Integrated Medication Documentation Policy

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 that all medication-related information is accurately and consistently documented within the BestNotes electronic health record (EHR) to support coordinated, safe, and compliant care across behavioral health, substance use, and primary care services.

II. Scope

This policy applies to all prescribers, nurses, medical assistants, case managers, and behavioral health staff who contribute to medication-related documentation or review medication information in the client record.

III. Policy Statement

REACH for Tomorrow maintains an integrated medication documentation system that supports the full continuum of medication management—from prescribing through monitoring and discontinuation. All medication documentation must be complete, timely, and accurately reflect clinical decision-making, communication, and follow-up actions. BestNotes serves as the single source of truth for all medication-related records, including administration, lab results, education, and adverse event tracking.

IV. Procedures

A. Documentation Standards

• All medication records (prescriptions, administration, and monitoring) shall be entered into the BestNotes EHR on the date of service.

• Each entry must include: date/time, staff credentials, medication details, rationale, and follow-up instructions.

• All entries must be legible, accurate, and free of unsafe abbreviations.

B. Medication Order Documentation

• All prescriptions are issued electronically via the EPCS module in BestNotes.

• Verbal orders must be electronically signed within 24 hours.

• Any modification, discontinuation, or dosage change must include rationale in the EHR.

C. Medication Administration Documentation

• All administrations are documented in BestNotes eMAR with medication details, dose, route, lot, and staff initials.

• PRN medications require indication, response, and reassessment.

• Missed or refused doses are documented with explanation.

D. Medication Reconciliation

• Performed at intake, each prescriber visit, and discharge.

• Includes verification of prescribed, OTC, and supplement use and allergies.

• Signed and dated by the responsible clinician.

E. Laboratory and Monitoring Documentation

• Labs, EKGs, and vitals related to medication monitoring are uploaded to EHR.

• Prescriber documents review, interpretation, and follow-up within 48 hours for abnormal results.

F. Adverse Event and Error Documentation

• All errors, adverse reactions, or near-misses are documented in the EHR and reported via Medication Incident Form within 24 hours.

• Follow-up is documented in the Medication Management Quality Review Log.

G. Controlled Substance Documentation

• Includes OARRS/PDMP check documentation, treatment justification, and diversion risk assessment.

• Inventory and sample use documented in Controlled Substance Log and verified monthly by DMCS.

H. Integration Across Care Team

• All medication-related communication between disciplines is documented in shared clinical notes and integrated into the plan of care.

• Care coordination, referrals, and case conferences must include medication relevance.

I. Documentation Auditing

• DMCS or designee conducts monthly chart audits for completeness, timeliness, and reconciliation accuracy.

• Findings are reported quarterly to the Medication Management and Quality Improvement Committees.

V. Quality Improvement Integration

Findings from audits, incidents, and medication reviews are analyzed through the Medication Management Quality Review process. Results are trended quarterly and incorporated into the Performance Indicator Tracking Log and Annual QI Report for CARF §1.M compliance.

VI. References

- CARF 2025 Standards Manual: Sections 1.M, 2.F
- OAC 5122-26-18: Medication Administration and Storage
- OAC 5122-26-16: Medical and Psychiatric Services
- 21 CFR §1304: Controlled Substances Recordkeeping
- HIPAA (45 CFR §164): Security and Privacy Rules

Medication Documentation Audit Checklist

To be completed monthly by the Director of Medical and Clinical Services or designee.

Audit Element	Compliant (Y/N)	Comments / Corrective Actions
Medication orders entered on day of service		
Verbal orders signed within 24 hours		
eMAR entries complete (dose, route, lot #, initials)		
PRN use documented with indication and response		
Medication reconciliation documented at each prescriber visit		
Allergies and adverse reactions updated		
Abnormal lab results followed up within 48 hours		
Controlled substance OARRS/PDMP check documented		
Medication education documented in progress note		
Missed/refused doses explained		
Medication incidents reported within 24 hours		
Audit results shared with Medication Management Committee		

POLICY AND PROCEDURE

REACH for Tomorrow

Reviewed and Approved By:

Director of Medical and Clinical Services: _____ Date: _____
Medical Director: _____ Date: _____
Quality Improvement Committee Chair: _____ Date: _____