pennsylvania
DEPARTMENT OF HUMAN SERVICES

Standard Medication Administration Training Course

Transcript

Lesson 8: Documentation

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Title Slide

Slide 1 – This is Lesson 8 of the Commonwealth of Pennsylvania Medication Administration Training Course, "Documentation"

Lesson Objectives

Slide 2 –

By the end of this lesson, you will be able to:

- Accurately complete a paper medication record
- Document:
  - A typical administration.
  - A missed dose.
  - A late administration.
  - A refused dose of medication.
  - A medication administration that does not occur because the individual is on vacation or otherwise unavailable.
  - A PRN medication.
  - A discontinued medication.
- A time-limited medication.

Slide 3 – You learned how to administer medication in a previous lesson. Now, let's take a minute and review the information that you will need to document an administration of medication, the next step in the Medication Cycle.

Slide 4 – Remember that information about administration is found on a document called the medication record. The medication record contains information about the individual and the medication and tracks the administration. This is how you can go back and look at whether the individual has received the medication. The documentation of administration is a vital part of the process.

Slides 5 – This lesson will teach the process of documenting by hand using a paper medication record. While some service locations may use an electronic medication record, it is essential to learn the fundamentals of documentation as discussed here. The basic concepts discussed here apply to documentation whether the medication record is on paper or electronic. There may be times when an electronic system will be unavailable, such as during a power outage, computer failure, or a software glitch. Medication administration always must be documented, even when an electronic medication record system is not working. At these times, you will use what you have learned in this lesson to document on paper by hand.

Slides 6 – You have already learned about the prescription, the pharmacy label, and the "5 Rights" of administration. You practiced entering information on a medication record as you learned about recording in a previous lesson. Now you will put those pieces together in the documentation lesson. Let's start with reviewing what information is contained in a medication record. Please look at the following exercise:
Here is the pharmacy label and the medication record for Peter Bowen for his Amoxicillin. Take a moment to review the information that is on the pharmacy label and that will go on the medication record.
When you are finished reviewing, click Continue.

Slide 7 – First, enter the name of the individual.

Slides 8 – Next list the diagnoses.

Slide 9 – Enter allergies next.

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Slide 10 – Include the names of all of the health care practitioners.
Slide 11 – Make sure that the period of time that this medication record represents is indicated in the Dates of Administration.
Slide 12 – Verify that the individual's correct date of birth is present on the medication record.
Slide 13 – Now you are going to enter the pharmacy label information into the medication description box. For this example the pharmacy label reads Amoxicillin 250 mg Take 1 tablet 3 times a day by mouth for 7 days for infection.
Slide 14 – List the hour of administration in the hour column. In this case, we will use three times per day to mean 8 am, 4 pm, and 8 pm.
Documenting
Slide 15 – There are several situations that we will now address and learn how to document. This documentation is crucial for communication between medication administrators, especially when the staff person who administered the medication is not present. In addition to documentation of a typical medication administration, we will look at other situations that require a different manner of documentation. These include: a missed dose, a late administration, a refused dose, an absence, a PRN or as needed medication, discontinuing a medication, a time-limited medication entry and documentation about observations related to health conditions and medication administration.
Typical Administration
Slide 16 – This is how you document the routine administration of a medication that was administered at the right time. This documentation requires that you enter your initials in the correct date and time box. You also will need to have signed a signature list that includes your initials so that people can identify that you gave the medication. The signature list must be kept at each service location with the medication record.
Slide 17 – Even if you only administer medication on a limited basis you must make sure that you have signed the list. What if two staff people have the same initials? Then it is important for your agency to have a rule defining how they will document. One way would be to use first, middle, and last initials. Another way might be to assign a number with the initials. One staff member might be pab1 and the other staff member might be pab2. The key is that the initials need to identify the staff person who administered the medication.
Slide 18 – It is important for the documentation to identify the staff person. If a signature is difficult to read, then you should consider printing your name next to it. It is also important for each service location to have a key code to accompany the medication record. A key code is a listing of any symbols or abbreviations used in the medication record.
Slide 19 – The steps to document a typical administration are: • Identify the correct medication record for the individual. • Identify the medication administered on the medication record. • Identify the date and time of the administration. • Enter your initials in the box that corresponds to the date and time. • If you have not already signed and initialed that medication record or the signature list, then you must do so at this time.
Slide 20 – Note that the administration of a controlled substance is documented the same as any other category of medication. The administration of a controlled substance will be shown in the shift counts that are documented on the count sheet. You should be able to go back and accurately identify when each tablet was administered.

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Slide 21 – Documentation of an administration of a medication administered by a route other than by mouth is completed in the same manner as any other administration. The route is shown in the medication description box on the medication record.
Slide 22 – Let's look at documentation for a typical administration. Dolly Martin is administering a dose of 50 mg or 1 tablet of spironolactone to Peter Bowen at 8 am on the first day of the month. To document the administration, Dolly will identify the appropriate box in which to place her initials indicating that she administered that dose. She will confirm that her initials and signature are on the signature list.
Missed Dose
Slide 23 – Other Types of Administration Other types of administration that will require additional documentation are: missed doses, late administration, refused doses, vacation, PRN, discontinued medication, or time-limited medications. In addition to documenting the above types of administration on the medication record, you must also write a note describing the events that occurred following your agency's policy.
Slide 24 – Key elements of a good note 1. Individual's name 2. The date and time of the event. 3. The timing and description of events including: • When symptoms or events were observed or reported. • When the response to the medication was documented, if applicable.
Slide 25 – 4. The Observations including: • Behaviors and symptoms observed • Other interventions that were attempted (if applicable) • Instructions that were given by the health care practitioner. 5. Signature, date, and time of the note.
Slide 26 – Next, you will document a missed dose that is also referred to as an omission. A missed dose is one that has not been administered within the required timeframe or not at all. While the time of administration is shown as a single time, such as 8 am, it really reflects a range of time. The range is often defined as an hour before the time to an hour after the time. Using 8 am, this would mean that if the medication was given between 7 am and 9 am, then it would be given on time. Omissions often occur when a scheduled medication is not administered. Omissions are medication errors and must be reported. The most common kind of medication error is an omission.
Slide 27 – In order to document a missed dose or omission, we will follow some of the same steps as with the typical administration. Identify the correct medication record for the individual. Identify the medication missed on the medication record. Identify the date and time of the omission.
Slide 28 – • Enter the letter "O" in the box that matches that date and time. DO NOT INITIAL INSIDE THE LETTER "O"! This might be mistaken as an administered dose. The letter "O" must be defined and designated with a key code as a missed dose so that the codes you use are clear. • Make sure you have signed and initialed the medication record or the signature list.

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- Follow the policy at your service location to notify the appropriate staff about a missed dose.
- Write a note to document the missed dose per your agency's policy.

Slide 29 – Missed Dose Example: Dolly Martin missed administering a dose of 50 mg or 1 tablet of spironolactone to Peter Bowen at 8 am on the second day of the month. In order to document this missed administration, Dolly will identify the appropriate box in which to place the letter "O" indicating that dose was not administered.

Slide 30 – Your job is not complete just by documenting the missed dose with the letter "O" on the medication record. You must follow your agency policy or instructions from the health care practitioner for a missed dose of medication. Check for written instructions from the health care practitioner about what to do if a dose of this medication is missed. If there are not written instructions, the health care practitioner who prescribed the medication will need to be notified to get instructions about what to do next. Use your agency policy and procedures which should explain who will contact the health care practitioner and obtain the instructions.

Slide 31 – If the health care practitioner provides a new order regarding the missed dose, remember: Only a nurse can take a verbal order from a health care practitioner. Only a nurse is allowed to make a change in the medication record based on a verbal order.

Slide 32 – As an unlicensed staff person, you are not permitted to take a verbal order or to make a change in the medication administration based solely on a verbal order. An unlicensed staff person is required to get a written order that may be sent to you electronically. You can either get the order directly from the health care practitioner or the nurse can write the order and send it to you electronically. These types of situations, such as missed doses of medication, should be discussed at a future visit to the health care practitioner. The written instructions for what to do in this type of situation should be kept with the medication record.

Slide 33 – After you have determined what to do next, then complete those instructions. In general, the health care practitioner will direct you to do one of two things. The health care practitioner may have you administer the dose now, even though it is late. The health care practitioner may have you skip this dose and wait for the next scheduled dose. In either case, you must follow the instructions provided by the health care practitioner.

Slide 34 – Once you have completed the instructions the health care practitioner has given you, write a note to describe what happened related to that missed dose. Agency policies and procedures will define where to document the note. There are some rules about how to write a good note that communicate what occurred.

Slide 35 – A note relating to a missed dose will contain the following elements:

1. Individual's name
2. Date of note
3. Date and time of events
4. Behaviors and symptoms observed
5. Reason for missed dose
6. Health care practitioner notified per agency policy
7. Instructions given by health care practitioner.
8. Signature, date, and time of the note

Slide 36 – Example of key elements of a good note.

Slide 37 – Let's look at an example on how to document a missed dose. Pamela Dean comes into work on October 3rd and notes that Peter's 8 am dose of Amitriptyline was not administered. Click on the location

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where the letter "O" should be placed to document the missed dose.
Slide 38 – This is where the letter "O" should be placed to document the missed dose.
Slides 39 – Pamela also documents a note about the missed dose of Amitriptyline. Click on the note that includes all of the key elements of a good note.
Slides 40 – This includes all of the key elements of a good note.
Slides 41 – The key elements of a good note: • Individual's name • Date of note • Date and time of events • Behaviors and symptoms observed • Reason for missed dose • Health care practitioner notified per agency policy • Instructions given by health care practitioner. • Signature, date, and time of the note
Slides 42 – There are other ways that a dose may be missed. A missed dose may occur if the individual spits out the dose. If you observe this and the medication falls in a place where it is contaminated, such as the floor, then you must dispose of that tablet and administer a new tablet. If the medication is not contaminated, then you may be able to re-administer the same tablet. If you are able to re-administer the same tablet, then you can document this administration in the same way that you would any other one. If you have used two tablets, you need to document this on the medication record. Your agency policy will tell you what to do to get replacement medications for any destroyed or damaged doses.
Slides 43 – If you find a tablet lying on a surface such as the floor or a table and you did not observe the individual spit it out, then you must report this. Use your agency policy to identify who to report to. You should not re-administer this pill as you have no idea how long it was there, and it might be contaminated. The tablet may have been there since last week and the individual may have taken today's dose. You may not know whose tablet it is if several individuals take the same medications. In this case, there would not be any documentation on the medication record.
Slides 44 – If you know whose medication it is, document in the individual's chart that you found the medication in case this becomes a regular occurrence. As a reminder, carefully observe the individual to make sure that they take their medication. You also should talk with the individual about why they are not taking the medication. This may help identify a side effect or resolve another issue that will help the individual feel better and be able to take their medication.
Late Administration
Slides 45 – If the health care practitioner provides a written order to administer the missed dose late, then this is called a late administration. A late administration is one that is administered outside of the defined time frame for administration. You will learn how to document this.
Slides 46 – You cannot use the time on the medication record because it doesn't match the actual time and it already shows that the dose was missed. You will add a new entry on the medication record for the late administration. You will include the time that you actually administered the late dose. Please review the next slide that includes the steps to follow.
Slides 47 – On the medication record find the next blank description box under the existing entries. Put all of the information from the pharmacy label into the description box as you learned previously. Add the new written instructions from the health care practitioner about this late administration.

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Instructions for this administration will be to give the 12 pm dose at 3 pm today 10/7/2019 only.
Slides 48 – Write the time that you administered the medication in the hour column. You will do this instead of writing the hour of administration from the label. Do not add the standard times of administration to the hour column.
Slides 49 – Draw a line from the time in the hour column across the medication record until you reach the date box corresponding to the date of the late administration which is 10/7/2019.
Slides 50 – Write your initials in that box to document the late administration.
Slides 51 – Draw a diagonal line or forward slash in the next date box corresponding to 10/8/2019 to indicate that there will not be any additional doses documented for that medication and time.
Slides 52 – Draw a line through all of the remaining date boxes to the end of that row or month.
Slides 53 – Remember to write a note about the late administration and what happened, including the written order that you received. Be sure to include the health care practitioner's written order in the individual's record. Be sure to document this in a manner that is consistent with your agency's policy.
Slides 54– If the individual receives the same medication at other times in the day, the health care practitioner may order changes in times of administration so that the medication doses are not too close together. In addition to documenting the missed dose on the medication record with the specific instructions for today and documenting a note in the chart, report the new instructions to your coworkers.
Refusal
Slides 55 – Next, we are going to discuss a special situation that you might encounter related to medication administration. We will talk about how to approach an individual who refuses to take their medication within the required time-frame. Sometimes individuals refuse to take medication. There may be many reasons for a refusal. The individual may be having a bad day and may just want to be left alone. Another possibility is that the individual may be having a side effect from the medication, such as feeling sleepy. The individual may have been unable to tell you this and the way that they communicate is by refusing to take the medication.
Slides 56 – There are many ways to approach working with individuals who refuse medication. Some strategies include: try to administer the medication again within the required time-frame, talk with them about why they don't want to take it, or ask about how the medication makes them feel. There may be strategies that will become part of the treatment plan for an individual. You will need to be familiar with how to approach each individual for whom this is an issue.
Slides 57 – Next, we will look at how to document a refused dose. This is one where the individual refused to take the medication within the required timeframe. Remember, never force an individual to take medication. Even though refusal is not a medication error, it may have the same impact on an individual's health as a missed dose.
Slides 58 – Continue to work with the individual to take the medication within the required time frame. Be sure that you keep the medication secured while attempting to administer it. Document the refusal if the individual does not choose to take the medication within the allowable timeframe. Dispose of the medication according to agency policy. Inform the individual's health care practitioner of this refusal according to the agency policy.
Slides 59 – To document a refused dose: • Identify the correct medication record for the individual. • Identify the refused medication on the medication record.

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Slides 60 –

- Identify the date and time of the refusal, which for this example will be 8 pm on 10/2/2019.
- Put a circle in that block and print a letter "R" within the circle to distinguish a refused dose from a missed or administered dose.
- **DO NOT INITIAL WITHIN THE CIRCLE!**
- Put a note in the individual's chart about the circumstances around the refusal and what was done.

Slides 61 – As with a missed dose, a refused dose requires some additional instruction from the prescribing health care practitioner. The written order may instruct you to give the dose late. The health care practitioner may give you a limit in terms of the latest time to administer the medication. For someone with multiple refusals, you may want to have written instructions on how to approach this situation when it occurs. Consider how you can support the individual to take their medication as prescribed. You and the team should work to identify why the individual is refusing medication and ways to support the individual in taking their medication.

Vacation or Leave

Slides 62 – Sometimes an individual will not be present to receive the medication because they are on vacation, visiting family, or in the hospital. The administration of medication will be the responsibility of those caring for the individual during that time. These are not missed doses because the individual is not present to receive them and not physically in your care. In some cases, the absence may be planned, although in others it may be unexpected. While you are not responsible for administering medication during those times, you still need to document this on the medication record so that everyone knows that the individual didn't get the medication from you during their absence.

Slides 63 –

Because the time period that an individual is away from the service location may change, it is important to only document the individual's absence as each dose is due. In order to do this:

- Identify the correct medication record for the individual.
- Identify the medications on the medication record that would have been given for that date and time during the individual's absence.

Slides 64 –

- Mark the appropriate date and time box with the designated code that your agency uses for an absence. Note that you may use different codes for different reasons for absences. For example, the letter "V" may be used for vacation, while the letter "H" could be used if the individual is admitted into a hospital.
- In the first example, the individual is on vacation on July 4th and 5th. The individual is due to return at 10:00 PM on July 5th. The last dose administered was the 8:00 PM dose on July 3rd. By 9:00 am on July 4th a "V" should be marked in the box for the July 4th 8:00 AM administration. Even though the individual is not scheduled to return until July 5th, do not enter V in any other boxes as they could return early. In the second example, by 6:00 pm on July 5th several more date boxes are marked with the "V" for vacation. However, there is nothing marked in the 8:00 pm administration. If the individual returned at 7:00 pm, the 8:00 pm dose would be administered. If the individual arrives at 10:00 pm, the 8:00 pm dose would not be administered.

Slides 65 – Put a note in the individual's chart for the first entry for the absence or upon the individual's return. Upon the individual's return, document any incidents related to health that occurred during their absence.

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Slides 66 – Remember that not getting medication during an absence is not a medication error. Even if an individual does not take the medication that was sent along with them, it still is not reported as a medication error. It was not your responsibility to administer the medication during their absence. Write a note in the record if the medication is returned unused when the individual returns. If the medication is not taken while the individual is gone, then this has the same potential effect as a missed dose. You will need to observe the individual for the effect of not taking medication if it was not administered. For example, if an individual with a seizure disorder doesn't take their seizure medication for a week, they may begin to have seizures. The health care practitioner should be informed about this. Notify the health care practitioner about any medications that were not administered.
PRN Medication
Slides 67 – Pro re nata (or PRN) means literally "in the circumstances" and refers to use "as needed." A medication that is prescribed as PRN is taken on an as-needed basis, rather than on a routine schedule. Common uses include over the counter medications such as ibuprofen for pain or loratadine for allergies. Some disease conditions such as asthma are commonly treated with a PRN prescription medication using a standard protocol. In the case of an asthma attack or the development of an upper respiratory infection, additional medication will need to be administered to control and prevent asthma symptoms. Examples of other medical conditions that may be treated with medication on an as-needed basis are angina or chest pain treated with nitroglycerine; periodic constipation treated with laxatives, or breakthrough seizures treated with rectal diazepam. Each of these conditions requires a clear description of the symptoms when the "as-needed" medication will be used as well as instructions for care after the administration of the medication.
Slides 68 – As a reminder, when administering a PRN medication, the pharmacy label must include the 5 Rights and additional information including: • A clear description of the symptoms for which the medication will be used. • How often the dose may be repeated if there are continued symptoms or no improvement related to the previous dose. • How many times the medication can be given before calling the health care practitioner for further instructions regarding the next steps for treatment.
Slides 69 – When administering PRN medication you must: ○ Compare the 5 Rights on the pharmacy label including the specific dose for the medication. Over-the-counter medications should have the dose specified for the individual rather than the range of doses included on the label. ○ Know when the last dose of the PRN medication was given and the response. ○ Know that special instructions must be written and kept with the medication record so that they are available when administering the PRN medication. Remember over the counter medications should have a written order from the health care practitioner containing the 5 Rights and the additional information rather than just the instructions that are included on the box or bottle.
Slides 70 – PRN orders should be reviewed by the health care practitioner for changes related to changes in medical conditions, weight, and other factors like side effects or interactions with new medications.
Slides 71 – PRN medication requires documentation of the administration of the medication, documentation of the information related to symptoms before giving the medication, and documentation of the response to the medication.

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Slides 72 – The best practice for documentation of PRN medication is to separate the documentation of PRN medication from the documentation of routine daily medication administrations. It is best practice not to include the PRN medications with the routine medications on the medication record. Instead, you can list all of the PRN medications an individual is prescribed grouped together, usually immediately following the listed medications that an individual takes on a routine schedule. Keeping the PRN medications separated from the routinely administered medications in the medication record will help to prevent errors. The medication record for PRN medications should have all of the required documentation for the PRN administration including the "5 Rights", the observations before and after the administration, and the administrator's signature.
Slides 73 – To document a PRN medication: • Identify the correct medication record for the individual. • Identify the correct medication for the individual on the medication record. • Identify the date and enter the administration on the medication record. • Enter your initials and the time of administration in the box that corresponds to that date. If you administer more than one dose on the same day, then move to the box below the previous administration.
Slides 74 – For example: • Identify the correct medication record for the individual. • Identify the correct medication for the individual on the medication record. • Identify the date and enter the administration on the medication record. • Enter your initials and the time of administration in the box that corresponds to that date.
Slides 75 – • Put the additional information about the symptoms and why you gave the PRN medication on the individual's medication record or in their record as designated by your agency policy. • Record the response to the medication either on the medication record or in their record as per policy. • If you have not already signed and initialed the medication record, then you will need to do so at this time.
Discontinuation
Slides 76 – Next, we'll look at how to document the discontinuation of a medication. This happens in a few different situations. Some medications are prescribed for a set period of time, like an antibiotic for an ear infection. The medication is discontinued at the end of that period of time. Medications may be stopped because they are not having the desired effect or because the individual is experiencing side effects. A change in dose, time, or route also can trigger discontinuation of a medication that must be documented. We'll talk about how to document in these situations.
Slides 77 – Whenever you see a single line through a block on a medication record, this means that the medication was not ordered for that time. We saw this when we documented giving a missed dose late. We will use this same principle for documenting a discontinued medication. Remember only to use a single line to cross out information on a medication record so the information can still be read. If your agency uses a different strategy for discontinuation such as using a highlighter or X-ing (entering an "x" in) the unused boxes, this should be done so that the original information underneath can still be read. It is important to remember that highlighting does not appear in a copied document. Under no circumstances should the entry be made unreadable. Whiteout should never be used.

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Slides 78 – These are the steps to follow to document a discontinued medication. We will use drawing a single line in the steps to follow. However, if your policy is to highlight or **x** through information, then you should use that strategy instead. • Draw a single line through all of the information about the medication in the medication description box (its name, dose, time, and route). • Draw a single line through each of the administration times listed in the hour column.
Slides 79 – • Draw a slash in the block following the last initialed dose of this medication for each time. In the example below there are two slashes , one each for the 8:00 am and 8:00 pm doses.
Slides 80 – • Draw a single line through the remaining blocks after the slash marks for each of the times. Be sure to draw the line through to the end of the month. • Within the lined out spaces, write “discontinued”, your initials, and the date.
Slides 81 – In addition to documenting on the medication record, put a note in the individual’s record that this medication was discontinued and state why. The order from the health care practitioner, should also be filed in the record and referenced in your note. Also, remove the medication from the medication storage location. Dispose of the discontinued medication according to agency policy.
Time-Limited Medication
Slides 82 – Time-Limited Medication. Some medications like antibiotics are prescribed for a set period of time. The documentation of the initial entry of a time-limited medication looks a lot like a discontinued medication in some ways. These are the steps to follow to document a time-limited medication. In the upcoming example, we will use drawing a single line in the steps. However, if your policy is to highlight or **X** through information, then you should use that strategy instead.
Slides 83 – • Enter the information about the medication from the pharmacy label into the medication description box. For this example, we will be using Amoxicillin 250 mg. Take 1 tablet by mouth three times per day at 8 AM, 4 PM, and 8PM for 7 days. • Next, enter the times of administration into the hour column.
Slides 84 – • For this example Lola was seen by her health care practitioner on October 8th at 11 am and her prescription was picked up at 1 pm. Her first dose will be at 4 pm on October 8th. You will need to indicate that there will not be any doses given before 4 pm on October 8th. To do this, draw a single line through each date box for each administration time that precedes the first.
Slides 85 – • Count out the number of doses to be administered, in this example twenty-one. • Draw a slash line in the date box following the last dose of this administration for each time.
Slides 86 – • Draw a single line through the remaining date boxes after the slash marks for each of the times. Be sure to draw the line through to the end of the month. • It is best practice to discontinue the time-limted medication on the medication record after the last dose is given.

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Documentation Responsibilities
Slides 87 – Agencies may approach the initial entry of medications on a medication record in various ways, including an electronic medical record. All staff members that administer medication must understand and be able to use the information contained on the medication record and must know how to complete documentation in all of the situations discussed. Staff must know how to enter new medications onto a medication record as well as know how to document their administrations and to discontinue the medication. Therefore, regardless of your agency practices, it is important that you learn all of the material about documentation.
Summary
Slides 88 – This lesson about Documentation covered key points that included: • Accurate documentation of medication administration is an important communication tool that helps prevent medication errors. • There are multiple types of situations that must be documented on the medication record. • All administrations of medication must be documented. When administrations are put into the medication record, the medication record shows that the medication was given, or if not, what happened.
Next Step
Slides 89 – Now that you have completed the lesson, it is time to take the quiz. Please click on the link below to access the quiz.