All SYSC residents who receive medications shall have them recorded accurately on the Medication Administration Record form and/or a PRN Medication Sheet in order to assure that all medications given are charted in the proper manner.

**Purpose**

The purpose of this policy is to establish the Medication Administration Record procedure.

**Procedure**

I. **Medication Charting**

A. Two Forms are used for charting medications:

1. The Medication Administration Record (MAR) for:
   
   (a) Regularly scheduled medications with a nurses note section on the back.
   
   (b) Physician-ordered PRN medications.
   
   (c) Pre-OP (operative) medications.
   
   (d) STAT medications (immediate).

2. PRN Medication Sheet (when needed) for:
   
   (a) Nurse-generated over-the-counter (OTC) medications.

B. Preparation of the Form

1. Enter the resident’s name, date of birth, date of admission, allergies, and diagnosis.

2. Place form in alphabetical order in Kardex holder/chart used for this purpose.

C. Transcribing Medication Orders

1. When transcribing drug orders to the medication sheets, the following minimum information shall be required.
(a) medication name,
(b) strength,
(c) route of administration,
(d) frequency,
(e) date, and
(f) stop date if ordered.

II. **Medication Record Forms**

A. The following medication record forms procedure shall be followed:

1. MAR for Regularly Scheduled Medications. In addition to the minimum information listed above, the following information shall be entered:

(a) Date ordered.

(b) Initials of nurse transcribing order.

(c) Time of administration under hour heading. (Note: When transcribing the hour the medication is to be administered, begin with the date of the first medication to be administered.)

(d) A chronological listing of dates, beginning with the date of the first medication to be given.

(e) After administration for each dose, sign your initials in the space corresponding to the appropriate drug, date, and time of administration.

(f) Doses of a regularly scheduled medication that are not administered for whatever reason shall be charted as follows:

(1) Sign your initials in the appropriate space and circle.

(2) Note reason for omission on reverse side of nurse’s medication notes, indicating date, time, medication, dosage, reason, and initials.

(3) When a resident is not present to receive medications, but “on visit,” the nurse shall document the word “visit” in the appropriate space.

(4) The same procedure shall be followed when a resident has escaped or absconded for 72 hours, at which time the physician shall be consulted regarding the possibility of discontinuing the medications. A medication review shall be done upon the resident’s return.

(g) When medications are reviewed and remain the same, enter in review date and nurse’s initials in proper column. This review date may be in pencil.
(Note: Review dates may vary based on internal procedures, the pharmacy providing the medication, the “schedule” of the medication, and/or the physician ordering the medications.)

(h) If blood pressure or pulse is to be taken prior to administering medication, it shall be noted on the MAR on the line following the last regularly scheduled dose.

2. STAT orders on MAR

   (a) Transcribe the STAT medication on the MAR,
   (b) Note order date, time and initial.
   (c) After administering the STAT medication, document on the MAR.
   (d) When STAT medications are administered, they shall also be noted in a progress note.

III. Pre-OP medication

   A. Orders shall be transcribed to the MAR.
      1. Note order date, and initial.
      2. After administration of the pre-op medication, document MAR.
      3. Write a progress note.

IV. PRN Medication

   A. Physician ordered PRN orders shall be transcribed to a MAR in the following manner:
      1. Transcribe to MAR in the same manner as standing medications.
      2. Note order date and initial.
      3. After administration of the PRN medication, document on MAR.
      4. Effectiveness can be documented on the back of the MAR.

V. Nurse-Generated PRN OTC medications

   A. A list of OTC medications shall be generated by the Manager of Health Services and approved by the SYSC physician, and approved by the resident’s parent and/or guardian.
      1. A copy of this list shall be kept in the front of every medication Kardex.
      2. The nurse shall assess the resident using sound nursing assessment and then administer OTC medications as deemed appropriate from the list.
3. The nurse shall record the medication on the nurse's medication notes section of the PRN Medication Form, checking the box labeled RN OTC. This will distinguish the medication from those ordered on a PRN basis by the physician.

4. Nurse-generated OTC medication that necessitates daily administration shall be listed in the MAR and noted as RN OTC medication.

5. A copy of the parent approved OTC Med List shall be kept behind the MAR for each resident.

VI. **Regularly scheduled medications that also have a PRN order**

   A. Regularly scheduled medication orders that also include a PRN regimen shall be entered on the MAR.

   B. The nurse shall initial in the appropriate space.

VII. **Signature Initials Validation Sheet**

   A. Nurses administering medications shall enter their initials in the "Init" column. To validate their initials, each nurse shall sign their full name on the Medication Signature Form kept in front of the medication chart. Complete licensed name and professional title shall be noted after the signature. Validation of initials is necessary only once per month per chart.

VIII. **Treatments**

   A. Treatments requiring medication shall be charted on the MAR, the same as other medications. All other treatments shall be documented in the Progress Notes.

IX. **Correction of Errors**

   A. When an error is made on the MAR, indicate the error by drawing a single line through it, and write "error" with your initials and date above it and continue on the same sheet.

X. **Medications Discontinued or Changed**

   A. When a medication has been discontinued, changed, or has expired, a yellow hi-liter is traced over the medication name and hour(s). Any change in the dose, dosage regimen, route of administration, time, etc. shall constitute a new drug order, and the old entry shall be discontinued as above (yellowed out) and rewritten with the new information.

   1. Note: If any of the sections should become filled with entries, the number of pages in use, noted on the bottom of the front side, shall be changed to correspond (e.g., page 2 of 2 pages). A new form shall be placed in the Kardex under the original and new entries shall be continued on the second form in the manner prescribed.

   2. When an entire page becomes filled and no active orders remain, the form shall be removed from the MAR Kardex and placed in the resident's medical record. When the resident is discharged or transferred, all MAR forms shall be placed in his/her medical record.