Guidance for Care Inspectorate staff: tissue viability medication administration recording (MAR)

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About this guidance

This guidance applies to care settings where prescribed skin care creams and applications and dressings and wound care products may be used for residents.

The guidance highlights what good practice is for staff working in these care settings so they can demonstrate a clear record of how they have administered these treatments.

There are also tips on good practice about applying creams and dressings.

Recording application of prescribed topical skin products and dressings

1. **Skin care: topical applications - creams, ointments, emollients, barrier creams or sprays**

Prescribed topical skin applications are listed on the medication administration recording (MAR) chart.
These prescribed items should also be included in a skin care plan for the residents.
The information should include:

- what cream, ointment, emollient, barrier cream or spray (name and strength)
- which part of the body (body map would be useful)
- how much (fingertip measurements are recommended for steroid application)
- by which method – how the product is being applied
- how often (emollients are usually recommended to be applied twice daily).

The staff member who administers the prescribed or other topical applications should record this as evidence they have been administered. Examples of this are to record directly either on:

- the MAR chart
- specific skin care chart, for example topical MAR (TMAR) chart
- repositioning / skin care chart
- personal hygiene chart.

The method of recording these products should be outlined in the skin care policy and all staff should use the same method to record applications.

If the MAR chart is not used to record applications, then the MAR chart should cross-reference where the applications are to be recorded.

Staff should evaluate this planned care within specified appropriate timescales and amend or discontinue where appropriate.

Hints and tips on good practice

Staff applying these skin care products should wear gloves.
When applying emollients, especially greasy types such as liquid or soft paraffin (50/50), a layer of tubular gauze (if tolerated) can be useful as it will help the product to be absorbed and protect clothing and bedding.

For short-term use applications (for example steroid creams), the care plan should also identify the timescale these prescribed products should be used within. The GP or Dermatologist may prescribe a reducing regime where high doses of steroid creams are being used. These instructions should be recorded in the care plan.

Unprescribed, over the counter (OTC) skin care products may also be used according to the resident's preference, for example moisturisers. These products should also form part of the care plan with explicit instructions on application, frequency where it should be recorded when they are administered. Where residents are using their own OTC products, individual choice and preference is important, but perfumed products should be avoided.

Where possible, topical applications should be kept in the resident's room or ensuite bathroom for easy access unless they need to kept elsewhere; for example Daktacort or Timidine is kept in the fridge and steroids should be kept in the drug trolley or treatment room.

The date when the product was opened should be marked on the box or container.

Prescribed topical applications should only be used for the resident they are prescribed for – they should not be shared with other residents.

Prescribed topical applications should be returned to the pharmacy when they are no longer being used or discontinued.

Skin assessment on admission is good practice and we would recommend a body map type of assessment.

A care plan example:

Mary has dry skin on her legs and feet.
Aim - to rehydrate these areas, keep her skin in good condition and maintain skin integrity.
Plan of care:

- Check the skin on Mary's legs and feet twice daily before treatment and report any changes or deterioration (for example breaks and redness) to the person in charge. Record this in the daily progress notes and care plan.
- Apply prescribed 50% liquid paraffin/50% white soft paraffin (50/50) to Mary's legs and feet morning and evening before going to bed.
- Ensure that the 50/50 is applied wearing gloves and lightly massaging into the skin, covering all dry skin to her legs and feet.
- Record that 50/50 has been applied on Mary's personal care sheet.

- Review treatment on a monthly basis or sooner if there is any deterioration in skin condition of Mary's legs and feet.

You can get more information and further reading from:

- NHS Fife. Healthy Skin in Older People – the basics of skin care
- Best practice statement: Care of the older person's skin (2006) (Wounds UK).
- NHS Education Scotland Dermatology Pocket guide (2012)

www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/workforce-development/out-of-hours-unscheduled-care/news.aspx

2. Wound management products

Prescribed dressings and other items, for example dressing packs, cleansing fluids and so on required for dressing changes should be listed on the MAR charts.
It is not necessary to sign the MAR chart for the use of dressing sundries such as dry dressings, dressing packs, syringes for irrigation and so on.

To show that individual prescribed cleansing fluids and dressings with active ingredients have been administered, the following can be signed:

- MAR chart
- wound assessment documentation
- wound treatment plan and evaluation of care form (www.tvonline.com)

How these products will be recorded should be outlined in the wound management policy and all staff should use the same method to record applications.

If the MAR chart is not used to record dressing application, then the MAR chart should cross-reference where the dressing changes / applications are to be recorded.

Hints and tips on good practice

Cleansing fluids such as normal saline 0.9% and dressings such as adhesive foams dressings or preparations with active ingredients such as hydrogels which are in current use will form part of the wound management care plan and having a clear administration record in place is good practice.

Staff should use a clean, no-touch dressing technique, wear personal protective equipment (PPE) and carry out hand hygiene, before and after the dressing is changed.

Irrigation with warmed tap water or normal saline is best practice but if the area is clean and granulating, this will not be necessary.

Wounds can also be cleansed in the shower, and then a new dressing applied.

A dressing pack can be used to provide a clean area during the dressing procedure but may not always be necessary.

Dressing changes should be recorded in the care plan. Staff should evaluate this planned care within specified appropriate timescales and amend or discontinue where appropriate.

Dressings or treatments should not be altered without a full assessment being carried out and the reason for changing the choice of dressing should be recorded on the care plan.

The cleansing agents and dressing products should be kept in the resident's room or ensuite bathroom for easy access and dressings should be applied in the resident's room or in a designated treatment room.

Prescribed cleansing agents and dressings should only be used for the resident they are prescribed for. They should not be used for other residents.

Prescribed cleansing agents and dressings should be returned to the pharmacy when they are no longer being used or discontinued.

A care plan example:

Location of wound – David has a stage / grade 3 pressure ulcer to the sacral area. An initial wound assessment to be carried out to inform choice of dressings and treatment.
Care plan aim – the wound bed presents as sloughy which requires desloughing before healing can progress.
Plan of care:

- Observe the pressure ulcer and surrounding skin for any changes or deterioration and carry out wound assessment and re-evaluation if required. (good practice states weekly evaluation or more frequently if required)
- Irrigate area with warmed tap water.
- Apply Hydrogel (name of prescribed product) to the area to donate fluid to the area, helping removal of sloughy tissue.
- Protect the peri-wound (the surrounding skin) with barrier film or cream (name of prescribed product) at each dressing change.
- Apply foam sacral adhesive dressing (name of prescribed product) to cover and protect the area.
- Change the dressing daily or when needed if there is strikethrough of exudate (the wound fluid is oozing out of the dressing).
- Carry out a full wound assessment weekly or if the pressure ulcer changes or deteriorates.

You can get more information and further reading from:

- Healthcare Improvement Scotland (HIS) Best practice statement: the prevention and treatment of pressure ulcers. (2009)
- Scottish wound assessment and action guide (SWAGG) www.tvonline.com

- NHS Education Scotland (NES) educational workbook: The prevention and management of pressure ulcers.