Care Home Advice Pharmacy Service (CHAPS)

NHS Northamptonshire Clinical Commissioning Group

Medication Administration Records (MARS)

For local adaption to align with individual Care Home medicine policies

Version 2
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Medicine Administration Records (MARs) in care homes

A MAR chart is the record that details for each resident what is currently prescribed and what has been administered to a resident (including self-administered medicines). The carer or nurse signs each time a drug or device is administered to a patient. Staff administering medication in the care home setting should be suitably trained and competent to do so.

MAR charts may also include details of medicine receipt and disposal but if not, these records must be kept in another format. Taken together, these records should enable anyone to audit and account for every medicine brought into a care home.

MAR charts used in care homes look similar to 'prescription' charts used in hospitals but they are *not* equivalent to the prescription chart. The MAR is a record of what care workers administer to people who use care services, and belongs to the care provider. It is not a chart for prescribing medicines.

Why is the MAR chart so important?

Care workers who give medicines must have a chart that detail:

- which medicines are prescribed for the person
- when they must be given
- what the dose is
- any special information, such as giving the medicines with food.

It is also important to keep a record when prescribed medicine has not been given. Differing letter 'codes' are used to record when medicines have not been administered and the MAR must explain what these codes mean.

The information on the MAR will be supplemented by the resident's care plan. The care plan will include personal preferences.

The MAR can be a useful tool for the care provider to keep track of medicines that are not ordered every month. The provider may use the MAR to record medicines carried over onto a new chart. The practice of carrying over items is encouraged and not doing so contributes to the wasted medicines and NHS resources.

The MAR can be used to record when non-prescribed medicines are given, for example a homely remedy.

Administration of controlled drugs should be recorded on the resident's MAR chart as well as the controlled drug (CD) register.

Responsibility for providing MAR charts rests with the care provider. The pharmacist or dispensing GP are not responsible.

Can the care provider ask the prescriber to sign the MAR charts?

A GP does not have to sign any documents produced by a care provider for medicine administration. The NHS contract for general medical services does not require this. There are exceptions when a care provider has a private contract with a GP for medical services.

There are some occasions when it would be appropriate to ask the prescriber to sign the MAR chart, for example when the prescriber visits and changes the dose of a prescribed medicine. **It is good practice for the new medicine/dose to be written on a new line of the MAR rather than an alteration made to the existing record.**

Do care providers have to use printed MAR charts?

Poor records are a potential cause of preventable drug errors. Printed MAR charts are not essential but they are better than handwritten charts and there is less risk of error due to:

- clerical error - incorrectly transcribing the details from another document
- Handwriting that is difficult to read and can be misunderstood.

Example: The change of insulin dose for a resident was to give 4 units of insulin at night. The carer that dealt with the change in dose wrote ` 4 i.u.' on the chart (i.u. is an abbreviation for international units). But another nurse misread the dose and gave 41 units of insulin.

If handwritten charts are used they should be completed by suitably trained staff and be checked for accuracy by a second member of staff (also suitably trained) before administration.

Printed MAR charts are usually supplied from the pharmacy or dispensing GP practice and this is a complimentary service that the supplier is paying for.

There can also be problems with printed MARs that the care provider needs to be alert to:

- The chart is correct at the time it is printed and supplied. But the dose of a medicine may change. When this happens, the care provider must keep the chart up to date.
- New prescriptions can be issued at any time in the monthly cycle. This may result in the person having several MAR charts in a file, and some may start on different dates.
- Medicines that are prescribed for 'as required' use may not be needed every month. If the MAR only has a list of medicines that have been requested and prescribed that month, it may not list the 'as required' medicines previously supplied for that resident.
- The MAR should be supplemented by information that clearly describes the circumstances when 'as required' medicine may safely be given – PRN Protocol.
- The MAR may include a medicine that has not been supplied. The care provider must check whether the prescriber has stopped the medicine and if so cross it off the chart, date and sign. If the treatment is to continue, the care provider must check why there is no supply.

Can anyone write on the printed MAR?

Anyone can change the MAR chart. But the care provider should have a system to check the source and accuracy of the changes. This would also be the guidance for handwritten MARs for new residents to the care home. Cross reference to the daily notes and medication profile is recommended.

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

- cancel the original direction
- write the new directions legibly and in ink on a new line of the MAR
- write the name of the doctor or other prescriber who gave the new instructions
- date the entry and sign (including a witness when this is possible).

If the prescriber issues a new written prescription there should be a new printed MAR chart but following a change a new supply of medication is not always necessary. For example, if the dose has reduced and there is ample stock to administer to the resident, or on hospital discharge.

On occasions when a prescriber has not issued a prescription and given verbal instructions about a change of a medication, the care home staff must request a supporting fax or email for confirmation. NICE guideline managing medicines in care homes, recommendation 1.9.6 states that health professionals should ensure that care home staff understand any instructions and send written confirmation to the care home as soon as possible. **Health professionals should also make sure that the patient's clinical record is kept up to date and changes to repeat medication are made.**

Care homes keep a list of their staff signatures and initials so that they can confirm who has made a record on the MAR. So that the care home can confirm who has made changes to the MAR visiting health professionals can be asked to complete and sign below.

Name	Role	Signature	Initials	Date