Community Drug Charts and Medication Administration Record (MAR) Charts

LMC position statement

All those working in the NHS want our patients to have care which is of high quality and safe and delivered in the most efficient and effective way.

The completion of MARS charts is not a contractual requirement and it is unnecessary except for one or two specific situations, for example in end of life care.

When a prescriber issues a prescription, this is the authorisation to administer a drug at a certain dose, frequency and by a certain route. The prescription is then dispensed by a pharmacist. The pharmacist must dispense with the instructions written by the prescriber on the item. Community nurses who are delivering care in a patient's home can administer medicines using a range of patient specific directions. The dispensing label on a prescribed medicine which states dose and frequency of administration acts as a patient specific direction.

MARs charts are, as they are named, medicine administration records. There is a current belief that this is an authorisation for the medication to be administered, but it is in fact a record that a medication has been given. This may form part of a good governance process within an organisation. Therefore, if needed, MARs charts should be produced by the organisation who is required to administer the medications and do not require any prescriber involvement. Some community pharmacies may be able to provide the production of such printed charts as a service.

If medication is required to be administered by the community nurses, it is the responsibility of the person or organisation who is managing that aspect of care to ensure that the instructions are given in a clear and appropriate way. This may not be the GP. For example – a medication may have been issued when an individual was an inpatient. The GP will not have been involved in delivering this aspect of care and have had no input to the decision around the treatment, the dose of a medication or when to start or stop the treatment. In some areas the current practice is to ask the GP to complete a form to 'authorise' the administration of this treatment. This is neither safe, nor appropriate and would violate most clinical governance procedures.

Multiple transcriptions of instructions will inevitably lead to errors and remain an important patient safety issue.

From everyone's perspective it is therefore essential that when a prescription is produced, the instructions for administration are clear and unambiguous. This is essential good practice.

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The information on the prescription will be printed on the label attached to the medication when dispensed. To use terms such as 'as directed' would not be sufficient and would likely require someone who wanted to administer it to seek clarification from the prescriber. This would be time consuming and is not desirable or safe.

Good communication between the prescriber and the community nurse is essential and a point of patient safety in terms of starting, altering, stopping and monitoring any medication. All prescribers wherever they are based should be contactable and accountable for their prescribing instructions.

When drugs are prescribed for palliative care, whether used in a syringe driver or on a PRN (as needed) basis, it is important that these are detailed on a chart with clear instructions from the GP or whoever may be responsible for the overall care. This has been a significant area in terms of potential errors when writing the doses of these drugs. A major safety development has been the production of prepopulated charts with the normal end of life drugs and their normal starting doses. As an LMC we support the continued use of these. An electronic version of the MARS chart now needs to be developed to ensure that EOL requirements can be detailed and also for the prescribing of Insulin and we have asked that this be developed urgently.