medication(s)		
4. The person can perform **return demonstration/correctly verbalize** how and when meds will be self-administered including the appropriate documentation		

The MAS RN/LPN shall make one of the following determinations:		YES	NO
A	CAN self-medicate independently		
B	Can self-medicate with LIMITED assistance **(Describe limitations below)**		
C	Can self-medicate, but REFUSES to do so		
D	Other: **(Describe limitations below)**		

Assistance with medications by a MAC Worker is authorized by the MAS Nurse **(Check "Yes" here if MAC Workers will assist with med administration)**	YES	NO

NDP supports individualizing and maximizing the people served in certified ADMH programs right to independence, choice, privacy and dignity. Assessing for safe and accurate medication administration is the MAS nurse responsibility and should be completed with the expectation that the people served in ADMH certified community programs are both encouraged and allowed to maintain as much independence as possible, including the right to retain control of their medications when it can be done safely. A person with the mental and physical capacity to develop increased independence in medication administration should be supported with self-administration instruction/education/training.

SIGNATURE OF MAS RN/LPN MAKING THE DETERMINATION:

☐ MEDICATION TRAINING RECOMMENDED

MAS RN/LPN GOAL/RATIONALE/NOTES:

_____

_____

_____

Complete annually/status change

MAS RN ASSESSMENT

[The MAS RN is responsible and accountable for the completion of a comprehensive assessment and evaluation of patients' nursing care needs ABN 610-x-7-.06(3)]

□ **Initial** □ **Annual** □ **Status Change**

Person's Name					Case #/SS#
Date	Facility Name				
DOB	Gender: (✓ One) ☐ Male ☐ Female	Age	Race	Date of Admission/ Readmission (circle one)	Time of Admission (✓ One) ☐ AM ☐ PM
Transported By: ☐ Car ☐ Van ☐ Ambulance ☐ Other _____		Received From:		Accompanied By:	Relationship

MEDICAL HISTORY

Name of PCP/CRNP(s): (primary care provider)			
Phone #s:	( )		( )
Other Physicians:			
Date of Last PCP Visit:		**Date of Last Physical Exam**	
		Name of PCP performing exam	
Baseline Data	**BMI**	**WT** **HT**	**Waist Circumference**
Date of Last TB Skin Test or CXR (IF INDICATED)		**Result**	
Vital Signs	T _____ P _____ R _____ BP _____ Arm: ☐ R ☐ L	O2 SAT_____	FSBS _____ (IF APPLICABLE)
Pregnant?	☐ Yes ☐ No □ N/A	Last Menstrual Period	□ N/A
	Breast Discharge □ **Yes** □ **No** □**N/A**	**Changes in Libido** □ **Yes** □ **No** Comments:	
	Date of Last Mammogram _____ **Results**	**PSA Date** _____ **Results** _____ □ **N/A** Erectile/Ejaculatory Problems □ Yes □ No □N/A	
Allergies	☐ None ☐ Medication(s) _____ ☐ Food(s) _____ ☐ Other (Seasonal? Symptoms?) _____	□ EpiPen Required	

Pain	☐ None
	Location(s)
	Frequency ☐ Daily ☐ Daily/Intermittent ☐ Constant ☐ Other
	Intensity ____ (state # on 10 scale) ☐ Mild ☐ Distressing ☐ Severe ☐ Unbearable
	☐ No ☐ Yes *(If yes explain)*
	Pain on Admission ____

Special Treatments/Procedures/ Equipment (List all including purpose):	☐ None
Past Surgeries/Implants (list all including year and location):	☐ None
Past Psychiatric/Medical Hospitalizations (List all including year/location/reason):	☐ None

FAMILY / RELATIONSHIPS

Marital Status	Children	Parents	Siblings	Significant Others
☐ Married ☐ Single ☐ Divorced ☐ Other	☐ Yes Number: ____ ☐ No	Mother ☐ Alive ☐ Deceased Father ☐ Alive ☐ Deceased	☐ None ☐ Yes Number ____ # Alive ____ # Deceased ____	Legal Guardian ☐ Yes ☐ No Name ____ Friend(s) ☐ Yes ☐ No ☐ Other

RELIGIOUS/SPIRITUAL/CULTURAL

Religious Affiliation	☐ None
Attend Church?	☐ Yes ☐ No
Cultural/Ethnic Practices That Impact Care/Teaching (List)	☐ None

CURRENT STATUS

PHYSICAL LIMITATIONS (Muscle/Skeletal System)

☐ NONE	Site	Degree
Paralysis/paresis		
Contracture(s)		
Congenital Anomalies		
Prosthesis		
Other		

FUNCTIONAL ABILITY

AMBULATION	WEIGHT BEARING	TRANSFERS	SUPPORTIVE DEVICES
☐ Independent	☐ Full Weight	☐ Independent	☐ Elastic Hose
☐ 1 Person Assist	☐ Partial Weight	☐ 1 Person Assist	☐ Hand Rolls
☐ 2 Person Assist	☐ Non-Weight Bearing	☐ 2 Person Assist	☐ Sheepskin
☐ With Device *(name)* _____		☐ Total Dependence	☐ Other *(list)* _____
☐ WC only			_____
☐ WC Propels Self			_____

GENERAL SKIN CONDITION: *(Check all that apply)*

	SITE		SITE
☐ Dry		☐ Oily	
☐ Edematous		☐ Cyanotic	
☐ Pale		☐ Warm	
☐ Moist		☐ Cold	
☐ Reddened		☐ Jaundiced	
☐ Ashen		☐ Other	

Hearing	R	L	Vision	R	L	Speech	
☐ Adequate			☐ Adequate			☐ Clear	
☐ Poor			☐ Poor			☐ Aphasic	
☐ Deaf			☐ Blind			☐ Other	
☐ Hearing Aid			☐ Glasses/Contacts			Language:	

Oral	Eating/Nutrition	Sleep	Bathing/ Grooming	Indep	Assist	Dep
☐ Own Teeth *(Note condition)* **DENTURES** ☐ Partial ☐ Full ☐ Upper ☐ Lower **Fit** ☐ Yes ☐ No	☐ Independent ☐ Needs Assist ☐ Dysphasic (reason) _____ ☐ Adaptive Equipment *(type)* _____ ☐ Diet (Consistency/limitations)	Usual Bedtime _____ Usual Arising Time _____ **Nap** ☐ Yes ☐ No Frequency/ Length	☐ Tub	☐	☐	☐
			☐ Shower	☐	☐	☐
			☐ Bed Bath	☐	☐	☐
			Oral Hygiene	☐	☐	☐
			Shave	☐	☐	☐
			Shampoo	☐	☐	☐
			Grooming	☐	☐	☐
			Dressing	☐	☐	☐

BOWEL AND BLADDER EVALUATION (GENTIAL/URINARY)

Bowel Continent Other:		Bladder Continent Other:		Frequent Constipation	
☐ Y	☐ N	☐ Y	☐ N	☐ Y	☐ N
How managed?		How managed?		How managed?	

PERSONAL/FAMILY HISTORY

- Diabetes (Endocrine): ☐ No ☐ Self ☐ Family
- Cardiovascular Disease: ☐ No ☐ Self ☐ Family
  - ☐ Heart Attack ☐ Stroke ☐ Other _____
- High Cholesterol: ☐ No ☐ Self ☐ Family

PSYCHOSOCIAL FUNCTIONING

Oriented	☐Y ☐N	☐Person ☐Place ☐Time ☐Situation ☐Facility		
General Appearance	☐Dressed/groomed appropriately for age/sex/situation ☐Disheveled ☐Pale ☐Emaciated ☐Sad ☐Happy			
Level of Consciousness/ Behavior	☐ Alert ☐ Lethargic ☐ Expressionless ☐ Cooperative ☐ Rigid/Tense ☐ Other *(explain)*	☐ Responsive ☐ Combative ☐ Tics/Tremors ☐ Hostile ☐ Compulsive	☐ Hyperactive ☐ Joyful ☐ Pacing ☐ Calm	
Speech	☐ Talkative ☐ Nonverbal ☐ Loud ☐ Other *(explain)*	☐Forced ☐Slurred ☐Illogical	☐Pressured/Excessive ☐Impediment ☐Monosyllabic	
Affect/Mood	☐ Appropriate ☐ Anxious ☐ Angry ☐ Friendly ☐ Other *(explain)*	☐ Depressed ☐ Guarded ☐ Cooperative	☐ Elated ☐ Flat ☐ Uncooperative	
Thoughts	☐ Normal ☐ Wandering ☐ Illusions ☐ Homicidal ☐ Other *(explain)*	☐ Guarded ☐ Disorganized ☐ Delusional ☐ Suicidal	☐ Flighty ☐ Paranoid ☐ Hallucinations	
Memory	☐ Remote Memory (past) ☐ Recent Memory	☐ Delayed Recall (repeat after 5 minutes) ☐ Attention Level (ability to concentrate)		
Insight	☐ Good ☐ Fair ☐ Poor *(What is causing your problem? What causes you to be here today?)*			
Judgment	☐ Good ☐ Fair ☐ Poor (What would you do if you ran out of meds?)			
Personal Habits	Smokes Cigarettes/Cigar/Pipe ☐ Yes / ☐ No Amt./day	Drinks Alcohol ☐ Yes / ☐No Amt./day	Illegal Drug Use ☐ Yes / ☐ No Type/Freq	
	Have you received assistance to stop smoking? ☐ Yes / ☐ No If yes, when/where?	Have you received treatment for alcohol? ☐ Yes / ☐ No If yes, when/where?	Have you received treatment for drug misuse/abuse? ☐ Yes / ☐ No If yes, when/where?	
Family Support	☐ Good ☐ Fair ☐ Poor	**Family Relationship**	☐ Good ☐ Fair ☐ Poor	

CURRENT MEDICATIONS

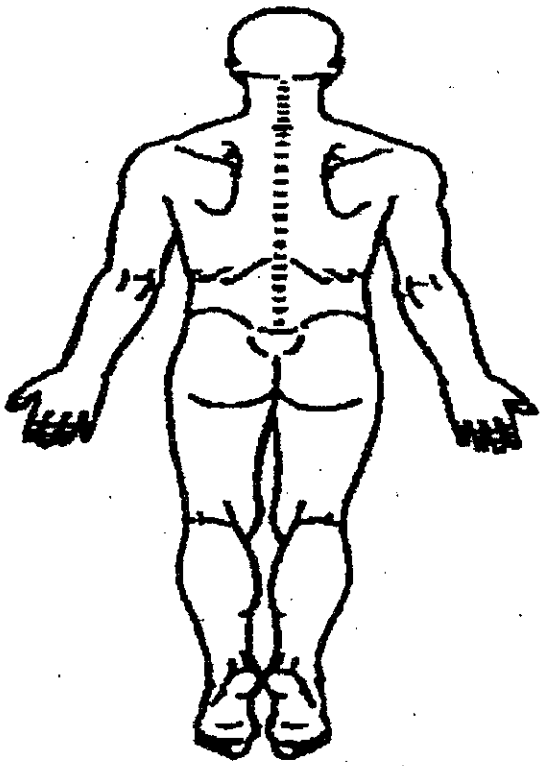
NAME	DOSE	FREQ	DIRECTIONS FOR USE/ ROUTE	REASON

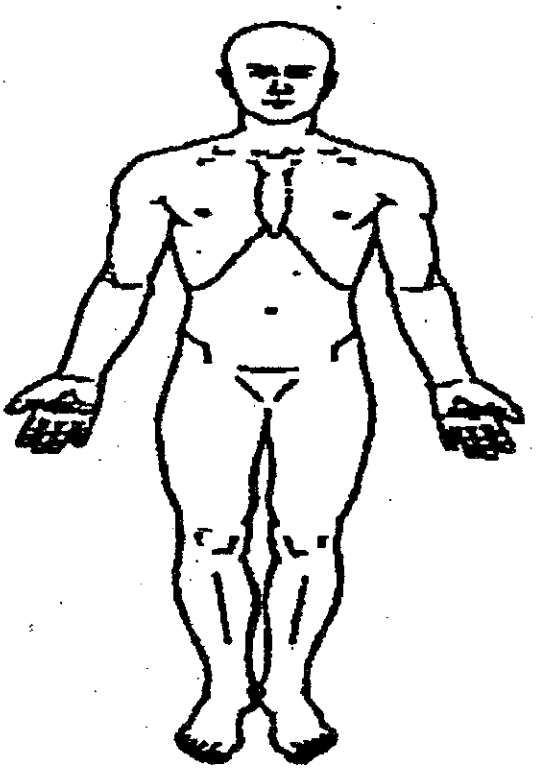
AIMS COMPLETED? ☐ **Yes** ☐ **No** ☐ **N/A**
FALLS COMPLETED? ☐ **Yes** ☐ **No** ☐ **N/A** **(File in clinical record)**

ATTACH ADDITIONAL SHEET IF NEEDED

MAS LPN SIGNATURE____________________________________

DATE: __________________





REVIEW OF SYSTEMS: (Skin, HEENT, Cardio, Respiratory, GastroIntestinal, Genitourinary, musculoskeletal, Psychosocial, Nervous, Blood)	
SKIN: □ Warm □ Dry □ Intact	Color:
Comments:	
HEENT (Head, Eyes, Ears, Nose, Throat): □ Symmetric □ Pupils equal/reactive □ No drainage/inflammation	
Comments:	
Cardiopulmonary: □ Heart beat regular □ No edema □ Pulses present (carotid, radial, pedal)	
Comments:	
Respiratory: □ Lung sounds clear □ cough □ SOB □ Reg Rate & Rhythm	
Comments:	
GI: □ Abd soft □ Bowel sounds present X 4 quads □ No distention □ Hx of GERD	
Comments:	
GU: □ "No pain/burning on urination" □ "No lesions" □ "No drainage" □ Breast WNL (Last mammogram _____)	
Comments:	
Musculoskeletal: □ Ambulatory □ Normal gait □ Normal posture □ No abnormal movements □Devices (list)	
Comments:	
Neuro/Psychosocial: □ No hx of Seizures □ A & O X3 □ No maladaptive behaviors	
Comments:	
Blood: □ No blood disorders □ Lab work done within last 12 months □ Lab WNL	
Comments:	
MAS RN SIGNATURE	**DATE**

Based on the problems listed the level of *nursing/medical care required* is:
(Select all that apply)

☐	**Skilled Nursing Only**
☐	MAC Worker Assistance with MAS Nurse Supervision 24/7
☐	Psychiatric status monitoring (state frequency)
☐	Medical/physical status monitoring (state frequency)
☐	Referral to: ☐PCP ☐Dentist ☐Optometrist ☐Other_____

Based on the problems listed and the level of nursing/medical care required, the following *nursing interventions will be implemented* directly or via delegation (SELECT ALL THAT APPLY. ADD ADDITIONAL INTERVENTIONS AS NEEDED

□	Skilled Nursing □ 24 hours □ Intermittent (state frequency)
□	MAS Nurse Supervision of MAC Worker
□	Fall Assessment (state frequency)
□	Choking Prevention/Assist with meals
□	I & O (state frequency)
□	T/P/R/BP/Wt. (state frequency)
□	Assisted ambulation/mobility/transfer
□	Assisted toileting/bathing
□	Monitor skin condition (state frequency)
□	Assisted communication
□	Lab (state frequency)_____ Date Due
□	Referral to service not provided by agency (List appointments made below)
	Appts:
□	MAS RN Care Plan(s) Completed
□	Assessment of ability to self-medicate completed (NDP 5) *Filled in clinical record*
	Other (Explain)

NAME _____ **DATE** _____ **TIME** _____ **A/P**

MAS RN SUMMARY OF ASSESSMENTS

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

MAS RN SIGNATURE/CREDENTIALS: _____

DATE: _____

RN assessment is completed/updated annually. Agency may use their own form, but the form is REQUIRED to have all the components of NDP 8

STATE OF ALABAMA
DEPARTMENT OF MENTAL HEALTH
RSA UNION BUILDING
100 NORTH UNION STREET
POST OFFICE BOX 301410
MONTGOMERY, ALABAMA 36130-1410
WWW.MH.ALABAMA.GOV

ROBERT BENTLEY
GOVERNOR

JIM REDDOCH, J.D.
COMMISSIONER

May 28, 2014

To: MAS/MATT Nurses

From: Vanessa B. Prater, BSN, RN, MATT
Director, NDP

Re: Updates

Over-the-counter medications (OTC meds)

A MAS RN/LPN may place a *prescribed, factory labeled, factory sealed,* single dose OR *multidose bottle* of over-the counter, as needed (PRN) medications in a plastic bag with a closure. *Each consumer must have their own individual bag of over-the-counter medications.*

The bag, with a closure, shall be labeled with the consumer's name, facility/program name, date over-the-counter medications were placed in the bag *by the MAS RN/LPN only.*

The MAS RN/LPN shall check expiration dates on *all* medications, initial the plastic bag ***and*** enclose a copy of the prescriber's standing orders inside the plastic bag with the over-the-counter medications.

Each consumer may now have their own multidose bottle of PRN, OTC medications. Due to Medicaid changes related to medication coverage, multidose bottles of prescribed, PRN, OTC may be purchased for each consumer as needed. The medication name and dosage part of the label placed on the bottle at the factory must read the same as the prescriber's standing orders. MAC Workers are trained to compare the label on the bottle to the order on the MAR.

NO BULK OR STOCK MEDICATIONS OF ANY KIND ARE ALLOWED TO BE USED BY MAC WORKERS IN COMMUNITY RESIDENTIAL PROGRAMS.

Do not resuscitate (DNR) orders

Do not resuscitate orders should be reviewed with the prescriber, consumer/family/significant other. Agency policy and procedures, approved by the agency's Board of Directors, should address the process for handling any do not resuscitate order. The treatment team, including MAS Nurses, should follow the agency's policy and procedure related to this issue.