Professional Advice:

Medicine administration records (MAR) in care homes and domiciliary care.

Purpose of this document

1. This document gives CSCI inspectors a guide to good practice in how the administration of medication by care workers should be recorded. The guidance applies to care homes and domiciliary care. It covers:
   • what the regulations and national minimum standards say
   • why a MAR chart is so important
   • who can write on MAR charts
   • the pros and cons of printed charts
   • what an inspector should look for.

This guidance will not apply when a person, who uses direct payments, takes responsibility for instructing their care worker in the administration of their own personal medication.

What do the regulations and national minimum standards say?

2. Regulation 17(1)(a) of the Care Home Regulations 2001 and Schedule 3(3)(i) require the registered person to keep ‘a record of all medicines kept in the care home for the service user; and the date on which they were administered to the service user’.
The national minimum standard for all care homes is that the records detail for each resident:
• what is received
• what is currently prescribed (including those self-administering medicines)
• what is given by care workers
• what is disposed of.

3. Regulation 19 (1), 19(2) of the Domiciliary Care Agencies Regulations 2002 and Schedule 4(4) require the registered person to keep ‘a detailed record of the personal care provided to the service user’. These records must be available for inspection and also kept at the person’s home, which therefore requires a dual recording system.

The national minimum standards for domiciliary care agencies requires recording the following activities:
• collection of prescriptions from the GP surgery
• collection of dispensed medicines from a chemist or dispensing GP
• observation of the person taking medication and any assistance given, including dosage and time of medication (10.7). This is a record of administration, no different from the records that a care home must keep.

Why is the MAR chart so important?

4. Care workers who give medicines must have a chart that details:
• which medicines are prescribed for the person
• when they must be given
• what the dose is
• any special information, such as giving the medicines with food.

This information is included in the NHS prescription that the pharmacist or dispensing GP keeps when the medicine is dispensed. The care provider must have a record of medicines currently prescribed for that person. These should be signed when they are given as individual doses or full packs if the person self-administers.
5. It is also important to keep a record when prescribed medicine has not been given. Differing letter ‘codes’ are used to record when medicines have not been given. The MAR must explain what the codes mean.

6. The information on the MAR will be supplemented by the person’s care plan. The care plan will include personal preferences, including ethnic issues such as should the care worker who gives the medicines be the same sex as the person.

7. The MAR can be a very useful tool for the care provider to use to keep track of medicines that are not ordered every month but only taken occasionally. The provider may use the MAR to record tablets carried over onto a new chart.

8. Responsibility for providing MAR charts rests with the care provider. The pharmacist or dispensing GP are not responsible.

Can the care provider ask the GP to sign the MAR charts?

9. A GP does not have to sign any documents produced by a care provider for medicine administration. The NHS contract for general medical services (GMS) does not require this. There are exceptions when a care provider has a private contract with a GP for medical services that exceed GMS.

10. There are some occasions when it would be appropriate to ask the GP to sign the MAR chart, for example when the doctor visits and changes the dose of a prescribed medicine.

Do care providers have to use printed MAR charts?

11. Poor records are a potential cause of preventable drug errors. Printed MAR charts are not essential but they are better than hand-written charts. This is because there is less risk of error due to:
- Clerical error: incorrectly transcribing the details from another document.
- Handwriting that is difficult to read and can be misunderstood.
The change of insulin dose for a resident was communicated verbally to staff and then hand written onto the MAR. The instruction was to give 4 units of insulin at night. The nurse who took the message wrote ‘4 i.u.’ on the chart (i.u. is an abbreviation for international units). But another nurse misread the dose and gave 41 units of insulin.

But 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.

12. Printed MAR charts are usually supplied from the pharmacy or dispensing GP practice when medicines are packaged in monitored dosage systems such as Manrex, Venalink and Nomad. This is a complimentary service that the supplier is paying for. Care providers cannot insist on having printed charts.

13. Printed charts ensure that both chart and labels attached to the medicines are produced from the same computer software and are therefore identical.

14. Care providers should not construct charts by sticking on duplicate medicine labels, as they are not classed as ‘printed’. This can lead to error if the label is stuck to the wrong person’s chart. (There are examples where this type of chart has been constructed by a pharmacist, despite professional advice against the practice issued by the Royal Pharmaceutical Society of Great Britain.)

Are there known problems associated with printed MAR charts?

15. Yes, there are problems that the care provider needs to be alert to:
   • The chart is correct at the time it is printed and supplied. But the dose of a medicine may change at some point. When this happens, the care provider must keep the chart up to date.
• New prescriptions can be issued at any time in the monthly cycle. This may result in the resident having several MAR charts in a file, and some may start on different dates.
• Medicines that are prescribed for ‘as required’ (PRN) use may not be needed every month. If the MAR only has a list of medicines that have been requested and prescribed that month, it may not list the PRN medicines previously supplied for that resident.
• The MAR may include a medicine that has not been supplied. The care provider must check whether the prescriber has stopped the medicine and if so cross it off the chart, date and sign. If the treatment is to continue, the care provider must check why there is no supply.

Can anyone write on the printed MAR?

16. Anyone can change the MAR chart. But the care provider should have a system to check the source and accuracy of the changes. A cross reference to the daily notes is recommended.

17. When a resident’s medication is altered, care staff are responsible for amending the MAR.
• cancel the original direction
• write the new directions legibly and in ink on a new line of the MAR
• write the name of the doctor or other prescriber who gave the new instructions
• date the entry and sign (including a witness when this is possible).

18. If the GP issues a new written prescription there should be a new MAR. But a new prescription is not always necessary.

Mr Brown has been taking 2 furosemide tablets (40mg) each morning. At the medication review the GP decides that this can be reduced to one tablet each morning. Mr Brown has a good supply of furosemide 40mg. If he lives in his own home with support from a domiciliary care agency, the doctor will not write a new prescription.
The doctor will record the change at the surgery so that when Mr Brown asks for a repeat prescription the new dose will be prescribed. The same applies if Mr Brown is a care home resident. If however the care provider insists on a new prescription for Mr Brown, the previous supply must be destroyed and this is a waste of NHS resources.

19. MAR charts used in care homes and domiciliary care look similar to ‘prescription’ charts used in hospitals but they are not equivalent to the prescription chart. The MAR is only a record of what care workers administer to people who use care services and belongs to the care provider. It is not a chart for prescribing medicines.

What are the unique problems for Domiciliary Care?

20. 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. Where the local authority commissions the domiciliary care, it is recommended that guidance is developed in conjunction with the NHS primary care trust’s pharmacy adviser.

21. 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).

22. 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.

23. 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.
Checkpoints for CSCI Inspectors

24. MAR charts form a 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 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.

25. MAR may include details of medicine receipt and disposal but if not, these records must be kept in another format.