CONNECTICUT VALLEY HOSPITAL
Nursing Policy and Procedure Manual

SECTION F: MEDICATION POLICIES & PROCEDURES
CHAPTER 23: MEDICATION MANAGEMENT

POLICY & PROCEDURE 23.6: MEDICATION DOCUMENTATION

Standard of Practice:
The nurse will ensure that all medications he/she administers is documented on the Medication Administration Record (MAR).

Standard of Care:
The patient can expect that all doses of medication he/she receives from the nurse are documented in the patient's medical record.

Every medication given to a patient, including STAT and PRN orders, are charted on the Medication Administration Record (MAR). Charting is done as soon as possible after administration.

Sign your initials, full name and title on each page of the MAR.

When the medication is administered, the RN enters his/her initials opposite the appropriate medication and time, in the appropriate "date" column.

Corollary Assessments required (i.e. vital signs, accu-check) for the administration of some medications are documented on the MAR. *Apical pulse rate for patients on Digoxin is to be recorded on the MAR in the box below each signed-off dose.* (See Example 1)

EXAMPLE 1

MEDICATION RECORD NAME OF PATIENT: M. Jones ALLERGIC TO: NKA

MONTH
YR December 20xx

IDENTIFICATION OF NURSES (INITIALS AND SIGNATURES)		
	NN	Nancy Nurse, RN
	JD	Jane Doe, RN

Date Ordered	Initials	DRUGS * DOSE MODE * INTERVAL	EXPIR DATE	HR	1	2	3	4	5	6	7	8	9	10	11	12
11/28/xx	NN/JD	Digoxin tab 0.25mg po qd Apical Pulse	12/29/xx	8a	NN											
					66											

Use the lower portion of side 1 of the MAR for transcription of STAT and PRN Medications.

STAT and PRN Medications: On the front of the MAR, record the time, including AM or PM, and your initials in the proper date column. Document the medication, reason given and the result on the back of the MAR. If another nurse assesses and documents the patients' response to the medication from the nurse administering, he/she initials the result. For STAT medications, the STAT order on the MAR is discontinued once administered.

Omitted/Refused Doses: Initial then circle the appropriate block on the MAR and write a corresponding note. *Notes will be recorded on the back of the MAR.* (See Example 2)

Pain Assessment Documentation:

1. On the front of the MAR, record the time, including AM or PM, and your initials in the proper date column. The nurse documents medication administered for pain, as well as the patient's response to the pain medication (efficacy) in the PRN Medication and Omitted Doses area of the MAR. The reason column denotes the specific patient complaint. The result column denotes whether the medication(s) had a positive effect or pain is relieved. If the medication does not provide relief, the RN will assess the patient's pain, documenting the results in the Integrated Progress Notes. The ACS Clinician is contacted for further evaluation.

EXAMPLE 2

IDENTIFICATION	NN	Nancy Nurse, RN				
OF NURSES						
(INITIALS AND SIGNATURES)						

PRN MEDICATION AND OMITTED DOSES

DATE	HOUR	INITIAL	MEDICATION	REASON	RESULT
11/27/xx	8am	NN	Motrin	H/A #5	B - 1
11/29/xx	8am	NN	Digoxin	Patient Refused	-

Medication education should be documented on the Patient/Family Education form and also in the Integrated Progress Note for medical conditions and the Psychiatric Progress Notes for related psychiatric conditions.

Insulin Documentation:

In a separate medication block record the time of accu-checks, including am/pm and results.

The nurse who prepares and administers the insulin records his/her initials in the first hour block.

The nurse who verifies that the correct type and dose of insulin was drawn, records the word "initials" in the second hour box, then records their initials in the corresponding day of the month.

Record the word "site" in the third hour box. Record the site insulin administered in the next designated box. Site designations are as follows: Left Upper Extremity (LUE); Right Upper Extremity (RUE); Left Lower Extremity (LLE); Right Lower Extremity (RLE); Abdomen

(ABD) or Left Abdomen (LABD) and Right Abdomen (RABD).

Record the word "unit(s)" **(no abbreviations)** in the fourth hour box when a sliding dosage of insulin is administered. Record only the number of units given in the adjacent box (i.e. 4) under the day of the month.

Standing Coverage

OriginalDate Ordered	Renewal Date	DRUGS * DOSE * MODE * INTERVAL	EXPIR DATE	HR	1	2	3	4	5	6	7	8
1/4/xx	CO / LW	Lantus Insulin 40 Units daily at 9 p.m. SC x 2 weeks	1/18/xx	9 p.m.			→	CO	JP	BK	MF	CO
				2nd Initials			→	LW	LW	LW	LW	LW
				Site			→	LABD	RABD	LLE	RLE	LUE

Sliding Scale Coverage

Do Accu-Chek every day at 6AM and 11AM for three days.

Dr. Smith, MD

OriginalDate Ordered	Renewal Date	DRUGS * DOSE * MODE * INTERVAL	EXPIR DATE	HR	1	2	3	4	5	6	7	8
1/4/xx	CO / LW	Do Accu-check Q6a – 11a – 4p X 3 days		6am			→	JP	JP	BF	←	
				Results			→	230	210	220	←	
				11am			→	BF	JP	BF	←	
				Site			→	190	185	190	←	

Give regular insulin SC to cover as follows:

Below 180mg/dl. No insulin;
180-200mg/dl, give 2Units;
201-250mg/dl, give 4Units;
251-300mg/dl, give 6Units.

Original Date Ordered	Renewal Date	DRUGS * DOSE * MODE * INTERVAL	EXPIR DATE	HR	1	2	3	4	5	6	7	8
1/4/xx	JP / LM	Do Accu-check Q6A-11A-4p x 3 days With regular insulin coverage as follows	1/18/xx	6a			→	JP	JP	BF	←	
				2nd Initials			→	LM	NS	PD	←	
		Below 180mg/dl, give no insulin 180-200mg.dl give 2Units 201-250mg/dl give 4Units 251-300mg/dl give 6Units		Site			→	RUE	RABD	LUE	←	
				Unit(s)			→	4	4	4	←	

First Dose of Newly Prescribed Medications

The nurse documents any change in the patient's condition following administration of newly prescribed medication in the Psychiatric Progress Note section of the medical record and reports findings to the Physician. If there is a change in the physical health status following administration of newly prescribed medication, the Nurse documents this in the Integrated Progress Notes.