For medication queries & support, contact the Medicines Optimisation in Care Homes team via:
bswicb.bswmoch@nhs.net

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Medication Administration Record (MAR) Charts in Care Homes: Good Practice Guidance

The MAR chart is individual to the person and reflects the items which are still being currently prescribed and administered, together with information about repeat prescriptions for PRN ("when required") medicines.

A good MAR chart should include information to assist with:

The six "R"s of medication administration

- **Right patient**
- **Right drug**
- **Right dose**
- **Right formulation**
- **Right route**
- **Right to refuse**

Purpose of a MAR chart

A Formal Confidential Record of Medication Administration. MAR charts must be clear, accurate and up to date.

A MAR chart should contain the following information:

Patient details: -Full name, date of birth and weight (if child or frail elderly) and include known allergies and type of reaction experienced.

Details of any medications taken or used (including creams):

- Name of medication, strength, form, dose, how often it is given and the route of administration.
- Special instructions on how the medication should be taken.

MAR charts in USE - keeping record, keeping residents safe...

- The MAR chart must be signed at the time of administration after a resident has taken their medication.
- Staff signatures must be easily identified and must not resemble the MAR chart codes.
- It must be clear what medication has been taken, on which date and at what time.
- With variable doses (e.g. 1-2 tablets) it must be clear what actual dose was given / taken.
- When a prescribed medication has not been given or taken the MAR chart codes must be used to reflect this. The reasons should be recorded in the notes section and in the residents' care notes.
- Administration of controlled drugs should be recorded on the MAR chart AND in the CD register. The CD register should be signed by the staff administering the medication AND a trained witness.

Problems to watch out for with printed MAR charts:

- Accurate at the time of printing but medications and dosages can change.
- New prescriptions and mid-cycle issues may result in many MAR charts with different start dates.
- Medications that are only for "as required use" may not be listed on the monthly MAR chart.
- MAR charts may include previously used medications that have now been discontinued.

Communicate with your supplying pharmacy to help rectify these matters.

Do MAR charts have to be printed?

Poor records are a potential cause of preventable drug errors. Printed records are not essential, but they are better than hand written charts. If a hand written chart must be used there should be robust procedures in place to check the accuracy BEFORE the MAR chart is used.

All hand written entries should be written in full, dated and signed by two trained members of staff.

Does the GP need to sign the MAR chart?

No, the GP does not have to sign any documents produced by a care provider for medicines administration. It may be appropriate, however, to ask the GP to sign the MAR chart if they change a dose of prescribed medication during a home visit.
A MAR chart is not a prescription and cannot be used to prescribe medication.

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When required and variable doses

MAR charts must be accurate and kept up to date.

"When required" (prn) medications should be kept in original packaging. Care homes should have individual patient care plans for each "prn" medication - indicating the reasons for the "prn" medication, when it can be given, how much to administer, the minimal time between doses and the maximum doses that can be given per day. Record "prn" medications when they have been given, noting the dose given and the amount left to make sure there is enough stock and reduce waste.

When administering variable doses, e.g. warfarin, there should be a documented cross reference made to the latest dosage information.

Carers should also document on the MAR chart when Homely Remedies are given.

How to amend a MAR chart

The care provider should have a system to check the source and accuracy of changes made to MAR charts. A cross reference in the daily notes is strongly recommended.

When a resident's medication is altered, suitably trained care staff are responsible for amending the MAR chart:

- Cancel the original entry so that further doses cannot be given.
- Write the medication in full with the amended directions legibly and in ink on a new line of the MAR chart.
- Write the name of the prescriber who gave the instructions.
- Date the entry, print your name and sign. It is good practice to get a second, suitably trained member of staff to verify the amendment, print their name and sign the entry.
- Take extra care when writing strengths and dosages to make sure they cannot be misunderstood.
- The dose "As Directed" is not appropriate and should be clarified with the GP or Pharmacist.

Mistakes should be corrected with a single line through them followed by the correction, signature, date, and time.

Correction fluid should not be used.

What will inspectors be looking for?

Things to consider…

- Is the person's name clearly identified?
- Is the print or handwriting legible and in ink?
- Are handwritten entries cross-referenced to daily notes?
- Does the chart show the date, including the year?
- Does the chart look "used" - an indication that it was completed after each medication administration?
- Are there gaps in the record? Have these been investigated?
- Can the reader identify exactly what has been given on specific dates e.g. with variable doses where 1-2 tablets can be given?
- Is there sufficient information to enable care workers to give "as required" medication safely?
- Is there a guide to the codes used to explain why a medication has not been given?
- Can you cross reference records for controlled drugs on both the MAR chart and in the CD register?

Good practice: MAR charts should include details of medicines received and disposed of. If not, these records must be kept in another format. Together these records enable an inspector to account for every medication that is brought into a care home. A clear AUDIT TRAIL of all medication must be available.

What's the best time?

Carers should liaise with the pharmacy to include times on the MAR chart when each medication should be given.
It may be helpful to use "breakfast, lunch, tea-time and bedtime" rather than specific times as these may not realistically indicate when the patient received the medication.
Times may be more suitable for medications that need to be given at regular intervals e.g. antibiotics, Parkinson's meds.

Many thanks to Cambridgeshire and Peterborough CCG for the information provided.

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