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DOCUMENTING MEDICATIONS
IN THE ELECTRONIC PUPIL HEALTH RECORD (EPHR)

MEDICATION LOGS

All medication orders entered into the system to be given routinely, or as needed (prn), will display on the Medication Log. The scheduled medications will be on the top of the list in chronological order. The PRN medications will follow in alphabetical order by student's last name. Medication doses recorded on the medication log will display in the student's record on the medication history screen.

When giving a medication:
1. Follow the normal protocol for checking the 6 Rights (right student, right medication, right time, right route, right dosage, and right documentation).
2. Enter the time the medication was given along with initials and job title of the person administering the medication (use BUP for backup).
3. Click **Save** or use **Alt + s** to save the entry. Scheduled medications that have been given will disappear from the list. PRN medications will remain on the list in case an additional dose is needed during the day.
4. If you are unsure whether or not a medication has been given, click the "Show Medication Taken" button, then **Search** (or **Alt + e**) and the recorded doses will become visible, although unchangeable. This is especially important in giving a PRN medication to make sure an adequate period of time has passed since the last dose.

If the medication was missed or a medication error occurred, that information can be added and saved at a later date. In addition, you can record if a parent was contacted to request more medication or report a medication error. You can also indicate that you have logged that dose in EdPlan (it will not automatically log the dose for you).

To Document a Missed or Late Medication Dose:
1. If dose was not given, enter your initials and staff type but leave the time blank.
2. If the dose was given late, enter the time it was given with your initials and staff type.
3. Choose from the menu of options why the medication was missed or late. You can further explain the situation (if needed) using the Notes field on the medication log.
4. If the dose fits criteria for a medication error, click the medication error box and complete a medication error report as instructed in the HRS Medication Procedures on the Staff Website.
5. Save after making any changes.

In circumstances where backup staff will be giving medication (HO staff absent or only work part time), the medication log can be printed out and given to the backup person. The backup should record the dose on the paper log and the health office staff should enter that dose into the electronic record when

available. If the dose is routinely given by backup staff, use a paper medication record and scan it at the end of the year. Special circumstances should be discussed between the HSA or LPN, school nurse and Nurse Manager.

If you realize you documented a dose for the wrong student or there was a problem of some other kind, it is possible to void and replace the record.

To Void and Replace Medication Record:
1. Check the medication date is correct and click "Show Medication Taken" then Search to be able to see the dose.
2. Find the Void box in the far right column and click on the box and Save.
3. Discovery will replace the voided record on the log so you can enter the correct information.

MEDICATION COUNT
The purpose of this screen is to account for the comings and goings of controlled medications, but it can also be used to keep track of any medications or of expiration dates for any medication. All doses of controlled medications received at school, sent home from school or destroyed should be recorded on this page. Other medications can be accounted for if desired. Common scheduled meds include Dexedrine, Adderall, Metadate, Concerta, Ritalin, Methylin, Clonopin, Valium, Diastat, Midrin, and Xanax.

To Document Medications Received at School:
1. Go to the student's Medication tab and look for the Count area.
2. Click on the **Add Record** button.
3. Enter the name of the medication.
4. Unit strength refers to the amount of medication in each pill, syringe, vial, etc. This is not the same as the prescribed dose. For example, a student is prescribed to get 20 mg of Ritalin per day, but the parent sends a bottle of 10 mg pills. In the unit strength box write "10 mg tablets".
5. Check the box if it is a controlled medication.
6. Choose "Received from home" from the Received/Dispensed dropdown.
7. There is a space to document an expiration date for the medication if relevant. You may want to know the expiration date of medications such as Epipens (expire after 1 year), Advair (expires 30 days after opening package), etc. It is not necessary to record an expiration date for all medications.
8. If you have pills left from before, record the number in the "# units on hand" box.
9. Choose "plus" from the Plus/Minus dropdown.
10. Indicate the date the medication was received (usually today's date)
11. Indicate the number of pills/units you just received.
12. Indicate the total supply now in the health office in the "Total # remaining units" space.
13. Enter your initials and staff type
14. If there are any unusual circumstances that you would like to document, use the Notes (ex. Student says pills dumped out in his backpack on the way to school).

To Document Medications Wasted or Sent Home From School, etc.:
1. Follow the procedure "To Document Medications Received at School", but choose the relevant code for wasted, sent home, sent to summer school, etc.
2. Record the number of pills you started with in the # units on hand box.
3. Below that indicate the number of pills wasted or sent elsewhere.
4. Choose "minus" from the Plus/Minus to indicate they are leaving your possession.
5. Finish documentation as above and save your work.

To Document Medications Counted but Left in HO:
1. Follow the procedure "To Document Medications Received at School", but choose the relevant code for "counted, left in HO".
2. Record the number of pills in the # units on hand box.
3. For the number of pills received/dispensed, enter 0.
4. Finish documentation as above and save your work.

MEDICATION HISTORY
This tab displays all medication doses recorded through the medication log. The area at the top allows the record to be searched by dates, medication type, medication, etc. Clicking on any column heading will also rearrange the data for easier viewing. There is no data entry on this screen. It can be referred to when documenting in Easy IEP for 3rd party billing.

STUDENT MEDICATION
This screen is designed to document medication orders available in the health office (daily or as needed). Medications entered in this screen will appear on the Medication Log (assuming today's date is between the start date and end date for the medication).

To Enter a New Medication Order:
1. Click the **Add Record** button next to Details.
2. Enter the name of the medication as it appears on the medication bottle or container. If the orders give the brand name and the bottle gives the generic name, enter both names ex. Methylphenidate (Ritalin).
3. Enter appropriate dose and route.
4. Medications can either be entered as scheduled or as needed (prn).
   - For a scheduled medication, enter the time it is to be given including AM or PM.
   - If the student is scheduled to receive the medication more than once in the school day, make an entry for each dose.
   - For a prn medication, write what need would prompt giving the medication (ex. Pain, headaches, cramps, wheezing, cough, yellow zone, etc). Note: you only have 15 characters, so be concise. It is not needed or helpful to say prn or as needed since that is implied.
   - If an oral medication is ordered for both daily and prn, it should be entered twice: once as scheduled and once as prn.
   - Asthma medications that are ordered for pre-exercise and prn can be entered just once as prn. Enter something like "B4 PE & q4-6 hr" in the PRN schedule box. You will also need to start a SHOAR (see Documenting Medications in EPHR)
   - Enter diabetic orders as clearly as is possible (it will be imperfect). Use the Note section to refer to Nurse Notes for more complete description of sliding scales, etc. You will also need to start a Diabetic Flow sheet (see Documenting Medications in EPHR).
5. Start date should be the first date the student will get a dose. Note: the dose will not appear on the medication log until the start date.
6. For end date, put in the end date from the medication order (if there is one) or use a date in August after the current school year. Medication orders will remain on the Medication Log as long as it is prior to the end date.
7. If the medication is a controlled substance, check the box marked controlled substance. Use the medication count screen to document doses received and destroyed.
8. For verbal consents, indicate date of consent, write a note in the narrative saying that it was a verbal consent. Leave the record in draft until the final consent date is received. Note: ONLY licensed nurses can take verbal orders (LPN or LSN).

9. HSA and LPNs will use the **LSN Approval** box to indicate the date the LSN gave approval to start giving the medication (in person or by phone). The LSN will use the **LSN Review** box to indicate the date s/he reviewed the order and finalized the record.
10. Location refers to where the medicine is kept. If it is kept in the health office and given in the classroom, indicate "In HO" for location, and put in the note that it is given in the classroom.
11. Use the NOTES box to record any special information or instructions (ex. open capsule and sprinkle on applesauce, only give after calling parent, given in classroom, etc). The instructions display on the medication log so they can easily be referred to when giving the medication.
12. Leave the order in draft form until the school nurse has reviewed it. The LSN is responsible for reviewing, completing and finalizing the record as soon as possible.
13. The VOID button is only used if the order was entered in error and the whole record is to be voided.

If the Medication is Discontinued:
1. Go to the student's Medication tab.
2. Click on the underlined medication name to get into the detail screen for that med order.
3. Change the end date to the last date the medication was to be given.
4. Save the changes (**Save** button or **Alt + s**).

If the Medication Dose is Changed:
1. Follow the directions above to get back to the medication detail screen.
2. Enter the end date for the current dose.
3. Click **Add Record** to enter the new medication order.
4. **Note: DO NOT make changes in dose or time to a medication order that has been left in draft. It will change the order retroactively, so the previous doses and scheduled times already will be eliminated and the medication history will be inaccurate.**

If a medication order needs to be voided (wrong student, major error in order that is already finalized), go into the med order as described above. Find and click on the VOID box then save the changes. If you just want to make a change to how the order is written, it is preferable to put in an end date and enter a replacement order.