

POLICY, PROCEDURES, & GUIDELINES FOR MEDICATION ADMINISTRATION

III. MAR GUIDELINES

Forms to assist staff with medication administration include, but are not limited to:

marlog - form used to document any medication administration
 ma-mednotes - form used to document medication administration (used with the Marlog)
 ma-prnotclist - list of prn medications approved by physician for client use
 demographics - client information sheet with personal, medical, and behavior information
 ma-healthhistory - client medical and mental health history
 ma-agreement - Medication Administration Agreement for client
 ma-narm - New and Refill Medication form
 ma-3dosetrack - Three dose tracking form to track any adverse reactions after starting a new or changed medication
 ma-medtreatlog - used to show when a client sees any medical, dental, or mental health practitioner
 ma-medexam - used as an alternative to the Medical Treatment Log when a client sees any medical, dental, or mental health practitioner
 ma-sezurrep - to document seizure activity, if necessary
 ma-policy - part I of policy and procedures
 ma-procedures - part II of policy and procedures
 ma-marguide - part III of policy and procedures

In addition, the following APD forms (or adaptations) will be used:

Medication Destruction Record
 Off-site Custody of Medications form
 Controlled Medication Count
 Medication Error Report
 Incident Report
 Authorization for Medication Administration form
 Informed Consent form - one for each staff assisting a client with medication administration

Staff may use either the pharmacy produced Medication Administration Record or the MAR log. Directions for documenting on the MAR log are provided here. If a pharmacy produced Medication Administration Record is used, follow the instructions provided here for documenting on the MAR log form. If the pharmacy provided form has an area for notes or other information either on the front or the back, follow the instructions provided here for documenting on the Medication Notes form.

Use either the pharmacy produced client MAR log or the **MAR log (marlog)** to document medication administration.

The MAR log may be used for documenting

- regular routine medication administration
- PRN medication administration

Mark in the upper right corner with an X for "regular MAR" or for "PRN MAR".

If a medication is a PRN, use the **PRN MAR log (marlog)**. The PRN log is identical to the regular MAR log except that you will mark an X in the upper right corner that it is a PRN MAR. You will document **ONLY** PRN medications on the PRN log. You will not document PRN medications on the regular MAR log. This will prevent confusion and errors. For PRN over-the-counter medications that are used on an occasional basis, you need direction from the physician. You can use the form **PRNOTCLIST** to have the doctor sign off on typical OTC medications (such as pepto bismol, tylenol, cough medicine, etc).

If the client takes over-the-counter (OTC) medications on a regular basis (such as a vitamin, calcium, etc), you must have a prescription from the doctor. These medications do **NOT** get listed on the PRN OTC List because you must have a prescription for them.

Ensure medications are accurately recorded and logged. Do not use abbreviations. Use black ink, preferably a fine tip pen. Draw 1 line through mistakes and rewrite. Include page number(s) if you need more than one sheet per month. Include printed staff name and initials in chart.

DO NOT CHANGE THE FONT ON THE MAR. Use the View option to Zoom in or out.

Initial clearly each time prescribed medications (including OTC and med samples) are administered.

Controlled Medications

Mark controlled medications on the MAR with a small **red c**. Mark the red c in the Medication Name column in the lower right hand corner of the box.

Routine Medications Not Given Every Day

If a medication is not given every day (once a month, every other day, etc), then place a box around the days the medication IS to be given. Ensure the box can be clearly seen. Make sure the directions are clearly stated in the Special Instructions section of the MAR. At the end of the month, write the next date the medication will be given the following month. Write this date after the prescribing practitioner's name in the Medication Name column.

Routine Medications Not Given

If a medication is not administered, use code (1=Home, 2=Work/ADT, 3=ER/Hospital, 4=Refused, 5=Med not available, 6=Med held by physician, 7=Other), and complete the procedures for Medication Errors, including documenting the error on the Medication Notes form.

Discontinued Medications

If a medication is discontinued (D/C), then:

- write the D/C date in the Medication Name column (the start date will already be in this column)
- immediately to the right of the last dose given, make a vertical line (|) in that space
- write D/C, the date, and your initials to the right of the vertical line – | D/C 01/01/01 RL (training, page 5)

- use a yellow marker to mark out the entire section that has been discontinued to avoid the error of giving a D/C'd medication. For example, a medication that is given 3 times a day may be discontinued only for one of the doses. Use the yellow marker to mark out only the time that has been discontinued from the day it was D/C'd to the end of the month. A medication that is discontinued completely will be marked with yellow from the name of the medication through all of the times to the end of the space for the last day of the month.

Start and Stop Dates

Include the medication was ordered and any date the medication is changed or stopped (dose increase/decrease, times, strength, D/C). Write the start date under the prescribing practitioner's name in the column where the Medication Name is located. If the medication is D/C, you will write the stop date in this area also.

Complete the **Medication Notes (mednotes)** when:

- 1- a PRN medication is administered
- 2- there is a problem:
 - an error occurred (client refused medication, count was incorrect, wrong time/dose/route, medication, client, etc)
 - an adverse reaction occurred (client got hives, headache, dizzy, heart palpitations, etc)
- 3- there is a change in medication (increase/decrease, D/C)
- 4- any code is used on the MAR (the client was away at the family home, ADT, work, etc, hospital, or any other reason)
- 5- you are not sure if you should document

Complete the **Medication Error Report** if the reason the medication was not administered is an error and is reportable.

What to Know

- 1- Know your **client**
- 2- Know the **names** of the medications the client takes
- 3- Know the **purpose** of each medication the client takes
- 4- Know the **possible side effects** of the medications the client takes
- 5- Know **what to do** if there is a problem
- 6- Know when to document

Remember the **9 Rights**:

- 1- Client name on the label and MAR match
- 2- Medication name on the label and MAR match
- 3- Time label states times per day or exact time; MAR states exact time
Administer at the exact time. You have from 1 hour before to 1 hour after the stated times.
- 4- Strength and Dose strength and dose on the label and MAR match
- 5- Route the how, way, and where on the label and MAR match
- 6- Reason the medication is administered for the correct reason
- 7- Position know the special needs for the client and the medication
- 8- Texture know the special instructions for the medication (crushed, liquid, in food, etc)
- 9- Documentation always document immediately after a medication is administered and document anytime there is a problem, when refills are needed, when there is an error, etc.

MAR Logs

On all MAR logs, whether they are regular or PRN logs, for each medication, staff will write:

In the first column:

- Name of the medication, the strength and the form
For example, ABC Medicine 1.5mg Tablet
- Directions for use
For example, One tablet by mouth the first Wed of each month
- Purpose specific to the client
For example, for osteoporosis
- Prescribing practitioner name
For example Dr. MMM
- Start date and Stop date, if the medication is D/C
For example, Start: 07-01-09 (Stop: write a date here when the medication is D/C)
- Next month's start date for those medications that are given every other day, once a week, once a month, etc.
For example, Next month: 08-05-09

In the second column:

- Special instructions for administering the medication, common side effects, and for PRN medications the maximum days and maximum doses to administer

In the third column:

- The exact times for administration

In the next 31 columns showing dates:

- initials when doses are administered
- a box around dates for when doses are administered that are not every day (not including PRN medications)
- the correct documentation for a D/C medication (a vertical line, D/C the month/day/year, initials, and a line to the end of the month) and yellow highlight on sections that are D/C
- a line through days when any medication is NOT given (such as when a medication is started or stopped sometime during the month), but not including doses that are not prescribed for every day or for errors)
- the correct documentation for an error (the code number corresponding to the error as listed on the MAR log)

SAMPLE MAR LOGS

Sample 1 – Regular MAR log

The first sample MAR log is for regular routine medication administration.

The first medication, omeprazole, was discontinued (D/C) on the 18th of the month only for the 9pm dose. A vertical line is placed on the 18th, D/C, the date, initials, and a horizontal line to the end of the month. The line that was discontinued for the 7am dose is then highlighted with yellow. On the 4th (both administration times) and 5th (only the morning time) the client was Away (maybe at his family's home) and the number 1 is used to indicate this. Staff would also document this on the Medication Notes and as necessary on the Off-site Custody of Medications form.

The second medication, clorazepate, is a Controlled Medication marked with a small red C. Again on the 4th and 5th the client was Away.

The third medication, boniva, is administered only once a month – in this case on the first Wednesday of each month. A box is drawn around the box for that date. There is no need to put the number 1 for this medication because the client did not miss his dose. The date for the next month's dose is written in the first column.

The fourth medication, amoxicilin, is an antibiotic started on the 28th of the month and to be stopped on the 6th of the next month.

The fifth medication, multivitamin, is an over-the-counter medication to be administered every day. Again on the 4th and 5th the client was Away.

The sixth medication, erythromycin, is an eye ointment that started on the 6th of the month and was stopped on the 17th of the month, per the directions. A line is drawn from the 1st to the 6th and a vertical line is put after the last dose, D/C, the date, initials, and another line to the end of the month. The entire section, from the column for Medication Name to the end of the month, is then highlighted with yellow. The client did not miss any doses, so there is no need to use the code for being away.

Sample 2 – PRN MAR log

The second sample MAR log is for PRN medications. None of the dates is marked because the medication was not administered because it was not needed by the client. In this sample, the PRN is a heart medication. Other examples of PRN medications might include:

- an antibiotic that must be taken prior to any kind of dental or medical procedure to prevent infection
- an anti-anxiety medication taken only when the client is experiencing anxiety
- a pre- or post-surgical medication such as eye drops

For medications that are PRN, but only used perhaps once or twice a year, such as the medication taken prior to dental or medical procedures or before or after surgery, staff does not need to make a new PRN MAR log each month. The PRN MAR log should be available with the date section left blank until needed. Staff must ensure, however, that the medications in this category are listed on a master list and provided to the office for filing.

For medications that are PRN, and used more than once each month, staff must create a PRN MAR log.

Remember that PRN medications are used only "as needed" and may include:

- regular medications with a doctor prescription
- sample medications with doctor directions for use
- over-the-counter medications with doctor directions for use

If staff notices that a PRN medication is being given on a regular basis, then the client should see the doctor to be evaluated.

Examples might include, but are not limited to, when a client:

- takes a tylenol every day for headaches
- takes pepto bismol on a fairly regular basis
- uses eyedrops every day
- uses nose spray on a regular basis

