WHITING FORENSIC 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 immediately after administration.

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

When the medication is administered, the Nurse 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 Lanoxin 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: Jones, M. 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	Lanoxin tab 0.25mg po 8am	12/29/xx	8a	NN												
		Apical Pulse X 1 minute HOLD for HR less than 60 bpm															
					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 a nurse, other than the nurse administering the medication, assesses the patients' response to the medication he/she must document 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 desired 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	JM	J. Moon, RN				
(INITIALS AND SIGNATURES)						

PRN MEDICATION AND OMITTED DOSES

DATE	HOUR	INITIAL	MEDICATION	REASON	RESULT
11/27/xx	8am	NN	Ibuprofen 600 mg PO PRN	Headache pain 5/10	(9am – JM) Pt states, "I feel much better." Rates pain 2/10
11/29/xx	8am	NN	Lanoxin 8am scheduled dose	Patient Refused	See Progress Notes for Details

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 fingersticks, 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 "2nd 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); Peri-umbilical area of the abdomen are designated by 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 Insulin Order

Glargine Insulin 40 units subcutaneous at 9pm X 2 weeks

Original Date Ordered	Renewal Date	DRUGS * DOSE * MODE * INTERVAL	EXPIR DATE	HR	1	2	3	4	5	6	7	8
1/4/xx	CO / LW	**Glargine Insulin 40 units subcutaneous at 9pm 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

Blood Sugar Orders

Fingersticks daily at 6AM and 11AM for three days.

Dr. Smith, MD

Original Date Ordered	Renewal Date	DRUGS * DOSE * MODE * INTERVAL	EXPIR DATE	HR	1	2	3	4	5	6	7	8
1/4/xx	CO / LW	Fingersticks daily at 6AM and 11AM X 3 days		6am	→	→	→	JP	JP	BF	←	
				Results	→	→	→	230	210	220	←	
				11am	→	→	→	BF	JP	BF	←	
				Site	→	→	→	190	185	190	←	

Sliding Scale Coverage

Regular insulin subcutaneously to cover 6AM and 11AM Fingersticks as follows:

Less than or equal to 180mg/dl No insulin;
181-200mg/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	Regular insulin subcutaneously to cover 6AM and 11AM Fingersticks as follows:	1/18/xx	6a	→	→	→	JP	JP	BF	←	
				2nd Initials	→	→	→	LM	NS	PD	←	
		Less than or equal to 180mg/dl, give NO insulin 181-200mg/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 Integrated 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.