Introduction

If a care worker has been asked to assist or administer medication to a client they must have a document to record onto. This is commonly called a MAR chart (previously known as a Form B). This is a record of administration and NOT a drug chart. It can only be used if the medication has been prescribed and labelled by a pharmacy or dispensing doctor or non-medical prescriber.

The MAR chart must detail:

- The client’s Name, address and date of birth and any allergies (if known)
- Which medicines are prescribed for the person
- When they must be given (date & time)
- What the route, dose & form e.g. Flucloxacillin Capsules 500mg. One to be taken four times a day.

It is also important to record when prescribed medicines are not given. Different ‘codes’ are used to record when medicines have not been given. The MAR chart must explain what the codes mean.

A MAR chart for medications outside of the NOMAD / MDS system may be generated by the client’s regular pharmacy. In order to maximise the potential for obtaining a MAR chart from a pharmacy please register all your clients with their regular pharmacies using the Pharmacy Introduction Letter template.

If a pharmacy generated MAR chart is not available then a Risk Assessment must be completed before a temporary MAR chart is written. The temporary MAR chart is completed by transcribing the information from the pharmacy labelled medication box. This must be carried out by someone deemed competent to do so by the Care provider Registered Care Manager.

The temporary MAR chart can be used until a pharmacy generated MAR is available. If it is a short course of medication then this may not become available but this should be a prompt by the office to make sure the client’s regular pharmacy is made aware of the need for MAR charts. This can be done using the Pharmacy Introduction Letter template.

The temporary MAR can be handwritten. Please DO NOT request secondary labels from the client’s pharmacy. Only pharmacists will use a secondary label to create a MAR. Please DO NOT attempt to peel the label off the medication and use it to create a MAR.
When a person’s medication is altered, the carer must let the Care manager know and a request for a new MAR chart made. You MUST NOT alter the current MAR. The old MAR must be crossed through with a single line and taken back to the office for record keeping.

If a medicine is discontinued a diagonal line should be drawn through the dosage instructions on the left hand side of the chart and a line placed through the remaining spaces for signing on the chart. This should be dated and signed and returned to the office for record keeping.

When a new chart is written for a medicine that is not administered on a daily basis a cross should be marked in the signature column against each day the medicine WILL NOT be given for the whole of the period of the chart, to avoid it accidentally being administered on a day when it is not needed.

**Dos and Don’ts of MAR Charts**

**Do**
- Complete all of the personal details at the top of the chart for each chart in use
- Copy the information exactly as it appears on the pharmacy label including the name, form, route and strength of the medicine, full directions for use
- Sign the chart for all the medicines you administer immediately after administration
- Record when you have not given a medicine using the codes on the chart to explain why you have not given it
- Make a permanent record on the MAR chart using ink

**Do not**
- ✗ Sign for medicines given by other people
- ✗ Change an existing entry on a MAR chart when a person’s medication is altered
- ✗ Use correction fluid on MAR charts
- ✗ Use a pencil to sign the MAR charts

**References:**
The Handling of Medicines in Social Care RPSGB 2007
Professional Advice: Medicine administration records (MAR) in care homes and domiciliary care (CQC)