MEDICATION ADMINISTRATION RECORD (MAR) REVIEW CRITERIA

Trainers and Practicum Observers will use the MAR Review criteria below to compare the medication administrator’s performance on the task of documentation to the standard criteria for this task. These criteria are used for MAR Reviews for the Annual Practicum. In the Guidelines, some errors are associated with a single staff and a single administration while others apply to all staff that have administered medication to that person in that month. Remediation is required for any error identified. MAR Reviews will use two MARs: the current month’s MAR and a completed MAR from the previous quarter.

Remediation activities provide additional practice for documentation skills for which staff demonstrate difficulty based on the MAR review. These should be completed using practice MARs. None of these activities should be added to actual records. Additional pharmacy labels for practice activities for remediation can be found in the Trainer Manual and online in Trainer Resources. In addition, trainers may create their own pharmacy labels using medication people are actually taking or make them up. For some staff, review of the online lesson indicated under Remediation in the Guidelines will be required. The number of the relevant online lesson is indicated under Remediation in the Guidelines. In addition to practice activities, trainers may choose to require staff to review the relevant online lessons even if the Program does not require this.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>CRITERIA</th>
<th>GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Use the current MAR for items 1, 2, 3, and 4</strong></td>
<td>PASS</td>
<td>APPLIES TO</td>
</tr>
<tr>
<td>1. There is a corresponding entry on the current MAR for each labeled medication container.</td>
<td>Each entry on the current MAR matches the pharmacy label for each medication container for the person. If PRN medications are listed, compare to the order if no pharmacy label is present. Do not include medication that has been discontinued during the month.</td>
<td>• All staff being reviewed who administered medication during the month.</td>
</tr>
<tr>
<td>FAIL</td>
<td>• A medication container in the storage area that does not have an entry on the current MAR.</td>
<td>REMEDIATION</td>
</tr>
<tr>
<td></td>
<td>• An entry on the current MAR that does not have a medication container in the storage area.</td>
<td>• Exercise should involve matching entries on an MAR to the pharmacy labels on the medication containers. The specific remediation activity needs to be based on the error that occurred. For example, errors in entry into the description box on the MAR should result in additional practice in entry.</td>
</tr>
<tr>
<td></td>
<td>• An entry on the current MAR that does not exactly match the pharmacy label.</td>
<td>• Online Lesson 5 – Recording and Storage</td>
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### MAR REVIEW CRITERIA

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<thead>
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| 2. All general information is present (e.g. name, allergies, diagnoses, etc.) | **PASS**<br>All below are present:<br>  • Person’s name<br>  • Allergies (none should be listed if there are no known allergies; should be on all MARs)<br>  • Healthcare practitioner’s name(s)<br>  • Diagnoses<br>  • Identification of month and year that corresponds to the dates of the administration represented by that MAR (should be on all MARs).<br>  • Other provider required information e.g. date of birth | **APPLIES TO**<br>• All staff being reviewed who administered medication during the month.  

**REMEDICATION**  
• To remediate, staff must take a blank MAR and complete the general information for one of the people they work with.  
  • *Online Lesson 5 – Recording and Storage* |
| | **FAIL**<br>• One or more than one of the above is absent | |
| 3. Initials and signature of the staff are present on the MAR or central record | **PASS**<br>MAR should have the initials and signature of the staff you are evaluating or there should be a copy of the central list which contains the staff’s initials and signature with the MAR. | **APPLIES TO**<br>• Staff being reviewed.  

**REMEDICATION**  
• Trainer/Practicum Observer should review with staff that they must sign and initial the MAR/central record each month in each work location regardless of how many medications they administer.  
  • *Online Lesson 8 – Documentation* |
<p>| | <strong>FAIL</strong>&lt;br&gt;• No initials or signature exist to identify that staff.&lt;br&gt;• A copy of the central record is not present with the MAR.&lt;br&gt;• Two individuals have the same initials, but no way to differentiate their documentation. | |</p>
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<td>4.</td>
<td><strong>PASS</strong></td>
<td>All boxes are initialed for each typical administration or contain other documentation up to the point of review.</td>
</tr>
<tr>
<td></td>
<td><strong>FAIL</strong></td>
<td>Any blank date and time box for the staff being reviewed. This requires you to identify who was responsible for administering the medication for that date and time.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inability to identify the staff administering the medication i.e. initials are illegible and cannot be matched to a signature.</td>
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<td></td>
<td><strong>APPLIES TO</strong></td>
<td>Staff being reviewed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Missing or unidentifiable initials not attributable to this staff should be followed up on according to provider policy.</td>
</tr>
<tr>
<td>Use the previous MAR for items 5 to 13</td>
<td><strong>APPLIES TO</strong></td>
<td>Staff being reviewed.</td>
</tr>
<tr>
<td>5.</td>
<td><strong>PASS</strong></td>
<td>The documentation complies with your provider policies for documenting a discontinued medication including that the date and time of the discontinuation matches that of the written instructions which are reviewed.</td>
</tr>
<tr>
<td></td>
<td><strong>FAIL</strong></td>
<td>The date and time of the discontinuation do not match the order for discontinuation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The documentation of the discontinuation is missing parts of the required steps on the MAR e.g. lining out the description box, date and initials discontinued, etc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The order for the discontinuation such as a medical visit sheet, verbal or faxed order from the healthcare practitioner or any other manner the agency gets changes in medication is absent.</td>
</tr>
<tr>
<td>Use the previous MAR for items 5 to 13</td>
<td><strong>REMEDIATION</strong></td>
<td>Remediation should occur by having staff complete documentation exercises for discontinuation of a medication.</td>
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<td><em>Online Lesson 8 – Documentation</em></td>
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### Item: New or Time-Limited Medication

**PASS**
The new medication was correctly entered into the description box on the MAR including the five rights, the hour column, and documentation of the date and time to start lining out the boxes that would not be used. If this is a time-limited medication, then the date and time to end should also be indicated.

**FAIL**
- The entry was not complete or missing required elements.
- There was no indication of when the medication was started.
- There was no indication of when the medication would end if time-limited.

**Applies To**
- Staff being reviewed

**Remediation**
- Remediation should occur by having staff complete documentation exercises for entering a new medication including a time-limited one.
- *Online Lesson 8 – Documentation*

### Item: PRN Medication

**PASS**
Entry includes the documentation of the medication and the five rights. If the medication was given, then the documentation includes why the medication was given, the actual documentation of giving the medication including the time given, and follow-up of the effects of the medication.

**FAIL**
- An error in the entry of the PRN medication related to the 5 rights.
- An error in the documentation of the administration e.g. missing the time given, response, etc.
- Missing note about why the medication was given.

**Applies To**
- Staff being reviewed

**Remediation**
- Remediation should occur by having staff complete documentation exercises for entering an administration of a PRN medication.
- *Online Lesson 8 – Documentation*
<table>
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<tr>
<th>ITEM</th>
<th>CRITERIA</th>
<th>GUIDELINES</th>
</tr>
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| 8. Omission of a medication                   | **PASS** The omission was correctly documented including a note describing the reason for the omission. For omissions that are not ordered, some response to the omission should be indicated in the note (e.g. the healthcare practitioner’s instructions were reviewed; the healthcare practitioner was called for instructions, etc.). Also, for omissions that were not ordered, a corresponding medication error should have been reported. **FAIL**  
  • The documentation of the omission is incorrect.  
  • There is no note describing the omission.  
  • The note is missing a response to the omission if not ordered.  
  • For an omission that was not ordered, there is no corresponding medication error reported.                                                                                                                                  | **APPLIES TO**  
  • Staff being reviewed                                                                                                                                                                                                                                                                                                                                 | **REMEDICATION**  
  • Remediation should occur by having staff complete documentation exercises for indicating a missed or omitted dose.  
  • Online Lesson 8 – Documentation                                                                                                                                                                                                                                                                                                                   |
| 9. Refusal of a medication                    | **PASS** The documentation is completed correctly for the refused medication and there is a corresponding note describing the circumstances. The note should reflect multiple attempts to encourage the person to take the medication and should not be timed until after the hour of administration is over. Some response to the refusal should be indicated in the note (e.g. the healthcare practitioner’s instructions were reviewed, the healthcare practitioner was called for instructions, etc.).  
  **FAIL**  
  • The documentation is completed incorrectly.  
  • The explanatory note is missing.  
  • The note was written before the end of the hour of administration.  
  • The note is missing a response to the refusal.                                                                                                                                  | **APPLIES TO**  
  • Staff being reviewed                                                                                                                                                                                                                                                                                                                                 | **REMEDICATION**  
  • Remediation should occur by having staff complete documentation exercises for entering documentation for a refusal of medication.  
  • Online Lesson 8 – Documentation                                                                                                                                                                                                                                                                                                                   |
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| 10. Late administration associated with an omitted or refused medication | **PASS** Documentation includes correctly entering the medication and the 5 rights as well as indicating in the hour of administration box the time the medication was given. This documentation needs to include lining out the date and time boxes prior to and after that time. There should also be a note or a corresponding order for the late administration (which could be included with the note for the omission or refusal) and an order for the late administration in the absence of previously written instructions from the healthcare practitioner. | **APPLIES TO** • Staff being reviewed  
**REMEDICATION** • Remediation should occur by having staff complete documentation exercises for entering a late administration of a medication.  
• *Online Lesson 8 – Documentation* |
| 11. Absence of a person at time of medication (e.g. absences like vacation, outing, etc.) | **PASS** The absence is documented correctly using the provider specific key code on the MAR (e.g. V for vacation, H for hospitalization, etc.). There should be a corresponding note(s) for the absence. If it is a planned absence and the medication is given to the person to take while they are gone, then the notes should include what was sent and what was brought back, if anything. | **APPLIES TO** • Staff being reviewed  
**REMEDICATION** • Remediation should occur by having staff complete documentation exercises for entering an administration of a planned absence.  
• *Online Lesson 8 – Documentation* |
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| 12. Controlled substance and count | **PASS**  
The review of the count sheets for a controlled substance show no evidence of gaps or missing medication and that the counts are signed by both staff participating in the count. In addition, the number of doses that are documented on the MAR as administered matches the number of doses removed from the count on the countable substance sheet for that time period. | **APPLIES TO**  
• Staff being reviewed  

**REMEDICATION**  
• Remediation should occur by having staff complete documentation exercises for documentation of the counting of controlled substances.  
• Missing doses of countable substances should be reported and investigated as required by provider policy and State and Federal regulation.  
• *Online Lesson 8 – Documentation* |
|                                    | **FAIL**  
• The countable substance sheet shows missing medication.  
• The countable substance sheet does not have counts and signatures for each shift change with a change of staff.  
• The count of doses from the MAR does not match the count of doses from the countable substance sheet. |                                                                                                                                                               |
| 13. External documentation         | **PASS**  
Use of external documentation, such as graphic sheets documenting vital signs, chart notes, blood pressure sheets, and anything else used to support the documentation of appropriate medication administration, complies with provider policies. | **APPLIES TO**  
• Staff being reviewed  

**REMEDICATION**  
• Remediation should occur by having staff complete documentation exercises for completing provider forms for which the documentation was not compliant. |
|                                    | **FAIL**  
• Documentation is not completed consistent with provider policies. |                                                                                                                                                               |