



DEPARTMENT: Nursing Services	POLICY AND PROCEDURE DESCRIPTION: Medications Policy and eMAR Documentation
PAGE: 1 of 5	REPLACES POLICY DATED: 11/11/2025
DATE: 5/20/2026	RETIRED: N/A
APPROVED: 5/27/2026	REFERENCE NUMBER: N/A
EFFECTIVE DATE: 5/28/2026	LAST REVISED/REVIEWED DATE: 11/2025

SCOPE: All George G. Glenner Alzheimer's Family Centers, Inc.®

PURPOSE: To ensure each Adult Day Program (ADP) and /or Adult Day Health Care Center (ADHC) have an established and active Medications Policy for the safety of all Participants, as well as an established Policy and Procedure to ensure accurate, complete, and timely eMAR documentation of all scheduled/required medications administered at the Center.

POLICY: Only medications in the original licensed pharmacy container with a proper pharmacy label listing the **Participant's name, medication name, strength and dosage, route of administration, frequency and administration time (if noted), prescribing physician, pharmacy name, prescription (Rx) number, date of prescription, expiration date, special instructions and precautions,** will be accepted at the Center for administration &/or monitoring by a Medication Administration Staff Member (RN, LVN, or CMT) on duty. Pharmacy containers with altered prescription labels will not be accepted at the Center. All prescription orders on file and pharmacy labels must be consistent and contain matching information.

Please note, for the safety of all Participants we serve, Participants are not allowed to have any medication/s (over the counter or prescription) on their possession at the Center. No medications are to be brought to the Center in a Ziploc-type bag/pillbox/lunch bag, etc.

It is also the policy of the Center to dispose of the Participant's medication/s, according to regulations, 30-days after the Participant's discharge from the Center. Therefore, if the Family/Primary Caregiver/Responsible Party so wishes, the Participant's medication/s may be picked-up from the Center during this 30-day period.

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PROCEDURE:

The following applies to all medications administered &/or monitored at the Center.

A. Medication Administration &/or Monitoring

- A physician's order is required for any medication/s administered &/or monitored at the Center. Upon request, a Medication Administration Staff Member (RN, LVN, or CMT) can assist in obtaining a copy of the order/s.
- The Participant's Family/Primary Caregiver/Responsible Party must directly supply the medication/s to the Center as described above, unless the medication/s are being filled by a pharmacy already established to provide a direct supply to the Center.
- If the Family/Primary Caregiver/Responsible Party, providing the medication supply to the Center, is concerned about not having a supply at home for the Participant during an absence, the Family/Primary Caregiver/Responsible Party may come to the Center to pick-up a supply of the Participant's medication/s. A Medication Administration Staff Member (RN, LVN, or CMT) on duty will sign-out the medication/s to the appropriate individual.
- Many times, an attending physician may wish to add or delete a dosage according to the Participant's needs. If the prescribing physician has changed the frequency or dosage, the Center will need an updated copy of the physician's order documenting this change prior to administration &/or monitoring of the medication/s.
- Many times, an attending physician may wish to add a PRN, or "as needed", medication to the Participant's existing medication regimen. PRNs are extremely important medication orders used for Alzheimer's/Dementia participants which assist the Participant to obtain an optimal level of functioning with the least amount of interference with activities. All PRN medications administered or monitored at the Center must have a physician's order and the order must include an indication for use.

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B. eMAR Documentation via Tablet

- Each Medication Administration Staff Member (RN, LVN, or CMT) shall be issued individual login credentials for the tablet. Staff must always use their individually assigned credentials when logging into the tablet for documentation of medication administration.
- To ensure adherence to best practices and protocols, all medication administration for Participants requiring medication at the Center must be entered via the tablet. Medication administration should only be entered via the computer in the event of an operational issue with the tablet.
- All medication administration must be documented accurately, promptly, and in real time.
- The *Notes* section on the tablet or computer shall be utilized to document any additional information relevant to the administration of the specified medication. This may include, but is not limited to, blood glucose readings, insulin administration details, or the reason a medication was not administered.

C. Electronic Health Record (EHR) Documentation – Medication Section of Member Health Profile (MHP)

1. Prescription Number Documentation –

- The **prescription (Rx) number** is to be documented in the EHR for each medication listed in the Participant's MHP. The Rx number is to be **entered directly after the medication name in the *Drug Name* field** [this will populate on the MHP under the ***Medication Name*** column].
- The prescription number must match the pharmacy label and be documented accurately in the Participant's medication profile and eMAR to support medication verification, auditing, and continuity of care.
- If the Physician prescribed medication is an ***Over The Counter (OTC) medication*** (i.e.: ***Systane eye drops***), enter "***Rx: OTC***" directly after the medication name in the ***Drug Name*** field

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[this will populate on the MHP under the **Medication Name** column].

- If the Center's **House Stock/Supply of Standing Orders medications** are used to meet a Physician prescribed medication (i.e.: acetaminophen) enter "**Rx: Standing Orders**" directly after the medication name in the **Drug Name** field [this information will populate on the MHP under the **Medication Name** column].

2. Procedure for Dosage Changes to Current Medications –

- a. When a dosage change is ordered for a current medication, the following procedure must be followed to ensure safe medication administration and accurate documentation:
 - Obtain the proper Physician Order – a Medication Administration Staff Member (RN, LVN, or CMT) must receive and verify the updated Physician Order prior to implementing any dosage change.
 - Update the **Medication Current** section in the MHP –
 - Discontinue previous dosage entry as follows: 1. Click on the proper medication to be discontinued. 2. Under **STATUS**, click on **Discontinue**. 3. Enter the effective date for the discontinuation of the medication in the **Discontinue on** field. **NOTE: DO NOT CHANGE ANY INFORMATION UNDER ADMINISTRATION** – “Administered at center (included on printed MAR)” must remain checked off. 4. Enter the reason for the discontinuation in the **Comments** field – (i.e. Dosage Change) [this information will populate on the MHP]. 5. Click on **SAVE**. 6. Check the **Medication Current** section of the MHP to ensure the entry is reflected correctly.
 - Add the updated medication, via the **ADD NEW MEDICATION** tab, to reflect the new dosage and any other prescription changes,



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including the Rx number [see Section C.1. above], based on the Physician Order received. In the Comments field, document that the entry is a Dosage Change along with the effective date of the change and the name and title of the Medication Administration Staff Member completing the update (i.e. -BSmith, RN). ▪ All actions related to the dosage change must be documented promptly and accurately in the EHR. 3. Standing Orders House Stock/Supply – ○ Complete a monthly review and replenishment of the house stock/supply as listed on the current Standing Orders on file for each Center.	
REFERENCES: <i>MEDICATIONS POLICY</i> included with enrollment documents and the establishment of the eMAR on the current Electronic Health Record (EHR) system (i.e., XCITE!™).	