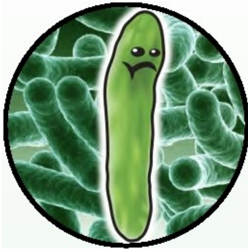
SECTION 4



MEDICATION RECORDS

LEARNING STEPS

The following steps are included in this section:

1. Charting on the Medication Record
2. Sample Medication Record
3. Medication Audits

LEARNING ACTIVITIES

1. Read the information in this section
2. Complete the self-test at the end of the section
3. Check your answers

Charting on the Medication Record

What is the Medication Record?

The Medication Record is a legal document and a permanent part of the client's health record. It is used to document directly observed therapy (DOT). It provides a record of events involving client care related to DOT delivery. TBPWs are required to chart DOT delivery and each attempt to deliver DOT on the Medication Record.

A new Medication Record must be started at the beginning of each 28-day medication cycle. More than one page may be needed to chart all of the doses given during one medication cycle. Blank Medication Records are available on the TB Prevention and Control Saskatchewan (TBPC SK) web page and can be printed as needed. Call TB Prevention and Control SK at 306.655.1740 or toll-free at 1.866.780.6482 to order copies if you are not able to access the web-page or to print on-demand.

Why chart on the Medication Record?

Charting is essential in order to ensure safe client care. It is not optional. It is important that your charting be clear, accurate and complete. What you chart on the Medication Record provides important information about the care you have given to the client, how they are doing and their concerns. Because of this, Medication Records may be reviewed during legal proceedings.

Your charting also tells other members of the health team what you have done and what the client has shared. It helps the TB Prevention and Control SK team make decisions about the client's treatment and overall care. The client's treatment will be longer if DOT is not charted or not charted accurately.

Who should chart?

The person that gave the DOT, or tried to give the DOT, must chart on the Medication Record. No other person can chart for your actions or the care you provide. Never chart for another TBPW.

When should you chart?

You should chart as close to the time that you gave DOT as possible.

If you did it, or saw it, or are required to report it,
you should chart it.

How should you chart?

- Write neatly so others can read and understand what you have written.
- Use black or blue pen.
- Never use pencil, gel or felt pens.
- Avoid abbreviations.
- Do not use white-out or correction tape if you make an error. If you make an error, draw a single line through the error so that what you had written can still be read. Then above it, write your name and the date. The Medication Record should never be recopied because of an error.

What should you chart?

- Chart the facts. Chart what you did or said and what the client did or said. Do not chart your assumptions, gossip, bias, or personal viewpoints.
- Chart each DOT dose that is taken by the client.
- Chart each attempt to locate the client on a separate line of the Medication Record.
- Chart the following in the comment section of the Medication Record:
  - Concerns expressed by the client
  - The reason for missed doses and any action taken such as who this was reported to
  - Any refusals of care and what action was taken as well as the reasons for the client's refusal if known
- Always date and sign your charting.

Clear, accurate and complete charting improves client care.

TB Medication Record

A Quick Guide for Health-care Providers

1. Ensure client identifiers are documented and check that they are the same as those on the TB Order Set (doctor's orders).
2. Place a check in the box if name alert procedures are required.
3. Transcribe the medication orders from the TB Order Set. Example: Isoniazid 900 mg 3 times a week. If already transcribed, ensure they are correct by checking the TB Order Set.
4. Place a check mark in the box when DOT is ordered.
5. Check the TB Order Set with the new shipment of medications to ensure the correct medications, dose and number of doses arrived. Document the number of doses that arrived and the date. Initial once steps 3 and 5 are complete. A new medication record should be used with each new medication shipment.
6. Document height/weight as ordered including the date they were taken.
7. Document the date medication delivery is attempted.
8. Place a number **1** in the column if the client took all of the medication in the dose package. Leave blank if the dose was not given.
9. Place a number **1** in the column if the client did not take the dose or if they only took part of the dose. Leave blank if the dose was given.
10. Document the date the next dose should be given. Example: if the client Is receiving medication three times a week (M-W-F) and the dose was given on Monday, November 2nd, the next dose will be due on Wednesday, November 4th.
11. Count the number of dose packages that remain on hand.
12. Include information such as side effects; missed doses and reason for missed dose; if dose wasted or withheld; and medication errors.
13. Document where the medication was delivered.
14. Sign your name once documentation is complete.
15. At the end of the medication cycle, document the number of full and number of empty dose packages before returning all used and unused medication and dose packages to TB Prevention and Control Saskatchewan. Date and initial once this is completed.
16. Place a check in the corresponding tick boxes to indicate the final location of the Medication Record.

TB Prevention and Control Saskatchewan 2019-07-24

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Sample Medication Record

Saskatchewan **Health Authority**

☑ **NAME ALERT**

TB Prevention and Control SK MEDICATION RECORD

MEDICATION LABEL(S)

Drug	Dose	Frequency
Isoniazid	900 mg	twice a week
Rifampin	600 mg	twice a week
Pyridoxine	25 mg	twice a week

Name: TEST, Patient Three

Address: Number 1 Community

Date of birth: 1985-02-02 PHN: 200 300 400

TB File #: TEST43

☑ DOT (Directly Observed Therapy) means **a health-care provider watches the person swallow EACH DOSE**

Verified with TB Order Set (initial): RN AB DOT worker CD

Number of doses received: 8 Date: Jan. 14, 2019

Date: ________ Height: ________ ☐ cm ☐ feet/inches

Date: Jan. 17, 2019 Weight: 76 ☑ Kg ☐ Lbs.

Date	Doses Given	Doses NOT Given	Date Next Dose Due	Doses Left on Hand	Comment	Where given (e.g., home, clinic, work)	Signature and Position
Jan. 17/19	1		Jan. 21/19	11	Took pills with water	home	C. Dee, TBPW
Jan. 21/19	1		Jan. 24/19	10	States felt good after last dose	home	C. Dee, TBPW
Jan. 24, 19	1		Jan. 28/19	9	Took pills with apple juice. States feels good.	home	C. Dee, TBPW
Jan. 28/19	1		Jan. 31/19	8	Took pills with apple juice, wants chocolate pudding. Felt good after last dose	home	C. Dee, TBPW
Jan. 31/19	1		Feb. 4/19	7	Swallowed pills with chocolate pudding. Tolerated last dose. No side effects.	home	C. Dee, TBPW
Feb. 4/19	1		Feb. 7/19	6	States felt "good" after last dose.	home	C. Dee, TBPW
Feb. 7/19	1		Feb. 11/19	5	States feels "fine."	home	C. Dee, TBPW
Feb. 11/19		1	Feb. 14/19	5	Unable to find client; left message for CHN; called TBPC nurse re missed dose.		C. Dee, TBPW

Medication returns/empty packages verified (initial): RN: AB TBW: CD Date: Feb. 15, 2019

full packages: 1 # empty packages: 7

☐ **FAX a copy of the Medication Record to TB Prevention & Control SK and retain a PHOTOCOPY for local health record**

☐ **Return ORIGINAL Medication Record to TB Prevention & Control SK at the end of the medication cycle**

TB Prevention & Control SK – Saskatoon Main Office
Box 100, Royal University Hospital
103 Hospital Drive
Saskatoon, SK S7N 0W8
Ph: (306) 655-1740 Fax: (306) 655-1495

TB Prevention & Control SK – Prince Albert Office
Room 246, Cooperative Health Centre
110 - 8th Street East
Prince Albert, SK S6V 0V7
Ph: (306) 765-4260 Fax (306) 765-4264

TB Prevention & Control SK – Regina Office
Room 1B10, Regina General Hospital
1440 – 14th Avenue
Regina, SK S4P 0W5
Ph: (306) 766-4311 Fax (306) 766-4710

TBPC SK 2019-07-23

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Medication Audits

At the end of each medication cycle the TBPW must:

- **Fax** the Medication Records to the TBPC SK nurse clinician,
- Make a copy of the Medication Records for the client's local health record, and
- Send the Medication Records to the TBPC SK nurse clinician with the empty and undelivered full medication dose packages. This must be done within five working days of the end of the medication cycle.

Medication returns are checked by the TBPC SK nurse clinician to find out how many doses the client took versus how many doses they were supposed to take. This helps determine how many doses the client needs to take in order to complete their treatment.

The TBPC SK nurse clinician checks to see that each dose prescribed has a corresponding entry on the Medication Record and that the Medication Record matches the dose packages returned. For example, the nurse clinician will check that each empty dose package is charted on the Medication Record as having been given and each full dose package that was returned is charted on the Medication Record along with the reason why it was not given.

Some of the things the TBPC SK nurse clinician looks for are:

- Were doses taken or were they missed and was the reason for missed doses charted
- Were the correct medications and correct amount of medication given
- Was the number of days between doses correct
- Did the client report any side effects or concerns
- Were doses spit out or did the client report throwing up after taking the medication

The TBPC SK nurse clinician will call the local nurse and TBPW if there are concerns with the Medication Record, returned dose packages or any DOT procedures.

Example Medication Audit

TB MEDICATION AUDIT SUMMARY							
							(YYYYMMDD)
NAME	DOE, John		**TOTALS**			**START DATE**	2016-03-22
LOCATION	Dog River, SK		**TAKEN**	**REQUIRED**	**%**	**END DATE**	2016-08
FILE #	99999		35	39	89.7		
DOB	1962-01-01						

DATE	**MONTHLY AUDIT**		**COMMENTS**
(YYYYMMDD)	**TAKEN**	**REQUIRED**	
2016-04-11	7	8	Unable to locate x 1 noted on MAR - not reported. *C.Jones, RN*
2016-05-09	6	8	2 missed doses not reported or documented on MAR.*C. Jones,*
2016-06-06	8	8	No concerns noted on MAR. *C. Jones, RN*
2016-07-04	7	8	One dose was given with only one day off between doses so dose could not be counted. *G. Smith, RN*
2016-08-01	7	7	Treatment for latent TB infection complete. *C. Jones, RN*

Section 4 Self-Test: Medication Records

Part A: True or False

☐ 1. The 'Date Next Dose Due' column indicates when the TBPW will receive the next 28-day supply of TB medication.

☐ 2. The 'Doses Left on Hand' column indicates how many doses are left of the 28-day supply of TB medication.

☐ 3. In the 'Date' column, the TBPW writes in the date the next dose is scheduled for the client.

☐ 4. The TBPW must use a separate Medication Record for each client.

☐ 5. The TBPW charts and signs on the Medication Record after each dose of medication is taken by the client.

☐ 6. The client must initial in the 'Signature' column that he/she received the medication.

☐ 7. It is okay to recopy the Medication Record if the TBPW makes a mistake.

☐ 8. Whiteout or correction tape should be used if you make a mistake on the Medication Record.

☐ 9. When the TBPW reports client information to the local nurse and/or the TBPC SK nurse, the call must be charted on the Medication Record. The same is true when the TBPW receives client information from the local nurse or TBPC SK nurse.

☐ 10. If needed, more than one Medication Record can be used to make sure information written is neat and can be read.

☐ 11. It is not important to return empty and unused dose packages promptly at the end of the medication cycle.

☐ 12. To make sure the client receives the correct dose of medication, the client's height and weight should be charted on the Medication Record as ordered by the physician.

Part B: List six examples of information that should be charted in the 'Comment' section of the Medication Record.

____

____

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____

____

____

Section 4 Self-Test Answers

Part A: True or False

1. False	7. False
2. True	8. False
3. False	9. True
4. True	10. True
5. True	11. False
6. False	12. True

Part B:

Examples of information that should be charted in the comment section of the Medication Record include:

- Calls to the local nurse or TBPC SK nurse
- Concerns voiced by the client
- Side effects reported by the client
- The reason for missed doses and who the missed dose was reported to
- If the dose was withheld or wasted
- Any medication errors
- How the client is tolerating the medication
- How the client felt after the last dose
- Challenges in delivering DOT
- Incentives provided when medication is given

References

TB Prevention and Control Saskatchewan. (2019). TB Medication Record: A Quick Guide for Health-care Providers.

Saskatchewan Registered Nurses' Association. (2011). Documentation: Guidelines for Registered Nurses.

Saskatoon Health Region. (2004). Region Wide Policy and Procedure #7311-75-007: Documentation Standards – Health Records.