# Medicine Administration Record (MAR) chart - procedure for use

# Ref: PHARM-0054-v3.1

**Status: Ratified**
**Document type: Procedure**

## Contents

# 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.

### 3.2.2 Reaccreditation for RNs

- Reaccreditation is not required for RNs working on units that operate a MAR & POD system.
- If an error occurs, the error will be reported and reflection will occur. If there are a number of errors or a theme in errors, the RN will be given the opportunity to re-train with the lead pharmacy technician – medication safety.

### 3.2.3 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.

### 3.2.4 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.

### 3.2.5 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 recommencement 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. Audit

- Pharmacy staff will audit the standards for writing and checking MAR charts as well sampling medicines reconciliation entries on the electronic patient record.

# 5. Errors

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

## 6. Definitions and abbreviations

| Term | Definition |
|---|---|
| MAR | • Medicine administration record |
| Medicines reconciliation | • 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 | • Over-the-counter (OTC) refers to a medication that can be purchased without a prescription |
| Prescriber external to the Trust | • A prescriber not employed by the Trust but who is responsible for the provision of medicines, e.g. GP |
| POD | • Patients own drug(s) |
| RN | • 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

| | | |
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| | Amanda Metcalf | Lead Pharmacy Technician |
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**Change record**

| Version | Date | Amendment details | Status |
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| 2.1 | 17.4.19 | Paragraph added to reflect OTC medication | Archived |
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# 8. Appendix 1 – Carer letter confirming prescribed medication (Adult respite)

Tees, Esk and Wear Valleys NHS Foundation Trust

Dear Mr/Mrs X

We would like to offer respite to ***Mr ……..*** at ……. (Unit) between the dates of …… ***and ……..*** 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.**

Please bring medication, in the original packaging along with this form, to the unit and hand to the nurse in charge.

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 supply ……. days of medication. If the medicines are unsuitable for use or there is an insufficient supply to last the planned stay, ……. cannot be admitted.**

| Drug name, strength & form | Tick if correct | Please complete if there are any changes to any medications or allergy status |
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| Please confirm allergy & sensitivities | | |
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***Patient representative signature:*** ***Date***

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Date

Address

Dear …..

**RESPITE ADMISSION INVITATION & MEDICAL INFORMATION**

We would like to offer respite to:

**Name D.O.B**

On: ……

Your check in time slot is **……** hours this will take up to 30 minutes.

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 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.

**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 …….**
4. **A visual monitor or sound 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 supervised off the unit.**
7. **MSA Requirements**

**We recommend that you pack the following items for your child's stay:**

- **Medications**
- **Any medical equipment that the young person requires**
- **Any nutritional supplements and feeds.**
- **Change of clothing and underwear**
- **Incontinence pads if required**
- **Spare pyjamas**
- **Toiletries**
- **They can bring any of their preferred toys**

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 be sent home. The unit is also a nurse led unit, where the nursing team write medication on the medicine administration chart.

It is important that we have an accurate list of medication and allergy status for the patient, to enable our team to write the medication on the medication administration chart. The medication list attached is a record of the medication written on our medication administration chart from your child's previous admission. **Each medication and allergy status must be checked and signed for to ensure accuracy.**

The unit must be informed of any changes to medication/allergy status at the point of the change being made; this is to allow the team to gather information from the prescriber and yourself to enable this to be written on the medication chart. If the prescriber cannot be contacted for information to confirm the change the team are unable to write the medication on the chart.

Please bring the child's medication, in the original packaging along with this form, to the unit on your child's admission date, and ensure there is enough for the duration of their stay. You will be allocated a time slot to check in to the unit, to allow checks to happen on the medication. **If the medicines are unsuitable for use or there is an insufficient supply to last the planned stay, the child cannot be admitted.**

**The child's admission is subject to**

- **The unit being informed of changes to medication and allergy status 72 hours before admission**
- **The unit being able to obtain evidence from the prescribers to enable the medication to be written and checked on the medicines administration chart.**
- **The medication being assessed as suitable to use for the child.**

Kind regards
……. Unit

**Please check allergy status, each medication and sign if this is correct (highlighted in grey).**
**If incorrect, please make any changes as necessary.**

**NB. IT IS IMPORTANT THAT YOU INFORM YOUR GP OF ANY ALLERGIES AND SENSITIVITIES.**

| Allergies & sensitivities | Date of confirmation | Patient representative signature | Please list any new allergies |
|---|---|---|---|
| No Known Allergies | | | |

| DRUG NAME FORM & STRENGTH | DOSE | TIMES | PARENT/CARER SIGN IF CORRECT OR MARK IF WRONG | NURSE SIGN IF CORRECT OR MARK IF WRONG |
|---|---|---|---|---|
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| **As required medication:** | | | | |
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| **Over the Counter Medication:** | | | | |
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**PATIENT REPRESENTATIVE SIGNATURE:** **DATE:**

**NAME IN FULL:** **TELEPHONE:**

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

**Assessment no. 1**

**Write and check five MAR charts**

**Pass** **Fail**

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**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.