Medicines Management
Care Homes Support

NHS
Coventry and Warwickshire

Medicines Administration Records (MAR) good practice

Medicines Administration Records (MAR) charts can be paper-based or electronic. All records should:

- Include the full name & date of birth of resident
- Be legible & easily understood by resident/family member/carer/other healthcare professionals
- Include allergy information including where possible nature of the allergic reaction
- Include medication details such as: name, strength, form, dose, frequency & route of administration
- Be signed by care home staff
- Be clear & accurate (write strengths clearly e.g. 'mg', 'microg', 'units')
- Be factual
- Avoid jargon & abbreviations
- Have the correct date & time
- Be completed as soon as possible after administration
- Record clearly when & why a medication is not administered

The MAR chart provision is the responsibility of the care provider, must record the current medication prescribed by the GP and provide a complete audit trail from supply to use or disposal. It must be referred to before the medicine is administered and must be signed immediately after the transaction. (Note that Community Pharmacies can only provide a MAR for medications they have dispensed).

Staff must take responsibility in using safe practices and procedures when there is a need to handwrite on MAR. It is good practice for handwriting to be done by members of staff trained to administer medication AND for their entries to be checked by a second trained member of staff.

Poor records are a potential cause of preventable medication errors. Any changes to the dosage or frequency of medication must be made as a new entry on the MAR – never amend an existing entry. Cross through the original entry (do not make it illegible), and rewrite with the new information in full.

If it is the only option, and with a robust system for checking, hand-written MAR should be: **complete**, **legible**, **up to date**, **written in ink** and must include the following:

- The name of drug
- The strength of the drug
- The form of the drug
- The doses of the medication
- The route of administration
- When they must be given
- Any special Information, such as giving the medicines with food
- A date and signature of the person making the record
- A countersignature – There must be a system to check that the details are correct
- The quantity received and/or quantity carried forward

Additionally, for medications not prescribed for daily administration:

- For 'when required' medications: record the date and time of administration, the dose given and number of doses remaining (balance check).
- For less frequent medication (e.g. once weekly/monthly/every 3 months), record the date/day of administration and the next dose due date.

Registered nurses must comply with their Professional Standards of Practice and Behaviour and Standards for Medicines Management, published by the NMC.

Providers should use this guidance in conjunction with Medicine Patient Information Leaflets, NICE Guidance 'Managing Medicines in Care Homes' SC1 and should check the CQC website for recent updates. Prepared by Care Home Support, Medicines Optimisation Team, NHS Coventry & Warwickshire April 2013. Reviewed July 2022.