DEPARTMENT OF CORRECTIONS

Policy Number:	**500.200**
Title:	**Management of Medications**
Effective Date:	**8/21/18**

PURPOSE: To provide a systematic method so that prescription and non-prescription medications are managed according to state and federal regulations, State Board of Pharmacy rules and regulations, accepted nursing practice, and in accordance with established guidelines. To provide accountability for administering or distributing medications in a timely manner and according to physician orders.

APPLICABILITY: All licensed and trained staff in all facilities

DEFINITIONS:

Administer – to give a prescribed medication to an offender/resident.

Adverse reaction – any undesired or unintended response to a medication that requires treatment or alteration of therapy.

Electronic medication administration record (eMAR) – a format used for documenting prescribed and administered medications.

Directly-observed therapy (DOT) – medications that are administered directly by trained staff.

Formulary – a listing of medications approved by the pharmacy and therapeutics committee of the department.

Mouth check – the act of visually inspecting the inside of the offender's/resident's mouth after a medication was administered. The offender/resident opens mouth wide and extends tongue out beyond the lip. While the mouth is still opened wide, the offender/resident must position the tongue up, down, and side-to-side, exposing all surfaces of the mouth. After the staff member has viewed the mouth, the offender/resident must hold the hands up, palms toward the nurse/security staff member and fingers extended.

Nonprescription medication – a therapeutic agent available over the counter without a prescription.

Prescription or prescribed medication – a therapeutic agent that is ordered by authorized prescriptive authorities.

Prescribing authority – physicians, psychiatrists, dentists, nurse practitioners and physician assistants who, by license or delegated authority, may write orders for prescription medications.

Qualified licensed/certified professionals – those individuals authorized by a regulatory board to practice their special skills (e.g., medical doctor (MD), registered nurse (RN), licensed practical nurse (LPN), nurse practitioner (NP), doctor of dental surgery (DDS), physician's assistant certified (PAC), certified medical assistant (CMA), and athletic trainer certified (ATC)).

Side effect – any reaction or consequence of a medication.

Trained staff – personnel who have completed an approved medication administration course and are authorized by the supervisory nurse to administer medications.

PROCEDURES:

A. Medication Administration

1. Only qualified, licensed/certified, or trained staff administer medications. Documentation of medication administration training is retained in the employee's supervisory file.

2. Each facility must establish standardized directly-observed therapy (DOT) medication times. Any requests for DOT medication administration not within established administration times must be directed to the health services administrator (HSA)/designee for approval.

3. Medications are administered within an hour of the physician-ordered administration time.

4. It is permissible to pre-set medications for administration in advance only when medications are to be delivered to the cell front (for example, due to lockdown, delivery to a living unit, etc.). Medications are only to be administered by the staff person who has pre-set those medications.

5. Licensed and trained staff administering medication must:

   a) Check the "six rights" (right patient, right dose, right route, right time, right medication, right documentation), and the stop date, prior to administering medication.

   b) Remain with the offender/resident until the medication is swallowed.

   c) Ensure that a mouth check is completed by nursing or security staff immediately after the medication administration. Security staff may complete a secondary verification mouth check.

   d) Not borrow medication for another offender/resident. If an offender/resident reports that the offender/resident is out of medications:

      (1) Check for medication adherence as to when the medication was last ordered and issued; and notify the watch commander if a room search is warranted;

      (2) Check the chart for the current order and contact the on-call practitioner for chronic care medication if the order must be immediately re-written and cannot wait until the facility practitioner is available;

      (3) Discuss the need for medication and use of the back-up pharmacy with the on-call practitioner, if medication is not stocked;

      (4) Document discussions and the plan in the offender's/resident's medical record; and

      (5) Educate the offender/resident on proper self-administration and document.

   e) When administering a prescription dose from stock medications, sign-out on the designated stock medication log book, ensuring that the medication count is accurate.

      (1) Report an inaccurate count to the registered nurse supervisor (RNS);

(2) Forward the completed Stock Prescription Medication Sign-Out sheet (attached) to the RNS to retain for two years; and

(3) A log book audit must be completed by the RNS on a monthly basis.

f) Document in the progress notes any side effects observed or reported to health services staff or trained staff, and discuss with practitioner.

6. A contracted pharmacist audits medication practice and documentation monthly at each facility

B. Insulin administration at adult medium and close custody settings is managed as follows:

1. Offenders prescribed insulin are instructed to report to the medication window (or cell doors, if applicable) at designated times with their glucometers, to verify their blood glucose readings with a nurse. A recheck may be requested if there are any concerns with accuracy.

2. The nurse or trained staff member reviews the glucometer reading. If more than 60 minutes have passed, the offender is to be directed to go to a designated area to retest and to show the reading again, prior to the nurse drawing up the insulin.

3. If the offender does not bring the offender's glucometer, the offender is instructed to check blood glucose at that time in a designated area and show the reading to the nurse.

4. Once the nurse verifies the offender's blood glucose, the nurse draws up the appropriate ordered dosage of insulin.

5. The nurse verifies that the correct dosage was drawn up, verifies the type and amount of insulin, and then hands the offender the syringe. The offender must self-administer the insulin and dispose of the syringe directly into the provided safety container.

6. The nurse documents the insulin taken by the offender on the electronic medication administration record (eMAR) as self-administered.

7. If the offender refuses to verify the offender's blood glucose level, the nurse must hold the insulin and notify the medical practitioner for further direction.

C. Offenders/residents in juvenile and minimum security settings are allowed to draw up and self-administer insulin under the direct supervision of security staff or other trained staff.

D. Monitoring DOT Medications

1. Nursing staff must document medication administration on the eMAR after each medication administration.

2. Nursing staff must document medication diversion/attempts of medication diversion (cheeking, palming, attempting to hide medications) in the offender's/resident's medical record and in an incident report.

3. Nursing staff must monitor and address offender/resident medication adherence on a weekly basis. (Medications monitored include those used to treat asthma, diabetes,

hypertension, heart disease, seizures, human immunodeficiency virus (HIV), Hepatitis C, and latent tuberculosis (TB), and antibiotics for acute infection.)

4. When non-adherence is noted:
   a) Health services staff meet with the offender/resident, if able, discuss medication adherence, and provide the offender/resident with education on the impact of medication adherence and the treatment of chronic or acute conditions. If indicated, staff have the offender/resident sign a Refusal of Health Care form (attached). Refusal of Health Care forms are retained in the legal section of the offender's medical file.

   b) If indicated, staff must document the review and/or assessment, and the education, in the offender's/resident's medical record.

   c) Staff must present the medical record to the medical practitioner at the next scheduled on-site date, or schedule the offender/resident to see the medical practitioner.

5. Behavioral health (BH) staff must monitor and address DOT psychiatric medication (including psychotropic and other medications used to treat psychiatric conditions ordered by a psychiatric practitioner) as follows:
   a) BH staff must monitor and address psychiatric medication adherence on a weekly basis.

   b) When non-adherence is determined, BH staff must review, and document in the mental health record the action taken and follow up if needed (e.g., file review, offender/resident visit, referral to practitioner) within three business days.

D. Monitoring Keep on Person (KOP) Medications

Keep on person (KOP medication must be monitored as follows:

1. Nursing staff must complete all medication pill counts ordered by the practitioner or other concerned staff.

2. Nursing staff must coordinate with correctional officers to retrieve all KOP medication from the offender's/resident's cell/room, per facility protocols, or must instruct the offender/resident to bring all KOP medications to health services for nursing review.

3. Nursing staff must document findings of pill counts and note any discrepancies in the offender's/resident's medical record and in an incident report.

4. When non-adherence of a non-psychiatric medication is determined, nursing staff must review and document in the medical record the action taken, and must follow up if needed (e.g., file review, offender/resident visit, referral to a practitioner).

5. BH staff must monitor and address incidents of non-adherence of psychiatric medications. When non-adherence is determined, BH staff must review and document in the mental health record the action taken, and must follow up if needed (e.g., file review, offender/resident visit, referral to a practitioner) within three business days.

6. The registered nurse supervisor or designee audits medication adherence randomly for medications used to treat chronic care conditions and other medications deemed appropriate as identified by the Continuous Quality Improvement Committee. These

medications include those medications used to treat asthma, diabetes, hypertension, heart disease, seizures, human immunodeficiency virus (HIV), Hepatitis C, and latent tuberculosis (TB), and antibiotics for acute infection.

E. Practitioner Responsibilities
The practitioner must:

1. When ordering medications, discuss the importance of medication compliance with the offender/resident and discuss the clinical risks of not taking medications as prescribed; also inform offenders/residents that medication non-adherence may result in a discontinuation of the medication or an alternative treatment plan, if indicated;

2. Review the eMAR for medication compliance and any documentation presented by nursing or BH staff;

3. Document the review and/or assessment, and the education, in the medical record and/or the behavioral health record;

4. Document in the record if it is determined to continue the medication, to discontinue the medication for non-adherence, to order any relevant lab work, and/or to prescribe an alternative treatment, if indicated; and

5. Notify the offender/resident that, if the offender/resident wishes to discuss further concerns, the offender/resident has the option of sick call for medical concerns or consulting BH staff for mental health concerns.

F. Prescribed medications must be listed in the department formulary. Non-formulary medications must be pre-approved by assigned contractors.

G. Medication variances must be reported and evaluated to determine the need for systems changes, training, and other actions necessary to prevent future occurrences. Medication variances and the actions taken must be documented on a variance medication form. The RN supervisor retains a copy for six months. (See Policy 500.202, "Medication/Treatment/Transcription Errors.")

H. All medications must be ordered by health care practitioners with prescriptive authority.

1. Medications are prescribed only when clinically indicated as one facet of a program of therapy.

2. A prescribing provider reevaluates a prescription prior to its renewal.

3. Medications dispensed by a facility practitioner or a consulting pharmacist must follow the Minnesota DOC Procedure Practitioner/Pharmacist Dispensing or Medications (attached) and must use only Minnesota DOC-approved pre-printed pharmacy labels.

I. Health services staff educate offenders/residents on indications for use and potential side effects (when indicated.)

J. All licensed and trained staff must report to the prescribing authority observed or reported side effects of medications.

K. Medications must be provided to offenders/residents upon release from a facility per Policy 500.203, "Release Medications."

L. A recording video camera monitors all restricted medication storage areas.

INTERNAL CONTROLS:

A. Documentation of medication variances and the action taken is documented on a variance medication form. The RN supervisor retains a copy for six months.

B. Documentation of medication administration training is retained in the employee's supervisory file.

C. A contracted pharmacist audits medication practice and documentation monthly at each facility.

D. Refusal of Health Care forms are retained in the legal section of the offender's medical file.

ACA STANDARDS: 4-4378, 4-4383, 1-ABC-4E-10, 1-ABC-4E-13, 1-ABC-4E-16, and 1-ABC-4E-17

REFERENCES:
Minn. Stat. §241.01 subd. 3(a)
Policy 500.202, "Medication/Treatment/Transcription Errors"
Policy 500.203, "Release Medications"
Minnesota Nurse Practice Act (Minn. Stat. §§ 148.171 to 148.285)
Minnesota Board of Pharmacy Rules

REPLACES:
Policy 500.200, "Management of Medications," 10/25/16.
All facility policies, memos, or other communications whether verbal, written, or transmitted by electronic means regarding this topic.

ATTACHMENTS:
Medication Administration Record CM # 3150 (500.200A)
INH - Positive Mantoux/Prevention Therapy form (500.200B)
Stock Prescription Medication Sign-Out (500.200C)
Medication Refill Request form (500.200D)
MN DOC Procedure Practitioner/Pharmacist Dispensing of Medications (500.200E)
MN DOC Medication Inventory and Dispensing Record (500.200F)
MN DOC Prescription Labeling Guidelines (500.200G)
Albuterol/Inhaler Dispensing Label – SAMPLE (500.200H)
Refusal of Health Care form (500.010A)

APPROVALS:
Deputy Commissioner, Facility Services
Deputy Commissioner, Community Services
Assistant Commissioner, Facility Services
Assistant Commissioner, Operations Support