MEDICATION ADMINISTRATION RECORD (MAR) Protocol- Extended Downtime

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Effective Date: 10/5/04		**Policy No:**	**8620.191b**
Cross Referenced: 8620.191a		**Origin:**	**Division of Nursing**
Reviewed Date: 11/07, 12/10		**Authority:**	**Chief Nursing Officer**
Revised Date: 12/2015		**Page:**	**1 of 4**

SCOPE
All RNs and Respiratory therapist who administer medications

PURPOSE
To define the process of managing physician medication orders using the paper medication record (MAR) when this is an extended downtime.

DEFINITIONS
Extended period of time- when the electronic medical record is down more than 8 hours without a known time of return.

POLICY
To create a safe administration documentation process when the electronic medical record is in downtime for an extended period of time.

PROCEDURE

A. General Guidelines
1. RNs, LPNs, Unit Secretary and trained Monitor Techs may transcribe physician orders onto a paper MAR.
2. The nurse who is administering the medication is responsible for the use of the MAR
3. The MAR must be brought to the bedside for all administration of medications.
4. The two identifiers (patient name and MRN) on the patient's ID band must be compared to the two identifiers on the MAR prior to administration of medications.
5. The paper MAR must accompany the patient with the chart if the patient is off the unit for any reason.
6. Yellow highlighter is to be used when discontinuing medications, or making any changes to the medication order such as a change in time or dose.
7. All pre-operative medications must be re-ordered or they are discontinued
8. Flushes- All flushes for IV therapy, medication administration process and line maintenance will be documented on the MAR
9. PRN medications- In addition to basic order all prn will require:
    a. Reason for the PRN, orders must be clarified if parameters for administration of PRN are not included. Example: Tylenol 650mg po q4h prn headache.
    b. When the PRN drug is administered enter the following:
        i. Date and time given. Initials and site if applicable if using paper MAR
        ii. Chart reason for giving prn medication in nurses notes/flowhsheet, followed by results of the prn medication.

B. Entering Medication Orders on the MAR
1. Scan pharmacy request
2. Enter month and day that meds are to be given on the routine medication sheets in each date box. Each routine and respiratory MAR hold up to 7days. Write in all 7 days on the front and the same dates on the back. All the routine medication sheets should have the same dates.
3. Enter order date on MAR in left-hand column with initials of person transcribing the medication.

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4. Enter all the elements of a complete medication order: Drug, Dosage, Route of administration, Frequency and any Special instructions in red if included (may need extra lines).

5. If there is no more room to transcribe medication on the existing MAR, start an additional one. If an additional MAR is required, then date it with the same dates as the first one.

6. With first dose of medication administered, give explanation of medication to patient if patient physiologically able to learn. Monitor for adverse reaction and notify physician if adverse reactions are present.

7. List hours(s) of dosage in vertical (scheduled time) column and use military time.
    a. Beginning with first dosage due each day (example: 0600 – 1200 – 1800).
    b. If times not designated by physician, use Pharmacy Standard Times. (PN .005a)

8. When the date ordered and the date to be started are different for routine medications:
    a. The date of the order will be written in the "order date" column. The medication order will be followed by the words (start-date) in red.
    b. An "X" will be placed through ALL the boxes under dates until a medication is to begin.

9. The instruction for medications to be given on odd or even days should be written in red. An "X" should be placed through the ALL boxes on the days when the medication is not to be administered. The same is done with weekly meds. "X" all boxes on the days when the medication is not to be administered.

10. Leave appropriate lines for parameters for BP and/or HR when ordered by the physician if electronic record not available   Injections: Leave appropriate lines/box so the site of injection can be documented. (See codes on MAR)

11. After a Unit Secretary, Monitor tech or LPN transcribes orders, a RN must co-initial each drug on the MAR before signing off the physician order sheet. If a nurse initiates the transcription of the MAR he/she must have a second person co initial the MAR as a second check.

12. *Physician's Order* should be written in red after the medication order on the MAR. So it is understood that the physician specifically ordered the times for the medication to be administered; the medication is specifically not given on the routinely scheduled times.

13. Enter initials when administered.

14. Transcription errors: (a) draw single black line through date, order and down the scheduled time column; (b) write *mistaken entry* above and initials.

15. Place a check mark in front of each order on the physician order sheet when transcription is completed.

16. When a second page of any MAR is required, each page should be sequentially numbered in red ink.

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C. Discontinuing Medication Orders
1. When discontinuing or changing the medications, highlight all drug lines in yellow. This includes the medication order, times and all boxes under the all the dates that correspond with that medication order. Indicate reason for change ie: Frequency changed
2. Draw brackets to encompass all lines and write D.C. for discontinue/date/initials, in red after the brackets.

D. Renewals
1. Draw a black line through the last order date.
2. Enter new order date and write initials.
      Note: If no space, recopy renewal order in new space

E. Recopying Medication Record
1. When a medication sheet needs to be recopied, follow all the above instructions to start a new MAR.
2. Use the original order date then write under it "recopy" and write in the recopy date followed by the transcriber's initials.
3. On the old MAR, Bracket off each medication order using the last column or shoulder of the form and write "recopied" date and the initials of the person doing the recopying.
4. After recopying medication have a second person co initial each transcription on the new MAR under the recopy date. One of the two initials must be a RN.

F. Medication given at different time than ordered
1. Do not change time in vertical scheduled time column.
2. In space allotted for initials, enter actual time the medication was given with initials in the box underneath. Document reasons in Nurses Notes (patient focus notes) if other than staggering medications to get on a scheduled time schedule.

G. Orders to be given every 1-2 hours
1. Transcribe as usual except for time.
2. In vertical scheduled time column, leave three lines (one for each shift). Each shift will initial only once for the entire shift.
3. Does not include Accuchecks.

H. Refusal/Omissions
1. Document on Patient Progress Notes/flowsheet why medication was not given, after physician notification. (Unless parameters were ordered)
2. Note omissions by placing a circle around initials on the MAR in addition to the progress note.

I. Single Dose or Pre-Operative
1. Record Rhogam in this section if electronic record not available.
2. Intradermal skin test; site of test, date given, site reading at 48 hours, and 72 hours if electronic record not available.
3. Vaccines are transcribed on routine medication sheet and indicate the time and site if electronic record not available.

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J. Stats and Now orders
1. STAT or NOW medications will be recorded in the single and pre-operative medication order section

K. Accuchek- Insulin Sliding Scale MAR
1. All blood glucose levels are to be recorded on the Accucheck paper MAR and to correspond with the appropriate sliding scale coverage ordered if electronic record not available

L. Anticoagulation
1. Use heparin titration change stickers for downtime heparin adjustments and scan pre-printed heparin order to pharmacy.
2. Schedule all Coumadin dosages for 1800 and chart daily PT/INR with medication administration on the MAR.

M. Respiratory
1. All respiratory orders are entered scanned to pharmacy
2. Medication orders will be transcribed onto the "respiratory medication record"
3. The front on the Respiratory MAR is for all routine medications. The back of this form is for all respiratory prn and stat/one time orders.
4. Follow respiratory department standard times for administration.
5. A Respiratory therapist or a RN can be the second check on the respiratory orders, and co-initial paper MAR.

REFERENCES

HRMC Pharmacy and Nursing Manual Policies: PN 05a Standard times and PN11 eMar policies
Potter, Patricia. Perry, Anne. Clinical Nursing Skills and Techniques, 7th edition. Mosby (2010) p. 515-520