

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN		<i>Policy and Procedure</i>	
Department Clinical Services		# of Pages:	
Policy Name ADMINISTRATION OF MEDICATION AND OTHER MEDICAL TREATMENT		Type of Policy: [] WCHO [<input checked="" type="checkbox"/>] Regional [] Network	
Policy Number 13.001	Effective Date	Revision Date	Approval Date
Administrative/Board of Directors Sign Off			
Administrative Signature:			Date:
Board of Directors Signature:			Date:

I. PURPOSE

To establish guidelines regarding the administration of psychotropic and other medications and medical treatment procedures by Community Mental Health Partnership of Southeastern Michigan (CMHP) and staff of organizations operating under contract to the CMHP.

II. APPLICATION

All recipients while under the care of any CMHP staff, students, volunteers and/or contractual agencies within the provider network. This policy does not apply to WCHO, however the WCHO will still have monitoring and oversight responsibility for medication administration.

IV. DEFINITIONS

Medication - A drug or medical treatment prescribed by a physician or clinical nurse specialist for the therapeutic benefit of a patient.

Physician - A person who is licensed to practice medicine or osteopathic medicine by the Bureau of Occupational and Professional Regulation, Michigan Department of Commerce.

Clinical Nurse Specialist – A licensed nurse that may prescribe medication within the scope of practice.

Stop Order - An order by a physician or clinical nurse specialist to discontinue the administration of a medication or medical treatment procedure.

Medical treatment procedures - Treatment procedures that must be ordered by the medical provider prior to implementation by staff, e.g. hot wet soak to left foot. In emergency situations where injury is apparent, first aid by trained individuals does not require orders from the medical provider prior to initiation.

IV. POLICY

Medication and medical treatments shall be administered only at the order of a physician or clinical nurse specialist as documented on the Physician Order Record by staff who are certified (per PA 368, of 1978 as amended, 33.1101 of the Michigan Compiled Laws) or supervised by staff who are so certified.

All staff that administer medications shall have satisfactorily completed a certified medication training program and shall demonstrate their knowledge of expected actions, side effects, and dosages of medications that are administered by them.

V. EXHIBITS

None

VI. REFERENCES

- A. DCH Administrative Rules – AR 7158.
- B. DCH Policy, Psychotropic Medication, III-7158-R-GL.

VII. STANDARDS

- A. Medication shall not be used as punishment, for the convenience of staff, or as a substitute for other appropriate treatment.
- B. Any use of medication for behavior control must be approved by the CMHP Behavior Management Committee.
- C. Orders for medication shall be effective only for the specific number of days indicated by the prescribing physician on the prescription form. The administration of psychotropic medication shall be reviewed at least quarterly to determine the appropriateness of continued use.
- D. Schedule II controlled substances (narcotics) shall not be prescribed by the CMHP physicians or physicians employed by organizations under contract to the CMHP.
- E. In a habilitation, supported living or group home setting, all medication orders will be initiated by the prescribing physician or clinical nurse specialist and implemented by staff as follows:

F.

1. Physician documents on the Medication Review Note and Physician Order Form that medication or treatment is to be discontinued and so informs the recipient.
2. Staff maintain current medication orders on site.
3. The mental health nurse reviews the medication review notes and assures that providers have correct medication prescription orders and dispensing information by reviewing the Medication and Treatment Record monthly.
4. Staff discontinues dispensing the medication, entering DISCONTINUE on the Medication and Treatment Record after the last dose or treatment along with the date of discontinuation and the initials of the staff making the entry.
5. Use of Schedule IV medications will be also documented on the Controlled Medication Record and a mental health nurse will monitor the inventory monthly.
6. Any remaining open bottles of medication stored on the premises shall be destroyed by a staff person and witnessed by one additional staff person. This action shall be documented on an Incident Report and forwarded to the responsible mental health nurse for review/comment, then to the ORR.
7. Discontinued, expired, recalled, and unopened bottles of medication shall be returned to the pharmacy if they were obtained through the Outpatient Pharmacy Contract, and documented the return on the Expired, Recalled or Discontinued Medication Inventory Sheet .

G. Medications shall be stored on the premises only to facilitate the delivery of services to recipients and shall be safeguarded as follows:

1. A "double-locked" system shall be employed such as a locked medication box in a locked file.
2. Keys to locked storage areas shall be available only to staff who are authorized to have access to medications.
3. All medications stored on the premises shall be inventoried a minimum of quarterly on the Expired, Recalled or Discontinued Medication Inventory Sheet by designated licensed staff and forwarded to the Medical Director or designee. If a client had received a recalled or discontinued medication the client will be notified as soon as possible and an Incident Report will be done.
4. Medication requiring storage in a refrigerator is governed by the same standards as other medications for security, control and inspection.

H. All medication containers stored on the premises must be in the original container which is labeled as follows:

1. Name of recipient
2. Name of prescribing physician
3. Name of medication
4. Strength of medication

5. Dosage of medication
 6. Schedule of administration
 7. Dispensing pharmacy: lot number and expiration information
- I. Staff will use at least two of the following identifiers whenever administering medication(s) or treatment(s):
1. Client photograph attached to the Medication and Treatment Record or Medication Injection Record
 2. Staff who knows the individual identifies the client.
 3. Client states their name and staff compares the name to the Medication and Treatment Record or Medication Injection Record
 4. Client states their birth date and staff compare it to the Medication and Treatment Record or Medication Injection Record.
- J. Each time a medication or medical treatment is administered, the administration shall be documented as follows:
1. Staff at supported living sites and habilitation services sites shall make a notation on the Medication and Treatment Record.
 2. Licensed staff that administers a medication by injection shall make a notation on the Medication Injection Record.
 3. Medications of oral route administration given to clients from outpatient clinics shall be documented in a Progress Note, including the name /dose /amount of medication given and the instructions for taking the medication given to client.
- K. Medication errors and adverse reactions shall be documented according to procedures for completion of the Medication and Treatment Record. The prescribing physician or medical director will be notified of a medication error and documented on an Incident Report. Medical emergencies caused by medication error will be reviewed according to Adverse Event Review protocol.
- L. Adverse drug reactions will be reported immediately to the prescriber. A significant drug reaction (requiring medical emergency intervention) will be documented in an Incident Report and the client's chart and reviewed following the Adverse Event Review protocol.
- M. Only medications that are prescribed by a physician shall be given to a recipient upon leave or discharge from a 24-hour facility. Expired or discontinued medications will be disposed of according to disposal guidelines.
- N. Clients may self-administer medication in a group home upon completion of an independent self-medication module. Home staff will assure the medications are safely stored and provide monitoring of an independent self-medication activity.

O. Telephone orders for medication are allowed only in urgent situations. Telephone orders shall be:

1. Received only by a Registered Nurse from a physician only.
2. Immediately recorded on the Physician Order Record, read back verbatim to the physician, signed by the Registered Nurse, and placed in the prescribing physician's inbox.
3. Countersigned by the physician at the physician's next regularly scheduled shift at CMHP.

P. A written referral for electroconvulsive therapy (ECT) should be routed to the Medical Director, who together with the CMHP liaison to the hospitals, will arrange for an evaluation for ECT by outside providers following authorization by the CMHP. Referrals should include the client's name, diagnosis, psychiatric history (including failure of at least two antidepressant trials at adequate doses for a suitable duration), physical health status, and other information deemed appropriate by the referring physician.