Section 3: Documentation

⇒ Documentation basics
⇒ Receiving new medication orders
⇒ Transcribing new medications onto the MAR
⇒ Discontinuing medications on the MAR
⇒ Omitted doses
⇒ Destruction
Documentation

Each boarding home must maintain documentation of storage and delivery of medications. These documents may include, for each resident, a roster of controlled substance medications, a record of medications destroyed at the community, a record of PRN medications given, and a monthly MAR.

With the responsibility of handling medications it is important that you communicate information to other caregivers, nurses, and others in an accurate and complete manner. Documenting your medication assistance and related activities not only provides a legal record of the care you have provided but also aids in ensuring continuity of care for your residents.

There are several records you will be expected to maintain and complete when handling and passing medications. They can include:

⇒ Medication Assistance/Administration Record (MAR)
⇒ PRN medication record
⇒ Controlled substances record
⇒ Record of destroyed medications

Examples of these forms will be provided and explained by your trainer.

**RECORDS VS. REPORTS**

**Record**
Permanent written communication that documents information relevant to resident care. Examples include the resident’s chart and MAR.

**Report**
Oral or written exchanges of information shared between caregivers. This can be done via a stand-up meeting, “end of shift” report, or a 24-hour report form. This report does not generally serve as a permanent record.
Documentation Basics

Documentation of medications is a vital component of medication assistance. The documentation of medications is the responsibility of the staff member who prepared and delivered the medicine. There are several aspects of documentation to consider:

Documenting:

⇒ Newly ordered medications on MAR
⇒ Changes in current orders on MAR
⇒ Discontinuing medications on the MAR
⇒ Each dose poured/assisted
⇒ PRN medications
⇒ Omitted doses

It is important to review your community’s policies and procedures in each of these areas. For instance, some facilities will have nurses transcribe medication orders (write new or changed orders onto the MAR), while other facilities will expect caregivers to do this. Since each boarding home is unique, it is important that you know your role in the documentation process.
Receiving Medication Orders

In order to assist residents with medications, you need to have medication orders (prescriptions) from the resident’s practitioner (doctor, nurse practitioner, or physician assistant). Ways to get these orders include:

- **FAX**
  A written fax, sent to the community, can provide you with the information you need to order the medication from the pharmacy and provide it to the resident.

- **MAIL**
  The community policy may include having the prescriber review all of the medication orders on a regular basis, and sign and mail those orders back to the community.

- **EMAIL**
  The community may have a method where prescribers can email medication orders.

- **DIRECT ORDER**
  The resident may visit the prescriber, and receive a written prescription from him/her directly. Or, the prescriber may visit the resident at the community and write a prescription directly in the resident’s health file.

- **PHARMACY**
  Sometimes the prescriber will call the pharmacy directly, and have the pharmacy fill the prescription and send it directly to the community. A pharmacy-prepared labeled container can serve as a medication order.

- **TELEPHONE ORDER**
  The practitioner may call the community and want to leave a telephone order. *Only a licensed nurse can accept telephone orders.*
Transcribing Medication Orders

Once you have a medication order, you may have to transcribe the order onto the MAR. This means you must copy the order, word for word, onto the MAR so that the resident receives the medication the way the prescriber intended.

It is important to follow your assisted living community’s policies and procedures when medications need to be transcribed. Some communities only allow licensed nurses to transcribe orders, while others have specially designated trained staff to do this task.

Some best practices relating to transcribing medication orders onto the MAR include:

- Write out any abbreviations in order to minimize confusion.

EXAMPLE:

**DOCTOR’S ORDER**

<table>
<thead>
<tr>
<th>Name: John Smith</th>
<th>Date: 2/4/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Order:</td>
<td></td>
</tr>
<tr>
<td>Tylenol 325 mg tabs—take 2 tabs q4h prn headache or muscle aches. NTE 5 doses in 24h.</td>
<td></td>
</tr>
<tr>
<td>Dr. Johanson</td>
<td></td>
</tr>
</tbody>
</table>

**TRANSCRIBED ONTO MAR**

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tylenol 325 milligram tablets. Take 2 tablets every 4 hours as needed for headache or muscle aches. Do not exceed 5 doses in 24 hours.</td>
</tr>
<tr>
<td>2/4/07 VLM</td>
</tr>
</tbody>
</table>

- Date and initial the MAR to show when the order was transcribed, and by whom (see above).
• Be clear to identify when the medication is to begin, and if it is a
time-limited medication, when it will end. This minimizes mistakes.

EXAMPLE:

| April 2007 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Cipro 500 milligrams | A | M |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Take 1 tablet twice a day for 7 days, then stop |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| 4/10/07 VLM |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |

• On the original order from the prescriber, write “noted” on it, with your
signature and a date. This tells the reader that you received the order, and
that you transcribed it onto the MAR. File this order in the resident’s
health file.
Discontinuing Medication Orders

- When medication orders are discontinued by the prescriber, it is important to clearly identify that on the MAR. This keeps others from delivering the medication in error.

EXAMPLE:

| April 2007 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| DOS 100    |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| milligrams. |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Take 1 caplet by mouth twice daily. |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| A | M | JF | JF | X | DISCONTINUED | 4/3/07 @ 2:30 pm | VAM |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |

- Be sure to date/time and initial the section on the MAR where you discontinued the order. This shows accountability.
- On the original discontinue order from the prescriber, write “noted” on it, with your signature and a date. This tells the reader that you received the order, and that you discontinued it onto the MAR. File this order in the resident’s health file.
- When there is a change in a current medication order (such as dose or medication time), discontinue the entire order on the MAR (as seen above) and rewrite a clean order, with the new information, in a separate box.
Omitted Medications

Sometimes a resident will choose not to take a prescribed medication. When this occurs, it is important to document accurately that the resident did not take the medication.

EXAMPLE:

- Initial in the correct date/time box where you offered the medication to the resident. Then circle your initials. This tells the reader that there is more detailed information on the reverse side of the MAR.
- Turn the MAR over and fill in all of the information on the next available line. Typically you will fill in the date, time, your initials, the name and dose of the drug, the reason you did not give it, and the results.

EXAMPLE:

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>STAFF</th>
<th>MEDICATION</th>
<th>DESCRIPTION</th>
<th>RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/1/07</td>
<td>5 PM</td>
<td>JF</td>
<td>DOSS 100 mg caplet</td>
<td>Said “I don’t need that pill.”</td>
<td>Notified LPN.</td>
</tr>
</tbody>
</table>

- Medications cannot be omitted because they are not onsite. The boarding home MUST have a plan in place to ensure residents are offered their medications as ordered. Check your community’s policy regarding unavailable medications.
Destroying Medications

When a medication is discontinued, expires, or is left behind after a resident dies or is discharged from the boarding home, it must be destroyed. Typically this is done by returning any unused portion, in the original pharmacy-prepared container, to the pharmacy. In certain circumstances, however, you will have to destroy the medication at the community.

If you are destroying a medication, it is important to follow your community’s policy and procedure. Appropriate documentation must be made in the resident’s record and two staff persons must witness the destruction.

Information that may need to be included on the Medication Destruction Record includes:

- Medication name
- Strength
- Quantity destroyed
- Date filled
- Prescription number
- Disposal date
- Name of pharmacy
- Method of destruction
- Signature of staff person destroying the medication
- Signature of witness (another staff person)