

Medicine Administration Record (MAR) chart - procedure for use

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1. Purpose

Following this procedure will help the Trust to:-

- Define when the use of MAR charts are appropriate
- Ensure clinicians using MAR charts do so appropriately and adhere to required parameters

2. Related documents

This procedure describes what you need to do to implement the Administration in respite care section of the [Medicines Overarching Framework](#)



The Medicine Overarching Framework defines **Administration in respite care or community residential units using medicines supplied via the GP or patient's own supplies**. Consult this information before carrying out the procedures described in this document.

This procedure also refers to:-

- ✓ Patient own drugs (PODs) procedure for use
- ✓ Medicine reconciliation procedure

3. Function and process of MAR charts

There are some TEWV services which receive medical and prescribing services from external providers; however the administration of medicines remains the responsibility of Trust staff. To accommodate these situations an agreed process is required to record administration of medicines that are not prescribed by Trust staff.

The function of a MAR chart is to provide a permanent record of the patients' treatment with medicines whilst in the care of the Trust; to direct and record the administration of the medicine to a patient.



A MAR chart **is not** a prescription – medicine supplies **cannot** be requested against a MAR chart

3.1 Appropriate services

MAR charts may be used in services where medicines are administered by Trust employees and:

- There is no regular Trust prescriber available to the service
- Supplies are obtained via the GP or a prescriber external to the Trust
- Patients' Own Drugs (PODs) are used (see [PODs procedure for use](#))

These services include respite units, day care centres and residential care units.

3.2 Who can write a MAR chart?

Only RNs appropriately trained and accredited in the use of Patient Own Drugs (PODs) and MAR charts can write and check MAR charts.

3.2.1 Training

MAR training will only be offered to appropriate services.

- RNs must have successfully completed and passed the POD training before being able to access MAR training.
- Registered nurses must successfully complete the MAR training module, which will include a practical assessment to enable writing and checking MAR charts.
- The training will be facilitated by the Lead pharmacy technician – medication safety
- A record of completion must be kept on their personal file with a central record held by the Team/Ward Manager
- A central record of all accredited RN MAR Chart writers and checkers will be held in Trust pharmacy.

RNs have to complete a further practical assessment every three years to maintain accreditation.

3.2.2 Student Nurses

- May be involved in the administration of medicines against a MAR chart, using PODs, under the **direct** supervision of a suitably accredited registered nurse who has completed the Trust approved POD and MAR training and has the Trust Pharmacy's authorisation to practice.
- Can observe the process of POD assessment for suitability of use but cannot be directly involved.
- Cannot write or check medications written on a MAR chart.

3.2.3 Preceptorship and Bank RNs

- Preceptorship and Bank RNs will not be able to access MAR chart training. It is the responsibility of the service manager to ensure there is appropriately trained staff on duty with preceptorship and bank nurses to support service delivery.

3.2.4 Pharmacy Staff

- Designated pharmacy technicians and pharmacists may be trained to write and check MAR charts as per service need

3.3 Process for using a MAR chart

- MAR charts should be ordered via Cardea **LP182233**
- A MAR chart should adhere to the same Trust record keeping requirements as for prescription and administration records (details on front of MAR chart) ([Writing a prescription/minimum standards procedures](#))
- Medicines must not be written up on a MAR chart or administered if supporting information from the prescriber is not available.

- An independent RN check is required but does not have to be completed simultaneously to the writing of the drug chart. It does however have to be completed and signed for prior to the first administration of any medication.
- Sources of information include: written information from the parent/carer (see appendix 1), written information from **all** prescribers confirming the current medication and dose e.g. computer print-out from a GP records system, a letter from the prescriber, printed information from PARIS entered by the prescriber, copy of the most recent FP10 or repeat request, patient own supply (i.e. medication label), Summary Care Record, hospital discharge letters
- Evidence of completion of the checks must be maintained, this should be kept alongside the MAR chart with an entry made into the patient PARIS records
- The medication, strength and doses from all sources must match; if these do not match the RN should contact the lead prescriber (usually the GP) and clarify any anomalies asking for written confirmation and documenting any action taken in the patients records.
- Allergy status must be checked and confirmed every time medicine reconciliation is completed.
- Any additional protocols, such as prn treatment for epilepsy should be reviewed on a yearly basis or sooner if notified of a change. The authorised RN(s) should only include medicines to be administered whilst the client is in the care of the service on the MAR chart

3.3.1 New admission

- For the first admission to any service using MAR charts a history of medicines previously prescribed and allergy/sensitivity status should be accessed and recorded comprehensively in the patient's notes.
- A process of medicines reconciliation must be completed.
- An entry for the medicines reconciliation must be documented in the patients' records.
- An entry must be made on the MAR chart stating medicines reconciliation completed and dated and signed by the RN completing it.
- For all medicines on the MAR chart original start dates of prescription should be included where known. If not known then the first date the MAR chart was written or first issue date on GP information should be used as the start date.
- Prior to the first visit/admission to service the MAR chart should be written by an authorised RN using a minimum of TWO sources of information. The chart should then be independently checked by another authorised RN to confirm the accuracy of the information.
- Current sources of evidence of prescribing should be kept with the MAR chart in use.

3.3.2 Subsequent admissions

- Medicines reconciliation should be completed six monthly using a minimum of two sources in respite services, day care and residential care units.
- If informed of any changes to prescribed medication, the full medicine reconciliation process must be completed as soon as practicable and documented on PARIS, and noted on the MAR chart.
- If a patient is regularly admitted to/attending a service then the same MAR chart can continue to be used providing all of the required checks have been completed prior to commencement of the chart. An annotation should be made on the MAR chart and in the patient notes that these checks have been completed
- Sources of information superseded by a notification of change and/or medicines reconciliation should be filed in the patients paper notes.

3.3.3 Medicines reconciliation recording

- An entry must be made on the MAR chart stating medicines reconciliation completed and dated and signed by the RN completing it
- When undertaking medicines reconciliation, this must be documented in the med rec case note in Paris.
- Any queries are to be documented in the query section of the medicines reconciliation template, this must be followed up and any actions taken to resolve added to this section.
- The free type box at the bottom of the case note should state the following information
 - Medications and allergy status checked and confirmed using the following sources of information.
 - All sources of information and their date are to be listed.
- Over the counter products should also be recorded in the medicines reconciliation entry on Paris.

3.4 Provision of medicines



All carers/relatives should receive information related to their role and responsibility for the provision of medicines including any issues if the correct medicines are not provided.

3.4.1 Respite services

Over The Counter medications can be written on the MAR chart providing confirmation from the carer/parent has been obtained.

Carer/parent must complete the OTC section on the medication/invite letter. Please see carer letter, appendix one.

Dosage and frequency being administered must be within the administration guidance on the packaging.

OTC medications must be brought in to the unit in the original packaging.

Medicines are to be written on the medicines administration record as per the MAR procedure, written and checked by two RNs who have completed MAR training. Please note the sources of evidence will be the carer/parent medication letter and the OTC instruction for use information on the packaging.

Nurses must always check allergies and sensitivities before writing over the counter medications onto a MAR chart.

Nurses are advised to consult the current BNF regarding incompatibilities with currently prescribed medication.

- For patients admitted into respite care the RN(s) should confirm with the carers prior to admission that
 - The necessary medicines to span the period of admission will be provided; the timeframe for this check to be completed should be locally agreed
 - Any changes to the prescribed medication are communicated to the unit in a timely manner.
- All supplies of medicines must meet the requirements for using PODs except where there are frequent dose changes and the medicine supply is not labelled with the current dose e.g. dose titration. In this instance the supply can be used provided that there is written evidence from the prescriber for the appropriate dose and the MAR chart contains the correct information (All other POD assessment criteria must be met). A copy of this evidence should be held alongside the MAR chart and an entry must be made in the patient's electronic record. **RNs cannot alter or amend dispensing labels.** This should be documented on the POD assessment record and a yellow sticker applied to the medication.
- At the end of the stay all remaining medicines must be returned home with the patient. The quantity returned should be documented on the POD assessment record which should then be filed in the patient's notes.
- If the medicines are unsuitable for use or there is an insufficient supply to last the planned stay, the patient **cannot** be admitted. Where this is not an option due to the patient's circumstances, seek advice from Trust pharmacy team or the on-call pharmacist.

3.4.2 Day care centres

- For patients attending day care centres, the RN should confirm with carers prior to attendance that they will provide the relevant medicines and that these should meet the requirements for using PODs.

3.4.3 Residential care units

- For patients in residential care local arrangements should be made to access medicines against the prescription provided by the GP or prescriber external to the Trust. This may include delivery by the carer/relative or an agreement with the local pharmacy which may include production of a printed MAR chart by the pharmacy. Where this occurs, seek advice from Trust Pharmacy.

3.5 Security of medicines

- All medicines must be stored securely and adhere to the parameters in the [Medicine Overarching Framework](#).
- When patients are transported to the service by either a Trust employee or an individual contracted by the Trust they should be informed of parameters required to adhere to the security of medicines as identified in the Medicines Overarching framework.

3.6 Reducing the risk

- Use of concurrent MAR charts increases the risk of administration errors. RNs should limit the number of MAR charts in use.

- If more than one MAR chart is in use, they should be held together and should indicate the existence of the other. Where possible, i.e. if some medicines are discontinued, multiple MAR charts should be condensed into one.
- The MAR chart should be rewritten in full if it becomes unclear or ambiguous.
- Where there is any doubt about the medicine to be administered the RN should withhold and contact the relevant prescriber for further clarification in writing. This must be documented in the patient's electronic records.



When a new MAR chart is required the RN(s) **must** comply fully with the standards and safeguards for checking medicines prescribed against sources of information; they **must not** copy across from one MAR chart to another

4. Errors

- A Datix form must be completed for any errors involving MAR charts. Staff involved must reflect on the error in clinical supervision.

5. Definitions and abbreviations

Term	Definition
MAR	<ul style="list-style-type: none"> • Medicine administration record
Medicines reconciliation	<ul style="list-style-type: none"> • Medicines reconciliation involves collecting and documenting relevant information about all current medicines prescribed for the patient from all/any services involved in their care
OTC	<ul style="list-style-type: none"> • Over-the-counter (OTC) refers to a medication that can be purchased without a prescription
Prescriber external to the Trust	<ul style="list-style-type: none"> • A prescriber not employed by the Trust but who is responsible for the provision of medicines, e.g. GP
POD	<ul style="list-style-type: none"> • Patients own drug(s)
RN	<ul style="list-style-type: none"> • Registered nurse

6. References

NMC Standards for Medicine Management
 Medicine Overarching Framework
 Patients Own Drugs (PODs) procedure for reuse
 Medicines Reconciliation Policy

7. Document control

Date of approval:	23 rd January 2020	
Next review date:	1 st August 2023	
This document replaces:	v2.1	
Lead:	Name	Title
	Amanda Metcalf	Lead Pharmacy Technician
Members of working party:	Name	Title
	Amanda Metcalf	Lead Pharmacy Technician
This document has been agreed and accepted by: (Director)	Name	Title
	Ruth Hill	Chief Operating Officer
This document was approved by:	Name of committee/group	Date
	Drugs and Therapeutics Committee	23 rd January 2020
This document was ratified by:	Name of committee/group	Date
	N/A	
An equality analysis was completed on this document on:	General Pharmacy EA statement applies	

Change record

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1.0	09 Jan 14		Archived
2.0	30 Sep 16	Reviewed	Archived
2.0	26.1.17	Approved	Archived
2.1	17.4.19	Paragraph added to reflect OTC medication	Archived
3.0	16.12.19	Reviewed. Added medicine reconciliation recording. Removed appendix 3	Approved
3.0	30 Jun 2020	Review date extended from 01 Feb 2023 to 01 Aug 2023.	Approved

8. Appendix 1 – Carer letter confirming prescribed medication (Adult respite)

Respite admission invitation & medication information

Dear Mr/Mrs X

We would like to offer respite to **Mr** at **Aysgarth** between the dates of **10th February 2013 and 15th February 2013**. The medication listed below is a record of the medication administered during the previous respite admission. Please check the list below, identify and add any changes and then sign if this is correct.

Please inform ward staff immediately if there have been any changes to prescribed medication or allergy status.

On this ward we operate a policy of using patient's medicines from home. Any medicines used will be for the patient's treatment only and at the end of the stay all remaining medicines will require collection. If the medicines are unsuitable for use or there is an insufficient supply to last the planned stay or the registered nurse is unable to confirm changes to current medication with appropriate sources, the patient cannot be admitted.

Please bring the patient's medication, in the original packaging along with this form, to the unit by **7th February 2013** and hand to the nurse in charge.

Drug name, strength & form	Tick if correct	Please complete if there are any changes to any medications or allergy status
Over the counter medication	Please confirm name, dosage and frequency of the medication	
Please confirm allergy & sensitivities		

Patient representative signature:

Date

9. Appendix 2 – Carer letter confirming prescribed medication (Children’s respite)

Baysdale, Roseberry Park Hospital
Marton Road, Middlesbrough
Cleveland TS4 3AF
Telephone: (01642) 837308
Fax: (01642) 838377

Dear _____ Date: _____

RESPITE ADMISSION INVITATION & MEDICAL INFORMATION

We would like to offer respite to on to.....

Admission 3pm, Discharge Before 11am; (School/Term time Before 9.30am)
(This is subject to the correct, current medication being in place).

On rare occasions we may need to cancel or rearrange the above admission. This may be because another child requires an emergency admission or we are unable to staff the unit safely. Any cancellation is not made unless absolutely necessary. If possible we will offer a substitute date/s.

On this unit, we operate a policy of using your child’s medicines from home. Any medicines used will be for the patient’s treatment only and at the end of the stay all remaining medicines will require collection.

The medication list attached is a record of the medication written on our drug chart from your child’s previous admission. Please check the list, identify any changes and then sign if this is correct.

If not, please tell our staff as soon as possible.

During your child’s stay, it may be necessary to apply **Sudocrem** and/or **Suncream**. To do this we need your consent. The suncream we use is **Nivea Sun Moisturising Cream SPF+50 very high**, and if you wish us to use these products, please give your consent below. If you want us to use a different brand of suncream then please send it in [note we can only accept a brand new, unopened tub/container/tube and it will need to be replaced every six months].

I give consent for: (please delete anything you do not give consent for):

- 1. Sudocrem (for nappy rash and dry skin) and Nivea cream (sunscreen) to be used as necessary.**
- 2. Student nurses to be involved during my child’s stay.**
- 3. Picture display photos of my child to be taken for use within Baysdale.**
- 4. A visual monitor to be in my child’s bedroom for safety purposes.**
- 5. Information to be shared with other professionals involved with my child’s care on a need-to-know basis.**
- 6. Participation in activities, including trips.**

PATIENT REPRESENTATIVE SIGNATURE:

DATE:

NAME IN FULL:

TELEPHONE:

Yours sincerely
THE BAYSDALE UNIT

10. Appendix 3: Assessment of competency for writing and checking MAR charts

Assessment no. 1

Write and check five MAR charts

Pass

Fail



Assessment no. 2

Write and check relevant number** of MAR charts

Pass

Fail



Assessment no. 3

Write and check relevant number** of MAR charts

Pass

Fail



Unable to write or check MAR charts



Actions –

Personal reflection,

Shadow accredited MAR writer and checker for three months, Supervision.

After all of the above has been actioned, a further assessment of writing and checking five MAR charts will occur.

** This is dependent on how many written or checked MAR charts are passed in each previous assessment. E.g. if 3/5 written MAR charts are passed then on the next assessment two would need to be written. Same principle for checking MAR charts in each assessment.

Re-assessment is required every 3 years to ensure evidence of continued competency. Writing three and checking three MAR charts will be assessed using the same process as above

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