Medication Administration Record (MAR) Sheet Training

This document explains the Medication Administration Record (MAR) sheet, which we use to record all medication that is administered to our clients. This document is extremely important, as if a client is taken ill, or has to go to hospital, the doctors need to know exactly what medication that client has had and if the client has any allergies. Each MAR sheet runs for one week and it must be filled out in capital letters. The MAR sheet should be completed on a Tuesday evening ready to start the following morning.

Page one of the MAR sheet

1. **Client details, date and sheet number.** The first thing that needs to be filled in is the client’s name, her reference number and date of birth. This information can be found on the heading of all the Christies Care documents for the client. Then the week commencing needs to be completed. Our working week runs from Wednesday to Wednesday so the date that will go in here will always be a Wednesday’s date. Then we have sheet 1 of 1 (the MAR sheet has space for 14 medications). If client has more than 14 medications, then the sheets will be marked 1 of 2 and 2 of 2.
2. **Details of outgoing carer.** Next, you write down the details of the outgoing carer (the carer who is leaving that client). These are written on the top line. On Wednesday the incoming carer will arrive, she will check the information and if this is correct, she will complete the details for the incoming carer. If there is no changeover on the Wednesday leave the incoming carer section blank and tick the box to say there is no changeover.

3. **Details of those who are administering medication.** If the carer who fills out the form on a Tuesday evening is there, she needs to complete the first line – even if she is leaving (we need to have the outgoing carer’s initials on record). Anybody else who administers medication (the incoming carer, a ‘pop-in’ hourly carer, district nurse, doctor, even family members) enters their details in this section.
4. **Allergies.** It is very important to record if the client has an allergy, and if so, what the client is allergic to.

![Image of MAR sheet with Allergies section]

**Questions:**
Why is it so important that a carer fills out the MAR sheet correctly?
Who fills in the first page on a Tuesday?
Who checks the MAR sheet on a Wednesday?

**Part two (still filled out by the carer on Tuesday):**
**What medication is given, how, when, and other information.** You should be able to find all of this information on the medication packaging and/ or prescription.

First record the week commencing – this is the Wednesday’s date.

1. **Recording the name of the medication to be given.** In the box that states ‘medicine 1’, write down the name of the medication, as it appears on the packet. If you look at the example below, you can see that this client has Paracetamol 500mg. Ensure that you write all of the information, because it is important to be as clear as possible.

2. **The dose.** Write down the number of tablets x the dose. In this case, you would write 1 x 500mg. This means that anyone looking at the MAR sheet knows the precise dose that has been prescribed.

3. **Frequency.** In this box, write the number of times the medication is taken in a 24 hour period. It may be 1 x day, 2 x day or more. In this case it is 4 times a day. Sometimes you will write PRN. This is when medication is to be taken as and when required (PRN is short for pro re nata – meaning as and when required). Headache pills (e.g. aspirin, paracetamol) are an example of this, you don’t take it every day just in case you might get a headache, you only take one when you have a headache.

4. **Route.** In this box write the route of the medication. It could be:
   a. **Oral.** When someone takes medication through their mouth (most medication).
   b. **Topical.** When the medication is applied directly to the skin (for example eczema cream)
   c. **Inhalation.** When the client inhales medication (for example, an asthma inhaler)
d. **Instillation.** When the medicine is dropped directly onto the client's body (for example, eye drops)
e. **Infusion.** When medication is delivered through a drip or pump.

5. ‘**Other directions.**’ This is anything else that could be useful, that hasn’t been recorded already. For example it could be store in a cool dark place, take with water or if it is PRN medication (see above for a definition of PRN) it should be documented the maximum amount of tablets to be taken in 24 hours and the period that need to be between medication doses.

6. **Start date.** The start date is the date you open the box or bottle of medication and start to use it. If more than one bottle/box of medication is collected from the pharmacy then the start date is the date you open the first bottle/box of medication and will remain the same until you finish the last bottle/box.

7. **End date.** The ‘end date’ is the date the client finishes taking the medication. Because you don’t know this in advance, this is left blank until all of the medication has been taken

8. **Controlled drugs.**
   a. **What are they?** Controlled drugs are drugs are controlled under the Misuse of Drugs legislation. The chemist will tell you if a drug is controlled or not. One example is Morphine. In the right amount, it is one of the best painkillers but too much is addictive and can kill you.
   b. **What do you have to do, as a carer?** It is a legal requirement that controlled drugs are stock controlled. This means that the carer must keep a count of how many tablets are left after the medication has been administered (we also stock control pain relief medication although this is not a legal requirement).

9. **Prescribed medication.** Circle yes or no. Prescribed medications are medications that come on a prescription from the doctor.

10. **The time the medication is given.**
   a. Sometimes medication should be given at a specific time. If so, please record it (use the 24 hour clock). You can see in the example below, that the medication is administered at 0800, 1200 and 1600. There is a tick by each of these – the tick alongside is a ‘double check’ that this is the correct time for the medication to be administered.
b. Sometimes, medication can be administered at a less specific time, such as breakfast, lunch, supper. In the case of the example below, the medication is also required to be administered at bedtime and there is a tick in the box showing this.

![Image of medication schedule]

Questions
What should you write in the Dose box?
What is a controlled drug?
What medication should you always keep stock control of?
What is PRN?

**Filling out the actual medication given.**

1. *When you see the medication being taken.* Write your initials in the TOP half of the appropriate box for the medication, just after you give it. If you look at the example, you can see that LB administered the medication for the client at 0800, in the bottom half of the box we have stock control this is because Paracetamol is pain relief medication. At 1200 MC (Mel Cross) has arrived and had changeover and administered the 1200 dose and did the same at 1600.

2. *If you haven’t seen the medication being taken.* Sometimes you won’t see the client take their medication. They could have refused to take it, or you could just have put it out and they took it themselves. In these cases, please write the appropriate code in the BOTTOM half of the box (if the initials are always in the top half of the box, and codes are always in the bottom half, there is less likely to be a muddle). In the example below, you will see that at bedtime, the carer has written NW (not witnessed) in the bottom half of the box, because in this case, the carer gets the medication ready and the client takes it herself. Codes include:
a. NW – Not Witnessed. If you look at the example, there are no initials in the top half of the box and in the bottom half of the box there is a code NW.
b. DC – Day Centre. If the client is at a day centre, and they help the client take her medication, you still haven’t witnessed it being taken but you believe it has been taken. Therefore you write DC.
c. R – Refused. Sometimes a client will refuse to take some medicine. Always ask why. You can’t force it (although sometimes you can wait a few minutes and try again) so write down R.
d. S – Sleeping. If the client is asleep and doesn’t want to be wakened to have her medicine, or doesn’t need to be wakened, then mark S.

3. **Stock control.** As noted above, carers should keep note of the remaining stock of all controlled drugs and pain relief medication. This can be put in the top or bottom half of the box, wherever space is available (see the illustration below, where it is in the bottom half of the box in the morning, and in the top half at bedtime).

![Image](https://example.com/image)

4. **A change in medication.** If the client’s medication changes (even if it is just that the dose, or the time of day it is taken changes), you must act as though that particular medication had finished, and start a new one, with the changed details. So, you write the end date when you give the last dose of the medication before the change. You then fill out all of the details of the new medication in the next available box. In the example below, you can see that the client had been taking 1x 10mg Amitryptiline. The dose was increased from one tablet to two tablets on Friday, after lunch. This meant that the client effectively has finished her old medication and started a new one. So, the carer wrote down that that particular medication had finished on 3/01/14. Then the carer filled out the new medication, in the next available box.
Questions
Do you put your initials in the top or the bottom half of the box, when you see medication being taken?
If the medication changes to be given to the client changes, how should you record this change?
If you don’t actually see the medication being taken by the client, do you initial the box to record that it has been taken?