KINGSTON GENERAL HOSPITAL

NURSING POLICY & PROCEDURE

SUBJECT	Documentation - Medication Administration Record	**NUMBER**	D-5710
		PAGE	1 of 7
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		REVIEW	
		REVISION	2014 May

Policy:

1. A standardized documentation process is required to ensure safe and timely administration of medications to patients.
   All medication orders are transcribed onto the Medication Administration Record (MAR).
   EXCEPTIONS:
   1.1 Some standardized order sets have associated MARS that have been pre-printed to support transcription. (D-5712 Documentation – Mediation Administration Record (MAR), PrePrinted)
   1.2 Continuous parenteral medication rate changes will be recorded on the Continuous Parenteral Therapy Record, the unit specific flowsheet, or the MAR, Titratable. (D-5714 Documentation – Medication Administration Record (MAR), Titratable) as per unit standard.
   1.3 Patient Controlled Analgesia and Neuraxial Analgesia will be recorded on the appropriate Analgesia Flowsheet.
   1.4 Orders generated by the Oncology Patient Information System (OPIS 2005) excluding those type coded H will be documented on the Chemotherapy Inpatient Nursing Record

2. Transcription and documentation is printed clearly in permanent, dark blue or black ink.

3. The prescriber order is transcribed exactly as written.

4. Continuous parenteral medication bag changes are transcribed within the appropriate section of the MAR
   4.1 The specific rate/dose will be recorded on the Continuous Parenteral Therapy Record, the unit specific flowsheet, or the MAR, Titratable.

5. The use of stickers on the MAR will be restricted for use by assessment of sticker size, font, message, safety concern, stakeholders, potential alternatives to managing the challenge and impact on the readability and flow of the MAR document. Use of a sticker on the MAR will be at the discretion of Professional Practice, Nursing, Director.

6. Medications requiring an independent double check will be co-signed by a second nurse (RN/RPN) at the time of administration.

Definitions:

Medication: any substance or mixture of substances manufactured, sold or represented for use in the diagnosis, treatment, mitigation or prevention of disease, disorder, abnormal physical or mental state, or the symptoms thereof; or in restoring, correcting or modifying organic functions (including electrolyte replacement and parenteral nutrition).

Medication Administration Record (MAR): tool used to communicate medications which have been prescribed for the patient, and document medications which have been administered.

- The SHORT form is used for planned short stay patients (e.g., post partum patients).
- The LONG form is used for all other patients.

One Dose Only, Preoperative and Stat Medications: medications ordered for specific "one time only" situations".

PRN/Unscheduled Medications: medications given on an "as needed" basis for a specific indication as ordered by the prescriber.

Continuous Parenteral Medication: Medications administered uninterrupted via intravenous, routes.

Generic Medication Name: Each medication has an approved generic name. Different companies that produce the medication may give it a brand name. A generic name medication produced by different companies may have a different brand name. For example, the generic medication acetaminophen may come under the company brand name of Tylenol, Panadol or others.

Procedure 1: Overview

1. Initiating the MAR:
   1.1 Affix a patient label in the upper right corner. If the patient label is unavailable, record the patient's surname, first initial(s) and central registry (CR) number.
   1.2 Fill in the dates across the top of the medication administration record on each page. The dates on each page should be identical.
   1.3 If more than one record is in use at the same time, the dates on each record must coincide. (See also #8).

2. If a sticker is being used on the MAR, it must be applied to the appropriately defined (watermarked) location.

3. Transcribing on the MAR:
   3.1 Enter the prescribed medications exactly as ordered
      3.1.1 If not ordered by generic name, the nurse will print the generic name in brackets below the trade name.
   3.2 If the order is prescribed by the APMS, print "APMS Order" in red ink with the medication name.
   3.3 The person who transcribes the order initials the "Transcriber" column or box.
   3.4 The nurse who checks transcription, checks all aspects of the order transcription, and records initials in the "Nurse Check" column or box.

4. Initials
   4.1 Each staff member will record their initials and signature on the MAR Signature Record if they have not completed the Signature Record on the daily Comprehensive Patient Care Record.
   4.2 Initials are used to indicate:
      4.2.1 transcription/copying of a medication order, administration of a medication, creation of a subsequent medication administration record; or
      4.2.2 a second person check of: transcription of a medication order, calculation of a drug dose, independent double checks, or creation of a subsequent medication administration record.

5. When documenting medication administration on the MAR:
   5.1 Each dose of medication will be recorded immediately after it is administered.
   5.2 Identified high alert medications require an independent double check and initial by a second nurse.

6. Recopying
   6.1 Copy the patient's current medications onto a new medication administration record, retaining the original order dates.
   6.2 The person who copies the MAR initials the transcribed ("Transcriber") box.
   6.3 The person who checks the record against the current medication administration record, initials the "Nurse Check" box.
   6.4 The person who copies the MAR checks the "RECOPIED" box at the bottom of the cover page and records the current date.

7. MAR's that have been recopied will be checked by a nurse using the current MAR as a reference, before the new MAR is used.

8. When more than one booklet is in use:
   8.1 On the front cover, indicate book ___ of ___ e.g. book 2 of 2
   8.2 Include all MAR's in the count e.g. MAR, Titratable, MAR Preprinted.

9. Use of chemotherapy agents is communicated on the front page of the MAR by checking the appropriate statement

10. File the completed MAR in the Therapy section of the patient care record.

Procedure 2: One Dose Only, Preoperative & Stat Medications

1. Transcription of Order
   1.1 Enter the order date
   1.2 Enter the prescribed medication
   1.3 Enter the prescribed dose
   1.4 Enter the prescribed route.
   1.5 If applicable, enter the requisite situation for administration. (e.g., "furosemide 40 mg IV after each unit of packed cells", or "cefazolin 1 gram IV on call to OR").

2. Record of Medication Administration
   2.1 Enter the current date in the "Given" column.
   2.2 Enter the time of administration in the "Given" column.
   2.3 Record initials in the "Administered. By/Independent Double Check" column.

Procedure 3: Routine Medications

1. Transcription of Order
   1.1 Routine orders:
      1.1.1 Enter the order date.
      1.1.2 Enter the prescribed medication
      1.1.3 Enter the prescribed dose.
      1.1.4 Enter the prescribed route.
      1.1.5 Enter the prescribed frequency for administration.
      1.1.6 Pencil will be used to circle the standard administration times in keeping with the prescribed frequency and KGH routine prescribed times. See also Administrative Policy 14-101 Medication Administration)
   1.2 Special orders:
      1.2.1 Daily orders (e.g., warfarin or insulin): Follow steps 1.1.1 to 1.1.6 above except:
         1.2.1.1 in the DOSE column enter "daily order"; and
         1.2.1.2 enter the prescribed dose under the intended date for administration.

1.2.2 Medications ordered for specific days: Follow steps 1.1.1 to 1.1.6 above and draw a line through days on which the medication is not to be given.

1.2.3 Medications with increasing or decreasing doses: e.g., dexamethasone follow steps 1.1.1 to 1.1.6 above except:
- 1.2.3.1 in the DOSE column enter "decreasing doses" or "increasing doses"; and
- 1.2.3.2 enter the prescribed dose(s) under the intended date(s) for administration.

1.2.4 Unusual frequency for administration (e.g., gentamicin q18 h) Follow steps 1.1.1 to 1.1.6 above except:
- 1.2.4.1 do not circle the standard administration times; and
- 1.2.4.2 enter the scheduled administration time(s) under the intended date(s) in pencil for administration.

1.2.5 If a medication is reordered, enter the reorder date.

2. Record of Medication Administration
   - 2.1 Enter the time of administration
   - 2.2 If there are multiple alternative prescribed routes or dose record the route or dose administered
   - 2.3 If applicable, enter parameters critical to administration of the medication (e.g., digoxin - apical heart rate or injection - administration site right arm)
   - 2.4 Record your initials
   - 2.5 Indicate medications held or refused with an asterisk and document reason in the Interprofessional Progress Note
   - 2.6 Indicate medications not available with N/A and complete a Safe Report

3. Transcription of Medication Administration or Changed Medications
   - 3.1 Draw a single diagonal line through the medication.
   - 3.2 Enter the date under the line.
   - 3.3 Enter your initials next to the date.
   - 3.4 Draw a single diagonal line through the dose, schedule and each of the subsequent days remaining on the record.

Procedure 4: PRN/Unscheduled Medications

1. Transcription of Order
   - 1.1 Enter the order date.
   - 1.2 Enter the prescribed medication.
   - 1.3 If applicable, enter the prescribed dose and medication concentration
     - 1.3.1 if a subcutaneous set is used for medication administration, document the concentration of medication under the medication name
   - 1.4 Enter the prescribed route
   - 1.5 Enter the indication for administration (e.g. "for breakthrough pain")
   - 1.6 Record initials
   - 1.7 If a medication is reordered, enter the reorder date

2. Record of Medication Administration
   - 2.1 Enter the time of administration
   - 2.2 If 2 doses (e.g.1mg to 2mg) are ordered, record the dose given
   - 2.3 Record initials.

3. Transcription of Discontinued of Changed Mediations
   - 3.1 Draw a single diagonal line through the medication.
   - 3.2 Enter the date under the line.
   - 3.3 Enter your initials next to the date.

3.4 Draw a single diagonal line through the dose, schedule and each of the subsequent days remaining on the record.

Procedure 5: Continuous Parenteral Medications Infusions and Bag Changes

1. Transcription of Order **(See Appendix A Transcription Sample)**
   1.1 Enter the order date
   1.2 Enter the prescribed medication
   1.3 Enter the prescribed dose/rate and/or route
   1.4 Record initials
   NOTE: The actual dose of continuous medication is recorded on the Continuous Parenteral Therapy Record, the MAR,Titratable, or the unit specific flowsheet

2. Record of Medication Administration
   2.1 Enter the time of initiation or bag change.
   2.2. Record initials.

3. Transcription of Discontinued or Changed Medication
   3.1 Draw a single diagonal line through the medication.
   3.2 Enter the date under the line.
   3.3 Enter your initials next to the date.
   3.4 Draw a single diagonal line through the dose, schedule and each of the subsequent days remaining on the record.

Related Policies and Procedures:
Nursing Policy M-1590 Standard Administration Times
Nursing Policy D-5712 Documentation – Medication Administration Record (MAR), Pre-Printed
Nursing Policy D- 5714 Documentation – Medication Administration Record (MAR), Titratable
Administrative Policy 14-101 Medication Administration

References:
College of Nurses (2008). *Medication, Revised 2008.* College of Nurses of Ontario. Toronto, ON.
College of Nurses (2008). *Documentation, Revised 2008*. College of Nurses of Ontario: Toronto, ON.

Director, Professional Practice – Nursing Signature _____ Date _____

Appendix A

Kingston General Hospital

PATIENT INDENDIFICATION LABEL

MEDICATION ADMINISTRATION RECORD
ROUTINE/SCHEDULED MEDICATIONS

REMARKS

Year (yyyy) 2013

	ROUTINE MEDICATIONS	DOSE	FREQUENCY	10/01 Time	10/01 Initial	10/02 Time	10/02 Initial	10/03 Time	10/03 Initial	10/04 Time	10/04 Initial	10/05 Time	10/05 Initial	10/06 Time	10/06 Initial
1.2.1	ORIGINAL ORDER DATE: 2013/10/01 (yyyy/mm/dd) Coumadin REORDER DATE: (yyyy/mm/dd)	Daily order	@ 1700h 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 ROUTE PO TRANS-CRIBER NURSE CHECK	5mg											
1.2.2	ORIGINAL ORDER DATE: 2013/10/01 (yyyy/mm/dd) Digoxin REORDER DATE: (yyyy/mm/dd)	0.25mg	Q2d OD 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 ROUTE PO TRANS-CRIBER NURSE CHECK												
1.2.3	ORIGINAL ORDER DATE: 2013/10/01 (yyyy/mm/dd) Prednisone REORDER DATE: (yyyy/mm/dd)	decreasing doses	BID 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 ROUTE PO TRANS-CRIBER NURSE CHECK	25mg		20mg		15mg		10mg		5mg		2.5mg	
1,2,4	ORIGINAL ORDER DATE: 2013/10/01 (yyyy/mm/dd) Gentamicin REORDER DATE: (yyyy/mm/dd)	80mg	@18H 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 ROUTE IV TRANS-CRIBER NURSE CHECK	1400h		0800h		0200h		2000h		1400h		0800h	
3.	ORIGINAL ORDER DATE: 2013/10/01 (yyyy/mm/dd) Heparin 2013/10/01 REORDER DATE: (yyyy/mm/dd)	5,000u	@12H 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 ROUTE SC TRANS-CRIBER NURSE CHECK												
	ORIGINAL ORDER DATE: (yyyy/mm/dd) REORDER DATE: (yyyy/mm/dd)		1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 ROUTE TRANS-CRIBER NURSE CHECK												

Appendix B

Kingston General Hospital

PATIENT IDENTIFICATION LABEL

Patient label

MEDICATION ADMINISTRATION RECORD

CONTINUOUS PARENTERAL MEDICATION INFUSIONS AND BAG CHANGES

REMARKS

Year (yyyy) 2014

MEDICATIONS	DOSE/RATE	Concentration	03/02 Time	03/02 Initial	03/03 Time	03/03 Initial	03/04 Time	03/04 Initial	03/05 Time	03/05 Initial	03/06 Time	03/06 Initial	03/07 Time	03/07 Initial
ORIGINAL ORDER DATE: 2014/03/02 Pantoloc REORDER DATE: ROUTE IV	8mg/hr or 10ml/hr	80mg in 80ml NS (total vol 100ml) (0.8mg/ml)	1410	CW	0730	CW	0120	RK						
					1610	CW								
		TRANSCRIBER CW	2300	CW										
		NURSE CHECK												
ORIGINAL ORDER DATE: 2014/03/02 2/3 1/3 = KCl REORDER DATE: ROUTE IV	125ml/hr	20meq/L	1500	CW										
		TRANSCRIBER CW	2230	CW										
		NURSE CHECK												
ORIGINAL ORDER DATE: 2014/03/02 Octreotide REORDER DATE: ROUTE IV	50mcg/hr or 25ml/hr	500mcg/250mlD5W (2mcg/ml)	1830	CW	0400	RK								
		TRANSCRIBER CW												
		NURSE CHECK												
ORIGINAL ORDER DATE: 2014/03/04 Lasix REORDER DATE: ROUTE IV	2mg/hr or 2ml/hr	250mg/250ml NS (1mg/ml)					0420	CW						
		TRANSCRIBER CW												
		NURSE CHECK												
ORIGINAL ORDER DATE: 2014/03/05 Amino Acids 5% and Dextrose 25% REORDER DATE: ROUTE IV	target rate 40ml/hr								1030	CW				
		TRANSCRIBER CW												
		NURSE CHECK												
ORIGINAL ORDER DATE: 2014/03/05 Lipids 20% REORDER DATE: ROUTE IV	10ml/hr								1030	CW				
		TRANSCRIBER CW												
		NURSE CHECK												

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