MEDICATION EDUCATION AND MEDICATION MANAGEMENT PROGRAM

1. **Purpose:** To provide medication education and preparation for personal medication management and to increase the level of individual responsibility associated with medication management in order to assure medication compliance.

2. **Scope:** These procedures apply to all residents receiving medication at Florida State Hospital with the exception of residents with acute medical or psychiatric illness, dementia, and/or organic brain damage. Unit 27 will develop their own procedure for medication education and management specific to their resident demographics. The Pharmacy Department, in collaboration with Nursing Services, will provide medication in-service for residents in the program.

3. **Training Requirements:** Nurses, Physicians, Advanced Registered Nurse Practitioners, Pharmacists, Unit Treatment Rehabilitative Staff, who are certified to give medications, will be trained on this operating procedure upon hire into the position during Worksite Education and Discipline-Specific Education and by their supervisor each time the operating procedure is revised. Dentists will be trained on this operating procedure upon hire into the position during Worksite Education and by their supervisor each time the operating procedure is revised.

4. **Policy:** All residents identified in the scope of this policy will have an active treatment issue for medication education with a service plan. Medication education will be tailored to each individual resident’s needs and will consist of either structured individual or group sessions at the time of medication administration. Resident participating in each phase of the Medication Management Program will require approval from the Recovery Team. Prior to Phase III of the Medication Management Program the resident will be assessed by the Psychiatrist/Advanced Registered Nurse Practitioner to determine competency to participate. If the resident is approved for Phase III, an order will be written by the attending Psychiatrist/Physician/Advanced Registered Nurse Practitioner for the specific medications that are to be included in the program prior to beginning Phase III. Pro Re Nata (PRN) medication will not be included in the Medication Management Program.

5. **References:**

   a. Florida State Hospital Operating Procedure 150-35, Unit Dose System.

   b. Florida State Hospital Operating Procedure 152-5.10, Use of Blood Glucose Monitors.

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**This Operating Procedure supersedes:** Operating Procedure 155-11, dated March 19, 2007  
**Office of Primary Responsibility:** Nursing Management Team/Pharmacy Services  
**Distribution:** Florida State Hospital Computer Network Users
6. **Definitions:**

   a. **Medication Education:** Instruction or information given by the nurse and/or pharmacist may include the Psychiatric Medication Education individual education and phases 1, 2, & 3 of psychotherapeutic medication education. The instructions will cover the following areas at a minimum: medication name, medication time, medication dosage, medication side effects and related interventions, prevention of side effects, signs and symptoms of illness, target symptoms, prevention of relapse (medication compliance). The Recovery Plan will address the areas specific for each resident and weekly/monthly nursing progress notes will reflect the areas where the resident demonstrates understanding of the medication regimen.

   b. **Medication Management Program:** This is a supervised step-progressive program which develops the resident’s skills to self-administer prescribed medications. It begins with the resident requesting his/her medication at the prescribed time and progresses to self-administration and documentation with supervision.

   c. **Phase:** Refers to the three phases of progression through higher levels of independence in the Medication Management Program.

7. **Procedure:**

   a. **Medication Education:** Each resident at Florida State Hospital will receive Medication Education in accordance with the scope, policy and definition in this procedure.

      (1) Resident’s understanding of medications will be documented in the weekly/monthly progress note by the nurse.

      (2) Medication Education will be updated as medications are changed or discontinued.

   b. **Medication Management Program:**

      (1) **Resident Selection:** When the resident has successfully completed Medication Education, the nurse will encourage the resident to participate in the Medication Management Program. If the resident has an interest in beginning Phase One, the nurse will request the Recovery Team to consider/approve the resident for entering Phase One.

         (a) Recovery Team approval will be required for progression from one phase to another.

         (b) Prior to the resident entering Phase Three, following the recommendation of the Recovery Team, the Psychiatrist will interview the resident in order to determine competency to participate in the program. (See Attachment 1, Form 332)

         (c) Select residents receiving injectable medications may participate in the program with direct supervision (in the direct presence) of a nurse. (Example: Diabetics prescribed insulin therapy)

         (d) Any unit which is not staffed with a nurse on duty 24 hours a day, seven (7) days a week will not be able to select an insulin dependent diabetic resident for this program.
(e) In order for a resident with insulin-dependent diabetes to participate in the program, a nurse must be available to monitor/supervise the following:

1. Correct preparation of the injection using aseptic technique.
2. Administration of the injection.
3. Potential effects and side effects of the medication.
4. Consumption of prescribed caloric intake (i.e., diet and snacks) to include those consumed away from the unit.
5. Blood glucose checks with a blood glucose monitoring machine which must be in compliance with the Florida State Hospital Operating Procedure 152-5.10, Use of Blood Glucose Monitors.

(2) **Phase One:**

(a) In Phase One, the resident will be responsible for requesting each dose of medication by name, at the scheduled time, from the person administering medication. The unit personnel will administer and chart the medication on the Medication Administration Record. Compliance or noncompliance will be indicated by (+) or (-), respectively, placed above the initials of the person documenting the medication administration.

(b) Phase One allows designated personnel to prompt or give reminders to the resident of the dosage period. Progress note documentation shall reflect that the resident failed to request his/her medication. This notation will be reviewed by the Recovery Team.

(c) Phase One residents will be evaluated for advancement to Phase Two by the Recovery Team.

(3) **Phase Two:** Phase Two will increase the responsibility of the resident.

(a) In Phase Two, the resident will request each dose of medication by name, at the scheduled time without reminders from the staff.

(b) If a resident does not request his/her medication at the scheduled time, a 30 minute grace period will be allowed where the resident may go up to designated staff and request the medication. If the resident does not request the medication during this 30 minute grace period, the supervising nurse shall be notified. The supervising nurse shall decide the next course of action. Consideration must be given to the class of medication(s), indications and pharmacokinetics (i.e., anticonvulsant, antimicrobial, etc.). Incident and rationale for course of action will be documented in the progress notes by the licensed nurse.

(c) If the resident does not request the medication for a second consecutive dosage period, the licensed nurse will take the appropriate course of action and document in the progress notes. Missing the second consecutive dosage period will require the Recovery Team to evaluate and determine the resident’s next step.

(d) Resident may remain in Phase Two indefinitely. Progression to Phase Three will require approval from the Recovery Team. Progression to Phase Three will also
require the psychiatrist’s assessment of competency. The attending psychiatrist or Advanced Registered Nurse Practitioner will write the order to progress to Phase Three, along with completion of Form 332 by the psychiatrist.

(4) Phase Three: Phase Three requires a signed Agreement To Participate in the Medication Management Program (Attachment 2, Form 286) by the resident; witnessed by the nurse and pharmacist. The resident will receive a copy of the signed Form 286 as well as a description of the program. Form 286 will be filed in the resident’s chart and a copy will be kept in a designated place in the medication room to identify program participants. Phase Three establishes independence for the resident to administer his/her own medications.

(a) A Physician Order for advancement to Phase Three with a 28 day supply of medications shall be written. Appropriate documentation will be made in the progress note.

(b) The resident will take the medication order to the Pharmacy escorted by staff until the resident is deemed eligible by the Recovery Team to go unescorted. The pharmacist will dispense a 28 day supply of medication in an appropriate container with labeling that meets community standards.

(c) The dispensing pharmacist shall review each medication with the resident; provide medication information on dosage requirements, dosage periods and any other pertinent information required to meet pharmacy medication counseling standards.

(d) Upon return to the unit, the licensed nurse will count the medication with the resident. The licensed nurse shall also determine whether the resident needs further medication counseling.

(e) Individual locked boxes will be kept in the designated area deemed appropriate by the unit and will be labeled with the resident’s name. The resident will be responsible for the key. The supervising nurse will have a duplicate key. At dosage times, the resident will unlock the box and self-administer medications without supervision. Documentation of the Medication Administration Record is completed by the resident. The Medication Administration Record will be inspected by appropriate unit personnel on each shift.

(f) Any changes (i.e., changes in mental status, medical condition, etc.) regarding residents in this phase should be brought to the immediate attention of the licensed nurse and reported to the Recovery Team.

(g) Residents may continue in the program until transferred to another facility or discharged to the community.

(h) Any phase may be repeated upon recommendation by the Recovery Team.

(i) Safeguards will include the nurse or designee regularly counting medications in the resident’s medication box to assure dosing compliance as well as observation for changes in mental status which may warrant further investigation and checking psychotropic medication blood levels, when appropriate, upon the discretion of the prescriber. Dose omissions, unaccounted for medications and or changes in mental/physical status will
result in an investigation/evaluation of the circumstances by the supervising nurse or the recovery team.

(5) **Monitoring and Documentation:** The supervising nurse or designee(s) will monitor the progress of the participants, identify a treatment issue (i.e., Medication Education, Medication Management), formulate an individual Recovery plan, provide documentation in each resident's chart, report to the Recovery Team, and complete the following forms:

(a) A Follow-Up Measure #1 (Attachment 3, Form 337) will be administered after completion of Phase One and prior to beginning Phase Two to obtain data on the resident’s knowledge of medication and of Phase Two responsibilities, as well as to chart progress. This form will be kept in the individual resident’s file.

(b) A Follow-Up Measure #2 (Attachment 4, Form 338) will be given after completion of Phase Two and before progression to Phase Three to assess each resident’s knowledge of his/her medication regimen, potential side effects, symptoms of his/her mental illness, medication target symptoms and procedural knowledge of Phase Three. This form will be kept in the individual resident’s file.

(c) A thorough and comprehensive prerelease assessment (Attachment 5, Form 339) will be done after a resident has been on Phase Three for 60 days and/or just before release or transfer to another setting. This assessment will ensure that a given resident will again be exposed to the crucial information presented in the educational training component and can utilize this information in an appropriate manner. The pre-release assessment form will be filed in the individual resident’s file.

(6) **Failure to Advance:** Failure to advance in the program will be addressed on an individual basis and will be documented in the Progress Note section of the chart.

*(Signed original on file in Central Health Information Services)*

DIANE R. JAMES  
Hospital Administrator

5 Attachments

1. Determination of Competency for Phase Three of the Medication Management Program (Form 332)
2. Agreement to Participate in Medication Management Program--Phase Three (Form 286)
3. Follow-up Measure #1 (Form 337)
4. Follow-up Measure #2 (Form 338)
5. Follow-up/Prerelease During Phase Three (Form 339)
**SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL**

The revisions to this operating procedure include: spelling out abbreviations/acronyms; deletion of the management team module associated with the Florida Algorithm Team Solutions; deletion of immediate notification of the physician or ARNP when a resident fails to request a medication after the second dosage period; meeting pharmacy medication education standards was added; the medication administration record will be inspected by appropriate unit personnel each shift was added; and several grammatical changes were made. Dentists are not included in the discipline specific training and will be trained on this operating procedure upon hire into the position during Worksite Education and by their supervisor each time the operating procedure is revised.
COMPETENCY EXAMINATION

I, ________________________________________, have examined, the above referenced individual on ___________________________, ______, to ascertain whether the individual is competent with regard to understanding and making decisions required for participation in Phase Three of the Medication Management Program; and,

I questioned the individual about the following:

- Why is it important to take the medication?
- What will you be able to achieve if you take the medication?
- What will happen if you do not take the medication?
- How long will it be necessary to take the medication?

The individual indicated that he/she did ____ did not ____ understand the issues related to Phase Three of the Medication Management Program.

Based on the above, it is my opinion that ________________________________________ is ____ is not ____ competent with regard to participating in Phase Three of the Medication Management Program.

_______________________________________________                   ____________________________
Psychiatrist’s Signature                                                                        Date

INSTRUCTIONS: To be completed by the Psychiatrist in accordance with Hospital Procedure 155-11.

Original to be filed in the Legal section of the ward chart.

** CONFIDENTIAL & PRIVILEGED INFORMATION ** FOR PROFESSIONAL USE ONLY **

FLORIDA STATE HOSPITAL, CHATTANOOCHEE, FL 32324
I agree to participate in the Florida State Hospital Medication Management Program, Phase Three.

The policy and description of Phase Three of the Program has been explained to me and I have been given a description of the Program.

I certify that my medication routine including names, dosages, and times medications are to be taken were discussed with me along with potential side-effects.

I will abide by the rules of the Medication Management Program, Phase Three and understand that I will accept the responsibility for any missed dose(s). I agree to random psychotropic medication blood levels to be obtained at the discretion of my attending physician/ARNP.

Resident’s Signature __________________________________________ Date _______________________

Nurse _________________________________________________________________________

Pharmacist _____________________________________________________________________

INSTRUCTIONS: Nurse and Pharmacist will review form with the resident, obtain and witness the resident’s signature, and sign the form in accordance with Hospital Procedure # 155-11.

Original to be filed in the Legal section of the ward chart.

** CONFIDENTIAL & PRIVILEGED INFORMATION *** FOR PROFESSIONAL USE ONLY **

FLORIDA STATE HOSPITAL, CHATTAHOOCHEE, FL 32324

Form 286, (Revised) Jul 99 FLORIDA STATE HOSPITAL
Office of Primary Responsibility: Nursing Management Team & Pharmacy

AGREEMENT TO PARTICIPATE IN MEDICATION MANAGEMENT PROGRAM—PHASE THREE

ADDRESSOGRAPH

Attachment 2
Operating Procedure 155-11
FOLLOW-UP MEASURE #1
AFTER COMPLETION OF PHASE ONE AND
BEFORE PROCEEDING TO PHASE TWO

INSTRUCTIONS: This assessment is to be completed by a nurse and filed in the nurse’s individual resident files.

INDIVIDUAL’S NAME & NUMBER: __________________________________________________________
DATE THIS ASSESSMENT COMPLETED: ___________________________________________________
NAME OF PERSON DOING THIS ASSESSMENT: _____________________________________________

Questions for the nurse to ask individual:

1. Is your medication schedule easy to follow:
   Record Response: _________________________________________________________________
   Does the individual seem to feel comfortable with their medication routine?  ____ Yes  ____ No

2. How many different medications do you take a day?
   Record Response: _________________________________________________________________
   Is individual able to tell you how many different medications they are required to take per day?
   ____ Yes  ____ No

3. What will your responsibility be when it comes to getting your medication on Phase Two of the
   Self-Medication Program? How is Phase Two different from Phase One?
   Record Response: _________________________________________________________________
   Is individual aware that they will be required to request each dose of medication by name at the
   appropriate time and will not receive prompts/reminders from staff?  ____ Yes  ____ No

4. What happens if you forget to request a dose of medication at the scheduled time?
   Record Response: _________________________________________________________________
   Does the individual know and report that a 30 minute grace period will be given in the event that they do
   not request their medication at the scheduled time?  ____ Yes  ____ No

5. While on Phase One, were there any times that you forgot to request your medication when you
   were supposed to?
   Record Response: _________________________________________________________________
   Is individual aware of any incident(s) when they did not request their medication at the scheduled time and
   required a 30 minute grace period, or when staff had to intervene?  ____ Yes  ____ No

6. How long will you be on Phase Two before you are able to progress to Phase Three?
   Record Response: _________________________________________________________________
   Does the individual know that they will remain on Phase Two until the Service Team determines they are
   ready to advance and the psychiatrist determines competency to advance?
   ____ Yes  ____ No
INSTRUCTIONS: This assessment is to be completed by a nurse and filed in the nurse’s individual resident files.

INDIVIDUAL’S NAME & NUMBER: __________________________________________________________

DATE THIS ASSESSMENT COMPLETED: ___________________________________________________

NAME OF PERSON DOING THIS ASSESSMENT: _____________________________________________

Questions for the nurse to ask individual:

1. I am going to ask you to tell me some things about your medication schedule. Ask individual to provide the following information about each medication they are currently taking and record the individual’s responses:

   a. names of the medications individual is taking
   b. when individual takes the medications (times/frequency)
   c. how much of each medication individual is taking (dose)
   d. function of the medication—what each medication is used for/how it helps them

Medication: _________________________________________________________________________
Time(s) this medication is taken: ______________________________________________________
Dose/How many milligrams of this medication: ___________________________________________
What is this medication used for? What does it do for you? ________________________________
___________________________________________________________________________________

Medication: _________________________________________________________________________
Time(s) this medication is taken: ______________________________________________________
Dose/How many milligrams of this medication: ___________________________________________
What is this medication used for? What does it do for you? ________________________________
___________________________________________________________________________________

Medication: _________________________________________________________________________
Time(s) this medication is taken: ______________________________________________________
Dose/How many milligrams of this medication: ___________________________________________
What is this medication used for? What does it do for you? ________________________________
___________________________________________________________________________________

Medication: _________________________________________________________________________
Time(s) this medication is taken: ______________________________________________________
Dose/How many milligrams of this medication: ___________________________________________
What is this medication used for? What does it do for you? ________________________________
___________________________________________________________________________________
Medication: __________________________________________________________
Time(s) this medication is taken: _______________________________________
Dose/How many milligrams of this medication: ____________________________
What is this medication used for? What does it do for you? ____________________

Can individual correctly recite the current medication regimen including names of meds, times they receive meds, dosage of meds, and what meds do for them?  ____ Yes  ____ No

2. Can you tell me two possible side effects that are associated with the medications you are taking?
Record Response: ___________________________________________________________
Is the individual aware of at least two potential side effects such as dry mouth, dizziness, drowsiness, sunburn, problems with urination or bowel movements, nausea, etc.?  ____ Yes  ____ No

3. Can you tell me some of the symptoms your medications are targeted to treat/help?
Record Response: ___________________________________________________________
Can the individual name any of the symptoms of their mental illness?  ____ Yes  ____ No

4. What is likely to happen if you stop taking your medications?
Record Response: ___________________________________________________________
Is the individual aware that they may experience a decline in mental status and that their symptoms may get worse if they stop taking their medication?  ____ Yes  ____ No

5. What will your responsibilities be when it comes to getting your medication on Phase Three of the Self-Medication Program? How is Phase Three different from Phase Two?
Record Response: ___________________________________________________________
Is the individual aware that they will now be fully responsible for self-administering their own medication without supervision, and that they will need to document on the MAR when they take a dose of medication?  ____ Yes  ____ No

6. How long will you remain on Phase Three of the Self-Medication Program?
Record Response: ___________________________________________________________
Does the individual know that they will remain on Phase Three indefinitely, unless they do something at this facility to warrant being taken off the Self-Medication Program, or unless they are transferred to another facility that does not allow residents to self-administer their own medication? If released to the community or a place that allows them to self-administer their own medication, they could technically stay on Phase Three for the rest of their lives with medications for psychiatric and/or physical illness.  ____ Yes  ____ No
FOLLOW-UP/PRE-RELEASE DURING PHASE THREE

INSTRUCTIONS: This assessment is to be completed by a nurse and filed in the nurse’s individual resident files.

INDIVIDUAL’S NAME & NUMBER: __________________________________________________________

DATE INDIVIDUAL BEGAN PHASE THREE: ________________________________________________

TODAY’S DATE: ______________________________________________________________________

1. Do you have a mental illness? ____ Yes     ____ No
   What is the name of it? What is it called? _______________________________________________
   ___________________________________________________________________________________

2. Do you need to take medication for a mental disorder or psychiatric problem? ____ Yes     ____ No
   Why do you take medication? _________________________________________________________
   ___________________________________________________________________________________

3. Are there any potential side effects of the medication(s) you are taking? ____ Yes     ____ No
   What are the potential side effects? ____________________________________________________
   ___________________________________________________________________________________

4. Are you comfortable with your medication routine and do you feel it is easy enough to follow? ____ Yes     ____ No
   How do you remember to take your medication(s) when you are supposed to? ________________
   ___________________________________________________________________________________

5. Do you talk to your doctor or ARNP and ask them questions about your medication? ____ Yes     ____ No
   Why is it important to talk to your doctor or ARNP and know about your medication?
   ___________________________________________________________________________________

6. Are you allergic to any medications or do you have any allergies (to foods, products, particles, etc.)? ____ Yes     ____ No
   How would you alert your care-takers of any allergies you may have? ______________________
   ___________________________________________________________________________________

7. Should you always follow your prescribed medication routine exactly? ____ Yes     ____ No
   What should you do if you forget to take a dose of medication? _____________________________
   ___________________________________________________________________________________
8. Would you know if you were getting sick? Would you be able to recognize symptoms of your mental illness if they got worse?  ____ Yes  ____ No
What are some of the symptoms of your mental illness that might be seen if you began to get sick again?
___________________________________________________________________________
_________________________________________________________________________________

9. Would you believe someone else if they said they had noticed a change in you and thought you seemed to be getting sick?  ____ Yes  ____ No
How would you react and what would you do if a friend or family member told you they thought you might be getting sick?
___________________________________________________________________________
_________________________________________________________________________________

10. If it was completely up to you and you were living on your own, would you choose to keep taking your medication?  ____ Yes  ____ No
Why or why not?
___________________________________________________________________________
_________________________________________________________________________________

11. If you stopped taking your medications for a period of time, do you think you would get sick or that your symptoms would resurface?  ____ Yes  ____ No
What would likely happen if you were released from the Hospital and later stopped taking your medications?
___________________________________________________________________________
_________________________________________________________________________________

12. If/When you are transferred to another facility or have to spend time in jail, what can you do to make sure you receive your medications?
___________________________________________________________________________
_________________________________________________________________________________

13. What are the potential dangers of combining over the counter medications, alcohol and/or street drugs with the medications you are taking right now?
___________________________________________________________________________
_________________________________________________________________________________

14. When you go back into the community, will you be able to keep the same friends you used to have even if they are drinking and/or doing drugs?  Why or why not?
___________________________________________________________________________
_________________________________________________________________________________

15. If your friends or relatives tried to talk you into drinking or doing drugs and you were feeling pressured by them to do it, how would you handle that situation?
___________________________________________________________________________

16. If you are released to a group home or to the community, how will you resist the temptation to do drugs and/or consume alcohol?
___________________________________________________________________________
INDIVIDUAL’S NAME & NUMBER: __________________________________________________________

17. Where would you need to go to get medication if you were living in the community? __________
_________________________________________________________________________________

18. What are some situations in which you should seek help from mental health professionals when living in
the community? _______________________________________________________________________
_________________________________________________________________________________

19. If you were living in the community, and noticed that some of your symptoms resurfaced and began to
bother you (i.e., you started hearing voices), who should you report that to? ______________________
_________________________________________________________________________________

20. If you were living on your own, how would you keep up with when to take your medications to make sure
you took the right dose at the prescribed times? _______________________________________
_________________________________________________________________________________

Now I’m going to ask you to do some things that are involved with taking medications.

A. Ask individual to open a variety of pill bottles/medication containers.

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<tr>
<td>does with ease</td>
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<td>unable to do</td>
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Number of trials required to complete this task? ______

B. Give individual a medication planner. First, you demonstrate how to place pills in the proper boxes
according to a prescription you generate. Then, have the individual fill the boxes of the planner using that
same prescription. Next, ask the individual to fill the planner according to their own medication regimen.

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<tbody>
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<td>does with ease</td>
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Number of trials needed to effectively complete this task? ______