SANTA BARBARA COUNTY DEPARTMENT OF Behavioral Wellness
A System of Care and Recovery

Programmatic Policy and Procedure

Section	Psychiatric Health Facility (PHF)	**Effective:**	6/1/2003
Sub-section	Operations - Medications	**Version:**	~~2.1~~3.0
Policy	Medication Administration	**Last Revised:**	8/28/2019

Director's Approval _____ **Date** _____
Alice Gleghorn, PhD

PHF Medical Director's Approval _____ **Date** _____
Ole Behrendtsen, MD

Supersedes: Medication Administration rev. 1/27/2016

Approvals: PHF Medical Practice Committee: 8/28/2019 PHF Governing Board: 8/28/2019

1. PURPOSE/SCOPE

1.1. To provide standards and procedures for the safe administration of medications for the patients admitted to the Psychiatric Health Facility (PHF).
1.2. To ensure all medications are administered in compliance with federal and state laws and standards of professional practice.

2. DEFINITIONS

The following terms are limited to the purposes of this policy:

2.1. **Medication Administration Record (MAR)** ~~– Medication Administration Record,~~ part of a patient's permanent medical record.
2.2. **Pro Re Nata (PRN)** – Medication ordered without specific administration times and given ~~on an as needed basis~~ with parameters per a physician's order on an as needed basis.
2.3. **Licensed nursing staff (LNS)** – an individual employed or contracted by the PHF who holds a valid California license as a: registered nurse (RN); licensed vocational nurse (LVN); or psychiatric technician (PT).
2.4. **Prescriber** – PHF psychiatrists, staff physicians, or nurse practitioners who are responsible for the care of PHF patients and~~who~~ order medications for PHF patients.

3. POLICY

3.1. All medications are ordered by ~~PHF psychiatrists, staff physicians or nurse practitioners (hereafter referred to as "prescriber")~~ a Prescriber, and are administered by LNS.

~~LNS must adhere to the seven "rights" of medication administration:~~

~~Right Patient~~

~~Right Medication~~

~~Right Dose~~

~~Right Route~~

~~Right Time and Frequency~~

~~Right Reason~~

~~Right Documentation~~

~~Medications are administered within 60 minutes before or after the scheduled administration time unless an order allows for a broader timeframe.~~

~~Medication orders may be written using the approved list of abbreviations.~~

4. MEDICATION ORDERS

4.1. All medication orders shall be written, dated, timed, and signed. ~~(~~See *Transcribing New Medication Orders* policy~~)~~.

4.2. Prescribers may order medications using the approved list of abbreviations.~~Medication orders may be written using the approved list of abbreviations.~~[1]

4.3. Once a Prescriber orders a medication, an LNS will note the order and transcribe the information on the MAR ("noting").

1. An LNS on the following shift will audit the ~~noting LNS~~ transcription to ensure ~~accuracy of~~accuracy ~~transcription~~.
2. A night shift LNS will perform a 24 hour check on medication orders for accuracy of transcription.
3. Noting and auditing will be documented in red ink on the Physician's Order Sheet.

~~4.3.~~4.4. Orders for ~~scheduled~~ routine medications ~~must~~ may include the rationale for ~~which~~ why ~~the~~ medication is being given.

4.5. Orders for PRN medications must include specific indications for when the medication is to be administered and must ~~document them~~be documented in the MAR.[2]

1. Additional documentation may be recorded in the nurse's notes.
2. Results of the PRN medication order must be documented in the medical record within one (1) hour of administration.

[1] Please refer to PHF policy "Standard Abbreviations" for further details.

[2] Please refer to PHF policy "PRN Medications" for further details.

4.4.4.6. When a Prescriber wants to make change tochanges a medication order is changed, they willthe Prescriber will discontinue the existing order will be discontinued and write a new replacement order written.[3]

1. Written orders that have been noted cannot be errored out and must be discontinued and re-written.may not be altered except to correct an error by drawing a single line through the error
2. Prior to an LNS noting a written order, all error corrections must include the signature and discipline of the individual who corrected the errors.; accompanied by the signature and discipline, date and time of the error correction.

1. New medication orders will be double checked by the assigned night staff to ensure accuracy. The prescriber's order will be checked and compared with the MAR. The assigned night staff will sign the prescriber's order sheet (in red ink) statingthe medication transcription is accurate, or correct any errors.

If a patient is not given medications per prescriber-ordered parameters (e.g., if medication is held), after 7 days of the patient not receiving the medication, notify the patient's treating physician and current prescriber for consideration of discontinuation of the medication. Documentation will be noted on the back of the MAR and flow sheet. For information on what to do when a medication is refused or not administered, see Section 6 of this policy.

If at the time of discharge a patient has not been receiving a medication per prescriber-ordered parameters (e.g., if a patient refuses the medication or medication is held), patient's physician will be notified when obtaining discharge medication orders.

5. ADMINISTRATION PROCEDURES

5.1. Prior to administering any medication, the assigned medication nurseLNSmedication LNS will:

1. Practice hand hygiene and prepare the administration area with all necessary supplies;.
2. Minimize or eliminate distractions and interruptions;.
3. Check a patient's chart for medication allergies and ensure this information is written prominently on the cover of patient's chart and on every medication order sheet;.
4. Ensure a current informed consent for psychotropics medications is in place;.[4]
5. Check labels medication for expiration dates or transcription errors;.
6. Ensure he/shethey the assigned medication nurseLNS has the right patient before any medications are administered by:.
   a. Confirming the patient's identity using at least two patient identifiers to minimize the potential for a medication error; and Two (2) forms of identification are

[3] Please refer to PHF policy "Documenting and Auditing Medication Order Changes" for further details.
[4] Please refer to PHF policy "Informed Consent for Psychiatric Medications" for further details.

~~required. A current photograph, confirmation by the patient's assigned LNS or asking the patient to verbalize their date of birth may be used.~~

~~a.~~b. Comparing the information with the MAR.

~~6.~~7. Compare the MAR with the written ~~prescriber's~~ order to ensure accuracy~~.~~;

~~7.~~8. Compare the medication label with the MAR to ensure correct medication and dose~~and repeat the comparison with the prescriber's order.~~;

~~8.~~9. Before administering insulin, ask another nurse to perform an independent double check to verify the patient's identity, ~~When giving insulin from a sliding scale, document the exact dose given on the MAR in addition to the injection site code. The~~ blood glucose level~~s will be documented by the nurse~~ and that the dose aligns with the order~~.~~;

~~Document the administration in the MAR by placing their initials and license discipline in the box that corresponds with the date and time the medication was given.~~;

~~If the medication is by injection (intramuscular or subcutaneous), document the site of injection using the site code listed on the back of the MAR.~~

~~If a medication is written with vital sign parameters, document the required vital signs in the same box in which the medication is signed off.~~

~~Monitor and document the patient's response to the medications administered.~~

5.2 After administering any medication, the assigned ~~medication nurse~~LNS will document the following in the MAR:

1. The administration of the medication by placing the~~ir~~ LNS' initials and license discipline in the box that corresponds with the date and time that the medication was given;
2. The injection site codes (listed on the back of the MAR) for any intramuscular or subcutaneous medication injections;
3. When giving insulin from a sliding scale, the exact dose given, the injection site code, and blood glucose levels;
4. When a medication is written with vital sign parameters, the required vital signs in the same box in which the medication is signed off; and
5. The patient's response to the medication administered.

5.3 An LNS will refer to safe medication administration practices as indicated in the Lippincott Nursing Procedures book (see *Nursing Procedures* policy).

5.4 LNS will administer medications within 60 minutes before or after the scheduled administration time unless an order allows for a broader timeframe. ~~Medications are administered within 60 minutes before or after the scheduled administration time unless an order allows for a broader timeframe.~~

1. Medications will be administered only by the ~~staff~~ LNS preparing them. Packaging ~~and~~ may only be opened at the time of administration. ~~not be pre-poured before the patient receives them.~~

5.5 LNS should not administer medications if they have any concerns regarding the medication's consistency, color, odor or the presence of precipitants. ~~Medications must not be administered if staff have any concerns regarding consistency, color, odor or the presence of precipitants.~~

1. Any ~~concerning issues~~concerns or findings must be reported to the Pharmacist.~~Nursing Supervisor and documented via an Unusual Occurrence Incident Report.~~

6. ~~REFUSALS AND~~ MEDICATIONS NOT ADMINISTERED

~~Based on their scope of practice, an LNS may place a medication on hold following an evaluation of the patient's disposition (e.g. blood pressure reading). If a medication is held and not administered per prescriber ordered parameters for 7 days, an LNS will notify the patient's treating physician and current prescriber for consideration of discontinuation of the medication.~~

6.1. If a medication is not administered, the assigned LNS will document the following: ~~(see *Nursing Procedures* policy) :~~

1. Their initials circled in red ink on the front of the MAR.
2. On the reverse side, ~~The~~the reason why not administered~~;~~ and
3. The~~practitioner~~ name of the Prescriber notified.~~'s notification.~~

6.2. For those instances when a medication is not administered per P~~p~~rescriber~~-~~ ordered parameters for 7 days, an LNS will notify the patient's treating physician.

6.3. If at the time of discharge a patient has not been receiving a medication per P~~p~~rescriber-ordered parameters, the Prescriber ~~treating~~ will be notified when obtaining discharge medication orders.

6.4. Any unused portion of any single medication dose will be discarded per the PHF's *Medication Wasting and Destruction* policy.[5]

~~Any interventions taken;~~
~~The patient's response to any interventions; and~~

~~When a medication is refused or not administered, the assigned medication nurse will:~~

~~Circle their initials in red ink on the MAR.~~

~~On the reverse side, document the reason the medication was refused or not administered. Document the name of the patient's physician who was notified of the refusal.~~

~~Place their initials, signature and license discipline in the corresponding section.~~

[5] Please refer to the PHF policy "Medication Disposal" for further details.

~~Also document refusal on the PHF Daily Flow Sheet (~~Attachment ~~A); information documented here should align with the MAR documentation. Additional information can be documented in the narrative section of the PHF Daily Flow Sheet if needed.~~

~~Any unused portion of any single medication dose will be discarded per the PHF's medication disposal procedures.~~

~~If the patient refuses any ordered medication, LNS will inform the prescriber. The notification will be documented in the medical record.~~

~~Based on their scope of practice, an LNS may place a medication on hold following an evaluation of the patient's disposition (e.g. blood pressure reading) and inform the prescriber.~~

7. MEDICATION EDUCATION

7.1 Medication education is offered throughout a patient's stay, beginning with the informed consent, through medication administration and ending at discharge.

7.2 During the discharge process, LNS will:

1. Fill out a *Discharge Medication Knowledge* form (Attachment A) for each patient who received medication;
2. Document it on the *PHF Daily Flow Sheet* (see Attachment B); and
3. Include it in the patient's medical record.

~~provide medication teaching opportunities and will document the activity on the *Medication Education Flow Sheet* (see Attachment B) for each patient.~~

~~When education is provided, LNS will document on the Medication Education Flow Sheet:~~
~~What information was provided and taught by listing the class of drug and the medication name.~~
~~What mode was utilized to educate the patient (i.e. Verbal, Written or Demonstration).~~
~~The patient's comprehension of what was taught.~~
~~Their name, initials and license discipline.~~

REFERENCE

Code of Federal Regulations - Condition of Participation: Nursing Services
Title 42, Chapter IV, Sections 482.23(c)~~(1) and (c)(2)~~

California Code of Regulations – Licensing and Certification of Health Care
Title 22, Chapter 9, Sections 77079.5(b) and 77079.7

Business and Professions Code – California Nurse Practice Act, Scope of Regulation
Division 2, Chapter 6, Article 2. S~~ubs~~ection 2725 ~~(~~(b)(2)

ATTACHMENTS

Attachment A: Discharge Medication Knowledge form

Attachment ~~A~~ B – PHF Daily Flow Sheet

~~Attachment B – Medication Education Flow Sheet~~

RELATED POLICIES

Standard Abbreviations

PRN Medications

Documenting and Auditing Medication Order Changes

Unusual Occurrence Reporting

Informed Consent for Psychiatric Medications

Medication Disposal

Nursing Procedures

Medication Errors and Adverse Drug Reactions

Transcribing New Med Orders

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION
DRAFT	3	• Added to Related Policies Section: Nursing Procedures, Medication, Errors and Adverse Drug Reactions, Transcribing New Med Orders. • Deleted most procedures that referenced PHF Daily Flow Sheet. • Deleted and replaced Section 7. • Moved 4.1, 5.2, and 5.3 from policy statement to procedure sections. • Updated Procedures in Sections 4,5, and 6. • Deleted Medication Education Flow Sheet. • Changed language from active to passive voice where appropriate.
8/28/2019	2.1	• Added language around documentation of med refusals. • Added directions for nursing staff regarding medications not administered.
12/27/16	2.0	• Significant changes made to update medication orders, administrative procedures and patient education.

Culturally and Linguistically Competent Policies

The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be

provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).

DISCHARGE MEDICATION KNOWLEDGE

1. Can patient state at time of D/C the name of 2 of his/her meds? (or one if only on one medication) ☐ yes ☐ no

2. Can patient state the purpose of both medications? ☐ yes ☐ no

3. Can patient state 1-2 side effects of each medication? ☐ yes ☐ no

4. Patient provided printed medication information/education materials at time of discharge? ☐ yes ☐ no

Comments:_____
_____
_____
_____
_____
_____

_____ _____
Staff Signature and Title Date Time

STICKER

Santa Barbara County Department of Behavioral Wellness

PSYCHIATRIC HEALTH FACILITY– Daily Flow Sheet

Daily Shift Assessment	Date:	07-19	19-07	Document for each shift using the following format **B** = Behavior that shows the patient has an acute mental illness (specific descriptive behaviors that require intervention and hospitalization) **I** = Interventions in response to the patient's behavior(s). Use the Treatment Plan to guide interventions. **R** = Response to interventions, progress towards identified treatment goals **P =** next step in the plan of care/recommendations for Treatment Plan ** Asterisked items in Shift Assessment are to be evidenced/addressed in shift note*
	Observation Level: Q15; 1:1 ES; 1:1 AL			
	Hours slept this shift:			
	Meals: % Eaten B:			
	L:			
	D:			
	Snack: Health Shake:			
	Bathing/Grooming/Oral Hygiene **S** =Self **A** = With Assist **P** = Prompting required **T** = Total care			**Problem #**_____ _____
	BM* (*if no BM in 24 hrs, document intervention)			**Problem #**_____ _____
	Voiding			**Problem #**_____ _____
	Diagnostics Completed: (circle below) **R** = refused CBC/BMP/UA/UDS/EKG/EEG/MRI/XRAY			**Problem #**_____ _____
Daily Mental Status Assessment	**Alert and Oriented X /3**			**Nursing Note: Legible Date/Time/Signature and Title with each entry**
	Memory: (+) Intact (-) Impaired			
	Judgment: (+) Intact (-) Impaired			
	Thought Content: Logical			
	Hallucinations*			
	Delusions*			
	Tangential*			
	Blocked*			
	Grandiose*			
	Paranoid*			
	Risk Assessment: None			
	Suicidal Ideation*			
	Homicidal Ideation*			
	Seclusion & Restraint*			
	Affect: Appropriate			
	Inappropriate*			
	Blunted/Restricted*			
	Flat*			
	Hostile*			
	Depressed*			
	Euphoric*			
	Labile*			
	Mood: Appropriate			
	Depressed*			
	Labile*			
	Anxious*			
	Irritable*			
	Interaction: Participating			
	Withdrawn/Isolative*			
	Intrusive/Disruptive*			
	Hostile/Aggressive*			
	Initials of nurse completing assessment			
D	Date:	07-19	19-07	

Patient Label

Formatted: Bottom: 0.69"

Attachment B

	Appearance: Appropriate			
	Disheveled*			
	Bizarre*			
	Speech: Clear/normal			
	Pressured*			
	Loud*			
	Slurred*			
	Slow*			
	Soft*			
	Mute*			
	Ambulation/Gait:			
	Steady/Unassisted			
	Unsteady*			
	Shuffling*			
	With Assistance* (indicate **W** = walker, **WC** = wheelchair)			
	EPS Evaluation: no signs			
	Fine Tremor*			
	Facial Twitching*			
	Restlessness*			
	Rigidity*			
	Drooling*			
	Shuffling*			
	V/S Stable (Yes or No*)			
	Med ~~Compliant~~ Education Offered (Yes or No*) - circle Verbal Written Demonstration ~~Emergency Meds Utilized*~~			
	Initials of nurse completing assessment			

Formatted: Font: 8 pt

Formatted: Left

Alternative Group Activity

Time Start/ End	Staff Signature and title	Group Alternative ~~* With Doctor's Order~~	Patient's Response
		Read Paper/Book Activity of Daily Living ~~Off Unit Walk*~~ Face to Face Conversation Journaling Listen to Music Watch TV Other:	Cooperative Refused with Prompting
		Read Paper/Book Activity of Daily Living ~~Off Unit Walk*~~ Face to Face Conversation Journaling Listen to Music Watch TV Other:	Cooperative Refused with Prompting
		Read Paper/Book Activity of Daily Living ~~Off Unit Walk*~~ Face to Face Conversation Journaling Listen to Music Watch TV Other:	Cooperative Refused with Prompting

Daily Vital Signs

Time	Blood Pressure	Pulse	Resp	Temp	Pain (scale, location)	Weight	Staff Initial

Female patients: **Menstruating? Y N N/A**

Date	Print Name and title	Initials	Signature	Date	Print Name and title	Initials	Signature

Patient Label