

<b>MAR/MEDICATION AUDIT</b>	<b>NAME</b>	<b>NAME</b>	<b>NAME</b>
<b>DATE</b>			
Copies of all current prescriptions in file (correlate with MAR, Meds on hand and Healthcare Communication Forms)			
MAR reflects current correct medications, correct dose, correct times and correct dates to be given (correlate with prescriptions and Healthcare Communication Forms)			
All meds have a start and if appropriate a stop date especially Antibiotics. Check that appropriate dates are marked off when not to be given			
All meds not given daily ( ex: Fosamax ) have appropriate date to be given noted			
All PRN medications state specific parameters upon which a medication is to be given and when physician is to be notified			
Documentation of effectiveness of all PRN meds is noted (strongly encouraged)			
Diagnosis is noted for each medication on MAR (strongly encouraged)			
Allergies noted on MAR			
Diet noted on MAR (Strongly encouraged) Must be able to show you the diet listed)			
Current action, side effects, adverse reactions and interaction information sheets in file for all medications			
Reason for missed medications meds is noted along with appropriate physician notification			
If medication unavailable from pharmacy documentation of follow up according to Policy and Procedure followed and med obtained			
If indicated - Medication error reports are noted with appropriate notification of physician, district, and documentation that correction action has been carried out			
Documentation of monitoring client for 20 minutes after first three doses of a new med and after PRN meds			
All new orders instituted within 24 hours (Correlate with Healthcare Forms and prescriptions)			
Signatures and initials of all persons administering meds or supervising administration of meds are noted			

**CORRECTIVE ACTION:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Recommendations for use of Mar Audit

1. Monthly at time new MAR is initiated – new MAR reconciled with old MAR with corrections/additions per physician orders. Must be done prior to putting new MAR in the book.
2. When a client has new medication or change in dose, frequency, or med is discontinued.
3. If a medication error occurs.
4. If “holes” are noted.
5. When new employee, who has been trained and validated, begins to administer or supervise the administration of medications. Would recommend auditing the new employee for at least the first week.
6. Written Policy and Procedure for documentation of monitoring MAR should be in place and results of the auditing kept on file along with the corrective actions taken.

**PREVENTION  
OF  
MEDICATION ERRORS**



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Med Administration:

- Prescribe
- Dispense
- Transcribe
- Administer
- Monitor

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**Medication Error**

- WRONG MED
- DOSE
- ROUTE
- REASON OTHER THAN AS PRESCRIBED
- TIME
- CLIENT
- FAILURE TO DOCUMENT ON MAR
  - FILL WITHIN 24 HOURS
  - COUNT CONTROLLED MEDICATIONS
- MISSED DOSE
- EXPIRED MEDICATION ADMINISTERED
- MAR DOES NOT REFLECT CORRECT ORDER

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**MOST COMMON ERRORS**

- 52% MEDS NOT GIVEN
- 11% GIVEN BUT NOT DOCUMENTED
- 10% MAR INCORRECT
- 10% DOCUMENTED BUT NOT GIVEN
- 8% WRONG CLIENT
- 6% CONTROL COUNT ERRORS
- 3% OTHER

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**MEDICATION NOT GIVEN**

- Distraction**
- No reason**
- “Found” on floor, in drawer**
- Left on nightstand**
- Late from ADT or outing**
- Not delivered by pharmacy**
- Staff unaware of noon med pass**
- “Forgot”**

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**MEDICATION NOT GIVEN**

**REFUSAL**

- TIMING
- TASTE
- TOO BIG TO SWALLOW
- HOW MED MAKES CLIENT FEEL
- DOESN'T FEEL NEEDS IT

**COLLABORATE WITH PHYSICIAN RE:  
VARIABLES – CHANGE AS NEED SEE IF  
MAKES A DIFFERENCE**

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•PAM LASSITER RN  
813 233 4361

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**GIVEN NOT DOCUMENTED**  
Bubblepack initialed and dated but MAR blank

**MAR INCORRECT**  
Physician orders change never entered on MAR

**DOCUMENTED BUT NOT GIVEN**  
Bubblepack or count reveals med not given

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**WRONG CLIENT**  
Distraction

**CONTROL COUNT ERRORS**

**OTHER**  
Wrong dose  
Wrong time  
Wrong med  
New med not given w/i 24 hours  
Family error

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**PREVENTION**

- RESPONSIBILITY
- STAFF MUST KNOW THEIR CLIENTS
- ELIMINATE DISTRACTIONS
- FOLLOW POLICY AND PROCEDURE
- MAR AUDITS
- **SIX RIGHTS**

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**The 6 Rights of Medication Administration**



The diagram features a central caduceus symbol. Six callout bubbles are arranged around it, each containing one of the '6 Rights': Right Drug, Right Person, Right Dosage, Right Time, Right Route, and Right Documentation. Lines connect each bubble to the central symbol.

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**?**

**CHECK RX**



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**RIGHT DOCUMENTATION**  
IMMEDIATELY document on MAR

If new or changed med -documentation of monitoring client for 20 min for first 3 doses is entered on reverse of MAR in same area as documenting the results of PRN medication and documenting reason when meds not given

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**MISCELLANEOUS INFORMATION**

- Have a back up pharmacy
- Ask physician to enter diagnosis or reason on Rx
- When med discontinued immediately remove it from the client's med box, store separately till destroyed or sent back to pharmacy and IMMEDIATELY make correction to the MAR
- Two staff to check all entries on MAR for new or changed medication orders
- NEVER pass meds without using current MAR
- When meds arrive check label against MAR, check to be sure all bubbles filled, note if any refills left
- Creams and ointments need to be check twice a month to be sure not running low
- Use X to mark out days not to give for meds not given daily
- When appropriate change times to meet need

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**ERROR REPORTING**

- Notify any supervisory personnel
- In case of wrong med or dose
  - Observe client closely for 20 minutes
  - Report to prescribing physician
  - Follow up as directed by physician
- Notify client's prescribing physician of error, any orders given will then need to be faxed
- Fully document event, observations and contacts on Medication Error Report - APD form 65G-7-05 submit to APD within 24 hours

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- Staff take responsibility seriously
- Follow the rules
- Appropriate staff on duty to meet need
- Give meds in quiet area
- Using the MAR triple check performed
- Immediately chart
- MAR audits

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Questions Comments Ideas

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"... and, with the proper medication, they lived happily ever after."

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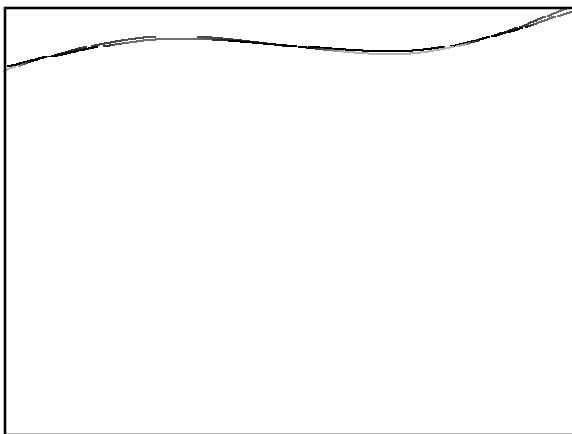
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FROM: \_\_\_\_\_  
FAX# \_\_\_\_\_

## Medication Clarification/Verification

We have received a medication from our pharmacy ( \_\_\_\_\_ ) which was filled pursuant to a phone order to said pharmacy. In order for our medication assistance providers to administer/supervise self-administration of this medication a written verification that this is a current and correct order is required.

The information provided on that pharmacy label is listed below. Please verify that all of the information is correct. If any information is incorrect please make corrections in the space provided. Please sign and date this form and include your license number in the space provided.

Thank you for your assistance in helping us comply with Fl. Rule 65G-7.

Order as it appears on the Pharmacy Label:

Date Ordered: \_\_\_\_\_

Consumer Name: \_\_\_\_\_

Drug Name and strength: \_\_\_\_\_

Dose and \_\_\_\_\_

Directions for Use: \_\_\_\_\_

Quantity and # of Refills: \_\_\_\_\_

Information Needed: \_\_\_\_\_

Or Clarification \_\_\_\_\_

Signature of Physician: \_\_\_\_\_

Date of Signature: \_\_\_\_\_

Physician's License #: \_\_\_\_\_

# NEW or CHANGED MEDICATION ORDER

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Medication Order: \_\_\_\_\_

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- Faxed to pharmacy
  
- Medication received **IF NOT RECEIVED IN 24H MUST NOTIFY PHARMACY AND MANAGER and MUST DOCUMENT info on reverse of MAR**
  
- Order entered on MAR - **must match exactly the Prescription as written by physician and the label from pharmacy - if not manager MUST be notified**  
**All PRN Meds must include When Physician to be Notified**  
**\*\*\*If dose change be sure to DC the old order on MAR**
  
- Side effects/adverse reaction sheets placed in MAR file
  
- First dose given. Documented on reverse of MAR
  
- Second dose given. Documented on reverse of MAR
  
- Third dose given. Documented on reverse of MAR
  
- Physician notified of any side effects or adverse reaction

**PRN MEDICATION INSTRUCTIONS SHEET**

(In accordance with the Florida 65G-7 Policy)

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_

Take \_\_\_\_\_ Tablet(s)/Capsule(s) by mouth every \_\_\_\_\_ for \_\_\_\_\_  
(No variable interval) (indication)

Maximum \_\_\_\_\_ in 24 hours

Notify health care provider for: \_\_\_\_\_

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_

Take \_\_\_\_\_ Tablet(s)/Capsule(s) by mouth every \_\_\_\_\_ for \_\_\_\_\_  
(No variable interval) (indication)

Maximum \_\_\_\_\_ in 24 hours

Notify health care provider for: \_\_\_\_\_

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_

Apply \_\_\_\_\_ to \_\_\_\_\_ Every \_\_\_\_\_ for \_\_\_\_\_  
(No variable interval) (indication)

Maximum \_\_\_\_\_ in 24 hours

Notify health care provider for: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## PRN/OTC Medication Request

Non licensed staff for Agency for Persons with Disabilities clients must follow this list of requirements before they may administer/supervise medications. Thank you for your assistance.

**65G-7.005 Medication Administration Procedures.** (6) The medication assistance provider may not assist with PRN medications, including OTC medications, unless a health care practitioner has provided written directions for the medication. The provider must attach to the client's MAR a copy of the prescription or order legibly displaying the following information: *(a) The name of the medication;* *(b) The prescription number, if applicable;* *(c) The prescribed dosage;* *and (d) Specific directions for use, including the medical basis for the medication, the time intervals for administration, the maximum number of doses, the maximum number of days that the medication should be administered, and conditions under which the health care practitioner should be notified.*

To: \_\_\_\_\_

From: \_\_\_\_\_ Date: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Consumer Name: \_\_\_\_\_

Why Requested/Needed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name and strength of medication: \_\_\_\_\_

Specific dose of medication: \_\_\_\_\_

Specific reason(s) this medication may be given \_\_\_\_\_

\_\_\_\_\_

May administer/supervise every \_\_\_\_\_ hours

Maximum of \_\_\_\_\_ doses in a 24 hour period

"If \_\_\_\_\_ or symptoms persist greater than

\_\_\_\_\_ Call the physician."

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_