STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Long-Term Support Administration
PO Box 45600, Olympia, Washington 98504-5600

January 4, 2019

ALTSA: ALF #2019-001
ALTSA: ICF/IID #2019-001
CARE ASSESSMENT CHANGES: MEDICATION DOCUMENTATION

Dear Assisted Living Facility Administrator:
Dear ICF/IID (licensed as ALF) Administrator:

NOTE: Only those ICF/IID facilities that are dually-licensed as assisted living facilities are affected.

On December 28, 2018, a change was made to the CARE application used by ALTSA and DDA Case Managers in how they document medications in the CARE assessment.

ALTSA is working to revert the system design back to documenting individual medications. When this process is complete, the list of medications will print on the plan of care document as they did prior to this change.

In in the interim, here is a detailed description of what you will see in CARE assessments:

1. The detailed Medication List has been removed from the CARE Assessment and plan of care document. **NOTE:** It is important to note that although the assessor does not have to type individual medications, they will still have a discussion with the client or client representative to identify medications, supplements or other products that are prescribed/recommended and used by the client. This information is important to ensure the accuracy in other areas of the assessment. (i.e., Diagnoses, Treatments, Skin, etc.). It will also be necessary to answer the new subsequent Medications questions.

2. The question label of "Medication Used?" has been changed to "**Does the client take prescription medication, over the counter medication, or herbal supplements?**"
NOTE: The 7 day look back period for "Medications Used?" has been removed. The question now refers to the present and whether the client currently takes medications.

3. If the question "**Does the client take prescription medication, over the counter medication, or herbal supplements?**" is **No**, the subsequent questions related to medications will not be documented as they will not be relevant; however, the Comments box will remain enabled for the assessor to enter any comments or notes about medications or medication management.

4. If the question "Does the client take prescription medication, over the counter medication, or herbal supplements?" is **Yes**, the following four new questions will be enabled and must be answered:
a) At most, how many times per day? The Case Manager will enter the greatest number of times the client will take medications in one day. For example, if the client takes a total of 10 medications and the frequency the client takes the medications ranges from every other day up to four times per day, the greatest number of daily medications would be 4.

b) How many prescription medication(s) does the client take? One of the following options must be selected: 0, 1-5, 6-10, 11-15, 16-20, 21+
c) How many over the counter medication(s), or herbal supplements does the client take? One of the following options must be selected: 0, 1-5, 6-10, 11-15, 16-20, 21+
d) What are the routes? The Case Manager can select one or more from the following selections: Oral, Feeding tube, Inhalant, Injections, Intramuscular injection, IV, Pump, Rectal/vaginal, Sublingual, Transdermal, Other

5. The **Client Limitations** and **Caregiver Instructions** selections have not changed and will be selected and print on the plan of care document when identified in the assessment.

6. **Strengths** and **Preferences** will no longer have a label on the plan of care document, but rather be indicated through the identified Caregiver Instructions selections or comments.

7. The assessment of **Self Administration** and **status** of informal supports for **Medication Management** has not changed.

8. All of the answers and selections to the preceding questions indicated in the assessment will print on the plan of care document for the provider. Enclosed is a sample image of what the printed plan would look like for Medications and Medication Management sections of the CARE Assessment.

9. For client assessments that will be used to inform a move to new residential setting, the Case Manager will document the list of client medications in the Medication Management Comments box in CARE. This will print on the client's plan of care document for the provider's review.

If you have questions regarding your resident's CARE assessment or plan of care, please contact the resident's HCS/DDA Case Manager.

If you have any questions regarding facility or agency regulations, please contact your local RCS Field Manager.

Thank you for your continued commitment to resident health and safety

Sincerely,

Candace Goehring, Director
Residential Care Services

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Enclosure

Medications

How many prescription medication(s) does the client take? 6-10

How many over the counter medication(s) or herbal supplements does the client take? 1-5

At most, how many times per day? 2

What are the routes?

Oral, Feeding tube, Inhalant, Injections, Intramusc.Inject., IV, Pump, Rectal/Vaginal, Sublingual, Topical, Transdermal, Other

Medication Management

Self Administration: Assistance required

Is assistance needed daily? Yes

Status and Assistance Available: Unmet

Client Limitations:

Forgets to take medications, Unable to read/see labels, Ability fluctuates, Cannot administer drops (eye/ear), Cannot crush pills, Cannot fill syringe, Cannot open containers, Cannot use syringe, Chokes/gags, Complex regimen, Does not follow frequency or dosage, Does not record blood sugars, Liquid meds only, Mixes alcohol w/Rx drugs, Multiple pharmacies, Multiple prescribers, On psychotropic drug needing monitoring, Poor coordination, Unaware of dosages

Caregiver Instructions:

Administer eye or ear drops, per orders, Assist with eye or ear drops, per orders, Cue to swallow medications, Document medication taken, Hand medication in cup or bowl, Inform client of each medication given, Open containers, Place medication in client's hand, Provide assistance at client's request, Put medications in lockbox, Re-order medications, Record blood sugars, Remind client to take medications, Report adverse reactions