

THE MEDICATION ADMINISTRATION RECORD

The final step in medication administration is to accurately document what you gave to the person! The medication administration record (MAR) is part of the individual's permanent record. It is important since it describes the medications (prescription and non-prescription/over-the-counter) used by the individual, the doses, the routes, and the times medications were taken.

REMEMBER:

***ALL MEDICAL FORMS ARE CONSIDERED LEGAL DOCUMENTS!
USE ONLY BLUE OR BLACK INK!
WHITE OUT MAY NOT BE USED!***

In general a medication administration record will contain the following information:
(each agency will have a form that meets its specific needs)

- The name of the individual taking the medication(s);
- The month and year the record is for;
- The name of the primary physician or other authorized practitioner;
- The name of the medication(s) and how it is to be taken, as ordered by the physician or other authorized practitioner;
- The time the medication(s) is to be taken;
- Any medication sensitivities and allergies. If there are not any known allergies then 'NKA' (no known allergies) or 'NKDA' (no known drug allergies) should be listed on the record;
- The identifying initials of the staff or other provider assisting the individual at the time each of the medications are taken, for each day and each time the medication was taken;
- The signatures and identifying initials of ALL staff or other providers who assisted with medications; and,
- Each time a PRN (as needed) medication is given the above items apply as well as the staff or other provider will note the reason the PRN medication was given and the results of the medication.

RULES FOR DOCUMENTION ON THE MEDICATION ADMINISTRATION RECORD

- Use blue or black ink. Never pencil.
- Never use white out.
- Chart each time after giving the medication, not before. Do not wait until end of shift.
- Only chart what you give. Never document medications given by another person and never allow another person to document for you.
- If the medication cannot be given or a person refuses a medication then initial the appropriate box, circle the initials, provide an explanation on the back of the MAR and notify the appropriate person as outlined by the agency's procedures.
- Follow specific agency procedures for medication administration, errors, etc.

MEDICATION ERRORS

The possibility of medication errors occurring is a constant danger. By following proper procedures (e.g. The 5 Rights) errors can be minimized. However, errors occasionally do happen and must be dealt with properly. The severity of an error will vary depending on the medication and the individual involved. When an error occurs, it is extremely important that you are willing to admit it, seek help, notify the nurse/nurse consultant and/or the physician or other authorized practitioner and document the error (e.g. MAR and incident report). For any medication error you must follow the agency's procedures. Some of the more common errors are:

- An individual taking or given the wrong medication.
- An individual taking a medication that is prescribed for someone else.
- A medication taken in the wrong dosage.
- A medication taken at the wrong time.
- A medication that is forgotten or not taken at all.
- A medication that is administered by the wrong route.
- The wrong procedure is followed in administering the medication.