ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE PROCEDURE

Date Issued 5/23

CHAPTER		**CHAPTER**	**SECTION**	**SUBJECT**
Health/Medical		04	001	0065
SECTION	**SUBJECT**			
Drugs and Medications	Transporting and Home-Delivery of Medications			
WRITTEN BY	**REVISED BY**		**AUTHORIZED BY**	
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I. APPLICATION:

☐ SCCCMHA Board
☐ SCCCMHA Providers & Subcontractors
☒ Direct-Operated Programs
☒ Community Agency Contractors
☒ Residential Programs
☒ Specialized Foster Care

II. PURPOSE STATEMENT:

St. Clair County Community Mental Health Authority (SCCCMHA) shall ensure medications taken by an individual at more than one (1) location are sent to programs safely, in accordance with the procedures delineated herein. It shall also be the process to ensure safe and proper transfer of home medications for individuals requiring their medications be delivered. It shall also be to ensure safe and proper transfer, as well as return of medications to appropriate storage areas.

III. DEFINITIONS:

A. Medication: A drug used in treatment or prevention of a disease or relief of pain, which includes prescription and over-the-counter drugs.

B. Controlled Substance: Includes those drugs that have potential for abuse or psychological or physical dependence. Those classified as "sleeping pills", sedatives, mild tranquilizers and potent painkillers mainly of the barbiturate, benzodiazepine and opium-derivative families are included in Schedule II-V, Chapters 1-2, Drug Control Act, State of Michigan. Amphetamines and some stimulants are classified as controlled substances and are included in CFR - Code of Federal Regulations Title 21.

IV. STANDARDS:

A. Individuals should be encouraged to come to SCCCMHA to pick up their medications.

B. Controlled substances will no longer be a home-delivered medication. Individuals who are prescribed controlled substances must make arrangements to pick them up from SCCCMHA. (There may be exceptions. Exceptions must be approved by an Assistant Division Director or Program Director/Medical Director.) This standard also applies to individuals served by Assertive Community Treatment (ACT).

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C. When the individual meets with the Nurse to receive the medications, the Nurse will review those medications with the individual present and both will sign the Controlled Substance Count Sheet (form #0112) verifying the medications provided.

V. PROCEDURES:

A. For Medications Delivered to Program

Group Home Supervisor/Designee/Parent/Specialized Foster Care Provider

1. Requests pharmacist to type the applicable designation on the prescription vial (i.e., school).

2. Transports the medication in the appropriate pharmacy filled and labeled container to the appropriate location via responsible person.

3. Completes sender portion of Medication Transfer Form--includes the consumer's name on the form (form #0008 in SCCCMHA Form Index).

Program Supervisor/Designee

4. Receives medications and checks to see that correct exchange of medication has occurred.

5. Completes the receiver portion of the Medication Transfer Form (#0008 in SCCCMHA Form Index) and returns to sender.

Group Home Supervisor/Designee/Parent

6. Maintains Medication Transfer Form (#008 in SCCCMHA Form Index) or similar form in a separate file for one (1) year then destroys.

   Note: SCCCMHA form #0008 can also be used for medication transport when an individual is transferred/moves from one Group Home/AFC to another (write resident's name on the form).

Program Supervisor/Designee

7. Notifies Group Home Supervisor/Designee or Parent one (1) week in advance of the need to have medication supply at program replenished.

Group Home Supervisor/Designee/Parent

8. Obtains a new supply of medication from the pharmacy following steps 2-3 and transports medication to location (program).

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Designee/ Responsible person

9. Do the following when transporting medications in own vehicle for purposes of assisting with medication box fills, and you are going to their home: you must return the medication to the appropriate storage site. (No medication should be left in vehicles/trunks overnight).

B. RN/Delivery Staff/Recipient

1. Notifies a Supervisor immediately, if there any concerns/discrepancies with medication.

2. Follows the Medication Errors administrative procedure (# 04-001-0045).

For Delivery of Controlled Substances (Exceptions for delivery of controlled substances)

3. Must follow the steps below. (In the cases when approval by an Assistant Division Director or Program Director/Medical Director permits delivery of controlled substances):

   a. Fills the medication box and/or gathers the bubble packs. This RN and the RN, who verifies the medications, both sign the Controlled Substances Count Sheet (form #0112).
   b. Secures the prepared medications in the double-locked medication room or locked tub until the Delivery Staff arrives to pick up the medications.
   c. Notifies the staff delivering medications that they are ready to be delivered.
   d. Retrieves the locked medications and RN reviews with the delivery staff the medications. The Nurse and Delivery Staff both sign the Medication Delivery Form (Form #0384), verifying the medications and counts.
   e. Secures the medication in a tamper-proof bag in the presence of the Delivery Staff (done by the RN) and the Nurse provides the tamper-proof medication to the Delivery Staff. The individual's name, address and phone number are included on the tamper-proof bag.
   f. Delivers the medications in the tamper-proof bag to the individual, who opens the tamper-proof bag in the delivery person's presence. The medications are reviewed and counted. Both Delivery Staff and the Individual sign the Medication Delivery Form, verifying the medications and counts.
   g. Documents the visit information into OASIS by the Delivery Staff.

For Delivery of Non-Controlled Substances

4. Must follow the steps below:

   a. Fills the medication box and/or gathers bubble packs and places in a tamper-proof bag with the individual's name, address and phone number. This is done by the RN.
   b. Secures the tamper-proof bag of medications in the double-locked medication room or locked tub until the delivery staff arrives to pick up the medications.
   c. Notifies the Delivery Staff that medications are ready to be delivered.
   d. RN documents in OASIS that medication has been given to Delivery Staff. .
   e. Delivery Staff documents the visit information into OASIS.

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VI. REFERENCES:

None Available

VII. EXHIBITS:

VIII. REVISION HISTORY:

Dates issued: 05/88, 01/90, 08/92, 04/95, 11/97, 11/99, 10/01, 12/03, 12/05, 12/07, 12/09, 03/12, 05/13, 05/14, 05/15, 05/16, 05/17, 05/18, 05/19, 7/20, 10/20, 05/21, 05/22.

EXHIBIT A

St. Clair County Community Mental Health Authority

MEDICATION TRANSFER FORM

On _____ The _____ Released:
(Date) (Care Provider/Program Provider)

To _____ For: _____
(Care Provider/Program Provider) (Consumer Name/Case Number)

Group Home Supervisor / Designee / Parent

Medication: _____ Medication:_____

Dosage: _____ Dosage: _____

Number:_____ Number:_____

Receiving Party Accepting Medication (Program / Designee)

Medication: _____ Medication:_____

Dosage: _____ Dosage: _____

Number:_____ Number:_____

Please Sign And Date When Items Are Delivered/Received.

_____

Sending Party Date

_____

Transporting Party Date

_____

Receiving Party Date

Health-Medical Form: #04-0008
Reviewed Date: 5/1/2022
Transfer Policy Ref: #04-001-0065
HER: Health Services, Other Health Documents Note: Medication

EXHIBIT B

St. Clair County Community Mental Health Authority

Controlled Substance Count Sheet

Consumer Name:				Case Number:			
Date	Time	Drug Name / mg	Start Count	# Provided	Remaining Count	Staff/Nurses Initials	Staff/Consumer Initials
SIGN SIGNATURE & INITIALS BELOW:							

St. Clair County Community Mental Health Authority

MEDICATION DELIVERY FORM

On _____, _____ provided to
(Date) (Nurse/Staff)

_____ the below medications for delivery to:_____
(Delivery Staff) (Initials/Case #)

(Attach additional forms if more than 4 medications being delivered.)

Medication:_____	Medication:_____	Medication:_____	Medication:_____
Dosage:_____	Dosage:_____	Dosage:_____	Dosage:_____
Number:_____	Number:_____	Number:_____	Number:_____

Please sign and date to confirm the above:

_____
Nurse/Staff Date

_____
Delivery Staff Date

The following medications were delivered on _____ at _____.
(date) (time)

Medication:_____	Medication:_____	Medication:_____	Medication:_____
Dosage:_____	Dosage:_____	Dosage:_____	Dosage:_____
Number:_____	Number:_____	Number:_____	Number:_____

Please sign and date to confirm the above were delivered:

_____
Delivery Staff Date

_____
Receiving Party Date