Medication Administration Record (MAR) Chart Audit

NHS
Northern, Eastern and Western Devon Clinical Commissioning Group
South Devon and Torbay Clinical Commissioning Group

Instructions:

1. Conduct audit in the last week of medication cycle to give at least 3 weeks of administration records.
2. Collect 5 MAR charts and complete audit.
3. If MAR charts collected do not cover all aspects (e.g. a "when required" medicine) please select another MAR chart to audit this area.
4. If there are no service users that cover all aspects (e.g. no one taking warfarin) consider re-auditing when possible.
5. Complete the "Action required" column including realistic target dates.
6. Re-audit as necessary.

General	Findings	Action required
Has a black pen been used for completion of MAR charts?		
Is the start date correct on the MAR charts?		
Are drug allergies recorded or "no known drug allergy" noted?		
Do these match the allergies recorded in the service user's notes?		
Is a record of the medicines received and the quantity noted on MAR chart and entry signed and dated?		
Has the quantity of any "as required" items that were not ordered this cycle been noted on MAR chart?		
Does the number of tablets left match the balance expected from the MAR chart?		

Medication details	Findings	Action required
Does the MAR chart match the record of current medication in the service user's notes?		
Do the medicine labels match the MAR chart instructions?		
Are all medicines prescribed for the service user in stock?		
Are there any medicines given to the service user that are not listed on the MAR chart?		
Are all directions clear i.e. not "as directed"?		
Do all directions for "as required" medicines include maximum dose and frequency of administration?		
Any mid-cycle changes should be clear and accurate. Have any entries been amended rather than crossed through and re-written?		
If there are any hand-written additions to the MAR chart are these written clearly, signed, dated and countersigned?		

Administration records	Findings	Action required
Are all signatures clear so that the staff member can be identified?		
Has the MAR chart been signed immediately after administration?		
Are there any gaps in the record i.e. no signature or non-administration code?		
Where there is a variable dose e.g. take 1 or 2 is the amount administered recorded?		
Is the reason and outcome of administration of "as required" medicines recorded? This may be in the care plan.		
Is the reason for any non-administration recorded appropriately? i.e. code on MAR chart and full explanation recorded as per local policy.		
Has the administration of all external preparations e.g. creams been signed for?		
Has the use of homely remedies been recorded appropriately?		

Warfarin (if applicable)	Findings	Action required
Is the INR result sheet and yellow book stored with the MAR chart?		
Are all the details in the general information section of the yellow book completed?		
Do all the doses on the MAR chart match the doses specified in the yellow book, or the INR results sheet, for the audit period?		
Is the current dose marked clearly in milligrams on the MAR chart (i.e. not number of tablets)?		
Warfarin tablets should not be broken in half. Has it been necessary to break any tablets in half in order to administer the prescribed dose?		
Is the date of next INR blood test noted on the MAR chart and/or in a diary?		

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