

WCHO PIHP POLICY for the COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN		<i>Policy and Procedure</i> <i>Psychotropic Medication Orders & Consents</i>	
Department: Clinical Care Author: Dr. K. Milner/Dr. T. Florence		Local Policy Number (if used)	
Revision Date 2/7/11	Approval Date 10/18/11	Implementation Date 10/18/11	
Archive Information			
Date:			
Reason:			

PURPOSE

To establish practice standards for the prescribing and monitoring of psychotropic medications.

I. POLICY

It is the policy of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) that medication and medical treatments shall be administered only at the order of a physician OR a prescriber who is a medical professional vested with legal authority through professional licensing or certification to prescribe medications. Psychotropic medications will be prescribed only following informed consent by the recipient pursuant to a court order authorizing treatment.

II. APPLICATION

All recipients while under the care of staff within the Community Mental Health Partnership of Southeast Michigan (CMHPSM) including students, volunteers, and those of organizations under contract with affiliation members. The CMHPSM is comprised of the WCHO (as the Prepaid Inpatient Health Plan/PIHP) and the Comprehensive Specialty Services Networks (CSSN's).

III. DEFINITIONS

Chemotherapy - The use of psychotropic medications.

Delegated Prescribing Authority - A licensed physician who is a credentialed and privileged member of the WCHO or a WCHO affiliated CSSN may delegate the authority to prescribe medications to a Mental Health Nurse Practitioner, Clinical Nurse Specialist or Physician Assistant. The physician shall supervise the performance of this delegated function in accordance with the Michigan Public Health Code (1978 P.A. 368), including, but not limited to Section 16109(2); 16215; 17210; 17708(2).

Informed Consent - Informed consent is defined as either of the following:

1. A written agreement signed by a recipient, unless the recipient has a designated legal representative with authority to execute consent. If the

recipient has a designated legal representative, the legal representative must provide written agreement.

2. A verbal agreement of a recipient, unless the recipient has a designated legal representative with authority to execute a consent, that is witnessed and documented by an individual other than the individual providing treatment. If the recipient has a designated legal representative, the legal representative must provide verbal agreement.

Legal Representative – A legal representative is defined as any of the following:

1. court-appointed guardian,
2. A parent with legal custody of a minor recipient,
3. In the case of a deceased recipient, the executor of the estate or court appointed personal representative,
4. A patient advocate under a durable power of attorney or other advanced directive.

Nurse Practitioner or Clinical Nurse Specialist– An individual licensed to practice as a registered nurse and certified in a nursing specialty by the State of Michigan.

Physician - An individual who is licensed to practice medicine or osteopathic medicine in the State of Michigan under article 15 of the Public Health Code, Act No. 368 of the Public Acts of 1978, being sections 33.16101 to 333.18838 of the Michigan Compiled Laws. The “practice of medicine” means the diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other physical or mental condition, by attendance, advice, device, diagnostic test, or other means, or offering, undertaking, attempting to do, or holding oneself out as able to do, any of these acts (MCL 333-1978-15-170).

Physician Assistant – An individual licensed to practice as a physician assistant by the State of Michigan.

Prescriber – A Physician who is licensed to prescribe medications, or Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist with delegated prescribing authority who is licensed to prescribe medications. A licensed physician who is a credentialed and privileged member of the WCHO or a WCHO affiliated CSSN may delegate the authority to prescribe medications to a Nurse Practitioner, Clinical Nurse Specialist or Physician Assistant in accordance with the Michigan Public Health Code (1978 P.A. 368) Section 16109(2), 16215, 17210, 17708(2).

Psychotropic Medications - Medications prescribed to treat or ameliorate disorders of thought, mood or behavior.

IV. STANDARDS

- A. The prescriber will be familiar with psychotropic medication through specific training and/or experience. Medication references, such as the Physicians’ Desk Reference, are available.

- B. Psychotropic chemotherapy shall not be administered unless: (1) the recipient gives informed consent; (2) there is a court order; (3) the administration is necessary to prevent physical injury to the recipient or others. A provider may administer chemotherapy to prevent physical harm or injury after signed documentation of the physician is placed in the recipient's clinical record and when the actions of a recipient or other objective criteria clearly demonstrate to the physician that a recipient poses a risk to him/herself or others. The initial course of medication may not extend beyond 48 hours unless there is consent. The duration of psychotropic chemotherapy shall be as short as possible and at the lowest possible dosage that is therapeutically effective. The medication shall be terminated as soon as there is little likelihood that the recipient will pose a substantial risk to him/herself or others.

- C. Medication Orders will include the name of the recipient and at least one other identifier, the name of the medication, dose and timing of medication administration, method of drug administration, number/amount of medication to be dispensed, number of refills allowed and special instructions, when indicated.

- D. Psychotropic medication will be selected by the prescriber based on best research evidence of effectiveness and safety, prescriber expertise, and recipient preference. To facilitate prescribing practices consistent with the community standard of care, the Michigan Implementation of Medication Algorithms (MIMA), a set of psychotropic medication algorithms for schizophrenia and schizoaffective disorder, bipolar disorder and major depressive disorder modeled after the Texas Medication Algorithm Project, is incorporated into the Psychiatric Evaluation and Medication Review Note. If a prescriber elects to use MIMA, a recipient is moved algorithmically through stages of treatment based on treatment response. Higher scores on symptom scales prompt movement to a higher stage. Recipients who are psychiatrically stable do not require progression through the algorithm in order to fit MIMA staging recommendations.

- E. Medications are selected from a list of medications, maintained in the electronic medical record, which comprises the formulary. The CMHPSM maintains an open formulary to insure that medication determined by the Medical Staff to meet the selection criteria noted above is available to the recipient.

- F. Medical Staff will identify the diagnosis, condition, or indication-for-use for each medication ordered.

- G. Medication orders are completed in the Psychiatric Evaluation or Medication Review Note and maintained in the recipient electronic record, showing the prescribed medication use/history. The recipient's medication history prior to involvement with the CMHSPSM is documented in the Psychiatric Evaluation.

- H. The prescriber will determine for each individual the initial psychotropic medication dosage for treatment by considering the recipient's, age, sex, weight, physical condition and any previous adverse reactions to medication.

- I. The use of all medications will follow Physician's Desk Reference (PDR) guidelines regarding contraindications, warnings, precautions, adverse effects, dosing and

administration. If a prescriber departs from these guidelines, the clinical justification for it shall be documented in the Psychiatric Evaluation or Medication Review Note in the electronic medical record.

- J. Justification and rationale for the concomitant use of two or more psychotropic medications from a category (e.g., Antipsychotic, Antidepressants), use of high dose pharmacotherapy (i.e., dosage greater than that recommended in the PDR), or prescription of controlled substances (i.e., benzodiazepines, psycho-stimulants) must be recorded in the Psychiatric Evaluation or Medication Review Note.
- K. Before initiating a course of treatment with psychotropic medication, the prescriber or another licensed health professional acting under his/her delegated authority, will explain the specific risks and potential side effects associated with the medication and shall provide the recipient with a written summary of the most common adverse effects.
- L. Except as delineated above (IV. Standard B.), informed consent is required prior to the initiation of psychotropic medication. The recipient or recipient's legal representative signify their consent to the use of psychotropic medication by signing the Consumer Medication Consent form. The consent form can be revoked by the recipient at any time.
- M. All apparent adverse reactions/side effects from psychotropic medications such as leukopenia, extra-pyramidal syndromes, etc. and action taken as a result of an adverse reaction/side effect will be documented in the Medication Review Note.
- N. Effects of the medication(s) on target symptoms will be recorded in the Medication Review Note each time the recipient is evaluated by the prescriber. Mental Health Nurses administering medication document recipient- reported and observed effects of medication(s), and CMHSPSM staff in contact with recipients monitor effects of medication(s) continuously. CMHSPSM staff has immediate access to CMHSPSM staff health professionals for consultation and/or triage in situations of potential adverse effects.
- O. For those recipients taking antipsychotic medications associated with the potential to induce tardive dyskinesia, an AIMS test will be performed at least quarterly.
- P. Medication use will be reviewed at least quarterly, or as indicated in the recipient's individual plan of services or based upon the recipient's clinical status, and either continued, revised, or discontinued.
 - 1. The following types of orders will be used as noted: Standing Orders are medication orders written for over-the-counter medications prescribed by the primary medical provider for recipients living in residential programs. These medications are reviewed by the CMHSPSM prescriber during the medication reconciliation process.
 - 2. Taper Orders and/or Titration Orders are written by CMHPSM prescribers when recommended by the manufacturer and/or as recommended in the Physicians' Desk Reference to minimize side effects when instituting a medication or to minimize withdrawal symptoms when terminating a medication.

3. The rationale or justification for the use of a psychotropic medication prescribed on an “as needed” basis must be documented in the Medication Review. The medication order will also document general indications for its use and length of time it is in effect.

- Q. Verbal/telephone orders for medication are allowed in urgent situations. The order is to be given to a mental health nurse (RN) by the prescriber, recorded in the EHR/Nurses Progress Note, read back verbatim to the prescriber, signed by the RN and co-signed by the prescriber.
- R. All forms referenced in this policy will become a part of the recipient's clinical record and scanned therein.
- S. CMHPSM prescribers will not prescribe medications for non-behavioral health conditions (including seizure disorders). Recipients that have known medical illness, or that are determined to have symptoms suggestive of medical illness by history, response to the Personal Health Review, or routine laboratory screening, will be referred to a primary care provider for medical assessment and treatment.
- T. Investigational or experimental medication usage is prohibited without review of proposed protocol as per the research review process.
- U. Incomplete or unclear medication orders will be brought to the prescriber's attention by the mental health nurse. The prescriber will rewrite the orders for clarity.
- V. Use of abbreviations, acronyms and symbols are to be avoided and a list of abbreviations to be avoided is available to prescribers and medication certified staff.

V. EXHIBITS

CMHPSM Consumer Medication Consent Form

VI. REFERENCES

Reference:	Check if applies:	Standard Numbers:
Michigan Mental Health Code Act 258 of 1974	X	Sec. 718, 719
JCAHO- Behavioral Health Standards	X	MM 3.10, 3.20, 5.10, 6.10, 6.20
MDCH Public Mental Health Manual	X	07-R-7158/GL Psychotropic Medication Guidelines.
MDCH Administrative Rules	X	AR 7158.

Physician's Desk Reference (PDR)	X	
----------------------------------	---	--

VII. PROCEDURES

None

(Insert Organization Name)

CONSUMER MEDICATION CONSENT

As part of my Person-Centered Plan, my doctor/nurse practitioner recommends the use of medication.

I understand that all medication may produce side effects, and that some side effects may be serious or permanent. I understand the importance of reporting side effects or unusual reactions to my prescriber. I have read and understood the written material explaining the medication I will be taking. I have had an opportunity to ask questions and have received full and complete answers.

Medication(s)	Dose range	Reason for Medication (place number(s) next to the proper symptom)		
1. _____	_____	<input type="checkbox"/> Depression	<input type="checkbox"/> Mania	<input type="checkbox"/> Stabilize Mood
2. _____	_____	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Attention or Cognition Problems	<input type="checkbox"/> Insomnia
3. _____	_____	<input type="checkbox"/> Paranoia	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Disorganized Thoughts
4. _____	_____	<input type="checkbox"/> Stiffness or Restlessness	<input type="checkbox"/> Agitation	<input type="checkbox"/> Other: _____

An information sheet was provided to the consumer:
See Prescriber note for more information:

Y / N/ Declined _____

I understand that medications like these have been used successfully in the treatment of conditions similar to mine but that no guarantee can be made that the medication will be equally effective for me. I am aware of the risks of not taking medications. I understand that my Doctor/Nurse Practitioner will inform me if my medication dosages increase beyond recommended levels. I have informed staff about my medical problems, current medications, and history of reactions to medications.

I understand that there are risks to taking these medications during pregnancy, and I should consult my obstetrician and my mental health prescriber about whether to stop or continue medications while pregnant. I agree to notify my prescriber immediately if I do become pregnant.

I understand that simple blood tests, cardiograms or other tests may be necessary to monitor my condition.

I understand that I will be informed if the dose of my medication is outside the recommend dose range.

I understand that I may decide to stop taking this medication or make changes in medication if I choose, without jeopardizing current services by completing the Consent for Participation in Treatment/Services.

_____ I have considered the benefits and consequences of the medication and freely consent to its use in my treatment. I also understand I have the right to withdraw my consent for the use of this medication at any time and that it would be desirable to first speak to my doctor/nurse practitioner before doing so.

_____ I have/am at risk for tardive dyskinesia, and I will be monitored at least every three months.

_____ I have/am at risk for metabolic syndrome, a precursor of diabetes, and I will be assessed once or twice per year for the presence of high sugar levels and high cholesterol in my blood.

_____ I understand that I have been court ordered to take this medication. I acknowledge receiving this notice.

_____	_____	_____	_____
Consumer's Name	Consumer's Signature	Date	
_____	_____	_____	_____
Consumer Refuses to Sign	Staff Name	Staff Signature	Date

I am revoking my consent for the following medication(s).

_____	_____	_____
Medication Name	Consumer's Signature	Date
_____	_____	_____
Medication Name	Consumer's Signature	Date
_____	_____	_____
Medication Name	Consumer's Signature	Date