ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE PROCEDURE

Date Issued: 7/24

CHAPTER Health/Medical		**CHAPTER** 04	**SECTION** 003	**SUBJECT** 0035
SECTION Residential and Day Programs	**SUBJECT** Medication and Treatment Records			
WRITTEN BY Residential Policy Committee	**REVIEWED BY:** Belinda Raymo		**AUTHORIZED BY** Telly Delor	

I. APPLICATION:

- ☐ SCCCMH Board
- ☐ SCCCMH Providers & Subcontractors
- ☐ Direct-Operated Programs
- ☐ Community Agency Contractors
- ☒ Residential Programs
- ☒ Specialized Foster Care

II. PURPOSE STATEMENT:

St. Clair County Community Mental Health (SCCCMH) shall have procedures that align with Adult Foster Care (AFC) Licensing Rules, which requires maintaining a separate Medication Record for each individual.

III. DEFINITIONS:

A. Medication Administration Record (MAR): A form (#0048) used to facilitate documentation of each medication or treatment administered. A printed original MAR, electronic MAR (eMAR) provided from a pharmacy licensed to do so, or AFC Resident Medication Record #BCAL-3267 may be used in place of SCCCMH Form #0048.

B. PRN: Means a medication that is prescribed and administered as needed or as requested.

IV. STANDARDS:

A. Residential Programs/Specialized Foster Care may use a Master Signature List in the Medication Record book. In this case, a copy of this list must be maintained in each individual's permanent file.

B. Medications may be administered to individuals **only** in the case of an emergency placement without a copy of the physician's prescription if;

1. Medications are in a container from the pharmacy with a current label.
2. Medications are administered only as indicated on the container label.
3. A copy of the prescription must be obtained within forty-eight (48) hours.

V. PROCEDURES:

Group Home Supervisor/Designee/ Specialized Foster Care Provider

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1. Ensures the Medication Administration Record lists all prescription and over-the-counter medications, treatments, stat and single dose medications.

2. Transcribes and verifies the information from the prescription, physician order, or standing medication order. If using an eMAR system, verify the pharmacy has entered the information from the prescription or standing medication order **EXACTLY** as written into the eMAR system.

3. Ensures the Medication Administration Record is used for a period of one (1) month and then returned to the individual's file after a new Medication Administration Record is started or provided by pharmacy.

4. Assigns a new Medication Administration Record for each month.

5. Maintains a copy of prescription or prescriber's order in the individual record for all medications and treatments administered. Updates prescriber prescriptions for all regularly administered, PRN, and Standing Medication Order medications annually or whenever there are changes in dosage, frequency, timing of dose, etc. (controlled substances every 6 months) and have a current prescription/prescriber order on file in the individual's record or in the MAR book.

6. Marks all copies of prescriptions "For Office Use Only."

7. Ensures new medications and all changes in the dosage, time or frequency of administration of medications or treatments are recorded on the Medication Administration Record.

8. Discontinues the original order in the proper date column by writing "D/C" and drawing a line to the edge of the sheet. If applicable, verify the pharmacy has discontinued the original order in the eMAR system.

9. Transcribes the new order on the same Medication Administration Record. Numbers the Medication Administration Record if a new sheet is added.

10. Initials the Medication Administration Record in the proper date column, using ink or electronically (eMAR) immediately after the medication(s) or treatment(s) are administered. This is done by the person who administers the medication(s) or treatment(s).

11. Signs legal name and initials once in the area provided either at the bottom of form #0048 Medication Administration Record or on the back of the page provided by the pharmacy after the first time the administration of medication is documented on each medication administration record. Legal name and initials are electronically recorded in the eMAR system.

12. Includes the time of administration and number of tablets, capsules, etc. when documenting the administration of PRN medications.

13. Documents date, time, and rationale when a PRN is administered on individual's form #0055 Health Care Chronological and/or in the area on the MAR, if applicable.

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14. Documents the effectiveness and/or response noted for "PRN" medications administered on the Health Care Chronological and in area provided on the MAR, if applicable.

15. Utilizes legend on Medication Administration Record by registering the initials P - Program; N - No Program, V - Visit; S - School; I - Inpatient/Hospital: A - Absent: H - Holiday; W/E - Weekend; NMS - No Meds Sent, when the individual is to receive a medication elsewhere.

16. Keeps Medication Records for the current month near the site where medication is stored and prepared.

17. Ensures each MAR has the following information written in the appropriate sections.

    a. Individual's full name on both sides of sheet.

    b. Month and year on both sides of sheet.

    c. All allergies (in red ink) on both sides of sheet; or may highlight in yellow on preprinted MAR.

    d. Home name.

    e. All medications or treatments given that month, including "PRN" medications.

    f. The name of the medication or type of treatment.

    g. The dosage.

    h. The times designated for administration.

    i. Where medication is stored if other than medication cabinet (i.e., refrigerator).

    j. How and where to administer if other than oral medication.

    k. Other special instructions (i.e., shake, do not give with milk, etc.).

18. Files MAR in the individual's file. Maintains for current year and one (1) year historical. The records can then be destroyed.

VI. REFERENCES:

A. Form #0048 Medication Administration Record

B. Form #0055 Health Care Chronological

VII. EXHIBITS:

A. AFC Resident Medication Record #BCAL-3267

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B. AFC Licensing Rules 400.1418 and 400.14312

VIII. REVISION HISTORY:

Dates issued 05/88, 10/92, 03/95, 11/97, 11/99, 10/01, 10/03, 10/05, 10/07, 12/07, 10/09, 10/11, 01/13, 05/14, 05/15, 05/16, 05/17, 05/18, 01/19, 01/20, 01/21, 05/22, 05/23.

A.F.C. RESIDENT MEDICATION RECORD

Michigan Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems

Medication Name And Instructions For Use	Time Of Day	Resident Name:_____ Month:_____ Year:_____ DAY OF THE MONTH 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Medication Name (Single Dose Only)	Time of Day	DAY OF THE MONTH 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Signature and Initials of Each Person Signing Initials Above			

LARA is an equal opportunity employer/program.	AUTHORITY: 1979 PA 218 COMPLETION: Mandatory. Family Home and Group Home Rule Requirements PENALTY: Violation of Rule R 400.1418 (4) (a) Family Rules, R 400.14312 (4) or R 400.15312 (4) Group Home Rules

AFC Family Homes

R 400.1418 Resident medications.

Rule 18.

(1) Prescription medication, including tranquilizers, sedatives, dietary supplements, or individual special medical procedures, shall be given or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy container which shall be labeled for the specific resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws.

(2) Medication shall be given pursuant to label instructions.

(3) Unless a resident's physician specifically states otherwise, all the giving, taking, or application of prescription medications shall be supervised by the licensee or responsible person.

(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions:

(a) Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years.

(b) Not adjust or modify a resident's prescription medication without agreement and instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record in writing any adjustments or modifications of a resident's prescription medication.

(5) Prescription medication shall be kept in the original pharmacy supplied and pharmacy-labeled container, stored in a locked cabinet or drawer, refrigerated if required, and labeled for the specific resident.

(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.

(7) Prescription medication which is no longer required by a resident shall be destroyed after consultation with a physician or a pharmacist.

History: 1984 MR 8, Eff. Sept. 15, 1984

AFC Small and Large Group Homes

R 400.14312 Resident medications.

Rule 312.

(l) Prescription medication, including dietary supplements or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

(2) Medication shall be given, taken, or applied pursuant to label instructions.

(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.

(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:

(a) Be trained in the proper handling and administration of medication.

(b) Complete an individual medication log that contains all of the following information:

(i) The medication.

(ii) The dosage.

(iii) Label instructions for use.

(iv) Time to be administered.

(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.

(vi) A resident's refusal to accept prescribed medication or procedures.

(c) Record the reason for each administration of medication that is prescribed on an as needed basis.

(d) Initiate a review process to evaluate a resident's condition if a resident requires the repeated and prolonged use of a medication that is prescribed on an as needed basis. The review process shall include the resident's prescribing physician, the resident or his or her designated representative, and the responsible agency.

(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.

(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.

(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.

(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.

(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.

History: 1994 MR 3, Eff. May 24, 1994