LESSON 5
DOCUMENTATION

Lesson 5: Documentation

OBJECTIVES.

5.1. Explain how to complete three commonly used forms for documenting medication administration

5.2 Explain procedures for receiving and transcribing physician's orders

5.3 Document medication administration on the Medication Administration Record

5.4 Document medication errors

PERFORMANCE OBJECTIVE

Given selected forms, demonstrate understanding of receiving and transcribing orders and documentation of medication administration.

Upon completion of Chapter 5, student will demonstrate understanding of chapter content by completing a written test with 80% accuracy.

ad lib
CP form
Medication Error Report form PO form
PRN order
stat order
Tele phone order (TO)
Transcribe
verbal order (VO)

5.1 Describe Three Types of Forms Commonly Used to Document Medication Administration

INTRODUCTION: Documentation is an important part of medication management. It is frequently referred to as the"6thRight" of medication administration. Forms used to document can be quite confusing to unlicensed persons who are unfamiliar with the process.

To simplify, without minimizing the importance of documentation, this chapter introduces examples of the three main forms used in most assisted living facilities. Medication Aides must know how to use these forms to insure safe medication management and compliance with laws and regulations. Medication Aides should assure this is part of their orientation to a new facility/job.

PERFORMANCE OBJECTIVE'

Demonstrate understanding of three commonly used forms for documenting medication administration by completing each of the three forms correctly.

TOPICAL OUTLINE'

A. The Physician's Order form or Health Care Provider Order Form

1. Used by HCP to record prescribed medication and treatment orders which caregivers are to follow.

2. No medication, diet, medical procedure or treatment may be started, changed or discontinued by the facility without an order by the HCP. The client's record must contain a written order or a dated notation of the HCP verbal order.

3. The HCP Order Form must be retained in the client's record.

4. Medication orders must be confirmed on the HCP Order Form before each administration or per facility policy.

B. The Medication Administration Record

1. The form onto which the HCP orders are transferred (from the HCP Order Form).
2. Daily record of all medications to be administered
3. Daily record of staff who administered medications.
4. Daily record of reason for administering and the results of PRN medications..

5. Daily record of medication exceptions (drugs not given and the reason).
6. Record of signatures and initials of all persons who administered medications

c. The Medication Error Report Form

1. The facility form on which a medication error is documented.

Other medication administration documentation forms

Client Controlled Drug form
Controlled Drug Count Documentation
Drug Disposal Disposition form

5.2 Explain Procedures for Receiving and Transcribing Physician's Orders

INTRODUCTION: Medication orders are written by the HCP. They are instructions for treatment and medications required to treat the client. Because Virginia law does not require that a licensed nurse be employed by an ALF, Medication Aides may be responsible for receiving and transcribing orders. They must clearly understand required procedures as well as the limitations regarding their role in medication documentation.

Performance Objectives.
Given sample HCP order forms and scenarios, demonstrate appropriate documentation procedures for medications administered or omitted and for medication errors.

TOPICAL OUTLINE]

A. Receiving medication orders

1. Written order

a. Written on the Physician's Order (PO) form of the Health Care Provider' (HCP) form.

b. A written order is the best type of medication order.

c. Contact the HCP if the order is not legible—DON'T GUESS!

2. Verbal order (VO)

a. When the HCP gives the medication order verbally directly to another person.

b. Avoid taking verbal orders.

c. Even though Medication Aides are permitted by law to receive verbal orders, some facilities allow only licensed nurses to do so. Always follow facility policies.

3. Telephone order (TO)

a. Referred to as 'oral order' in the Drug Control Act of Virginia

b. Avoid taking telephone orders for medication, when possible.

c. Some facilities do not allow Medication Aides to accept oral orders

B. Guidelines for receiving telephone orders.

1. When possible, have a second staff person listen on the extension phone to the HCP who is giving the order. Have this person countersign the order.
2. Identify yourself to the HCP by stating your name and position.
3. Write the order down on the appropriate form exactly as the HCP states it.

4.. Follow the "Five Rights".
5.. Repeat the order back to the HCP.
6.. Ask the HCP to spell words that you are unsure how to spell.
7. Repeat this process until the order is correct.
8. Virginia regulation requires that the order must be signed within ten (10) working days of receipt.

9. Be sure to inform the HCP that you are a Medication Aide and that the law forbids unlicensed persons to transmit orders for new prescription drugs to the pharmacy. The HCP will need to communicate the prescription to the pharmacy by phone or by fax.

C. The four types of medication orders are:

1. Routine medication order

a. This is a detailed order for a drug that is to be administered on a regularly scheduled basis.

b. The reason the medication is being given must be in the client's record, however, it does not normally appear in the order. This information is usually in the client's history and physical or in the HCP progress or office-visit notes.

Example: Digoxin 0.125 mg. Give one tablet by mouth every day. Hold if the pulse is below 60 beats per minute and notify physician.

Note: Occasionally the HCP order will be to simply increase or decrease the dosage of a medication that the client is currently taking. This is treated exactly the same as a new order. In other words, the old order is discontinued and a new order is written with the increased or decreased dose.

2. PRN medication (as needed) order:

a. A medication which is ordered to be given "when necessary' or "as needed" within a designated number of hours.

b. It may or may not be given on a daily basis

c. The Department of Social Services Standards for Assisted Living Facilities require that the following four points be included in a PRN order if a licensed health care professional (nurse) is not responsible for medication management or if the client is cognitively impaired and unable to self-administer:

1. The symptoms for which the medication is to be given.
2. The exact dose. (It may not state "1-2 tablets" rather, it must state "give one tablet" or "give two tablets."

3. The exact time in a 24 hour period (e.g.: must not state "every 4-6 hours" rather, it must state "every 4 hours" or "every six hours" specifically. The decision as to what hour the drug is to be given may NOT be made by the Medication Aide.

4. What to do if symptoms persist. (e.g.: "Notify HCP if no relief in 24 hours").

Example: Acetaminophen 500rrig. Give one tablet every 4 hours as needed for shoulder pain. Notify HCP if no relief within 24 hours.

Note: The Medication Aide may NOT give a PRN drug if any of the above four points are missing.

Medication Aides may not assess for medical need nor can the assessment of medical need be delegated to an unlicensed person by a registered nurse or a physician.

3. Stat medication order

a. An order to give a medication immediately.

b. A HCP may write that the medication be given "now" instead of "stat" to make sure that the medication is given right away.

4. Single dose

e. a. The order may be:

- to give a drug one-time only; or
- for the first dose of a drug that will become a routine order; or
- for an extra or increased dose of a medication that the client is currently routinely receiving.

Example: Lasix 40 mg. "Give one tablet by mouth, now".

D. Preventing misinterpretation of an order

1. Do not leave a decimal point alone.

Example:

a. .2 mg. is WRONG because there is no number or 0 in front of the decimal point.

b. 0.2mg is RIGHT because there is a 0 in front of the decimal. This minimizes the possibility of the dose being read as 2mg instead of 0.2mg.

2. Never place a decimal point and a zero after a whole number. Example:

a. 5.0mg is WRONG because it could be read as 50mg. instead of 5mg.
b. 5mg. is the RIGHT way to write the dosage.

3. ALWAYS QUESTION THE ORDER IF:

a. There is any difficulty interpreting the name or spelling of a medication

b. There is any difficulty understanding a number for the dose of a medication.

c.There is a reason to believe that the dose seems inappropriate.

REMEMBER: When in Doubt---DON'T!

E. Transcribing orders onto the Medication Administration Record

1. Transcribe — means to write down or to copy.
   a. In medication administration it means to copy orders from the HCP Order Form onto the Medication Administration Record (MAR)

2. Procedure for accurate transcribing:

a. Write the client's personal identification information onto a blank MAR and before transcribing any orders onto the form include the following:

- Client's name and room number
- Any known allergies (write in capital letters in red and/or circle)
- The name of the client's physician
- Diagnosis

b. Record each medication ordered from the HCP order form to include:

- Name of the drug and the strength of the drug
- Dose of the drug to be given (must be exact for PRN orders)
- The route the drug is to be given

The time(s) the drug is to be given (must be exact for PRN orders)

a. Write the client's personal identification information onto a blank MAR and before transcribing any orders onto the form include the following:

- Client's name and room number
- Any known allergies (write in capital letters in red and/or circle)
- The name of the client's physician
- Diagnosis

b. Record each medication ordered from the HCP order form to include:

- Name of the drug and the strength of the drug
- Dose of the drug to be given (must be exact for PRN orders)
- The route the drug is to be given

The time(s) the drug is to be given (must be exact for PRN orders)

- The date the drug is to be started
- The date the drug is to be stopped (if provided)

c. Document the date, time and name of the person who transcribed the order on the HCP Order Form.

3. Procedure for discontinuing a medication order on the MAR:

a. Highlight the discontinued drug in yellow and write "discontinued" and the date.

b. If the drug is not discontinued BUT the dose is reduced, this should be transcribed as a NEW drug order. The did order would be highlighted in yellow and "discontinued" written on the MAR .

The new order with the revised dosage is then transcribed onto the MAR exactly as a new order would be.

Note: It is important to follow the facility policy regarding how a discontinued drug is. indicated on the MAR as procedures may vary.

F. Transmitting the HCP order to the pharmacy

1. Medication Aides may not transmit oral orders for prescription drugs to the pharmacy. Medication Aides, when instructed by the HCP, may fax orders to the pharmacy if written at the facility by the HCP.

2. Medication Aides or nurses may forward a prescription to the pharmacy via fax if the prescription was faxed to the facility from the prescriber's practice location.

3. Neither a Medication Aide nor a nurse may fax a written prescription to the pharmacy which was brought to the facility by the patient or a patient representative.

CHAP 5

5.3 Document Medication Administration on the Medication Administration Record

INTRODUCTION: Once the student is familiar with the various documentation forms, types of medication orders, and how to receive and transcribe orders, he must be taught how to document the administration, refusal or omission of medications using the correct forms and proper procedures.

TOPICAL OUTLINE

A. What to document

All medications administered or omitted. -
Pulse and blood pressure measurements which are required before giving the medication or required to be monitored regularly.
Blood-glucose monitoring results.

B. Documenting routinely administered medications.

Place your initials in the box that corresponds with the date and time for the drug.

If the drug is given more than once daily, initial in the appropriate box each time.

Documentation per facility policy for extended absence of resident

C. **Documenting PRN medications**

Place your initials in the box which corresponds with the date for the drug.

On the back of the MAR document the following:

Date

Hour of administration

Name and dose of the drug

The reason the drug was administered

The results of administration (was it effective?).

3. To insure accurate documentation of the result of a PRN drug, the Medication Aide must follow-up with the client within a reasonable period of time and inquire as to whether the symptoms are relieved. Document the client's response.
Note: When documenting results of PRN administration, do not write "effective" or "ineffective". Document what the client says or state an objective observation. (See example on *Student Handout 5.1.C-page 2).* -

D. Documenting medication exceptions.

I. Documenting the client's refusal to take medication:

Place initials in the box that corresponds with the date and time for the drug.

If the client refuses the drug, circle the initials.

On the back of the MAR document the following:

- Date
- Hotir of administration attempt
- Name and dose of the drug
- The reason the drug was refused
- The method used to dispose of the refused medication.
- Report the refusal to the HCP or follow the facility policy for reporting.

2. Documenting medications that are omitted.
An omission means a drug was not given for reason other than client refusal.
The most common reasons for omissions are:
The client is out of the facility with family or on "leave".
The client is in the hospital.
The drug is not available (NOTE: every attempt must be made to get the drug and the attempt(s) must be documented).

When a drug is omitted place initials in the box which corresponds with the date and time for the drug.

Circle the initials.

On the back of the MAR document the following :

- Date
- Time the drug was to be administered
- Name and dose of the drug

- The reason the drug was omitted
- Follow-up actions
- The method used to dispose of the medication, if required. (**Note:** Forms may differ but must contain the information above).

f. Report the refusal to the HCP or follow the facility policy for reporting.

5.4 Document Medication Errors

INTRODUCTION: When one of the "5 Rights" of medication administration becomes a "wrong", a medication error has occurred. Students must understand that the most important action to take when a medication error occurs is to see that the client receives any treatment which might be required as a result of the error. The next step is to document the error in a way that indicates that the situation was analyzed as to the cause and what action was taken to prevent future errors.

TOPICAL **OUTLINE**

A. Medication error

1. When a medication is *not* given as prescribed by the HCP, a medication error has occurred. Errors are the opposite of the Five Rights and thus can be referred to as the *Five Wrongs.* They are:

The *Wrong Client* — the client receives another client's medication.
The *Wrong Medication* — the client received an un-prescribed medication.
The *Wrong Dose* -- was given to the client.
The *Wrong Time* — amedication was given at the wrong time or not at all.
This includes drugs that are given outside of the two-hour window.

Note: A common *wrong time* error is the administration of AC (before meals) and PC (after meals) medications at the wrong time.

The *Wrong Route* — example: drops are placed in the ears rather than the eyes.

B. Documenting medication errors

After measures have been taken to insure client safety and the HCP has been notified, the medication error must be documented on a *Medication Error Report Form.*

2. The following should be included on the report form:

The name of the client and the date and time of the error;

The type of error (which of the Five Wrongs);
Which medication was given in error;
Record of who was contacted and when;
Consequences to the client;
Treatment required as a result of the error;
The name of the Medication Aide responsible for the error.
Follow-up by the supervisor with recommendations for preventing future occurrence.

OBJECTIVES

5.1. Explain how to complete three commonly used forms for documenting medication administration

5.2 Explain procedures for receiving and transcribing physician's orders

5.3 Document medication administration on the Medication Administration Record

5.4 Document medication errors

PERFORMANCE OBJECTIVE

Given selected forms, demonstrate understanding of receiving and transcribing orders and documentation of medication administration.
Upon completion of Chapter 5, student will demonstrate understanding of chapter content by completing a written test with 80% accuracy.

KEY TERMS

ad lib

11CP form

Medication Error

Report form

PO form

PRN order

stat order

telephone order (TO)

transcribe

verbal order (VO)