Torbay and South Devon NHS
NHS Foundation Trust

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# Medicine Administration Records (MAR) in Care Homes and Domiciliary Care

Date: 17th February 2016



TORBAY COUNCIL

**Partners in Care**

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Amendment History

| Issue | Status | Date | Reason for Change | Authorised |
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| 2 | | 8th April 2013 | Organisation Name Change | |
| 3 | | 17th February 2016 | Update following review and Organisation change | |
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## Contents

## 1 Introduction

1.1 The aim of this policy is to provide guidance to care homes and domiciliary care providers on the safe use of Medication Administration Records (MAR). A MAR chart is the record that shows drugs have been administered to a patient. The carer signs each time a drug or medicine is administered to a patient. Carers administering medication in the care home or in domiciliary care should be suitably trained and competent. This should be documented and recorded by a senior carer or registered provider.

## 2 Statement/ Objective

2.1 This guidance supports Regulation 12 Safe care and treatment which service providers must meet under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This includes the requirement that providers must ensure 'the proper and safe management of medicines'. All standards must be applied to all aspects of care including administration of medication.

2.2 This document gives Domiciliary Care Agencies and Care Homes a guide to good practice in how the administration of medication by care workers should be recorded. It covers:

- Why a MAR chart is so important
- Who can write on MAR charts
- The pros and cons of printed charts produced by a pharmacy.
- What sort of policies and procedures Agencies and Care Homes should have
- What should be looked for in monitoring both by Agencies and Care Homes and others

2.3 This guidance relates to Registered Domiciliary Care Agencies and Registered Care Homes only. It does not apply to care purchased from an unregistered source by individuals using Direct Payments or any other form of Individual Budget.

2.4 This guidance should be considered together with local policies from Social Service Departments and Health Teams when available to Care Providers and National Guidance.

## 3 Roles & Responsibilities

3.1 It remains the responsibility of all care homes and domiciliary care agencies to ratify their own administration of medicines policy to include MAR chart. This policy provides best practice guidance for reference when writing or reviewing policies.

## 4 Medication Administration Records (MARs) chart in care homes and domiciliary care

4.1 Regulations

4.1.1 Where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs;

4.1.2 The proper and safe management of medicines

4.1.3 As far as the Trust is concerned, our expectation is that Agencies and Care Homes will meet these regulations and ensure that any reasonable request by Officers and Staff of the Trust for records that can evidence compliance and Service User safety will be available.

4.2 Agencies and Care Homes are required to keep 'a detailed record of the personal care provided to the service user'. These records must be available for inspection and also kept either at the person's home in the case of Domiciliary Care or in the Care Home. In the case of Domiciliary Care therefore, it requires a dual recording system.

4.3 The Standards require Agencies and Care Homes recording in the following activities:

- Collection of prescriptions from the GP surgery
- Collection of dispensed medicines from a pharmacy or dispensing GP
- Observation of the person taking medication and any assistance given, including dosage and time of medication. This is a record of administration, and there is no difference in the case of Domiciliary Care from the records that a Care Home must keep.

4.4 General guidance for the MAR chart

4.4.1 Care workers who administer medicines must have a MAR chart that details:

- Which medication(s) are prescribed for the patient (this must include medicine name, strength and quantity )
- When they must be given (frequency of the administration)
- What the dose of the medication
- The route of administration
- Any special information from supplementary label, such as giving the medicines with or after food.

4.4.2 Prescribed medication information is included in the NHS FP10 prescription from the supplying pharmacy or from the patient GP records. The Agency or Care Home must have a record of medicines currently prescribed for that person.

4.4.3 The MAR chart should be signed when the patient is administered an individual dose of medicine by the staff member who administers the medication.

4.4.4 A record should also be made of any prescribed medicines that have not been administered. MAR charts should include provision for this and ensure that it is clear what should be recorded.

4.4.5 The information on the MAR chart should be supplemented by the patient's care plan.

4.4.6 The MAR chart can be a very useful tool for the Agency or Care Home to use to keep track of medicines that are not ordered every month but only taken occasionally. The MAR chart can be used to record medicines carried over onto a new chart. The Agency or Care Home should liaise with the pharmacy to ensure all current medications are listed including those that are not ordered in the current month.

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

4.4.8 Administration of controlled drugs should be recorded on the person's MAR chart as well as in the controlled drug (CD) record book. The person administering should sign the record book as well as a witness.

NB: CD registers only apply in care homes, not domiciliary care).

4.4.9 Responsibility for providing suitable and up to date MAR charts rests with the Agency or Care Home.

4.4.10 A GP does not have to sign any documents produced by an Agency or Care Home for medicine administration. The NHS contract for general medical services (GMS) does not require this.

4.5 Printed and handwritten MAR charts

4.5.1 Poor records are a potential cause of preventable drug errors. Printed MAR charts produced by a pharmacy are not essential but they may be safer than handwritten charts.

4.5.2 Handwritten charts may introduce transcription errors and be less legible than printed MARs.

4.5.3 If a handwritten MAR is the only available option, there must be a robust system to check that the MAR is correct before it is used.

4.5.4 Printed MAR charts are usually supplied from the pharmacy when medicines are packaged in monitored dosage systems such as Manrex, Venalink and Nomad. This is a service that the pharmacy is paying for. Agencies and Care Homes cannot insist on having printed charts.

4.5.5 Printed MAR charts may also be provided when medicines are supplied in their dispensing containers to assist in safe recording of administration.

4.6 Potential problems with printed MAR chart are as follows;

- The MAR charts are only correct at the time it is printed and supplied. But the dose of a medicine may change at some point. When this happens, the Agency or Care Home 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 chart only has a list of medicines that have been requested, prescribed and dispensed that month, it may not list the 'as required' medicines previously supplied for that patient. Please ensure that 'as required' or 'when required' medication is added onto the MAR chart or medication carried over.
- The MAR chart should be supplemented by information that clearly describes the circumstances when 'as required' medicine may safely be given. There should be clear and precise documentation in the service user's care plan as to when a particular 'as required' medicine should or should not be given.
- The MAR chart may include a medicine that has not been supplied. The Agency or Care Home must check whether the prescriber has stopped the medicine and if so cross it off, clearly document the reason i.e. stopped, date and sign. If the treatment is to continue, the Agency or Care Home must check why there is no supply.

4.7 Can anyone write on the printed MAR chart?

4.7.1 Staff who administer medication should receive adequate training and competency assessment before they are permitted to administer medication and record on a MAR chart.

4.7.2 When a service user's medication is changed, care staff are responsible for amending the MAR chart and this may include;

- Cancelling the original entry.
- Writing the new directions legibly and in ink on a new line of the MAR chart
- Recording the name of the prescriber who gave the new instructions
- Dating the entry and signing (including a witness when this is possible).

4.8 What are the unique problems for Domiciliary Care?

4.8.1 Because the Agency may not be responsible for organising repeat supplies of medicines or setting up appointments with the GP, the Agency may find it difficult to keep up to date with changes.

4.8.2 A Domiciliary Care Agency provides care to a range of people who do not necessarily get their prescribed medicines from the same pharmacy. A pharmacist may be unwilling to issue MAR charts for individuals, and especially when the medicines are not in a monitored dosage or compliance system. There are some exceptions where local arrangements exist between the Local Authority commissioning care and the NHS Primary Care trust(s).

4.8.3 There are situations where more than one Agency provides a service to the same person. The Agencies must agree how medication will be recorded on the record that is kept in the person's own home. And this arrangement must be included in the care plan. Clear communication channels must be agreed, to include information sharing with GPs, community

nurses or any other appropriate professional.

4.8.4 All Agency care workers must keep a record of the medicines they give, including the dose that is dated and signed to meet the regulatory requirements.

4.9 Checkpoints for monitoring

4.9.1 MAR charts form an essential element in determining whether people who use social care have been given medicines as the prescriber instructed. Important questions to follow up include:

- 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 at each medication administration?
- Are there gaps in the records? If so, do these need to be investigated further?
- Can the reader identify exactly what has been given on specified dates, for example when the dose is one or two tablets?
- Is there sufficient information to enable care workers to give 'as required' medicine safely?
- Is there a guide to the codes used to explain why medicine has not been given?
- Can you confirm that the records are valid, for example by checking whether the number of signatures recorded for the administration of an antibiotic such as amoxicillin are consistent with the quantity supplied.
- In Care Homes, can you cross reference records for controlled drugs in both MAR chart and CD register?

4.9.2 The MAR chart may 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 monitoring to account for every medicine brought into a Care Home/ Service User's own home.

4.9.3 Any allergies should be clearly identified on the MAR chart for the patient.

4.10 Record Keeping

4.10.1 Once the current monthly cycle has been finished it is a legal requirement for these records to be kept in the home even when the service user has left. It is recommended they be retained for a minimum of 3 years and should be retrievable, if needed.

## 5 Training

5.1 N/A

## 6 Monitoring, Auditing, Reviewing & Evaluation

6.1 This policy will be reviewed in February 2018 or sooner as any regulatory or contractual changes may dictate.

## 7 References

7.1 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

7.2 NICE guidelines for Managing Medicines in Care Homes (Social Care Guideline) 2014

## 8 Distribution

8.1 This policy will be available to staff via The Trust Website and distributed to the Service Managers and Leads for onward circulation to their teams.

## 9 Appendices

9.1 N/A