

Documentation

General Discussion:

Documentation is an important component of medication administration. Documentation related to medication management and administration should include the following:

- Physician's orders
- Transcription of orders
- Medication administration record, including scheduled and PRN medications
- Effect of medications, including the monitoring of side effects
- Controlled medication records (see [Controlled Substances.](#))
- Pharmacy reviews (see [Role of the Pharmacist.](#))
- Review of psychotropic medications (see [Psychotropic Medications.](#))
- Disposal (see [Medication Storage & Disposal.](#))
- Staff medication training (see [Staff Training.](#))
- Medication errors (see [Medication Errors.](#))

Relevant regulations:

ADC:

Standard I.F.(3)(f) The administration of medications must be documented in ink in the participant's permanent record (documentation includes the name of the medication, dosage, method of administration, date and time administered, and name of the staff member who administered the medication).

FAMILY ADC:

Standard I.D.(3)(f) The administration of medications must be documented in ink in the participant's permanent record (documentation includes the name of the medication, dosage, method of administration, date and time administered, and name of the staff member who administered the medication).

AFH:

DHS 88.07(3)(d) Before a licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file.

DHS 88.07(3)(e)1. The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by licensee shall be kept in a locked place.

DHS 88.07(3)(e)2. The record shall also contain information describing potential side effects and adverse reactions caused by each prescription medication.

RCAC: Although there is no specific regulation related to documentation, you should consider best practices for documentation to protect the health, safety and welfare of your tenants.

CBRF:

DHS 83.37(1)(a) There shall be a written practitioner's order in the resident's record for any prescription medication, over-the-counter medication or dietary supplements administered to a resident.

DHS 83.37(1)(d) As required in [s. DHS 83.42 \(1\) \(m\)](#), when a resident is taking prescription or over-the-counter medications or dietary supplements, the resident's record shall include a current list of the type and dosage of medications or supplements, directions for use, and any change in the resident's condition.

DHS 83.37(1)(g)3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount.

DHS 83.37(1)(h)1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident's record as required under [s. DHS 83.42 \(1\) \(n\)](#).

DHS 83.37(1)(i)3. Documentation in the resident's record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given.

DHS 83.37(1)(k)1. The CBRF shall document in the resident's record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication.

DHS 83.37(2)(d) As required under [s. DHS 83.42 \(1\) \(o\)](#), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident's response shall be documented.

Relevant DQA Memos:

[BQA Memo 04-026 Physician Orders and Medications](#)

Other Resources:

Best Practice, Tools & Forms:

Sample Medication Administration Form:

http://www.med-pass.com/Docs/Products/samples/2-1101_sp.pdf

Disclaimer: Inclusion of resources on this website does not constitute an endorsement by the department/DQA, and the department/DQA does not guarantee that the information is up-to-date or accurate.