The Newcastle Upon Tyne Hospitals
NHS Trust

Procedures for the Prescribing
Recording and Administration of
Medicines

SIXTH EDITION
January 2006
The Prescribing, Recording and Administration of Medicines

A policy document and instruction manual for medical, nursing and pharmacy staff. Approved for use within Newcastle upon Tyne Hospitals NHS Trust.

Trust Drug & Therapeutics Panel

First published 1977
New Edition 1978
Second Edition 1985
Third Edition 1989
Fourth Edition 1995
Fifth Edition 2001
Sixth Edition 2006
**Contents**

1. Notes on Prescribing ................................................................. 1
2. Notes on the In-patient Medicines Chart ................................. 5
3. The Administration of Medicines ............................................. 17
4. Prescribing for Out-Patients, Discharge and Regular Day Attenders ....................................................... 21
5. Controlled Drugs ................................................................. 26
7. Medicine Procedure Documents ........................................ 29
8. Bibliography ................................................................. 30
1. Notes on Prescribing

British National Formulary and The Newcastle Formulary

Every prescriber or ward/clinical department can access the latest editions of the BNF and Newcastle Formulary via the front page of the Trust intranet. In addition some staff will have personal copies. Where medicines are supplied under patient group directions a copy of the protocols in use must be available.

General guidance on prescribing is given in the first section of the BNF and the attention of all staff is drawn to this section. In addition, emphasis is placed on the following points:

Prescriptions must be written legibly in black pen so as to be indelible. A poorly written prescription can be hazardous for the patient. It is particularly important when prescribing on multi part discharge and out patient prescription forms to ensure that all copies are clearly legible. The patient’s medical record should always be checked before a new prescription is written.

Approved names (rINN) must be used to ensure consistency in the names used on prescriptions and drug labels. Proprietary names should be used only in the case of compound preparations when a generic compound name does not exist or where there are important differences in bioavailability between brands e.g. lithium, modified release theophylline and sustained release opiates.

Start dates for inpatient prescriptions should be the date the medicine is commenced, if started whilst the patient is in hospital. For previously prescribed medicines use date of admission.

Stop dates or review dates for short course treatments. e.g. antibiotics, MUST be recorded by the doctor ON THE Medicines Chart at the time of prescribing.

Dose Quantities

Prescriptions must be written in metric units according to the following BNF guidelines:

- For solids, quantities of 1 gram or more are expressed as 1g etc.
- Quantities of solid less than 1 gram are expressed as milligrams e.g. 500 mg NOT 0.5g.
- Similarly, quantities less than 1 milligram are expressed in micrograms e.g. 100 microgram NOT 0.1 mg.
- The term microgram, nanogram and unit should not be abbreviated. The terms mcg, µg, u etc, MUST NOT be used.
- A zero must be written in front of decimal points where there is no other figure e.g. 0.5 ml NOT .5 ml. The term millilitre is used in medicine and pharmacy and cubic centimetre, cc, or cm³ must not be used.

For liquid oral preparations, where the dose is other than 5 or 10 ml, oral syringes are available, so that the dose can be measured accurately.

For combination products the name of the product should be stated IN FULL together with the number of units to be administered e.g. Peptac Liquid 10ml, Co-codamol 8/500 2 tablets.
Calculations

The prescriber must pay careful attention checking the accuracy of ALL dose calculations, particularly where potentially hazardous medicines such as opiates, cytotoxics and IV potassium salts are involved.

The prescriber must double check the accuracy of complex dose calculations, particularly for opiates.

Time

The 24-hour clock must be used when stating times of administration.

Routes of Administration

The route of administration must be indicated in the appropriate column.

The following abbreviations are acceptable:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV</td>
<td>Intravenous</td>
</tr>
<tr>
<td>IM</td>
<td>Intramuscular</td>
</tr>
<tr>
<td>SC</td>
<td>Subcutaneous</td>
</tr>
<tr>
<td>NEB</td>
<td>Nebuliser</td>
</tr>
<tr>
<td>S/L</td>
<td>Sublingual</td>
</tr>
<tr>
<td>PR</td>
<td>Rectal</td>
</tr>
<tr>
<td>INH</td>
<td>Inhalation</td>
</tr>
<tr>
<td>PO</td>
<td>Oral</td>
</tr>
<tr>
<td>PV</td>
<td>Vaginal</td>
</tr>
</tbody>
</table>

All other routes must be written in full e.g. Intradermal, Intrathecal. If a drug is prescribed for intravenous administration directly into a vein the route of administration should be written 'IV'.

If a drug fluid is to be given intravenously by dilution in an infusion fluid, it must be prescribed in full on the intravenous infusion chart. The type of chart and the name of the added drug(s) must be entered in the “Other Charts in Use” section.

Signature

A full signature and printed name of a registered or provisionally registered Medical or Dental practitioner is essential for each prescription. The signature of a student acting as a Locum House Officer is not valid.

For non-medical prescribers a full signature and printed name for each prescription is also required. In addition the prescriber’s identification number (PIN) must be recorded in the box provided (discharge prescriptions) or in the ‘Prescriber’s Signature’ box (in-patient prescriptions) together with an indication of whether they are acting as a supplementary or independent prescriber (discharge prescriptions).

A specimen signature must have been supplied to the Pharmacy in order to maintain a register of authentic prescribers' signatures.

Each drug prescribed on inpatient prescription charts must be signed for individually. Bracketed signatures for several drugs are unacceptable except for adjacent prescriptions written at the same time on day-patient charts, such as those used for renal dialysis patients.
Discontinuing or Cancelling Drugs

Medicine Charts should be regularly and frequently reviewed by medical staff with particular reference to the cancellation of treatment no longer required.

To discontinue a “Regular” or “As Required” prescription, draw a diagonal line through the left hand side prescribing section containing the drug name, dose and route of administration, and a vertical line through the administration section. Indicate the date in the “Date Stopped” box and initial (see illustration below). Prescriptions must not be cancelled in such a way as to make them unreadable.

Pharmacy

Medicines Charts will be regularly and frequently reviewed by pharmacy staff with particular reference to compliance with the requirements of this policy document. They will endorse a prescription written using a proprietary name with the appropriate approved name. The “Notes” section of the prescription may be used for endorsement of the strength of a preparation, confirmation of units, for special directions and various miscellaneous purposes by either prescribers or pharmacy staff.

Telephone Messages

Under exceptional circumstances telephone messages may be accepted from a prescriber by two nurses (one of whom must be a Registered Nurse and one of whom acts as witness to receipt of the message) for a drug to be administered once only. This must be recorded in the “Once Only Section”. Controlled Drugs must not be prescribed in this way. It is the responsibility of the prescriber to sign the prescription within 12 hours of giving the message.
**Insulin**

Subcutaneous insulin and/or intravenous insulin infusions may be prescribed by telephone only in exceptional circumstances and where there are clear advantages for an individual patient’s care.

Any telephone instruction regarding insulin must be written on the insulin or fluid chart by the Registered Nurse looking after the patient. A second nurse must confirm the instructions by reading them back to the prescriber – dosage must be read back in single figures (e.g. 18 units read as ONE, EIGHT units). The names of the doctor and the two nurses must be recorded in the nursing notes.

It is the responsibility of the doctor to sign the prescription within 12 hours of giving the message.

**Faxed Prescriptions**

Where a local agreement has been reached to fax prescriptions, the original must be either collected or delivered to the Pharmacy (according to local arrangements) within 72 hours, in order to comply with legal requirements.

**Oral Methotrexate**

Care must be taken when prescribing oral, once weekly, methotrexate. In order to reduce the risk errors and confusion resulting from the availability of different strengths of tablets, it is policy only to use the 2.5mg strength of methotrexate tablets in Newcastle’s hospitals.

- With in-patients, it is the prescriber’s responsibility to record the correct dosage and frequency on the hospital In-patient Medicines Chart, and to strike out the six days of the week when a dose must not be administered in the administration section of the chart.

- Handwritten prescriptions and discharge summary information must be complete and legible and include in full the form, strength, dose and directions.

Out-patients and those discharged from hospital on methotrexate should be given a methotrexate information leaflet and a hand held dosage summary card.
2 Notes on the In-Patient Medicine Chart

The chart is a combined prescription and medication administration record document. These notes are intended to be used in conjunction with the general notes in Section 1.

All prescriptions must be written and medicines administered and recorded according to the principles outlined in this document. Prescriptions must also be reviewed and rewritten by the prescriber when the period of time accommodated by the Medicine Chart is complete.

Long Stay Patients
A long stay version of the Medicine Chart is available for use on wards where the length of stay is longer than can be conveniently recorded on the standard chart.

Special Prescribing
Certain categories of drugs present special problems of dosage and frequency of administration, as these depend upon monitoring of therapeutic effect.

In the case of anticoagulants and of insulin, special charts may be used for prescribing.

Special charts are also available for intravenous infusions, Patient Controlled Analgesia (PCA), Oxygen administration and Paediatric oncology prescribing.

When used, reference to the appropriate special chart MUST be made in the “Other Charts in Use” section, so that there is a complete central reference to all medication prescribed for the patient (see page 9).

Intensive Care Patients
Various special prescription and administration record sheets are available for use on intensive care wards.

Ophthalmology Patients
A specific medicines chart is available for use on ophthalmology wards when patients are prescribed frequent medication e.g. 2 hourly eye drops.

Chart Number
If more than one Medicine Chart of the same type is in current use then the appropriate warning sticker should be used on all charts.

The minimum number of Medicine Charts should be in use at all times to reduce medication errors. If necessary all current medication should be rewritten onto a new medicine chart by the appropriate prescriber.

CAUTION
This patient has more than one drug chart in current use.
This chart is No. _____ of____ CHECK ALL CHARTS
The Medicine Chart

The medicine chart is divided into a number of sections:

A. Patient details
B. Drug and Other Sensitivities
C. Once only Medicines
D. Other Charts in Use
E. Regular Prescriptions
F. Variable Dose Prescriptions
G. As Required Prescriptions

A. Patient Details

The section giving details about the patient must be completed fully. It is recommended that computer generated labels are used in this section whenever possible. The hospital and chart number must also be added.

It is also important that the patient’s name and number are entered in the appropriate places on the inside pages of the chart.

The Pharmacy Use Only section will be completed by pharmacy staff in those locations where they are involved in drug history taking, the completion of charts and/or writing of discharge prescriptions.
B. Drug and Other Sensitivities

Drug and other sensitivities that may affect treatment e.g. Elastoplast, latex, should be recorded in the box provided. An appropriate entry must also be made on the front of the patient’s medical records. Drugs to which the patient is allergic MUST NOT be prescribed for that patient.

<table>
<thead>
<tr>
<th>DRUG and OTHER SENSITIVITIES*</th>
<th>Completed by Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>METOCLOPRAMIDE - OCOLOGYRIC CRISIS</td>
<td>A. Smith</td>
</tr>
<tr>
<td>ELASTOPLAST</td>
<td></td>
</tr>
</tbody>
</table>

* If there are no known allergies, write ‘None known’ in box

If there are no known allergies this must also be recorded on the medication chart.

<table>
<thead>
<tr>
<th>DRUG and OTHER SENSITIVITIES*</th>
<th>Completed by Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>None known</td>
<td>P. Brown</td>
</tr>
</tbody>
</table>

* If there are no known allergies, write ‘None known’ in box
C. Once Only and Pre-medication Medicines

This section is intended for the prescribing of once only and pre-medication drugs. It should also be used for recording medicines that are given following a telephoned instruction (see Section 1).

Indicate the actual time, or write:

- “On order” if the medicine is to be given at a time to be requested, e.g. just before the patient is subjected to some test or surgical procedure
- “By phone” if the instruction has been telephoned to the ward.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Pharmacy</th>
<th>Drug (Approved Name)</th>
<th>Dose</th>
<th>Route</th>
<th>Prescriber’s Signature NAME</th>
<th>Time Given</th>
<th>Given by</th>
<th>Checked by</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/1/06</td>
<td>On Order</td>
<td></td>
<td>CEFUROXIME</td>
<td>750mg</td>
<td>IV</td>
<td>A Smith</td>
<td>1400</td>
<td>PJ</td>
<td>BC</td>
</tr>
<tr>
<td>4/1/06</td>
<td>On Order</td>
<td></td>
<td>METRONIDAZOLE</td>
<td>500mg</td>
<td>IV</td>
<td>A Smith</td>
<td>1400</td>
<td>PJ</td>
<td>AC</td>
</tr>
<tr>
<td>4/1/06</td>
<td>1800</td>
<td></td>
<td>MORPHINE</td>
<td>10mg</td>
<td>SC</td>
<td>P Brown</td>
<td>1805</td>
<td>AC</td>
<td>JS</td>
</tr>
<tr>
<td>4/1/06</td>
<td>1845</td>
<td></td>
<td>CYCLOZINE</td>
<td>50mg</td>
<td>IV</td>
<td>P Brown</td>
<td>1850</td>
<td>AC</td>
<td>JS</td>
</tr>
</tbody>
</table>
D. Other Charts in Use

Whenever a special chart is used e.g.

Intravenous infusions,
Anticoagulant,
Diabetic,
P.C.A.,
Eye Medication Chart,
Paediatric Oncology,

reference to it MUST be made in the “Other Charts in Use” section of the Medicine Chart. This is essential in order to maintain a complete and central record of all medication prescribed for the patient.

<table>
<thead>
<tr>
<th>Date</th>
<th>Type of Chart</th>
<th>Details</th>
<th>Signature NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/8/05</td>
<td>Insulin Chart</td>
<td></td>
<td>A. Brown</td>
</tr>
<tr>
<td>6/8/05</td>
<td>IV Infusion chart</td>
<td></td>
<td>A. Brown</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**E. Regular Therapy**

*a) Times of Administration*

For medicines to be administered during medicines administration rounds, the time(s) of administration should be highlighted by drawing a ring round the printed time(s).

The times stated in the columns apply to a medicine administration round in progress 45 minutes before and 1 hour after the indicated time e.g. 0800 hours refers to medicines administered between 0715 and 0900 hours.

Where it is necessary for drugs to be given outside this range of standard times the actual times may be written in the space provided and ringed, overwriting printed times where necessary - see illustration.
b) *Duration of Therapy Box*

A duration of therapy box is included to facilitate the prescribing of fixed length courses of treatment, e.g. the use of short course antibiotics in the treatment of simple urinary tract infections.

When using this facility, the unused portion of administration section should be cancelled – see illustration.

When the course of treatment is complete, the prescription should be cancelled in the normal way – see ‘Discontinuing or Cancelling Drugs’ in Section 1 (page 3).
c) Medicine Administration Record

i) Recording Administration
The initials of the nurse or nurses (or other practitioners) administering the medicine must be recorded in the appropriate space.

If two nurses are involved, both initials should be recorded on either side of the diagonal line.

<table>
<thead>
<tr>
<th>Please state DURATION OF THERAPY for short course treatment e.g. antibiotics</th>
<th>Date 24/10 25/10 26/10 27/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG (Approved Name)</td>
<td></td>
</tr>
<tr>
<td>MORPHINE SULPHATE N.R. (MST)</td>
<td></td>
</tr>
<tr>
<td>Dose</td>
<td></td>
</tr>
<tr>
<td>30mg</td>
<td></td>
</tr>
<tr>
<td>Route</td>
<td></td>
</tr>
<tr>
<td>PO</td>
<td></td>
</tr>
<tr>
<td>Start Date</td>
<td>24/10/05</td>
</tr>
<tr>
<td>Duration of therapy</td>
<td>1200</td>
</tr>
<tr>
<td>Prescriber’s Signature</td>
<td></td>
</tr>
<tr>
<td>P. Brown</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>P. Brown</td>
<td></td>
</tr>
<tr>
<td>Date Stopped</td>
<td></td>
</tr>
<tr>
<td>Initials</td>
<td></td>
</tr>
<tr>
<td>Pharmacy use</td>
<td></td>
</tr>
</tbody>
</table>
ii) Dates
The current date must be entered in the row across the top of the page.

Some users have attempted to make Medicine Charts last longer by starting the administration record for each new item in the first column regardless of the previous period of use. **This practice is not allowed.**

One of the main functions of the chart is to give a visual record of drug administration on each day over a period of time. This is totally lost if each new medicine is recorded from the left. The example below shows the correct method.

<table>
<thead>
<tr>
<th>Please state DURATION OF THERAPY for short course treatment e.g. antibiotics</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BENDROFLUMETHIZIDE</strong></td>
<td>Date</td>
</tr>
<tr>
<td>Dose: 2.5 mg</td>
<td>Route: PO</td>
</tr>
<tr>
<td>Prescriber's Signature: P Brown</td>
<td>Notes:</td>
</tr>
<tr>
<td>Name: P Brown</td>
<td></td>
</tr>
<tr>
<td>Date Stopped: 12/00</td>
<td>Initials: Pharmacy use:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ATENOLOL</strong></th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose: 50 mg</td>
<td>Route: PO</td>
</tr>
<tr>
<td>Prescriber's Signature: P Brown</td>
<td>Notes:</td>
</tr>
<tr>
<td>Name: P Brown</td>
<td></td>
</tr>
<tr>
<td>Date Stopped: 12/00</td>
<td>Initials: Pharmacy use:</td>
</tr>
</tbody>
</table>
iii) Codes for Non-Administration
Non administration of medicines must be recorded on the administration section of the chart. Numbers are used instead of letters to avoid confusion between the codes and nurses’ initials.

The codes are:

<table>
<thead>
<tr>
<th></th>
<th>Codes to be specified in the Administration Comments Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Patient refuses</td>
</tr>
<tr>
<td>2</td>
<td>Patient not present on ward</td>
</tr>
<tr>
<td>3</td>
<td>Medicine not available</td>
</tr>
<tr>
<td>4</td>
<td>Instructions not clear or legal</td>
</tr>
<tr>
<td>5</td>
<td>Patient self-administered medicine</td>
</tr>
<tr>
<td>6</td>
<td>Nil by mouth</td>
</tr>
<tr>
<td>7</td>
<td>Asleep/drowsy</td>
</tr>
<tr>
<td>8</td>
<td>Unable to swallow</td>
</tr>
<tr>
<td>9</td>
<td>Vomiting/nausea</td>
</tr>
<tr>
<td>10</td>
<td>Time varied on Dr’s instructions</td>
</tr>
<tr>
<td>11</td>
<td>Once only/PRN medication given</td>
</tr>
<tr>
<td>12</td>
<td>Possible drug reaction/side effects</td>
</tr>
<tr>
<td>13</td>
<td>Other reasons</td>
</tr>
</tbody>
</table>

To supplement the codes for non-administration, there is an additional section for recording ‘Administration Comments’ relating to possible drug reactions/side effects (Code 12) and reasons for non-administration not covered by codes 1 to 11 (Code 13).
F. Variable Dose Therapy

This section is intended to facilitate the prescribing of medicines where dose changes are needed as part of complex regimens for dose initiation or discontinuation e.g. reducing doses of prednisolone, or where the dose may need to be adjusted according to response. While this section of the chart is suitable for patients who are stabilised on anticoagulants, the Trust anticoagulant chart should be used for new patients and those who are unstable. Insulins should normally be prescribed on a chart that has been specifically designed for the prescribing of insulins.

<table>
<thead>
<tr>
<th>Drug (Approved Name)</th>
<th>Route</th>
<th>Target INR</th>
<th>Indication / Instructions</th>
<th>Start date</th>
<th>Signature</th>
<th>Name</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREDNISOLONE</strong></td>
<td>PO</td>
<td></td>
<td></td>
<td></td>
<td>A Brown</td>
<td>BROWN</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>1/6</td>
<td>2/6</td>
<td>2/6</td>
<td>2/6</td>
<td>3/6</td>
<td>3/6</td>
<td>3/6</td>
</tr>
<tr>
<td>Time</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dose</td>
<td>20</td>
<td>20</td>
<td>15</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>INR</td>
<td>2.2</td>
<td>2.2</td>
<td></td>
<td>2.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribed by (initials)</td>
<td>AB</td>
<td>AB</td>
<td>AB</td>
<td>AB</td>
<td>AB</td>
<td>AB</td>
<td>AB</td>
</tr>
<tr>
<td>Given by</td>
<td>JH</td>
<td>JH</td>
<td>JH</td>
<td>JH</td>
<td>JH</td>
<td>JH</td>
<td>JH</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug (Approved Name)</th>
<th>Route</th>
<th>Target INR</th>
<th>Indication / Instructions</th>
<th>Start date</th>
<th>Signature</th>
<th>Name</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WARFARIN</strong></td>
<td>PO</td>
<td>2 to 3</td>
<td></td>
<td></td>
<td>A Brown</td>
<td>BROWN</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>1/6</td>
<td>1/6</td>
<td>2/6</td>
<td>2/6</td>
<td>2/6</td>
<td>2/6</td>
<td>2/6</td>
</tr>
<tr>
<td>Time</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Dose</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>INR</td>
<td>2.1</td>
<td>2.1</td>
<td></td>
<td>2.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribed by (initials)</td>
<td>AB</td>
<td>AB</td>
<td>AB</td>
<td>AB</td>
<td>JS</td>
<td>JS</td>
<td>JS</td>
</tr>
<tr>
<td>Given by</td>
<td>MS</td>
<td>MS</td>
<td>MS</td>
<td>MS</td>
<td>MS</td>
<td>MS</td>
<td>MS</td>
</tr>
</tbody>
</table>
### G. As Required Prescriptions

Instructions must be complete and written clearly in English in the box provided. They should state both the maximum frequency of administration and the indication e.g. “up to 4 hourly for pain” or “up to twice nightly for sleep”. A maximum dosage or number of doses per day should also be stated where relevant e.g. “Up to 8 tablets per day”.

This section also includes the facility to include an alternative dose/route of administration that can be varied according to clinical need e.g. to give some flexibility in the dosage of analgesic or the ability to administer a drug by different routes in the presence of nausea and vomiting as illustrated below:

<table>
<thead>
<tr>
<th>Drug (Approved Name)</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paracetamol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>500mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Route</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18/12/05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose / Route</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1g</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>1g</td>
<td>01</td>
<td></td>
</tr>
<tr>
<td>1g</td>
<td>02</td>
<td></td>
</tr>
<tr>
<td>1g</td>
<td>03</td>
<td></td>
</tr>
<tr>
<td>5g</td>
<td>04</td>
<td></td>
</tr>
<tr>
<td>1g</td>
<td>05</td>
<td></td>
</tr>
<tr>
<td>1g</td>
<td>06</td>
<td></td>
</tr>
<tr>
<td>5g</td>
<td>07</td>
<td></td>
</tr>
<tr>
<td>1g</td>
<td>08</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brown</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stop Date</th>
<th>Initials</th>
<th>Pharmacy</th>
<th>Dose / Route</th>
<th>Given by</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug (Approved Name)</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procainamide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Route</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18/12/05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose / Route</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1g</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>1g</td>
<td>01</td>
<td></td>
</tr>
<tr>
<td>1g</td>
<td>02</td>
<td></td>
</tr>
<tr>
<td>1g</td>
<td>03</td>
<td></td>
</tr>
<tr>
<td>5g</td>
<td>04</td>
<td></td>
</tr>
<tr>
<td>1g</td>
<td>05</td>
<td></td>
</tr>
<tr>
<td>1g</td>
<td>06</td>
<td></td>
</tr>
<tr>
<td>5g</td>
<td>07</td>
<td></td>
</tr>
<tr>
<td>1g</td>
<td>08</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brown</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stop Date</th>
<th>Initials</th>
<th>Pharmacy</th>
<th>Dose / Route</th>
<th>Given by</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3 The Administration of Medicines

The safe administration of all medicines is the responsibility of an approved Registered Nurse, Midwife or Doctor. In certain instances, as described by local nursing policy, two nurses are required.

Procedures for the administration of drugs involve several distinct steps that MUST be taken sequentially. In this way the correct drug prescribed will be given to the correct patient by the right route at the time directed.

Medicines to be given orally and by injection must be prepared and given at separate times.

**ORAL SYRINGES** only must be used to administer small doses of oral medicine. It is forbidden to use syringes intended for parenteral use for this purpose.

Intravenous potassium chloride should only be administered using ready diluted intravenous fluids that contain either 20 or 40mmol per litre. Use of concentrated potassium chloride ampoules (15%) is restricted to specialised areas with extra record keeping required. Further information is available on the Newcastle Hospitals Trust Intranet.

**THE SEQUENCE**

1. Identify the patient

Make a positive identification of the patient against the details given on the Medicine Chart. If practicable, the name should be checked verbally with the patient or with a member of staff who is able to identify the patient. In addition, in all cases where identification wrist-bands are in use the hospital number must be checked against the patient number on the Medicine Chart.

In situations where there is more than one patient with the same name, or when wrist-bands are not in use, additional precautions should be taken to confirm the patient's identity e.g. date of birth.

**It is the nurse’s responsibility to identify the correct patient. The task of ensuring the medication is seen to be taken by the patient can be delegated to a carer or relative.**

2. Check for drug sensitivity

Observe any entry made in the “Drug Sensitivities” section. If there is reason to suspect that a patient may be sensitive to a prescribed medicine, then the matter should be referred to a member of the medical staff before the drug is administered.

3. Check that the prescription is clear and valid

If the prescription or container information is illegible, unclear, ambiguous or incomplete, or where the practitioner has concerns about the dose or method of administration, the medicine should not be administered to the patient and the matter should be referred back promptly to an appropriate doctor, pharmacist or professional colleague.
4. Check that the dose has not already been administered

**Regular prescriptions**
See that the box and time in the recording section of the Medicine Chart is blank.

**As Required prescriptions**
Inspect the boxes corresponding to the day and ensure that the drug has not been given within the time interval stated in the “frequency and instructions” column on the Medicine Chart.

**Once only and pre-medication drugs**
Check the prescription itself and ensure that the “given by” column on the Medicine Chart is blank.

5. Select the drug

Select the drug required, ensuring that the label corresponds exactly with the prescription. With medicines given by mouth check the required dose into an appropriate measure or cup.

It is recommended that the label is **READ THREE TIMES**, as this has been shown to reduce the risk of error.

All dose calculations, particularly for opiates, **MUST** be double checked.

6. Administer the drug

When administering the medicine observe or confirm that the patient has taken the prescribed dose.

7. Record the administration

The administration must be recorded by the initials of the responsible nurse(s) or the appropriate code for self administration.

**Additional Notes**

**If a medicine is not administered**
In situations where a dose of a medicine is not administered and the matter cannot be resolved immediately the nurse must:

a) Record on the In-patient Medicines Chart the appropriate code number for the reason why the due dose was not administered and initial this code.

   In some situations approved by the Drug & Therapeutics Panel, where the standard Medicines Chart is not in use, non-administration cannot be recorded in this manner e.g. use of transfusion charts for Haematology Day Case Patients. Where possible an appropriate note about the non-administration should be made on the relevant chart.

b) Take appropriate action to resolve the matter promptly so that patient treatment is not compromised. This may include discussion with a doctor, more senior nurse or pharmacist in which case the appropriate code number should be entered onto the Medicines Chart and initialled.

N.B. If, in the professional judgment of the nurse, failure to administer a dose of prescribed medicine for whatever reason, may compromise treatment of the patient, an appropriate doctor must be notified immediately.
Missed Doses

It is normally acceptable to administer medicines up to 45 minutes before and 1 hour after the prescribed time. If a missed dose is required to be given outside of these time limits a doctor must be contacted for advice and authorisation. Where authorisation is given to administer outside the prescribed time the appropriate Code should be entered on the Medicines Chart and initialled.

Once Only Medication

Record the time of administration and initial the “given by” column on the Medicine Chart. Repeat for as many prescriptions as required.

“Nil by mouth”

Patients who have been ordered “nil by mouth” prior to surgery or other procedures should have their regular medication administered with a small amount of fluid, unless there is a specific instruction to the contrary.

Using Patient’s Own Drugs

A patient’s own medicine may only be used for the patient to whom it belongs as part of an agreed local ‘Patient’s Own Drugs (PODs)’ scheme according to a defined protocol or in situations where a supply cannot be obtained from the Pharmacy before the next dose is due or the product is not stocked in the Pharmacy. Further guidance can be obtained from the WeBNF on the Newcastle Hospitals Trust’s Intranet and Newcastle Formulary’s List of Formulary Medicines.

Self Administration

If a decision is taken that a patient may self medicate this must follow a defined protocol drawn up after discussion locally between nurses, doctors and pharmacists. The prescriber must record the prescription by writing it in the usual manner, with “Self-Admin.” noted in the box provided. Each day that the patient self-administers the number (5) will be written across the administration record together with the initials of the nurse responsible for monitoring the patient’s compliance with prescribed medication.
Patient Group Directions

In certain circumstances it is acceptable for designated staff to administer or supply medicines to patients in the absence of a doctor’s prescription provided that a local multidisciplinary protocol has been prepared and approved by the relevant Trust Committees.

Patient group directions involving the supply of medicines without a patient specific prescription must not be introduced into clinical practice until formal Trust approval via the Drug & Therapeutics Panel has been obtained.

Named Patient Medicines

Supplies of medicines made on a “named patient” basis should normally only be administered to the individual for whom they were supplied. Further guidance is available from the Pharmacy.
4. Prescribing for Out-Patients, Discharge and Regular Day Attenders

Prescription Forms

The appropriate prescription form must be used:

a) Out-Patient (green or blue [non-medical prescriber]).
b) Discharge summary/prescription or Discharge Prescription only (both pink).
c) Regular day attender e.g. dialysis patient (white).

Information Required

The prescription must bear full details of medicines to be dispensed: this includes appropriate directions (‘as directed’ should never be used) and the following patient information:

- Patient name and address
- Hospital number
- Date for birth
- Body weight for children under 12 years of age
- Consultant
- Clinic (out-patient prescription)
- Ward (all discharge/regular day attender prescriptions)
- Planned time and date of discharge (all discharge prescriptions)
- Whether each medicine prescribed is to be continued (all discharge prescriptions)
- Medicines which have been intentionally stopped (all discharge and out-patient prescriptions)

Where possible patient labels should be used on all prescriptions. Where patient labels are used on out-patient or discharge prescriptions each of the multiple copies must bear a patient label.

Discharge planning should take into account pharmacy opening hours and the time taken between sending a prescription to Pharmacy and receiving it back on the ward to be ready for when the patient finally leaves the ward.

Quantities

a) The Trust has received funding from PCTs to allow complete packs to be dispensed for discharge and out-patients. Therefore please prescribe 4 weeks supply for all medicines UNLESS they are not required for as long or the patient is being supplied with medicines in a Medidose or similar device - see b) below.

The Pharmacy will modify the quantity to meet the pack sizes available and for some drugs e.g. Controlled Drugs will supply the exact quantity required.

b) Where it has been agreed with Pharmacy that patients should receive their medication in a ‘Medidose’ or similar device only 7 days supply should be prescribed (NOT 28 days). A copy of the patient’s prescription/ discharge summary must be faxed promptly to the GP surgery, to allow the GP to continue prescribing treatment.
c) For discharge and out-patient prescriptions the number of
days supply required should be indicated in the box
provided. Only in the case of indeterminate or “when
required” dosage, or of original pack dispensing (e.g.
creams/ointments) should the quantity be specified.

With **Discharge Prescriptions** (see illustration next page)
- **ALL** medication should be listed for completeness.
- Place a tick in the “supply not required” column if
  patient already has sufficient.
- Indicate whether or not treatment is to be continued
  by the GP.
- Where treatment is to be continued but not
  indefinitely, indicate the intended duration of
  treatment or stop date.

Particular care is necessary when prescribing
chemotherapeutic agents for the treatment of cancer, to
ensure that the GP does not continue repeat prescribing
unless, under very exceptional circumstances, a patient
specific arrangement has been made between the
prescribing hospital specialist and the patient’s GP.

d) For regular ‘day attenders’ supplies will be dispensed by the
Pharmacy according to entries made, dated and initialled in
the record part of the form.

**Discontinued Medicines**

Details of medicines previously prescribed by the patient’s GP, but
no longer required, should be recorded in the appropriate place on
out-patient and discharge prescription forms, to help prevent future
inadvertent prescribing by the patient’s GP.
<table>
<thead>
<tr>
<th>Approved Name</th>
<th>Form</th>
<th>Dose / Frequency</th>
<th>Planned duration of treatment / comments</th>
<th>Supply NOT req'd</th>
<th>No. of days supply OR No. of doses required</th>
<th>Treatment to be continued by GP</th>
<th>Pharmacy use: Quantity supplied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lisinopril</td>
<td>20mg</td>
<td>daily</td>
<td></td>
<td>✓</td>
<td></td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>Simvastatin</td>
<td>40mg</td>
<td>at night</td>
<td></td>
<td>✓</td>
<td></td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>Omeprazole</td>
<td>40mg</td>
<td>daily</td>
<td>Reduces to 20mg after 21/2</td>
<td></td>
<td>28</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>Aspirin</td>
<td>dispersible tablets 75mg</td>
<td>daily</td>
<td></td>
<td></td>
<td>28</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>Clopidogrel</td>
<td>75mg</td>
<td>daily</td>
<td>Stop DEC 2006</td>
<td></td>
<td>28</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>Amoxicillin</td>
<td>500mg</td>
<td>tds</td>
<td></td>
<td></td>
<td>5</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>Paracetamol</td>
<td>500mg qv, 6 hourly prn</td>
<td>1-2 tablets</td>
<td></td>
<td></td>
<td>30</td>
<td>YES / NO</td>
<td></td>
</tr>
</tbody>
</table>

Medication on Admission No Longer Required / Other Comments Regarding Medication

RANITIDINE

Please check the compatibility of drugs supplied with ALL the patient's current medication

| PRESCRIBER'S SIGNATURE | A Smith  
NAME (Print): A Smith  
DESIGNATION: SHO  
Date: 2/1/06  
Dect No: 12345 |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PIN No. (non-medical prescriber)</td>
<td>Initial here if Child Resistant Container is NOT required</td>
</tr>
</tbody>
</table>
**Commissioner’s Requirements**

Agreement has been made with commissioners regarding prescribing for out-patients and patients on discharge where the GP is expected to continue drug therapy. These include:

**Discharge Medication**
Night sedation COMMENCED in hospital must not be continued/prescribed on discharge unless clinically required.

**Discharge and Out-Patient Reports**
1. All drugs, except proprietary combination products and modified release formulations of diltiazem, nifedipine theophylline & lithium, must be prescribed/recommended in reports to GPs by their approved (rINN) name.
2. All drugs recommended/prescribed by hospital staff must be drawn from the Newcastle Formulary, except for those being used as part of a clinical trial or where formulary medicines are unsuitable due to treatment failure, contraindications or adverse effects. If a non-formulary drug is initiated by a hospital doctor the reason for its use must be explained to the patient’s GP.
3. Drugs identified in the BNF with a black triangle (those for which special adverse drug reaction reporting arrangements apply) may only be recommended by hospital staff to GPs for use within their licensed indications.
4. Monitoring arrangements and duration of treatment must be explicitly stated.

**Child Resistant Containers**

Medicines not supplied in manufacturers’ packs will normally be dispensed in a child resistant container (CRC). If, because of arthritic hands or other disability an ordinary medicine container is considered preferable the “no CRC” space on the out-patient or discharge prescription forms should be initialled by the prescriber, nurse or pharmacist.

Specific arrangements may be set up with the agreement of ward and pharmacy staff in situations where it is inappropriate for patients to have CRCs e.g. elderly day units.
Security

Unused sections of the out-patient and discharge forms should be cancelled through by the prescriber.

- The prescriber must sign and date each out-patient/discharge prescription form and print his/her name and DECT (bleep) number, to assist pharmacy staff if the prescriber needs to be contacted.

Copies

A four part combined interim discharge letter and prescription form is in use in many clinical areas.

Both the discharge and out-patient prescriptions are in three/four parts. All copies are sent to the Pharmacy and the top copy is retained by the Pharmacy. For discharge prescriptions the other copies are returned to the ward with the dispensed medicines.

For out-patient prescriptions the second copy is given to the patient by the Pharmacy to be passed on to the GP. The third copy should be retained, according to local policy, for inclusion in the patient’s notes.

Supply When the Pharmacy is Closed

Arrangements should normally be made in advance for discharge prescriptions to be written up and dispensed by the hospital pharmacy department in time for the patient leaving hospital. When the Pharmacy is closed and patients are being discharged at short notice it is acceptable for nursing staff to dispense a limited supply from ward stock according to a locally agreed policy.

Controlled Drugs must not be dispensed in this manner.

Further advice can be obtained from the emergency duty pharmacists.
5. Controlled Drugs

In-Patient Prescribing

Prescriptions for in-patients are entered on the Medicines Chart as for all other drugs.

Administration

1. Controlled Drugs must be double checked, in accordance with the Newcastle Hospitals and Community Policy on Medicines by an approved Registered Nurse, Midwife or a registered or provisionally registered Medical or Dental practitioner, who must follow the usual procedure and, where necessary, check any calculations associated with the dose determination.

2. Details of the DRUG PREPARATION AND THE DOSE must be recorded in the controlled drug register IMMEDIATELY BEFORE administration to the patient.

3. The TIME OF GIVING THE DRUG must be recorded in the controlled drug register IMMEDIATELY AFTER the giving of the drug to the patient.

Out-Patients and Patients on Discharge

They must be signed by the prescriber and must clearly state:

1. The name and address of the patient.

2. The name and form of the medicine (e.g. morphine injection, methadone tablets etc.). If the product to be supplied is a modified release formulation, this must made clear on the prescription.

3. The strength of the preparation (where more than one strength of the preparation exists).

4. The dose and frequency of administration.

5. The total quantity to be dispensed in both words AND figures.

For preparations supplied in dose units e.g. tablets, the total quantity should be expressed as the number of dose units e.g. Twenty (20) tablets.

For other preparations such as solutions the total quantity of the preparation should be stated e.g. Two hundred (200)ml.

If two or more strengths of a preparation are needed to provide the required dose, both should be specified as in example (c).
Some examples of suitable wording for controlled drug prescriptions are:-

a) **Where a product is supplied in dose units (e.g. tablets).**

Methadone 5 mg tablets
One bd
Please supply 14 (fourteen) tablets.

b) **Where a product is not supplied in dose units (e.g. solution).**

Oxycodone 5 mg in 5 ml solution
10 mg every 4 hours
Please supply two hundred and fifty (250) ml

c) **Where more than one strength is needed to give the required dose, e.g. for a 50 mg dose of morphine sulphate in modified release tablets.**

Morphine sulphate m/r tablets
50 mg bd
Please supply as 28 (twenty eight) 30 mg tablets and 56 (fifty six) 10 mg tablets.

d) **Where more than one dose unit is required to give a dose.**

Diamorphine injection
60 mg daily by subcutaneous infusion
Please supply 10 (ten) 30 mg ampoules

**N.B.**

- Stating the number of doses to be supplied or the duration of treatment in words and figures does not meet legal requirements.
- Likewise stating the total quantity of the controlled substance itself (e.g. 1800 mg morphine sulphate) is unacceptable unless it is being supplied in its pure form (e.g. morphine sulphate powder) and not as a preparation.
- The strength of the preparation does not need to be stated in words and figures.
- If necessary controlled drug prescriptions can be supplied in installments. In such cases the prescription must state the quantity to be supplied in the installments and the frequency at which the installments are to be supplied.
6 Security Procedures

Stationery

All Medicine Charts, Prescription Forms, Temporary Stock and Controlled Drug Requisition Books are classified as “Controlled Stationery” as they may be used to obtain medicines fraudulently. Supplies can only be obtained from Departments of Pharmacy. All Controlled Stationery MUST be kept locked away when not in use and the key kept on the person in charge of the ward. In areas of frequent use it is acceptable to have a small supply of in-patient medication Kardexes, discharge prescriptions and temporary stock orders within easy access, for example on ward rounds and medication rounds. Controlled Drug stationery and out-patient prescriptions must be locked away at all times when not for immediate use. Controlled Stationery of any kind must never be left unattended.
These guidelines do not cover all aspects of the administration of medicines. Staff should always refer to and follow where appropriate the relevant Policy documents, the Newcastle Hospitals and Community Policy on Medicines, and the Newcastle Formulary copies of which are available to all wards and clinical departments*. These include:

- Cytotoxic Chemotherapy – Procedures for Administration
- Intravenous Drug Administration Policy
- Missing Controlled Drugs Policy
- Out of Hours Drug Dispensing Policy
- Patient Self Administration of Drugs in Hospital Policy
- Pre-Filled Patient Controlled Analgesia (PCA) Syringes Policy
- Subcutaneous Drug and Fluid Administration
- Treatment of Anaphylactic Reactions

* Current versions of policy documents are accessible on the Newcastle Hospital Trust's Intranet via the Policies, Procedures and Clinical Guidelines Link on the Home Page.
8 Bibliography

1. British National Formulary

2. DoH Guidelines for the Safe and Secure Handling of Medicines.
   Joint sub-committee of the Standing Medicine,
   Nursing and Midwifery and Pharmaceutical
   Advisory Committees
   Chaired by Professor R.B. Duthie CBE MA ChM FRCS
   September 1988

3. Newcastle Formulary/List of Formulary Medicines

4. Newcastle Hospitals and Community Policy on Medicines
   Revised 2001
   (New edition in preparation)

5. NMC Code of Professional Conduct: standards for conduct, performance and ethics
   2004

6. NMC Standards for the Administration of Medicines
   2002

7. NMC Guidelines for Records and Record Keeping
   2002

8. Ward Drug Policies – Accessible to all Wards of Newcastle upon Tyne NHS Hospitals Trust via Trust’s Intranet

   1998

10. HSC 2000/026 Patient Group Directions (England Only)

    Hospital Pharmacists’ Group of the Royal Pharmaceutical Society of Great Britain
    Chaired by Professor G B A Veitch / Dr J Farewell
    March 2005

   A training programme based upon the principles outlined in this document is available on the Newcastle Hospital Trust’s Intranet.

---

1 Click on the ‘Policies, Procedures & Clinical Guidelines’ link on the Trust Intranet Home Page and search policies using the keyword ‘Drug’.