Monthly Medication Audit Tool

Date of Audit: _____Month Audited_____
Auditor(s) Name with credentials: _____

Resident Name: _____ MID# _____
Primary Medical Diagnosis: _____

Medication Audit	YES	NO	N/A
Documentation			
Initial completed by each person administering medication?			
All boxes filled with initials or appropriate code?			
All documentation completed in black ink?			
Right Medication/Right Dose/Right Time/Right Route			
Are medication bottles or packaging properly labeled?			
Does medication order, medication packaging, and MAR match?			
Have any of the medications expired to include "House" meds?			
Correct name, dosage, and time transcribed onto the MAR?			
Communication Note utilized to explain unusual circumstances?			
Medication Error report completed for any errors?			
Medication stored and secured properly?			

Resident Interviews	YES	NO	N/A
Do you understand what medications you are supposed to take and what the tablet or capsule looks like?			
Have you been getting your medications as ordered by the physician?			
Does the facility staff take the time to ask you about medical concerns that you may have on a daily basis? *(ie, ingrown toenail, rashes, etc)*			
Do you feel as though the staff are making efforts to ensure you are safe in the home?			
Do you feel the staff have your best interest in mind and care about your success in the treatment program?			
Do you have any concerns that you would like to discuss with me?			

Any ***NO*** responses require an explanation

Signature of Auditor