Policy Title: Documentation of Each Medication Administration in the Electronic Health Record (EHR)

Effective Date: 08/15/2025

Approved By: Director of Medical and Clinical Services

Review Schedule: Annually or as Needed

Applies To: All Programs — Outpatient MH/SUD, IOP, PHP, and Integrated Primary Care/Behavioral Health

I. Purpose

To ensure accurate, timely, and complete documentation of every medication administration in the Electronic Health Record (EHR), including medication details, route, timing, and lot number when applicable, in accordance with CARF, DEA, FDA, and Ohio Board of Pharmacy standards.

II. Scope

Applies to all licensed and authorized staff involved in medication administration at REACH for Tomorrow facilities, including prescribers, nurses, and qualified medical assistants.

III. Policy Statement

All medication administrations must be documented in the EHR at the time of administration or immediately thereafter. Entries must include all required data elements to ensure client safety, continuity of care, and regulatory compliance. Lot numbers and expiration dates must be recorded for any medication that is injectable, dispensed as a sample, or drawn from a multi-dose vial.

IV. Required Documentation Elements

Each EHR entry must include:

1. Client identifiers (name, DOB)
2. Medication name (generic/brand), strength, dosage form, and dose administered
3. Route and site (if applicable)
4. Date and time of administration
5. Initials and credentials of administering staff
6. Co-signature when required (controlled substances, high-alert meds)

7. Lot number and expiration date (when applicable)
8. Verification of five rights: right client, right medication, right dose, right route, right time
9. Client response and education provided

V. Procedure

1. Document administration immediately after administration.
2. Verify client identity using two identifiers prior to administration.
3. Controlled substances require co-signature and entry in both the Controlled Substance Log and EHR.
4. Sample medications must include manufacturer, lot number, and expiration.
5. Corrections to documentation must follow EHR audit trail protocols; deletions are prohibited.
6. During system downtime, document on paper MAR and back-enter into EHR when restored.

VI. Quality Assurance

1. Monthly audits of medication records by Director of Medical and Clinical Services.
2. Quarterly review of audit findings by Medication Management Committee.
3. Corrective actions and retraining implemented as necessary.

VII. Staff Training

All staff authorized to administer medications receive initial and annual training on EHR documentation, controlled substance co-sign requirements, lot number recording, and audit procedures.