

Good Practice Guide for Handwriting Medication Administration Record (MAR) Charts in Care Homes and Domiciliary Care Settings

Each prescribed medicine a resident receives should be documented on a printed MAR chart. Only in exceptional circumstances, when a MAR chart has not been provided, should the guidance below be used in conjunction with the care providers own policies/procedures.

MAR charts should ONLY be handwritten by a designated, appropriately trained and competent member of staff. Handwriting needs to be legible, and independently checked by a second designated appropriately trained and competent person.

Entries should be clear, legible, in full without abbreviations or jargon and indelible ink used. It is important to ensure that the entry can be clearly read and understood. Therefore if necessary the MAR entry should be re-written rather than an amendment made to the existing one.

The entry should be written in the next blank section on the current MAR chart, if it is full then a new blank MAR chart should be used. If a resident has more than one MAR chart then they should be numbered sequentially e.g. 1 of 2, 2 of 2.

It is important to ensure all resident and prescriber required details are completed and are up to date.

What is required on a MAR Chart: patient name, date of birth, address, allergies, GP name, weight, date of weight, start date/period, stop date and day.

Make sure you have the:

- Right resident
- Right prescribed item
- Right MAR chart

Check before transcribing:

- The resident doesn't have any allergies and or sensitivities to the prescribed item
- Medication supplied is in date, and has clear instructions from a reliable source

Record the information as it appears on the dispensing label:

- Quantity supplied and date received
- Name of prescribed item
- Strength (e.g. 50mg/250micrograms/20units)
- Form (e.g. tablets/capsules/liquid/modified release/dispersible tablet)
- Dose (e.g. one tablet, one fingertip measurement, 10mLs)
- How often (e.g. once a day)
- What time of day (e.g. before breakfast/at night)
- Special precautions (e.g. after food/swallow whole)
- Start/Stop date if applicable (e.g. antibiotics)
- Route of administration where appropriate to the e.g. eye, topically (to the skin), under the tongue, via feeding tube

Remember:

- Cancel any discontinued medication with a clear line through the entry, initial and date (and document who discontinued it i.e. Dr's name)
- Initial and date each medication added to MAR
- Another designated, appropriately trained and competent member of staff must independently check then initial and date the completed MAR **chart before it is used.**
- It is important that registered nurses adhere to the guidelines set out by the Nursing Midwifery Council (NMC)