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Communities Connected for Kids

Title		Number	
Management of Medication & Medically Assistive Devices		202	
Department: Clinical Services	**Owner** Director of Clinical & Placement Services	**Regulatory Authority/ Related Policies:** CFOP 170-108, Sections 39.407 (3)(a)1, 394.455(9), & 394.459(3)(a), Florida Statutes; rule 65C-30.011 & Chapter 65C-35, F.A.C., SSHP Vendor Services Agreement Related Policy: 203	**Attachments:** 30-Day Home Visit Psychotropic Medication Review Form, Placement Change Form for Children on Medications, Placement Change Form for Children with DME CCKids Medication Log

Effective Date:	Last Revision:	Review Date:
April 2003	July 2026	July 2026

Purpose:

CCKids adopted Chapter 3 of the Children & Families Operation Procedures (CFOP) 170-18 for *Psychotropic Medications* as procedure with specific lead agency responsibilities outlined below.

Policy:

It is the policy of Communities Connected for Kids (CCKids) to ensure proper administration of medications to children placed in out-of-home care by the Department, including the requirement for express and informed consent by parents or legal guardians and the alternative court authorization for providing these medications.

Continuation of Medical Care & Treatment When a Child Changes Placement

The child welfare professional with primary assignment is responsible for obtaining any medication currently taken by the child. To continue medication as directed, the person making placement shall obtain the medication in labeled medication bottles, inventory the medications on the **CCKids Placement Change Form for Children on Medications**, and transport the medications to the child's caregiver.

If a child uses medically assisted devices, the assigned person making placement shall ensure these devices are taken with the child to the out-of-home placement using the **CCKids Placement Change Form for Children with DME**. The primary assigned child welfare professional will ensure the caregiver receives the appropriate information and instruction concerning the use of devices from the child's health care provider.

Medication Administration & Monitoring

The responsibility for administering authorized psychotropic medication primarily lies with the child's caregiver. Monitoring is a shared responsibility.

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The child's caregiver must keep current medical records of a child in out-of-home in the child resource record, commonly referred to as a "Green Book". The records include medical appointments, follow-up reports (also known as after visit summaries) provided to the caregiver, any immunization records obtained, and a record of all prescribed medications administered to the child (copy of med report/5339) and current medication log provided by CCKids (**CCKids Medication Log**). Medical Foster Care (MFC) parents shall maintain the MFC Medication Logs as required by the MFC program instead.

Caregivers must give completed medication logs or copies of the MFC logs to DCM at each home visit. DCMs are responsible for uploading the logs into the case file (FSFN/CCWIS). DCMs will document monitoring of medication management in the child's case record. **CCKids 30-Day Home Visit Psychotropic Medication Review Form** can be used and uploaded into the child case record to satisfy documentation requirements.

Training

Anyone who administers psychotropic medication must complete medication management training. This includes child welfare professionals who may, in unusual situations, may need to administer and document the administrations of medications as well as document the circumstances that resulted in them administering the medication on the back of the medication log.

Child Welfare Professionals and level II-V Foster Parents are required to complete the Department's online training, *Navigating Psychotropic Medications for Children in Out-of-Home Care,* through My Florida Learn. Level II-V foster parents take the training annually, and CCKids verifies that it has been completed at licensing/relicensing time. Level I Foster Parents complete a different version of the training, *Navigating Psychotropic Medications for level I Foster Parents,* in My Florida Learn and is tracked during licensing/relicensing.

Relative and non-relative caregivers complete *Navigating Psychotropic Medications for Children in Out-of-Home Care* through My Florida Learn only if a child in their care is prescribed psychotropic medication and is documented by the DCM in the case file.

Over The Counter (OTC) Medications

Non-prescription medication prescribed by a physician will be logged in the medication log as the medication log must still be completed when dispensing OTC medications. Non-prescription medication prescribed by a physician will be treated as prescribed medication. If a child refuses to take a non-prescription medication as prescribed, the attempt to administer must be documented.

Care Coordination

In the event a caregiver needs assistance in obtaining any ordered psychotropic medications in a timely manner, to identify any potential medication compliance issues and/or identify any issues with obtaining medications, they may contact CCKids Clinical Team for Behavioral Health or Nurse Care Coordination assistance (see Policy #203).

Approved by:

DocuSigned by:
Carol DeLoach
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Carol DeLoach, CEO

Communities Connected for Kids

30-Day Home Visit Psychotropic Medication Review

Child Name:_____ DOB:_____ Case Name:_____

Date of Home Visit:_____ Placement Type:_____

Treating Physician:_____ Name of Placement/Caregiver:_____

Date of Last med Mgmt Appt:_____ Date of Next Med Mgmt Appt:_____

Psychotropic Medication	Dosage	How many times a day?	Diagnosis and symptoms treated	Date Filled	Quantity Filled	# of Refills	Pill Count	Stopped? Y/N	If Yes, Reason Stopped

Are parental rights still intact to consent to medication? Yes ☐ No ☐
If no, is there a court order authorizing medication? Yes ☐ No ☐
If yes, did the parent(s) receive a copy of the Physician's Report? Yes ☐ No ☐
If yes, has a parent consented to the meds by signing the Physician's Report? Yes ☐ No ☐
If yes, did the parent(s) receive a monthly progress update as to the child's medication? Yes ☐ No ☐
Is the child taking medication as prescribed? Yes ☐ No ☐
If no, please explain reasons and follow-up action to be taken:

_____

Has the med log been reviewed and medication count been completed with administration showing as accurate? Yes ☐ No ☐
If no, please explain reasons and follow-up action to be taken:

_____

Has the caregiver reported any side effects from the medication(s)? Yes ☐ No ☐
If Yes, what side effects and please explain the reasons and follow-up action to be taken:

_____

Has the caregiver noticed that the medication(S) have had a positive impact on the child's functioning/behavior? Yes ☐ No ☐
If no, please explain reasons and follow-up action to be taken:

_____

Does the child feel that the medication is helpful? Yes ☐ No ☐
If no, please explain reasons and follow-up action to be taken:

_____

Does the child or caregiver have any questions or concerns about the medication? Yes ☐ No ☐
If yes, please list them as well as any follow-up action to be taken:

_____

_____ _____ _____ _____
Dependency Case Manager Signature Date Caregiver Signature Date

Communities Connected for Kids

Medication Administration Log

Please submit the completed form to our office by the 5th of each month.

Child's Name:		*DOB:*	

Medication & Prescribing Physician	*Dosage*	*Reason for Medication*	*Frequency & Time of Day*	*MONTH OF _____, YEAR OF_____*																												
				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Medication Allergies:

1._____
2._____
3._____

Notes:

My signature/initial indicates that I have, on **a daily basis**, administered or monitored self-administered prescribed dosage as evidenced by my initials on the medication log.

Caregiver Name	Caregiver Signature	Caregiver Initial

Key

R-Refused
C- Crisis Unit or ER
M-Missed D-DJJ/detention

Communities Connected *for* Kids

PLACEMENT CHANGE FORM FOR CHILDREN WITH DURABLE MEDICAL EQUIPTMENT

Case Name:_____ **Date of Placement Change:**_____
Child Name: _____ **Child DOB:** _____
Prescribing Provider Name & Phone: _____
Person Transporting DME: _____ **Primary DCM:**_____

As of this date, the next appointment with prescribing provider for the child is on_____ **at** _____**am/pm.**

Equipment Description(s): (Include exact name e.g. nebulizer, wheelchair, etc.):

Is equipment in good working condition (yes/no & explain):

Asset/Serial Number (unique manufacturer identifier & company contact info):

Accessories Included (power cords masks, manuals, or specific attachments) & last time cleaned:

_____	_____	_____	_____
Signature Caregiver's Name	Date	Signature Caregiver's Name	Date
_____	_____	_____	_____
Signature DCM/ Transporter	Date	Signature DCM/ Transporter	Date

Caregiver: I verify that the DCM spoke with me about the information on this form. I verify that I have received the DME listed above and necessary instructions on how to use it.

Communities Connected for Kids

PLACEMENT CHANGE FORM FOR CHILDREN ON MEDICATION

Note: Pill counts are to be completed **IN PERSON** *when picking the child up from his/her current placement and then again at the time of placing the child.*

Case Name: _____ **Date of Placement Change:** _____
Name of Child: _____ **DOB:** _____
PCP Name & Phone: _____ **Psychiatrist Name & Phone:** _____
Pharmacy Name & Phone: _____
Person Transporting Child: _____ **DCM:** _____

As of this date, the next *Psychotropic Medication* appointment for the child is _____ at _____ am/pm.

The DCM has reviewed possible side effects of the medications and the reason the child is on the medication with me as indicated in the most recent med report (5339).

Inventory							
Medication Name & Dosage	**RX #**	**Diagnosis or purpose**	**Prescribing Physician**	**Time & frequency of administration**	**Side effects**	**Pill Count Leaving Placement**	**Pill Count upon Arrival to New Placement**

_____ _____ _____ _____

Signature Caregiver Child is Moving from | Date | Signature Caregiver Child is Moving to | Date

_____ _____ _____ _____

Signature DCM/ Transporter | Date | Signature DCM/ Transporter | Date

Caregiver: I verify that the DCM spoke with me about the information on this form. I verify that I have received these medications, their instructions and that I clearly understand and read the dosage information on the medication bottle.

Transporter: I have verified the Name of the Child on the medication, the quantity of each medication and entered the quantity in the form above.