

# MAR Chart Audit

## Domiciliary Care

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# Example MAR Chart

The person's name, address, date of birth and GP should be filled in on each chart in use

The start date of the chart (including the year) should be clearly marked.

Any known allergies must be recorded on the chart. If the person has no known allergies then this must be recorded

The name, strength and form of the medicine should be copied from the dispensing label onto the appropriate space on the chart along with the full dosage instructions (exactly as they appear on the label) and any additional instructions.

When a new chart is written for a medicine that is not administered on a daily basis a cross should be marked in the signature column against each day the medicine WILL NOT be given for the whole of the period of the chart, to avoid it accidentally being administered on a day when it is not due.

Each time a medicine is given the person administering the medicine must sign the chart. If for any reason the medicine is not administered the appropriate code should be entered onto the chart. There should be no gaps on charts

MAR charts can be computer generated or handwritten. They cannot be produced by attaching dispensing labels to a blank chart. Staff must sign the charts in ink and correction fluid cannot be used to make any amendments.

When medicines are prescribed 'as required' the MAR chart should be supplemented by additional information recorded in the care plan that clearly describes the circumstances when the medicine should be given. The time and dose administered should be clearly recorded on the MAR chart.

Where a variable dose of a medicine is prescribed e.g. "Take ONE or TWO tablets at night", the number of tablets administered on each occasion should be recorded on the chart.

Medication Administration Record (MAR)

MAR Chart Prepared by: *Sarah Jones (Care)*

Name: *FREDERICK SMITH* DOB: *13.7.1921* GP: *DR. POLLARD* Allergies: *NONE KNOWN*

Address: *64 MAIN STREET ANY TOWN* Start Day: *MONDAY* Start Date: *1.8.2011* End Date: *28.8.2011*

Medication		Week 1							Week 2							Week 3							Week 4						
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
<i>ALENDRONIC ACID 70mg tablets</i>	<i>AM</i>	X	X	X	<i>cl</i>	X	X	X	X	X	X	<i>cl</i>	X	X	X	X	X	X		X	X	X	X	X	X		X	X	X
<i>Take ONE tablet WEEKLY</i>																													
<i>Warning. Read the additional information you have been given with this medicine.</i>																													
<i>CALCIHEW D3 FORTE tablets</i>																													
<i>Take Two tablets in the EVENING.</i>																													
<i>Suck or chew this medicine.</i>		<i>PM</i>	<i>cl</i>	<i>JP</i>	<i>ST</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	<i>cl</i>	
<i>SENNA 7.5mg tablets</i>																													
<i>Take ONE or Two tablets at NIGHT.</i>																													
<i>SALBUTAMOL CFC-free inhaler 100microgram/puff</i>																													
<i>Inhale Two puffs when required.</i>																													
<i>Quantity Rec'd 56 Sig ST Date 29/7/11</i>																													
<i>Quantity Rec'd 60 Sig ST Date 29/7/11</i>																													
<i>Quantity Rec'd 60 Sig ST Date 29/7/11</i>																													
<i>Quantity Rec'd 20 Sig ST Date 29/7/11</i>																													

1 - Refused 2 - Nausea/vomiting 3 - Left for later 4 - Other (please define) *LOOSE BOWELS*

North Yorkshire County Council

# MAR Chart Audit - Domiciliary Care

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Name of Service:

Date of Audit:

Are MAR charts in use for each person where care staff administer medication?

Y/N

Number of people at level 5:

Number audited:

Are charts archived appropriately and retained for three years?

Y/N

	<i>Where the answer is 'No' please enter the number of charts this applies to in the third column</i>	<b>Y</b>	<b>N</b>	
1.1	Has the person's name, address, date of birth, allergy status and GP been filled in on each MAR chart in use?			
1.2	Do all MAR charts clearly identify the start date including the year?			
1.3	Do the MAR charts list all the medicines prescribed for the person?			
1.4	Do all entries show the name, strength and form of the medicine and full directions for use and has this been signed by the member of staff making the entry?			
1.5	Do all entries show any additional information/warnings e.g. take with or after food?			
1.6	Are MAR charts signed for each individual medicine administered including "bought" medicines? There should be no gaps.			
1.7	If a medicine has not been given has an appropriate code been recorded on the chart and can this be cross-referenced to an entry in the care plan?			
1.8	Were all medicines available for staff to administer at the time of their visit? Medicines should not be out of stock.			
1.9	When a variable dose is prescribed is the dose administered carefully recorded?			
1.10	Where warfarin has been prescribed is the dose administered clear from the MAR Chart and can this be cross-referenced to information provided by the anticoagulant clinic or GP practice?			
1.11	Is there sufficient information to allow care staff to give 'as required' medicines safely, e.g. information in the care plan or "as required medicine" protocol			

Where the answer to any of the above questions is 'no' please make notes about the problems on each chart below.

....continued

Problems to be clarified:	
Problem	Outcome

Action Plan: – include what action needed, who by, when by and when completed			
Action	Who	When	Completed Date and Sign

Registered Manager's comments:

Signed:

Date:

