

Shift Medication Pass Audit Form

Residential Care

Auditor Name

Date

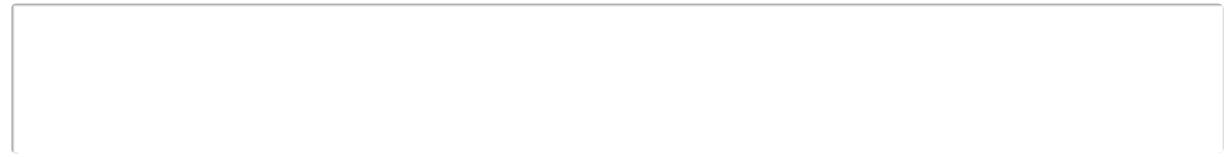
Shift

Select Shift

Staff Observed

Audit Item	Yes	No	Comments
Was hand hygiene performed?	<input type="checkbox"/>	<input type="checkbox"/>	
Medication checked against MAR?	<input type="checkbox"/>	<input type="checkbox"/>	
Right resident confirmed?	<input type="checkbox"/>	<input type="checkbox"/>	
Right medication administered at correct time?	<input type="checkbox"/>	<input type="checkbox"/>	
Right dose administered?	<input type="checkbox"/>	<input type="checkbox"/>	
Documentation completed immediately?	<input type="checkbox"/>	<input type="checkbox"/>	
MAR correctly initialled and signed?	<input type="checkbox"/>	<input type="checkbox"/>	
Medication stored securely after administration?	<input type="checkbox"/>	<input type="checkbox"/>	
Unused medication disposed of according to procedure?	<input type="checkbox"/>	<input type="checkbox"/>	

General Comments / Recommendations



Auditor Signature



Date Signed

