**Section 116.70 Medication Administration Record and Required Documentation**

a) All medications, including patent or proprietary medications (e.g., cathartics, headache remedies or vitamins, but not limited to those) shall be given only upon the written order of a physician, advanced practice nurse, or physician assistant. All orders shall be given as prescribed by the physician and at the designated time. Telephone orders may be taken by a registered professional nurse or licensed practical nurse. All orders shall be immediately written on the individual's record or a "telephone order form" and signed by the nurse taking the order. These orders shall be countersigned or documented by facsimile prescription or electronically signed by the physician within 10 days.

b) Medication Administration Record

1) Except as provided in Section 116.60(g), an individualized MAR shall be kept for each individual for medications administered, including PRN medications, and shall contain at least the following:

A) the individual's name;

B) the name and dosage form of the medication;

C) the name of the prescribing physician, physician assistant, dentist, podiatrist or certified optometrist;

D) dose or quantity to be taken;

E) frequency or times of administration;

F) route of administration;

G) date and time given;

H) most recent date of the order;

I) allergies to medication; and

J) special considerations, including special directions and precautions for the medication's preparation and administration and contraindications for the medication.

2) PRN medication must be documented on the MAR in accordance with Section 116.70(b)(1). In addition, the following information must be included on the MAR:

A) conditions for which the medication may be given; and

B) maximum or stop dosage.

3) The MAR for the current month shall be kept with the medications or in the individual's record.

4) The MAR shall be completed and initialed immediately after medication is administered by the registered professional nurse, licensed practical nurse, or authorized direct care staff. Each MAR shall have a section that contains the full signature and title of each individual who initials the MAR.

5) All changes in medication shall be noted on the MAR by a licensed practical nurse, registered professional nurse, advanced practice nurse, pharmacist, physician, physician assistant, dentist, podiatrist, or certified optometrist and reported to the Nurse-Trainer prior to the next dose. Upon the direct instruction of a Nurse-Trainer, authorized direct care staff may indicate on the MAR completion of the following actions:

A) discontinuation of a medication;

B) change in medication schedule; and/or

C) application of a medication information label issued with a medication by a licensed pharmacy.

6) Individual refusal to take medications shall be noted on the MAR. Authorized direct care staff shall document in the individual's record the reasons for refusal and notify the registered professional nurse, Nurse-Trainer, or person licensed to prescribe medication in Illinois to receive direction on any action to be taken. Refusal of medication by an individual is not considered a medication error.

7) For individuals who are independently self-administering medications, no MAR shall be required. However, any medication that individuals take shall be listed in their records, including dosage, frequency and identity of the prescribing physician, physician assistant, dentist, podiatrist or certified optometrist. Each agency shall develop and implement a quality assurance system to ensure that self-administered medications are taken in accordance with prescribed orders.

c) In the event of a medication error, authorized direct care staff shall immediately report the error to the registered professional nurse, Nurse-Trainer or person licensed to prescribe medication in Illinois to receive direction on any action to be taken. All medication errors shall be documented in the individual's record and a medication error report shall be completed within eight hours or before the end of the shift in which the error was discovered, whichever is earlier. The medication error report shall be sent to the Nurse-Trainer for review and further action within 7 calendar days after the occurrence. A copy of the medication error report shall be maintained as part of the agency's quality assurance program. Medication errors must be documented and are subject to review by DHS or DPH, whichever is applicable. Medication errors that meet the reporting criteria of DHS' rules on Office of Inspector General Investigations of Alleged Abuse or Neglect or Deaths in State-Operated and Community Agency Facilities (59 Ill. Adm. Code 50) shall be reported to the Office of Inspector General.

d) In the event of suspected drug reaction, authorized direct care staff shall immediately report the signs and symptoms to the registered professional nurse, advanced practice nurse, physician, physician assistant, dentist, podiatrist, or certified optometrist to receive direction on any action to be taken. All adverse drug reactions shall be documented in the individual's record and an adverse drug reaction report shall be completed within eight hours or before the end of the shift in which the reaction was discovered, whichever is earlier. The adverse drug reaction report shall be sent to the prescriber and the Nurse-Trainer for review and further action. A copy of the adverse drug reaction report shall be maintained as a part of the agency's quality assurance program.

e) An inventory and a record of use of controlled substances shall be maintained by the registered professional nurse in the program, and each substance shall require a separate sheet indicating the:

1) name of the individual;

2) name of the prescriber;

3) prescription number;

4) name of the drug and strength;

5) amount used;

6) amount remaining;

7) time and date administered;

8) name of the individual who administered the medication; and

9) documentation of a shift count done by authorized direct care staff. Any discrepancies shall be reported to the Nurse-Trainer for review and action in accordance with written policy.

A) A shift count must be completed when the responsibility for administering medications changes from one authorized direct care staff or nurse to another authorized direct care staff or nurse.

B) The authorized direct care staff or nurse passing on responsibility for medication administration will count the controlled substances with the authorized direct care staff or nurse assuming responsibility for medication administration.

C) The count completed when a controlled substance is administered is not considered a shift count.

f) Host Family Community Integrated Living Arrangements as described in 59 Ill. Adm. Code 115 must develop a quality assurance procedure to ensure accurate inventory and record of use of controlled substances.

(Source: Amended at 41 Ill. Reg. 6534, effective May 26, 2017)