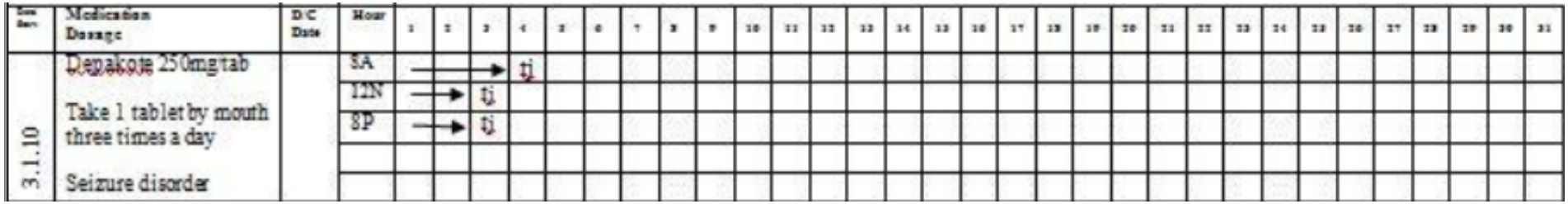
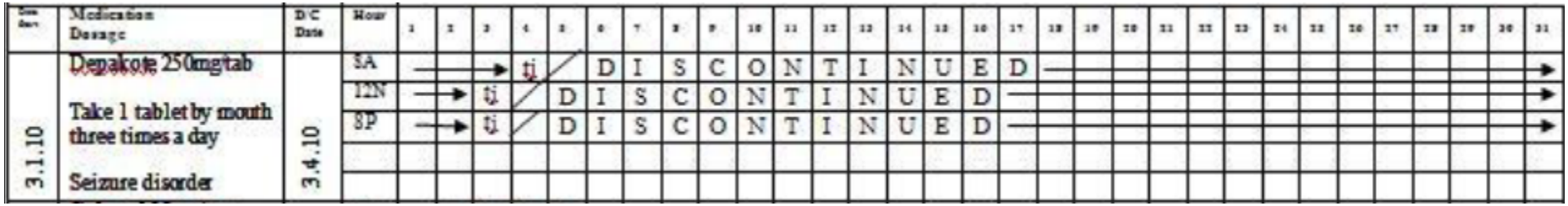
Documenting Occasional Events on the Medication Administration Record (MAR) – Front

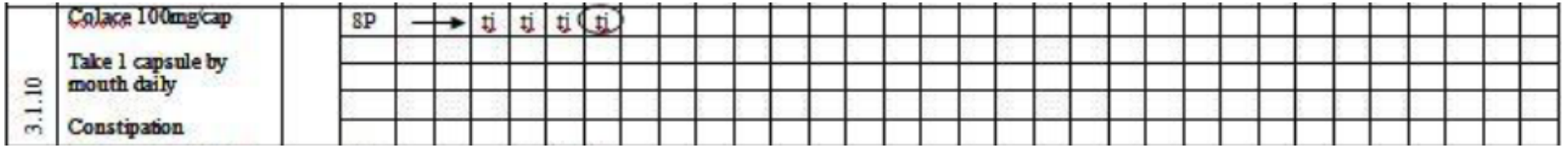
Posting a new order: the **Start Date** should be the date of the order, not the date the medication was first administered. Draw a line with an arrow to the date of first administration. Below, Depakote was ordered 3/1/10, and first given 3/3/10 at 12N. You will not need to enter any information on the back of the MAR.



Discontinuing a medication: complete the **D/C Date**, and draw a slash through the next administration date, followed by the word "Discontinued" or "D/C" and an arrow to the end of the month. Below, Depakote was discontinued 3/4/10 after 8AM. You ***will*** need to enter additional information on the back of the MAR.



Medication omission, or medication/documentation error: initial the appropriate box, then circle your initials. You ***will*** need to enter additional information on the back of the MAR.



PRN administration: initial the appropriate box. You ***will*** need to enter additional information on the back of the MAR. Do not record administration time on the front of the MAR, as this information will be recorded on the back.

Documenting Occasional Events on the Medication Administration Record (MAR) – Back

PRN Orders: Complete any time a PRN is administered. Record the administration time under **Hour**. Under **Reason**, document the symptom, notification of the RN, and any instructions received. Under **Results**, document the observed effect on the individual's symptoms and any follow-up actions taken.

PRN ORDERS					
DATE	HOUR	INITIALS	MEDICATION	REASON	RESULTS
3.8.10	4P	tj	Imodium	Diarrhea. RN ok'd	No further
				administration.	diarrhea by 6P

Medication Errors: Complete any time an error is made documenting or administering a medication – i.e., medication not given, wrong dose administered, wrong row signed, wrong pill popped from blister pack, or medication posted incorrectly. Under **Date** and **Hour**, record the date/time you are documenting the error. Under **Action Taken**, document the error, notification of the RN, instructions received, and follow-up actions taken.

MEDICATION ERRORS				
DATE	HOUR	INITIALS	MEDICATION	ACTION TAKEN
3.6.10	12N	tj	12N Depakote	2 tabs given at 12N. RN CM/DN
				informed. Told to monitor for
				sleepiness.

Prescribed Omissions and Changes: Complete whenever a medication dosage is changed, a medication is discontinued, or a dosage is missed due to reasons other than medication errors (i.e., RN instructions, individual absent or refused, medication not available, etc.). Always document informing RN. For omissions due to an individual's absence, document the expected return date/time.

MEDICATION OMISSION- MEDICATION CHANGES					
DATE	HOUR	INITIALS	MEDICATION	REASON	ACTION TAKEN
3.4.10	11A	tj	Depakote increased	Blood levels low	RN CM/DN
			to 4 times/day		informed
3.6.10	8P	tj	8P: Colace.	LOA. Family	RN CM/DN
			Depakote. Bactrim	responsible. To	informed.
				Return 10P.	
3.7.10	8P	tj	8P: Colace	Refused due to 2	RN CM/DN
				BMs today	Informed. Told
					to resume on 3.8
3.8.10	8A	tj	Hold 8P Colace 3.8&9	diarrhea	Directed by RN CM/DN