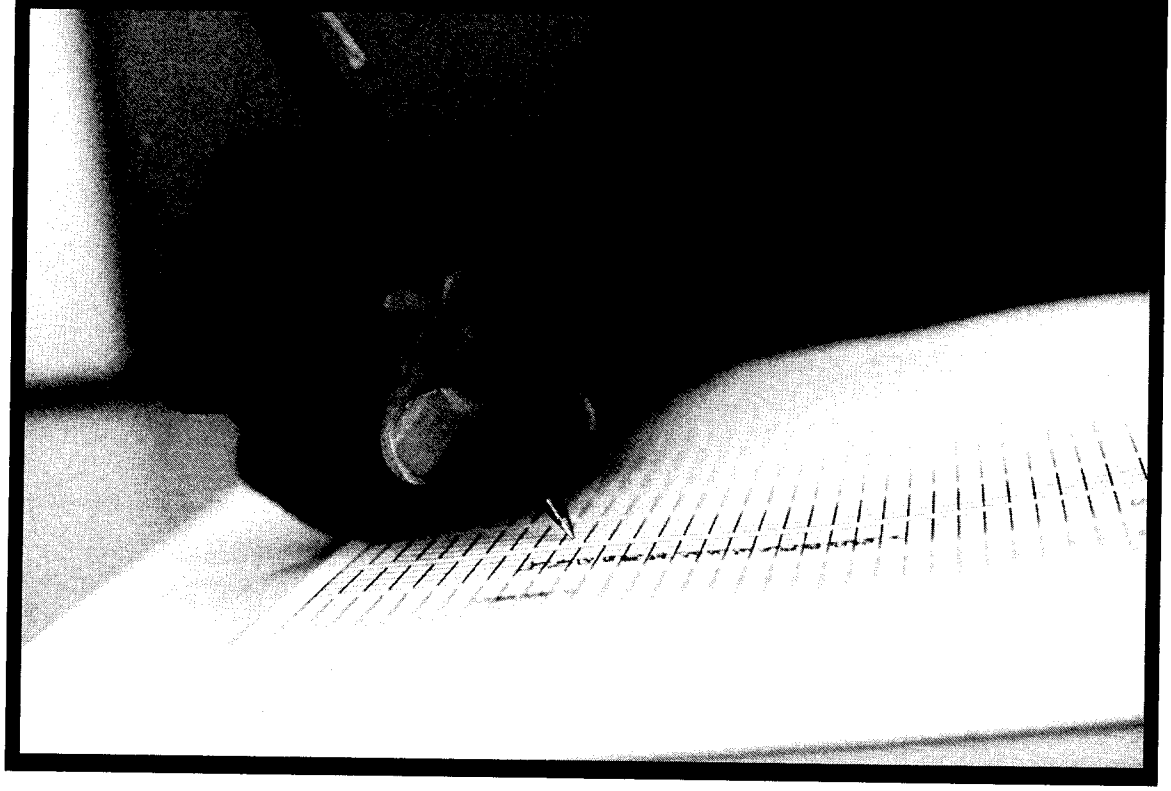
Module 6:
Medication Management, Part 3

Documentation Basics
Common Medication Records

Assisted Living Medication Training



DOCUMENTATION BASICS

Regardless of the type of document you are completing there are some basic fundamentals that should always be followed.

1. Accurate and Objective

   Documentation should always be accurate and objective. Document only the things you see, hear, or touch. Never, for example, document something was done if you didn't in fact do it yourself or witness first hand. For example, do not document that a resident self-administered his morning dose of aspirin if you didn't see him take the medication.

   If you are documenting something reported to you by someone else make that clear. For example, if a resident tells you he fell when getting out of be this morning do not write "Resident fell while getting out of bed." in his resident record. Rather, you would chart "Resident John Smith stated, 'I fell when I got out of bed this morning'" noting that it was reported by the resident and using quotes to indicate this clearly.

   Use exact measurements when possible. You can use measurements for things like a resident's weight or other vital signs such as blood pressure, pulse, etc. You may also use exact measurements when documenting things like urine output, meal consumption, etc. Documenting "John ate 80% of dinner" is much more descriptive than "John ate well at dinner," for example.

   Avoid subjective references to behavior, such as "Resident seems upset." Rather, clearly describe the behavior "Resident was found in her room crying and looking through a book of old photos."

2. Date and Time

   Every record, form, narrative entry, and piece of documentation should be dated, and the time should also be recorded with narrative entries. Be clear when documenting times. In some care settings "military time" may be used for better clarity, e.g., 1300 instead of 1:00 pm. Clarify the policy in your workplace.

   Specify the exact time in your documentation. For example, "7:30 pm" is much more accurate than "between 7 and 8 pm." A range of time is vague and implies an inattention to the situation. The more details you provide in your documentation, the more complete the record will be, and the better able you will be to recall details based on that documentation should the need arise, such as while testifying in court.

3. Do Not Assign Blame

   Avoid assigning blame or calling attention to errors. Staff disputes regarding resident care may occur and may be valid, but they do not belong in the resident's record. "Resident was found soiled in bed when I arrived on shift. She probably didn't receive her shower last night" would be an inappropriate charting entry.

4. Abbreviations

   Only use standard and setting-approved abbreviations. Do not make up your own abbreviations as they may not be easily understood be other members of your team and can create confusion dangerous errors in resident care.

5. No Blank Spaces

   Do not leave any blank spaced on a form or in a record. Blank spaces could be filled out by someone else at a later time, allowing your entry to be modified. Always line out blank spaces or list "n/a" as appropriate.

6. Write Legibly

   Your documentation doesn't help anyone if you are the only person who can read it. Although we sometimes find ourselves in a hurry at work, take time to write neatly and clearly.

   Assisted living and residential care communities are increasingly turning to electronic records that can dramatically improve legibility. Speak to your supervisor to see if electronic documentation is available in your care setting.

7. Ink

   Always write in blue or black ink. This prevents the possibility of a record being modified at a later date, and if it is ever necessary to photocopy or fax a document blue or black ink will reproduce clearly.

8. Do Not Document Care by Someone Else

   Unless state otherwise, anyone reading your documentation assumes that you performed the care being described. If, for example, another caregiver assisted a resident with their morning shower, that caregiver should be the one to note it in the record.

9. Correct Errors

   It's ok if you make a mistake in a record. What's not ok is to use the wrong technique when correcting your error.

   NEVER:
   - Use white out
   - Completely obscure an error with a pen or marker
   - Destroy a document and attempt to recreate it
   - Erase an entry

   Anything that could create the appearance that you attempted to alter a record should be avoided. If the record is ever reviewed in a legal action, the resident's attorney will look for any evidence that may suggest that the documentation is inaccurate. A record that has erasures, correction fluid, or heavy black ink to make an entry unreadable are red flags.

   If you make a mistake, simply line it out with a single straight line, write the word "error" and initial the entry. Then go to the next blank line and start a new entry.

10. Sign

    Last, but certainly not least, always sign your entries, forms, and documents. Be sure to include your credentials, if applicable, such as "RN."

COMMON MEDICATION RECORDS

When handling medications it is important that you communicate information to other Med Aides, 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. Common medication records may include, but are not limited to:

- Medication Assistance/Administration Record (MAR)
- PRN medication record
- Omitted/missed doses
- Record of destroyed medications
- Centrally stored medication record

The MAR

Although it is not always required by regulations, it is a standard of care in the assisted living and residential care industry to document each time a dose is given. A MAR (Medication Assistance/Administration Record) is used for this purpose. This is often referred to as the Medication Assistance Record or Medication Administration Record, abbreviated as a MAR.

Omitted Dose

If for any reason a dose of a medication is not taken it must be documented and reported appropriately. Most MARs have a space for this on the back of the form. To document a missed dose, circle your initials, turn the MAR over, and document:

- Date
- Time
- Medication and dose that was omitted
- The reason for omission (e.g., resident is out of the building, refusal, etc.)
- Your signature

If the dose is omitted because of refusal, indicate the exact reason the resident gave for refusal in his/her words. Such as, "That medication makes me sick" or "I don't want any more pills." Contact the resident's physician if a dose of medication is not taken.

A sample MAR can be found on the following page.

Medication Assistance Record

Month: Year:

Start Date	Stop Date	Medication	Assist Times	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	31

Resident	Room #	Allergies	Signature/Title	Initials

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PRN Medication Records

Because a PRN medication is not taken on a routine basis, a PRN medication record is used to document each time a resident takes a PRN medication. Some communities will use a MAR for this purpose, in others it is a separate designated form.

In addition to documenting when a PRN medication is taken, the result/effect of the medication should also be recorded. Approximately 30-60 minutes after a PRN medication is taken by the resident, return to see if the medication was effective (e.g., is the headache gone?). Document accordingly.

A sample PRN Medication Record can be found on the following page.

PRN Medication Record

Date Started	Medication & Instructions	Date Started	Medication & Instructions	Date Started	Medication & Instructions

Date Given	Time	Medication	Dose	Route	Reason Given	Initials	Results	Time	Initials

Resident	Room #	Allergies	Signature/Title	Initials

Centrally Stored Medication Record

All medications brought into the community, whether in central storage or resident control, should be logged/recorded. The purpose of logging the medications is for both resident safety and risk management. Centrally storage records should contain at least the following:

1. The resident's name
2. Date brought into the community
3. The medication name
4. Dosage (mg, g, ml, etc.)
5. Form (pills, liquid, tablet, etc.)
6. Quantity (amount left in bottle)
7. Name of prescribing physician

Record of Destroyed/Disposed/Returned Medications

When a medication is discontinued, expires, or is left behind by the resident, it must be destroyed, or returned to the pharmacy, per community policy. Two staff members must witness the destruction and document accordingly. Medication destruction records typically include:

- Medication name
- Strength/quantity
- Date filled
- Prescription number
- Disposal date
- Name of pharmacy
- Signature of staff person
- Signature of witness

A sample Central Storage Record and Record of Destroyed Medications can be found on the following page.

Centrally Stored Medication Record

RESIDENT				ADMISSION DATE		ATTENDING PHYSICIAN			
MEDICATION NAME	STRENGTH/ QUANTITY	INSTRUCTIONS CONTROL/CUSTODY	EXPIRATION DATE	DATE FILLED	DATE STARTED	PRESCRIBING PHYSICIAN	PRESCRIPTION NUMBER	NO. OF REFILLS	NAME OF PHARMACY

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Medication Destruction Record

RESIDENT	ADMISSION DATE	ATTENDING PHYSICIAN

INSTRUCTIONS: *Prescription drugs not taken with the client/resident upon termination of services or otherwise disposed of shall be destroyed in the facility by the Administrator or Designated Representative and witnessed by one other adult who is not a client/resident.*

MEDICATION NAME	STRENGTH/ QUANTITY	DATE FILLED	PRESCRIPTION NUMBER	DISPOSAL DATE	NAME OF PHARMACY	SIGNATURE OF ADMINISTRATOR OR DESIGNATED REP.	SIGNATURE OF ADULT WITNESS

Learning Exercise:
Know Your Community Documentation

Work with your supervisor and practice the following:

1. Enter this order on the MAR used in your community.

   Vitamin C, 75mg, Take one by mouth every day

2. A resident tells you she has a headache and wants a Tylenol. Describe how you would handle this request, including the documentation that must be completed.

3. Locate all documents used for refilling and ordering new medications from the pharmacies commonly used in your community.

4. A medication has expired and must be destroyed. Describe how you would handle this, including the documentation that must be completed.

5. Fill in the following information:

   a. Name of your primary pharmacy: _____

   b. Where is your pharmacy contact information located? (fax number, telephone number, etc.)?

      _____

   c. What day(s) are your cycle medications delivered?

      _____