_____
PSYCHIATRIC HOSPITAL NAME

Psychotropic Medication Emergency
Certification Form

_____
STAMP ADDRESSOGRAPH

Emergency Certification: *An emergency exists when, in the professional opinion of the prescriber, a patient presents a risk of such imminent or reasonably impending harm or danger to self or others that following the nonemergency procedures to involuntarily medicate a patient would increase risk of harm to the patient or another person.*

I. CERTIFICATIONS AND DOCUMENTATION

A. Treatment Team Staff/RN Certification of Emergency:

_____ (name) is a patient on _____ (unit) and is under my care as his/her _____ (state title and position on team or unit).

The patient's legal status is: ☐ voluntary ☐ civilly committed ☐ CEPP
☐ NGRI ☐ IST-30 ☐ IST -90

The patient's clinical status and behavior meets the above Emer. Cert. definition, as follows:

_____

_____

_____

☐ I am familiar with the patient's safety plan; I have offered the patient his or her preferred behavioral supports and interventions, and they were unsuccessful in resolving the emergency (describe below).

☐ I am familiar with the patient's safety plan; I did <u>not</u> offer the patient his or her preferred behavioral supports and interventions because (describe below):

_____

_____

_____

Less restrictive alternatives considered and rejected, or attempted, without success:

☐ verbal de-escalation ☐ consensual oral medication ☐ other non-psychotropic medication

☐ other(describe):_____

_____

☐ Patient does <u>not</u> have an advance directive.

☐ Patient does not have an advance directive that can be implemented in time to resolve the emergency (no time to contact proxy; proxy not available, instructions inapplicable or unsuccessful in resolving situation).

Patient ☐does ☐ does <u>not</u> have a guardian, or the guardian is unavailable.

I, _____, certify that the above information and statements are correct and that the patients' clinical situation meets the requirements for Emergency Certification.

Signature_____ Date: _____ Time:_____ ☐ am ☐ pm

Print Name_____

_____
PSYCHIATRIC HOSPITAL NAME

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B. Prescriber's Certification of Emergency (First Certification)

I, _____, a ☐ psychiatrist; ☐ physician; ☐ advanced practice nurse, certify that _____ is refusing the administration of _____, a short-acting psychotropic medication that, in my professional opinion, will mitigate the emergency situation described above that will otherwise probably result in harm to the following:
☐ the patient ☐ another person or persons ☐ both.
☐ I have reviewed the description of the efforts made pursuant to Section A above to resolve the emergency without medication and agree that no less restrictive alternative to the involuntary administration of emergency medication will adequately mitigate this harm. The 24-hour medication order is as follows:

Date/time of order _____ Medication and dosage_____
Schedule of administration_____
This order will need to be reviewed prior to its expiration on Date: _____ Time:_____ ☐ am ☐ pm

Signature_____ Date: _____ Time:_____ ☐ am ☐ pm

Print Name_____

==========

C. Nursing Documentation (First 24 hour period)

☐ The Prescriber conducted a face-to-face examination, and he/she wrote the above order.

☐ I advised the patient that s/he was going to be involuntarily medicated to resolve an emergency.
On Date: _____ Time:_____ ☐ am ☐ pm
Signature_____ Print Name_____

☐ First dose of medication was given: Date:_____ Time:_____ ☐ am ☐ pm
Signature_____ Print Name_____

Within the next 24 hours after this dose was first administered, the following was completed:

☐ Progress Notes were written every shift documenting the patient's condition
Side Effects: ☐ None Reported ☐ On Date:_____ Time_____ ☐am ☐ pm, any negative effects were reported to prescriber and to the Rennie Advocate and were also fully documented in the patient record.
Describe negative response:
_____
_____
_____
☐ Medical Director and ☐Rennie Advocate notified by ☐ telephone ☐ email at
Time: _____a.m/pm. Date:_____
I, _____, certify that the above information and statements are correct and that the patients' clinical situation meets the requirements for Emergency Certification.

Signature_____ Date: _____ Time:_____ ☐ am ☐ pm

Print Name_____

_____
PSYCHIATRIC HOSPITAL NAME

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D. Prescriber's Certification of Emergency – (Second Certification):

I, _____, a ☐ psychiatrist; ☐ physician; ☐ advanced practice nurse, certify that _____ continues to refuse the administration of _____, a short-acting psychotropic medication that, in my professional opinion, will mitigate the emergency situation described above that will otherwise probably result in harm to the following:
☐ the patient ☐ another person or persons ☐ both.

☐ I have evaluated the patient's record and seen the patient. The first 24-hour administration of medication did not resolve the emergency and no less restrictive alternative to the involuntary administration of emergency medication will adequately mitigate the harm. The 24-hour medication order is as follows:

Date/time of order _____ Medication and dosage_____
Schedule of administration_____
This order will need to be reviewed prior to its expiration on Date: _____ Time:_____ ☐ am ☐ pm

Signature_____ Date: _____ Time:_____ ☐ am ☐ pm

Print Name_____
==========

E. Nursing Documentation (Second 24 hour period)

☐ The Prescriber conducted a face-to-face examination, and he/she wrote the above order.

☐ I advised the patient that s/he was going to be involuntarily medicated to resolve an emergency.
On Date: _____ Time:_____ ☐ am ☐ pm
Signature_____ Print Name _____

☐ First dose of medication was given: Date:_____ Time:_____ ☐ am ☐ pm
Signature_____ Print Name _____

Within the next 24 hours after this dose was first administered, the following was completed:

☐ Progress Notes were written every shift documenting the patient's condition
Side Effects: ☐ None Reported ☐On Date:_____ Time_____ ☐am ☐ pm, any negative effects were reported to prescriber and to the Rennie Advocate and were also fully documented in the patient record. Describe negative response:
_____
_____
_____
☐ Medical Director and ☐Rennie Advocate notified by ☐ telephone ☐ email at
Time: _____a.m/pm. Date:_____
I, _____, certify that the above information and statements are correct and that the patients' clinical situation meets the requirements for Emergency Certification.

Signature_____ Date: _____ Time:_____ ☐ am ☐ pm

Print Name_____

_____
PSYCHIATRIC HOSPITAL NAME

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F. Prescriber's Certification of Emergency (Third Certification)

I, _____, a ☐ psychiatrist; ☐ physician; ☐ advanced practice nurse, certify that _____ continues to refuse the administration of _____, a short-acting psychotropic medication that, in my professional opinion, will mitigate the emergency situation described above that will otherwise probably result in harm to the following:
☐ the patient ☐ another person or persons ☐ both.
☐ I have evaluated the patient's record and seen the patient. The first 24-hour administration of medication did not resolve the emergency and no less restrictive alternative to the involuntary administration of emergency medication will adequately mitigate the harm. The 24-hour medication order is as follows:

Date/time of order _____medication and dosage_____
schedule of administration_____
This order will need to be reviewed prior to its expiration on Date: _____ Time:_____ ☐ am ☐ pm

Signature_____ Date: _____ Time:_____ ☐ am ☐ pm

Print Name_____
==========

G. Nursing Documentation (Third 24 hour period)

☐ The Prescriber conducted a face-to-face examination, and he/she wrote the above order.

☐ I advised the patient that s/he was going to be involuntarily medicated to resolve an emergency.
On Date: _____ Time:_____ ☐ am ☐ pm
Signature_____ Print Name _____

☐ First dose of medication was given: Date:_____ Time:_____ ☐ am ☐ pm
Signature _____ Print Name_____

Within the next 24 hours after this dose was first administered, the following was completed:

☐ Progress Notes were written every shift documenting the patient's condition
Side Effects: ☐ None Reported ☐ On Date:_____ Time_____ ☐am ☐ pm, any negative effects were reported to prescriber and to the Rennie Advocate and were also fully documented in the patient record.
Describe negative response:
_____
_____
_____
☐ Medical Director and ☐Rennie Advocate notified by ☐ telephone ☐ email at
Time: _____a.m/pm. Date:_____
I, _____, certify that the above information and statements are correct and that the patients' clinical situation meets the requirements for Emergency Certification.

Signature_____ Date: _____ Time:_____ ☐ am ☐ pm

Print Name_____

_____
PSYCHIATRIC HOSPITAL NAME

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H. Prescriber's Certification of Emergency (Fourth Certification) (only if one of the days in the 72 hours is a holiday)

I, _____, a ☐ psychiatrist; ☐ physician; ☐ advanced practice nurse, certify that _____ continues to refuse the administration of _____, a short-acting psychotropic medication that, in my professional opinion, will mitigate the emergency situation described above that will otherwise probably result in harm to the following:
☐ the patient ☐ another person or persons ☐ both.
☐ I have evaluated the patient's record and seen the patient. The first 24-hour administration of medication did not resolve the emergency and no less restrictive alternative to the involuntary administration of emergency medication will adequately mitigate the harm. The 24-hour medication order is as follows:

Date/time of order _____medication and dosage_____
schedule of administration_____
This order will need to be reviewed prior to its expiration on Date: _____ Time:_____ ☐ am ☐ pm

Signature_____ Date: _____ Time:_____ ☐ am ☐ pm

Print Name_____
==========

I. Nursing Documentation (Fourth 24 hour preiod) (only if one of the days in the 72 hours is a holiday)

☐ The Prescriber conducted a face-to-face examination, and he/she wrote the above order.

☐ I advised the patient that s/he was going to be involuntarily medicated to resolve an emergency.
On Date: _____ Time:_____ ☐ am ☐ pm
Signature _____ Print Name _____

☐ First dose of medication was given: Date:_____ Time:_____ ☐ am ☐ pm
Signature _____ Print Name_____

Within the next 24 hours after this dose was first administered, the following was completed:

☐ Progress Notes were written every shift documenting the patient's condition
Side Effects: ☐ None Reported ☐ On Date:_____ Time_____ ☐am ☐ pm, any negative effects were reported to prescriber and to the Rennie Advocate and were also fully documented in the patient record.
Describe negative response:
_____
_____
_____
☐ Medical Director and ☐Rennie Advocate notified by ☐ telephone ☐ email at
Time: _____a.m/pm. Date:_____
I, _____, certify that the above information and statements are correct and that the patients' clinical situation meets the requirements for Emergency Certification.

Signature_____ Date: _____ Time:_____ ☐ am ☐ pm

Print Name_____

II. 72-HOUR ADMINISTRATIVE REVIEW

A. Medical/Clinical Director or Chief of Psychiatry

Instructions: Shall be completed by the Medical/Clinical Director or Chief of Psychiatry, unless unavailable, When these individuals are unavailable, and when more than one prescriber is on duty, a prescriber who is not assigned to the patient will review the emergency. If the event takes place when the Medical/Clinical Director, Chief of Psychiatry and Acting Medical/Clinical Director and all non-treating prescribers are unavailable, and they continue to be unavailable for the entire 72-hour period after the first administration of emergency medication, the review will be conducted by the building nursing supervisor.

Review conducted by:_____, Title _____

After conducting a face-to-face evaluation of the patient and reviewing the prescriber's emergency certification and the patient record, I conclude the following:

☐ Administration of emergency medication ☐ was ☐ was not appropriate because danger to the patient or another person was imminent or reasonably impending,
☐ The prescriber based his or her professional judgment on best or effective practices, and all reasonable efforts to avoid the emergency administration of medication were made.
☐ The prescriber should have initiated the following interventions, in addition to, or in place of, his/her medication orders: _____
_____

Signature_____ Date: _____ Time:_____ ☐ am ☐ pm

Print Name_____

==========

B. Rennie Advocate Review

_____, Rennie Advocate, ☐ Reviewed chart on Date: _____ Time:_____
☐ All steps of emergency administration procedure were followed.
☐ Emergency medication was limited to 72 hours or less (including Saturdays/Sundays but not including holidays)

☐ The following problems in the procedure were noted in the chart and communicated in my monthly report to the CEO, Medical/Clinical Director, and DMHAS Medical Director:
_____
_____

Outcome
☐ Medication discontinued ☐ Medication continued, patient consenting
☐ Medication continued, 3 step process initiated ☐Medication continued, FI process initiated
☐ Other: _____

Signature_____ Date: _____ Time:_____ ☐ am ☐ pm

Print Name_____