

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"/>	<input type="text"/>
Medication checked against MAR?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Right resident confirmed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Right medication administered at correct time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Right dose administered?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Documentation completed immediately?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
MAR correctly initialled and signed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Medication stored securely after administration?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Unused medication disposed of according to procedure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

General Comments / Recommendations

Auditor Signature

Date Signed