Audit of Individual Service User Medication Records

Standard	Yes	No	N/A	Comments/Actions
Is there a self medication risk assessment in place?				
Has this been completed appropriately?				
Has the self medication risk assessment been reviewed in accordance with the identified timescales?				
Is there an over the counter/homely remedies consent letter signed by the person's GP?				
Is there an over the counter/homely remedies administration record in place?				
Is there a prompt/supervision by staff record in place?				
Do the actual amounts of medication match the theoretical amounts according to the MAR charts?				
MAR charts –				
Is there a photograph of the person?				
Is the person's name clearly identified?				
Is the print or handwriting legible and in ink?				
Are handwritten entries cross referenced to daily notes?				
Does the MAR chart show the date, including the year?				
Does the chart look 'used' indicating it is completed at each medication administration?				
Are there any gaps in the records?				
Can it easily be identified exactly what medication has been given on specific dates, for example when the dose is 1 or 2 tablets?				
Is there a guide to the codes being used to explain why prescribed medication has not been given?				
If codes have been used for non-administration of prescribed medication are these used appropriately?				
Can it be confirmed that the records are valid i.e. by checking that the number of signatures recorded for the administration of a short course of medication is consistent with the quantity supplied?				

Name of Service User ________________________ Date Audit Carried Out___________

Audit Carried Out by ________________________