Medicines Administration Record (MAR) Chart Audit

Instructions:

1. It is recommended that this audit is completed monthly.
2. Conduct audit in the last week of medication cycle to give at least 3 weeks of administration records.
3. Collect 5 MARs and complete audit.
4. If MARs collected do not cover all aspects (e.g.a ‘when required’ medicine) please select another MAR to audit this area.
5. If no MARs cover all aspects (e.g.no one taking warfarin) consider re-auditing when possible.
6. Complete the ‘Action required’ column including realistic target dates.
7. Re-audit as necessary.
8. Store the completed audits for a period of 2 years and ensure that they are available for review by relevant personnel e.g., pharmacy staff, CQC, local authority staff, etc.

Completed by: Name: …………………………………. Signature: ……………………………….. Job Title: ………………………….……..................…….. Date: ………………………

General	Findings	Action required
Have all the actions in the Action Plan from the last MAR audit been completed?		
Is there a recent photo of the resident present that is a true likeness?		
Does the MAR include the full name and date of birth of the resident?		
Has a black pen been used for completion of MARs?		
Is the start date correct on the MARs?		

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Are drug allergies/intolerances recorded or ‘no known drug allergy’ noted? If the type of reaction experienced is known this should also be recorded or stated as ‘type of reaction not known’		
Do these match the allergies recorded in the resident's notes?		
Is there an early morning section on the MAR to sign for medication which is administered before breakfast (e.g. alendronic acid, levothyroxine, lansoprazole)?		
Do the timings for administration state early morning, morning, lunch, teatime, and bedtime rather than specific times e.g., 9am (excluding time specific medication)?		
Is there a record of the medicines received and the quantity noted on the MAR and is this entry signed and dated?		
Has the quantity of any ‘when required’ items not ordered this cycle and carried forward been noted on MAR?		
Are other items such as creams, inhalers, nebules etc. carried forward to next month and not routinely disposed of?		
Does the number of tablets left match the balance expected from the MAR?		

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Are the MAR pages labelled correctly? Page 1 of 2, 2 of 2 etc?		

Medication details	Findings	Action required
Does the MAR match the record of current medication in the resident's notes?		
Do the medicine labels match the MAR directions?		
Are all medicines prescribed for the resident in stock?		
Is the MAR an accurate reflection of all medication that the patient is currently taking, including homeopathic, over the counter, medication supplied by hospital, medication administered by District Nurses?		
Does all medication detail the strength, form, dose, how often it is given and route of administration?		
Are there any medications listed that the patients are no longer using e.g. dressings no longer in use, ‘when required’ items no longer needed?		
Are there any items duplicated?		
Are all directions clear on the MAR (e.g. areas of application for creams, right or left eye specified for eye drops)? ‘As directed’ is not acceptable		

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Do all directions for 'when required' medicines include frequency of administration, maximum dose within 24-hour period and indication?		
Is there supplementary information in place e.g. 'when required' and 'variable dose' forms to guide the care home staff when to give 'when required' and 'variable dose' medication?		
Are supplementary forms in place to guide staff regarding the application of creams (e.g. body maps)?		
Have any entries been amended rather than crossed through and re-written? Any mid-cycle changes should be clear and accurate.		
If there are any hand-written additions to the MAR are these written clearly, signed, dated, and countersigned?		
Administration records	**Findings**	**Action required**
Is there a record of signatures and initials at the beginning of each medication file of staff (including agency staff) authorised to give medication?		
Are all signatures clear so that the staff member can be identified?		

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Has the MAR been signed immediately after administration by the staff member administering the medication?		
Are there any gaps on the MAR i.e. missing signatures or non-administration codes?		
Where supplementary charts for recording administration are in place e.g. thickener charts, topical charts, patch charts etc. are these completed?		
Where supplementary administration record charts are in place, is there information on the MAR to direct staff to sign for administration on the supplementary chart?		
Is it clear on the MAR that medication containing paracetamol is given with at least a four-hour gap? Times of administration can be recorded on the MAR or a supplementary form can be used.		
Where there is a variable dose e.g. take 1 or 2, is the amount administered recorded?		
Are eye drops given at different times of day or with at least a 5-minute gap between drops?		
Is the reason and outcome of administration of ‘when required’ medicines recorded? This may be in the care plan.		

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Is the reason for any non-administration recorded appropriately? i.e. correct code on MAR.		
Has the administration of all external preparations e.g., creams been signed for?		
Has the use of homely remedies been recorded appropriately?		
Anticoagulants (Warfarin and DOAC's)	**Findings**	**Action required**
Is there a written protocol in place specifically regarding warfarin and DOACs?		
Have staff received adequate training on administering anticoagulants?		
Are staff aware that both warfarin and DOACs increase the bleeding risk?		
Is the anticoagulant medicine administered at the same time each day? (And evenly spaced if prescribed twice a day)		
Are the MARs checked daily to ensure that residents prescribed anticoagulants have not missed their dose?		
If a dose has been missed, was a reason clearly stated on the MAR and advice sought from a GP or Pharmacist?		

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Does each resident who is prescribed an anticoagulant (warfarin or DOAC) have an alert card?		
Warfarin: Are dose changes always confirmed in writing by the prescriber?		
Warfarin: Can you clearly see what dose of warfarin was administered to the resident on each day?		
Is the yellow book and International Normalised Ratio (INR) results sheet stored with the MAR?		
Are all the details in the general information section of the yellow book completed?		
Do all the doses on the MAR match the doses specified in the yellow book for the audit period?		
Is the current dose marked clearly in milligrams on the MAR (i.e. not number of tablets)?		
Has it been necessary to break any warfarin tablets in half in order to administer the prescribed dose? Warfarin tablets should not be broken in half.		
Is the date of next INR blood test noted on the MAR and yellow book and/or in a diary?		
Is the warfarin supplied in boxes rather than in a multi-dose system?		

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