

CENTRAL CARE POLICY
MEDICATION PROFILE RECORD DOCUMENTATION GUIDELINES

SUBJECT:	MEDICATION PROFILE RECORD DOCUMENT ACTION GUIDELINES
ANNUAL REVIEW MONTH:	June
RESPONSIBLE FOR REVIEW:	Director of Central Care
LAST REVISION DATE:	August 2010

Purpose:

To provide accurate documentation of medication administration and utilization history.

The Medication Profile Record (MPR) is part of the consumer's permanent record. All entries are to be made in black ink.

The MPR consists of two parts:

1. Medications prescribed on a routine basis are noted on Part I of the record.
"MEDICATION PROFILE RECORD"
2. All PRN medications are noted on Part II of the record. "PRN MEDICATION RECORD"

The MPR Part I will be used for one month only. When necessary a second sheet can be used (if the consumer has more medications than will fit onto one sheet); if so, note on the bottom right hand corner, "see next sheet". The PRN sheet can be used until all spaces are filled, it does not have to be used for one month only.

Part I:**Documenting Self Administration on the Medication Profile Record**

1. The houseparent will initial the appropriate box after each medication is taken.
2. Do not initial prior to consumer taking his/her medication.
3. The houseparent will enter his/her initials at the bottom of the MPR along with the corresponding signature and title, i.e., BJ- Bess Jones, House Parent
4. When medications are not taken or omitted, the house parent will enter his/her

initials under the correct date and hour then circle the initials and document the reason the medication was not taken, or omitted. When medications are not taken or omitted, notify the team leader.

5. In the event medications are charted in the wrong box, one line will be drawn through the house parent's initials and the medications charted in the correct box. The house parent who later charts in the errored box will enter his/her initials above those errored out.
6. In the event there is no room in the box to add an additional initial, record below the Depakote 8pm box.
7. When a consumer is referred to the ER, make a handwritten copy of the medications, dose and times taken; take to the ER with the consumer.
8. When a consumer is on temporary leave (TV), or hospitalized address medication administration in the following manner:

Draw one (1) line through the dates on the MPR and write TV or hosp. whichever is applicable. NOTE: It is not necessary for the house parent to write his/her initials for each day on the MPR while the consumer is on TV or hospitalized.

A progress note is written in the medical record indicating that the consumer is on TV or hospitalized.

Part II: PRN RECORD

Documentation

1. Each time a consumer is assisted with a PRN medication, the month, date, time and initials of the one who is assisting will be recorded in the column next to the medication that is taken. (See attached PRN Record)
2. Each time a PRN medication is taken, a progress note must be made stating the reason for the PRN medication. A notation is also made on the 24 Hour Report
3. A follow up progress note must be made within one hour noting results of the PRN medication; when laxatives or antibiotic ointments are used, make a follow up progress note the following day.
4. Make a notation on the 24-hour report so that the following shifts will be aware

that a PRN has been taken, and requires a follow up progress note. If a bowel movement does not occur the following day after a laxative is taken, notify the Teal Leader.

5. The House Parent assisting with medications will enter his/her initials at the bottom of the PRN sheet along with the corresponding signature and title.

APPROVED:

George Harris, LCSW
Director of Central Care

Date