Caring for Care Homes

Using the Medication Administration Record (MAR)

Medication Administration Records may be on paper or electronic. For the purposes of this document, 'MAR' refers to both pMAR and eMAR unless specified	Paper Medication Administration Record	pMAR
	Electronic Medication Administration Record	eMAR

A Medication Administration Record (MAR) is the record of medications that have been administered to a resident. This includes both prescribed and purchased medicines.
The care home staff member signs each time a medication or device is administered to a resident. It is a **legal** document. Staff administering medication in the care home setting should be suitably trained and competent to do so. This should be documented and recorded by a manager.

Important: If the instructions or information on a MAR are not absolutely clear, immediately contact the pharmacy or GP surgery to get further clarification. Do not administer the medication until clarification has been sought.

General guidance on MARs

1. Care workers who give medication must have a MAR for the resident which details :
   - The full name and date of birth of the resident
   - Details of the medication the resident is taking, including the name, formulation and strength
   - The dose, times of administration and how the medication is taken or used (including route of administration)
   - When the medication should be reviewed, monitored or stopped (as appropriate)
   - Any special information, e.g., whether the medication should be taken with food
   - Any allergies: these should be cross-referenced with the resident's profile.
2. The information on the MAR should be supplemented by the resident's care plan. The care plan should include personal preferences, or specific support a person may need to take their medication.
3. The MAR must be completed when an individual dose is administered to a resident. This must be carried out for each resident when the medication is administered and not left until a later time, for example, at the end of a medicines round.
4. If a medication is not administered the reason must be recorded; there should not be any 'blank' entries or gaps. Use the omission codes as detailed on the MAR to describe when and why the medication was not given, and where appropriate provide additional information.
5. It is best practice that the administration of controlled drugs (CD) is recorded on the MAR by the person administering the medication and the witness. This is in addition to those records that are made in the controlled drugs register.
6. The MAR should be used to record medication which is carried over from a previous month. Ensure the quantities are checked before carrying over. Liaise with the pharmacy to ensure all current medications are listed, including those not ordered this cycle but still being taken. Ensure that discontinued medication is removed.
7. Ensure the quantities received are accurately noted on the MAR when booking in medication. If the amount stated on the MAR does not match the amount received, the quantity received should be re-checked, and then queried and changed as appropriate.

8. If an item is missing from the MAR and/or not received in the delivery, do not assume it has been discontinued. Check with the prescriber and re-order if necessary.
9. If an unexpected item has been added to the MAR and has been delivered, do not assume that this was intentional. Check with the prescriber before administering.
10. The MAR chart should be used to record when any non-prescribed medication is administered to a resident, e.g., a homely remedy or an over-the-counter medicine

Residents who self-administer

1. If a resident self-administers medication the MAR needs to state this, or a code recorded to reflect this.
2. The decision for a resident to self-administer should be regularly reviewed and risk assessed.
3. The resident does not have to complete a MAR.
4. The resident's care plan should make it clear where medication is stored and when it is handed over to the resident. For example, some residents may keep the whole pack in their room and others may be supplied with a single dose. The MAR does not have to be signed by staff as they are not administering the medication. However, a record of having supplied the medication to the resident must be kept; this could be on the MAR or in the care plan.

How to keep a MAR chart up to date

1. The responsibility for providing and using MAR charts is with the care provider, not the dispensing GP or community pharmacy.
2. Under the General Medical Services contract (GMS), the GP is not obliged to amend a MAR. However, when a GP is visiting a resident, they may choose to amend the MAR to reflect any changes they have made to the medication.
3. Poor records are a potential cause of preventable drug errors. It is best practice to use printed or eMARs. However, there will be occasions when hand-written MARs are necessary, for example, when new items are prescribed mid-cycle, on discharge from hospital or when Topical Medication Application Records (TMARs) are in use. Handwritten amendments should be kept to a minimum because of the risk of:
   - Incorrectly transcribing the details from another document.
   - Handwriting which may be difficult to read or may be misinterpreted.
   - Where handwriting is necessary, ensure there is a robust system in place for the new pMAR to be checked for accuracy by a second trained member of staff before it is used.
4. Only staff that are trained and accredited should amend a MAR. The care home should have a system in place to check the source and accuracy of any changes. The information for any amendments should be taken from written information whenever possible and a cross reference to the resident's care plan made, including the name of the prescriber who made the change.
5. When making handwritten entries the pMAR should be **amended**, ensuring the original details can still be read for completeness and audit purposes:
   - Write clearly and in black ink.
   - Write **'Stopped'** or **'Amended'** against the name of the original item, sign and date this comment and cross through any remaining days on the current pMAR.
   - On a new line, write full details of the new or amended item including name of the drug, dose and quantity. Date and sign the entry. Ensure a second check and signature.
6. Where a new pMAR is issued for a new medication it must be filed immediately with the current pMAR, to avoid it being overlooked or misplaced.
7. When a medication is **discontinued** it should be removed from the MAR:
   - Confirm with the resident's GP and document in the resident's care plan.
   - Write **'Stopped'** clearly against the name of the item and cross through any remaining days on the current MAR. Sign and date the amendment, ensure a second check and signature.
   - Ensure that you inform the pharmacy, so the item is removed from future MARs.

8. When medication is administered by a community nurse or other external healthcare professional (HCP), it is important for the care home staff to make a record on the MAR so that it is clear that the medication has been given. On the pMAR use the code for 'see back of chart'. On the reverse, record full details of the medication that has been administered and by whom; the visiting HCP will complete their own MAR.
9. Record on the MAR if a resident is admitted to hospital. It is very important to send a copy of the current MAR to the hospital with the resident.

'When required' (PRN) medication

1. Medicines prescribed for use 'when required' might not be ordered every month.
2. Liaise with the pharmacy to ensure all current medicines are printed on the MAR, including those not ordered that month.
3. Ensure that any supplementary information is on (or with) the MAR or in the resident's care plan.

Extra information for people using eMARs

1. Login details must never be shared.
2. The person who is logged into the eMAR must be the person administering the medication to the resident.
3. Where care homes are using eMARs, we recommend that only eMARs are used and not a mix of paper and electronic records, to reduce the risk of a patient having both versions and medication being missed.
4. Amendments should be made according to the system's protocols. Procedures must always be cross-referenced.

MAR chart audit

Complete the MAR chart audit every **one** to **two** months to identify whether your MARs meet the required standards. MARs form an essential element in determining whether people who use social care have been given medication as the prescriber instructed. Consider:

✓ Is the resident's name clearly identified?	✓ pMAR: Is the printing or handwriting legible and in ink?
✓ Are there gaps in the records? If so, investigate these further	✓ Does the MAR show the date, including the year?
✓ Is there a guide to explain the codes used for any medication which has not been given, as well as any additional information where appropriate?	✓ Can the reader clearly identify exactly what has been given on specified dates, for example if the dose administered was one or two tablets?
✓ Can you cross reference records for controlled drugs on both the MAR and in the CD register?	✓ Is there sufficient information to enable care workers to give 'when required' (PRN) medication safely?
✓ Are staff additions/amendments cross referenced with daily notes/ the resident's care plan?	✓ Can you confirm that the records are valid, for example by checking whether the number of signatures recorded for the administration of an antibiotic are consistent with the quantity left?
✓ Does the chart look 'in use', is there an indication that it was completed at each medication administration?	