

Instructions For NHS Grampian Staff On The Prescribing And Administration Of Medicines Using The NHS Grampian Prescription And Administration Record

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Operational Management Unit: Unit Operational Managers

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Review: This policy will be reviewed in three years or sooner if current treatment recommendations change

This document is also available in large print and other formats and languages, upon request. Please call NHS Grampian Corporate Communications on (01224) 551116 or (01224) 552245.

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* Changes marked should detail the section(s) of the document that have been amended i.e. page number and section heading.

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Instructions for NHS Grampian Staff on the Prescribing and Administration of Medicines using the NHS Grampian Prescription and Administration Record

1. Introduction

The safe prescribing and administration of medicines plays an important part in successful disease management.

'Medicines is a generic term within this document which includes medicinal and pharmaceutical products'

The system for prescribing and administration of medicines has the following **key objectives**:

- To achieve and maintain a safe and effective system for prescribing medicines and recording their administration.
- To reduce medicine incidents/errors and improve patient safety.
- To standardise and produce high quality records of the prescribing and administration of medicines.

Prescription and Administration Record (PAR)

Within NHS Grampian hospital settings, the main tool used to direct administration of medicines is the PAR. It is available in three formats to accommodate patients on varying numbers of medicines and lengths of stay in hospital. These are available from Central Stores using the following ordering codes:

2-page ZOP 112;
Standard ZOP 105;
Long stay (only to be used following discussion with Pharmacy Department)
 ZOP 109.

This document describes the process to be followed when prescribing and recording the administration of medicines on the PAR.

General Guidance

- A PAR should be generated for all inpatients on admission. Other approved medicine charts for specialist use are also available.
- All medicine prescription charts for an individual patient should be kept in a single location. This will reduce the risk of medicine errors, in particular those involving duplication and omission. The designated location should be in close proximity to the patient, ideally co-located with the other patient information, according to individual ward policy. It is the responsibility of

Department/Line Managers to ensure all staff are aware of the location of prescription sheets within their clinical area.

- All PAR entries must be written in English and in BLOCK CAPITAL LETTERS using indelible black ink. Some medicines have similar names and writing in capital letters helps to avoid confusion, therefore reducing the likelihood of errors in administration. Latin abbreviations such as 'p.r.n.' and symbols such as T must not be used.
- All PARs generated during an admission must be filed in the patient's health records on completion/discharge whether or not any entries have been made. PARs must be kept in the patient's appropriate health records from which they **originated**, e.g. acute, psychiatry or community hospital.
- A new PAR must be used for patients who are readmitted regardless of the time that has elapsed since last admission.
- PARs belonging to patients transferred within NHS Grampian may continue to be used in the receiving ward/hospital if appropriate.
- All medicines must only be prescribed by practitioners who have a recognised prescribing qualification, approved by NHS Grampian.
- Prescribers must comply with current prescribing legislation, relevant NHS Grampian prescribing policies, together with the procedures detailed in this document.
- Healthcare professionals (see glossary) can add information to the 'additional instructions' box and to the medicine care plan.
- To improve patient safety, staff should not be interrupted when they are prescribing and administering medicines to patients, except in exceptional circumstances.
- Resources are available to support prescribing and prescribers should familiarise themselves with these, namely, NHSG Joint Formulary (<https://www.grampianformulary.scot.nhs.uk/default.asp>), NHSG Non-medical Prescribing Policy (<https://www.nhsgrampian.org/service-hub/medicines-management/policies/non-medical-prescribing/>) and the NHSG Medicines Reconciliation Protocol (https://www.nhsgrampian.org/globalassets/foidocument/foi-public-documents1---all-documents/Guide_MedRP.pdf).
- Medicines that may be given in accordance with NHS Grampian's approved Protocols/Patient Group Directions (PGDs) should be recorded on the PAR as detailed in the protocol or PGD.

2. Completion of the Prescription and Administration Record (PAR)

2.1. Patient Demographics

The patient details section on the front page and at the top of each page of the PAR must be completed prior to prescribing any medicines. **Example 1**

Patient details can be completed by a health professional or administrative staff.

A patient 'end-of-bed label' should be used on the front sheet of the PAR. If unavailable, then the patient's identification details must be written in prior to prescribing as follows:

- **Patient name:** Full name in block capitals.
- **Community Health Index (CHI):** Patient's CHI number (10 digits must be used).
- **Date of birth:** Written stating day, month and year, e.g. dd/mm/yy, 09/09/32.
- The patient's full name, date of birth and CHI number must also be written at the top of **each page** of the PAR being used prior to prescribing.
- **Date of admission:** The date the patient was admitted: full date including year must be entered to assist when medicines are being reviewed retrospectively (dd/mm/yy).
- **Prescription number:** This refers to the number of PARs in use. If the patient requires more medicines than one PAR allows, an additional PAR should be commenced. The prescription number '1' should be amended to '1 of 2' and the second PAR numbered '2 of 2'. Patients should have a maximum of two PARs in use at any one time.
- **Date rewritten:** Should be entered when the previous PAR(s) have been re-written and replaced with a new PAR.
- **Hospital/Ward/Location:** Abbreviations may be used here (e.g. ARI/209). Update if the patient moves Ward or Hospital.
- **Consultant/GP:** Surname of consultant or GP (doctor responsible for care in hospital) should be PRINTED in full.
- **Weight:** This should be recorded on admission using the metric system (kg). The prescriber must have knowledge of the patient's current or estimated weight as this is necessary to determine the doses of certain medicines.
- **Height:** This should be recorded using the metric system (m) when necessary.
- **Date recorded:** This relates to the date when the weight and height were recorded and must be updated when nursing records are updated.
- **Gender Male/Female (M/F):** This should be circled as appropriate.

Demographic safety – Particular care must be taken where there are patients with the same or similar names

Example 1: Patient Demographics

NHS Grampian PRESCRIPTION & ADMINISTRATION RECORD

Patient Name: JOHN SMITH	Date of admission <u>02/04/21</u>	
CHI number: XXXXXXXXXX	Prescription number <u>1</u>	
Date of Birth: XXXXXX (Attach printed label here)	Date re-written _____	
Hospital / Ward: ARI WARD 1	Weight: 75 kg	Height: 1.85m
Consultant: A. CONSULTANT	Date recorded: 02/04/21	Gender: <input checked="" type="radio"/> M <input type="radio"/> F

KNOWN MEDICINE ALLERGIES/SENSITIVITIES (if NONE confirmed write NKDA in Box 1)

Must be documented before prescription/administration except in exceptional circumstances

1. NKDA	2.	3.	4.
----------------	----	----	----

VENOUS THROMBOEMBOLISM RISK ASSESSMENT HAS BEEN UNDERTAKEN ON ADMISSION sign A. DOCTOR

OTHER MEDICINE CHARTS OR TREATMENT PLANS IN USE (Please tick)

CHART TYPE		CHART TYPE		CHART TYPE	
1. Diabetes prescription sheet		5. Anaesthetic Record		9. Mental Health Care and Treatment (Scotland) Act 2003 - T2/T3 form	
2. Intravenous Patient-controlled analgesia prescription sheet		6. Oral anticoagulant prescription sheet		10. Adults with Incapacity (Scotland) Act 2000. (Section 47 Certificate and Treatment Plan)	
3. Fluid (additive medicine) prescription and recording sheet		7. Dermatology sheet		11. Syringe Driver	
4. Chemotherapy prescription sheet		8. Ophthalmology sheet		12. Other	

ONCE ONLY PRESCRIPTIONS

Date	Time	Medicine	Dose	Route	Prescribed By (signature / print name)	Time Given	Given By

2.2. Known Medicine Allergies/Sensitivities

Prior to prescribing, the generic name of any known medicine allergies/sensitivities and their nature must be recorded in the space(s) provided. If it has been confirmed that the patient has 'No Known Drug Allergies', write 'NKDA' in Box 1. **Example 2**

If NKDA is recorded, staff should remain vigilant for any new adverse drug reactions. Any adverse drug reaction during the patient's stay in hospital should be recorded along with the name of the medicine, reaction and date of reaction in this section of the PAR. Prescribers or pharmacists may enter this data.

All serious adverse drug reactions should be recorded in the appropriate section within the patient's health records.

Suspected new adverse drug reactions should be reported directly to the Medicines and Healthcare Products Regulatory Agency (MHRA) through the Yellow Card Scheme. Further information available at back of BNF (British National Formulary) or by accessing: [Yellow Card Scheme - MHRA](#)

Some patients may have an acute sensitivity to a medicine. It is vitally important to check for medicine allergy/sensitivity before prescribing or administering any medicine.

2.3. Venous Thromboembolism Risk Assessment Has Been Undertaken On Admission

This should be signed by the person completing the assessment. **Example 2**

Example 2: Known Medicine Allergies/Sensitivities and Venous Thromboembolism Risk Assessment Has Been Undertaken On Admission

KNOWN MEDICINE ALLERGIES/SENSITIVITIES (if NONE confirmed write NKDA in Box 1)			
Must be documented before prescription/administration except in exceptional circumstances			
1. NKDA	2.	3.	4.
VENOUS THROMBOEMBOLISM RISK ASSESSMENT HAS BEEN UNDERTAKEN ON ADMISSION sign			A. DOCTOR

2.4. Other Medicine Charts or Treatment Plans in Use

If the patient has ‘Other Medicine Charts or Treatment Plans in use’ e.g. Diabetes Prescription sheet, it is the prescriber’s responsibility to indicate which charts are in use by ticking the appropriate box. If the sheet or chart is not listed, it should be written in 12 ‘Other’ box. **Example 3**

Medicines on ‘Other Charts or Treatment Plans’ such as warfarin, insulin and intravenous patient controlled analgesia (PCA), should be written in the ‘Regular Therapy’ section of the PAR as a reminder to staff. **Example 4**

If any of these ‘Other Charts or Treatment Plans’ are discontinued, a double line should be drawn across the tick on the front of the PAR and the entry in the ‘Regular Therapy’ section should also be discontinued. **Examples 5 and 6**

Example 3: Other Medicine Charts or Treatment Plans in Use

OTHER MEDICINE CHARTS OR TREATMENT PLANS IN USE (Please tick)					
CHART TYPE		CHART TYPE		CHART TYPE	
1. Diabetes prescription sheet		5. Anaesthetic Record		9. Mental Health Care and Treatment (Scotland) Act 2003 - T2/T3 form	
2. Intravenous Patient-controlled analgesia prescription sheet		6. Oral anticoagulant prescription sheet	✓	10. Adults with Incapacity (Scotland) Act 2000. (Section 47 Certificate and Treatment Plan)	
3. Fluid (additive medicine) prescription and recording sheet		7. Dermatology sheet		11. Syringe Driver	
4. Chemotherapy prescription sheet		8. Ophthalmology sheet		12. Other	

Example 4: ‘Regular Therapy’ Entry Where Other Medicines Charts are in Use

REGULAR THERAPY		Date																	
		Time																	
Medicine/Form WARFARIN		08																	
Dose	Route	12	}	SEE ANTICOAGULANT PRESCRIPTION															
Signature/Print name		14																	
Pharmacy	Start Date	18																	
Frequency	Additional Instructions	20																	
		22																	

Example 5: Discontinuation of Other Medicine Charts or Treatment Plans in Use

OTHER MEDICINE CHARTS OR TREATMENT PLANS IN USE (Please tick)		
CHART TYPE	CHART TYPE	CHART TYPE
1. Diabetes prescription sheet	5. Anaesthetic Record	9. Mental Health Care and Treatment (Scotland) Act 2003 - T2/T3 form
2. Intravenous Patient-controlled analgesia prescription sheet	6. Oral anticoagulant prescription sheet	10. Adults with Incapacity (Scotland) Act 2000. (Section 47 Certificate and Treatment Plan)
3. Fluid (additive medicine) prescription and recording sheet	7. Dermatology sheet	11. Syringe Driver
4. Chemotherapy prescription sheet	8. Ophthalmology sheet	12. Other

Example 6: Discontinuation of 'Regular Therapy' Entry When Other Medicines Charts are in Use

REGULAR THERAPY	Date																		
	Time																		
Medicine/Form WARFARIN	08																		
Dose	12																		
Route	14																		
Signature/Print name	18																		
Pharmacy	20																		
Start Date	22																		
Frequency																			
Additional Instructions																			

SEE ANTICOAGULANT PRESCRIPTION

STOPPED ADoctor 07/04/21

3. Instructions for Prescribers

Prescriptions within the PAR may be written in any of the 3 sections: 'Once Only Prescriptions', 'Regular Therapy' and 'As Required Therapy' as appropriate.

3.1. General Instructions for All Sections

Medicine/Form: Example 7

- The full name of the medicine should be printed clearly in BLOCK CAPITAL LETTERS. Some medicines have similar names and printing helps to avoid confusion, reducing the likelihood of errors when administering.
- Most medicines have approved (non-proprietary or generic) names. The use of non-proprietary names is good practice and can facilitate economical use of medicines.
- Where bioavailability varies between brands or between formulations, the brand (proprietary) name must be specified. For example, beclometasone inhalers, lithium products, theophylline, some immunosuppressants (e.g. tacrolimus, to prevent organ transplant rejection), certain epilepsy medicines and modified release preparations.
- Brand (proprietary) names can be used where this would reduce the risk of an administration error. For example, oxycodone should be prescribed by brand name to distinguish between immediate or sustained release products, Shortec and Longtec respectively.
- Insulin should be prescribed using brand names.
- The following link provides guidance on which medicines should be prescribed by brand: <https://www.sps.nhs.uk/articles/which-medicines-should-be-considered-for-brand-name-prescribing-in-primary-care/>
- Where more than one strength of multi-ingredient preparation exists the strength must be specified as part of the medicine name, e.g. Revlar 92/22 Ellipta.
- Formulation must be specified when it is essential to assist in administration of the correct medicine, e.g. modified release, enteric coated, inhaler type (e.g. MDI, Accuhaler), etc.
- Form must be specified on ALL paediatric prescriptions.

Dose: Example 7

- Prescribe dose of medicine using metric system:
milligram = mg
gram = g
millilitre = mL
- Do not abbreviate micrograms or nanograms - 'mcg' and 'µg' are not acceptable.
- Do not abbreviate units to 'u' – 'units' must be written in full.
- Doses of less than one milligram must be expressed in micrograms, e.g. 62.5 micrograms and not 0.0625 mg. A leading zero should be added for numbers less than 1, e.g. 0.5mL and not .5mL. Whole numbers should not be followed by a decimal point and zero, e.g. 1 and not 1.0.
- Doses of liquid preparations should be expressed as milligrams or micrograms of the active ingredient. Doses in millilitres (mL) should only be used for multi-ingredient preparations.
- Where more than one strength combination of a multi-ingredient preparation exists, the dose to be administered must be stated, e.g. Revlar 92/22 Ellipta, one inhalation (puff) in the morning.
- A choice of dose may be prescribed where appropriate in the 'As Required Therapy' section only e.g. senna 7.5mg-15mg

The dose of a medicine must be expressed in terms that are explicit, e.g.
Furosemide dose - '60 mg'
or
Revlar 92/22 Ellipta dose - 'One inhalation'

Route of Administration: Example 7

- The route of administration must be appropriate to the medicine prescribed.
- The abbreviations listed are the only ones that may be used. All other routes must be written in full.
- More than one route e.g. 'IV/ORAL' must only be used if the dose of medicine is the same for BOTH routes. Particular care must be taken in paediatrics.

Oral	ORAL must be written in full 'O' is not acceptable						
Sublingual	SL	Subcutaneous	SC	Intramuscular	IM	Intravenous	IV
Intradermal	ID	Inhalation	INH	Nebulised	NEB	Topical	TOP
Rectal	PR	Vaginal	PV	Gastrostomy	Gastros	Nasogastric	NG
Orogastric	OG	Jejunostomy	Jej	Nasojejunostomy	NJ	Buccal	Buccal

Signature and Print Name: Example 7

- Each medicine prescribed must be signed by a prescriber with a recognised prescribing qualification.
- Prescribers must PRINT their name the first time they prescribe or discontinue a prescription on each PAR; this allows the prescriber to be identified and contacted when there is a lack of clarity. Each prescription thereafter can just be signed by that individual.
- Initials are not acceptable.
- Non-medical prescribers (NMP) should annotate the prescription as 'NMP' or 'IP' (Independent Prescriber) or 'SP' (Supplementary Prescriber).

Example 7: General Instructions for All Sections

REGULAR THERAPY			Date																								
			Time																								
Medicine/Form SIMVASTATIN			08	/																							
Dose 40mg	Route ORAL		12																								
Signature/Print name A. Doctor A. DOCTOR			14																								
			18																								
Pharmacy	Start Date 07/04/21	Frequency NIGHT	20																								
Additional Instructions			22																								

3.2. Specific Instructions for ‘Once Only Prescriptions’

Prescriber completes: Date; Time (to be given) using 24 hour clock (00:00); Medicine Name; Form (if appropriate); Dose; Route; and Prescribed By (signature/print name). **Example 8**

‘Ditto’ is not acceptable because it causes misinterpretation when previous prescriptions have been administered. Similarly, prescriptions must not be bracketed together because it causes misinterpretation when prescriptions are cancelled.

To cancel a ‘Once Only Prescriptions’ that no longer requires to be given, draw a line through the prescription and write ‘Cancelled’ and sign across the ‘Time Given’ and ‘Given By’ boxes. **Example 8**

Example 8: Specific Instructions for ‘Once Only Prescriptions’

ONCE ONLY PRESCRIPTIONS							
Date	Time	Medicine	Dose	Route	Prescribed By (signature / print name)	Time Given	Given By
07/04/21	13.30	AMOXICILLIN	1G	IV	A. Doctor A. DOCTOR	13.40	LQ JR
07/04/21	15.00	BISOPROLOL	2.5mg	ORAL	A. Doctor A. DOCTOR	CANCELLED	A. Doctor 7/4/21

3.3. Specific Instructions for 'Regular Therapy'

Prescriber completes: Medicine Name; Form (if appropriate); Dose; Route; Signature, Print Name; as previously detailed. **Example 7**

Special attention should be made to the 'Long Stay' PAR to ensure that medicines are written on consecutive pages and that no blank pages are left in error.

Start Date

- Write the date the medicine is to start. **Example 9**
- Prospective prescribing increases the potential for error and should only be used when essential. Clear instructions should be given to ensure that any prospective/future medicines are not given until the date/time specified e.g. using a line to score through the dates prior to the start date of the medicine.

Example 9: Start Date

REGULAR THERAPY			Date																		
			Time																		
Medicine/Form AMIODARONE			08																		
Dose	200mg	Route	12																		
Signature/Print name			14																		
ADoctor A. DOCTOR			18																		
Pharmacy	Start Date	Frequency	20																		
	07/04/21	3 X DAILY																			
Additional Instructions			22																		
FOR 7 DAYS ONLY																					
REGULAR THERAPY			Date																		
			Time																		
Medicine/Form AMIODARONE			08																		
Dose	200mg	Route	12																		
Signature/Print name			14																		
ADoctor A. DOCTOR			18																		
Pharmacy	Start Date	Frequency	20																		
	14/04/21	TWICE DAILY																			
Additional Instructions			22																		
FOR 7 DAYS ONLY																					
REGULAR THERAPY			Date																		
			Time																		
Medicine/Form AMIODARONE			08																		
Dose	200mg	Route	12																		
Signature/Print name			14																		
ADoctor A. DOCTOR			18																		
Pharmacy	Start Date	Frequency	20																		
	21/04/21	MORNING																			
Additional Instructions			22																		

Time of Administration / Alternative Times / More Than Six Administrations

- To prescribe a medicine to be given at regular times, circle the time of each administration in the 'Time' column, i.e. 08, 12, 14, 18, 20, 22.

Example 10

Example 10: Time of Administration

REGULAR THERAPY			Date																	
			Time																	
Medicine/Form SIMVASTATIN			08																	
Dose 40mg	Route ORAL		12																	
Signature/Print name ADoctor A. DOCTOR			14																	
Pharmacy	Start Date 07/04/21	Frequency NIGHT	18																	
Additional Instructions			20																	
			22																	

- Medicines can be prescribed at alternative times by entering and circling alternative times in the adjacent column and scoring out the pre-printed times not used with a line. **Example 11**

Example 11: Alternative Times

REGULAR THERAPY			Date																	
			Time																	
Medicine/Form NIMODIPINE			08	02																
Dose 60mg	Route ORAL		12	06																
Signature/Print name ADoctor A. DOCTOR			14	10																
Pharmacy	Start Date 07/04/21	Frequency 6 X DAILY	18	14																
Additional Instructions			20	18																
			22																	

- There may be instances when more than six administrations a day of a medicine are necessary. In these circumstances, the medicine should be prescribed in two consecutive boxes. In the adjacent time column, enter and circle the administration times, using the 24 hour clock, in chronological order. Score out the pre-printed times not used with a line. **Example 12**

Example 12: More Than Six Administrations

REGULAR THERAPY			Date																	
			Time																	
Medicine/Form SODIUM CHLORIDE 0.9%			08	00																
Dose 5ml	Route NEB		12	02																
Signature/Print name A. Doctor A. DOCTOR			14	04																
Pharmacy	Start Date 07/04/21	Frequency EVERY 2 HOURS	16	06																
Additional Instructions			20	08																
			22	10																
REGULAR THERAPY			Date																	
			Time																	
Medicine/Form SODIUM CHLORIDE 0.9%			08	12																
Dose 5ml	Route NEB		12	14																
Signature/Print name A. Doctor A. DOCTOR			14	16																
Pharmacy	Start Date 07/04/21	Frequency EVERY 2 HOURS	18																	
Additional Instructions			20																	
			22																	

- If the medicine is also prescribed in the ‘As Required Therapy’ section, a note of this must be made in the additional instructions.
Example 13

Example 13: Medicine Prescribed in ‘Regular Therapy’ and ‘As Required Therapy’

REGULAR THERAPY			Date																
			Time																
Medicine/Form DIHYDROCODEINE			08																
Dose 30mg	Route ORAL		12																
Signature/Print name ADoctor A. DOCTOR			14																
Pharmacy	Start Date 07/04/21	Frequency 4 X DAILY	18																
Additional Instructions SEE AS REQUIRED THERAPY			20																
			22																

AS REQUIRED THERAPY				Date															
Medicine/Form DIHYDROCODEINE																			
Dose 30mg	Route ORAL																		
Frequency & Indication EVERY 4-6 HOURS FOR PAIN		MAX Dose in 24hrs 120mg																	
Signature/Print name ADoctor A. DOCTOR			Start Date 07/04/21																
Pharmacy	Additional Instructions SEE REGULAR THERAPY																		

Frequency

- The frequency box must be completed for all prescriptions. This is especially important for dosage regimens that are administered less frequently than daily e.g. Methotrexate which is given once weekly.

Example 14

- If the medicine is not prescribed on a daily basis, the days on which the medicine is not to be administered should be crossed off to prevent administration

Example 14: Frequency Less Than Daily

REGULAR THERAPY			Date																	
			Time																	
Medicine/Form METHOTREXATE			08	XXXX		XXXXXXX				XXXXXX										
Dose 10mg		Route ORAL	12																	
Signature/Print name A Doctor A. DOCTOR			14																	
Pharmacy	Start Date 07/04/21	Frequency FRIDAY	18																	
Additional Instructions			20																	
			22																	

Pharmacy Box

- For use by pharmacy staff for stock control purposes and to indicate that the prescription has been clinically checked by a pharmacist.

Additional Instructions

- Instructions entered by pharmacist, prescriber or nurse, e.g. administration in relation to food, special instructions, storage, etc.
- A duration or stop/review date may be appropriate for some medicines prescribed as a defined course. A line must be drawn across the administration boxes to highlight the course should be complete.

Example 15

- For all antibiotic prescriptions, the indication and duration/stop/review date must be documented in this box (see antibiotic prescribing guidance [Antimicrobial Documentation Policy For Staff Working In NHS Grampian Acute and Community Hospitals](#) **Example 15**)

Example 15: Duration/Review Date

REGULAR THERAPY			Date															
			Time															
Medicine/Form TRIMETHOPRIM			08															
Dose 200mg		Route ORAL	12															
Signature/Print name A Doctor A. DOCTOR			14															
Pharmacy	Start Date 07/04/21	Frequency TWICE DAILY	18															
Additional Instructions UTI 3 DAYS			20															
			22															

3.4. Specific Instructions for 'As Required Therapy'

Prescriber completes: Medicine/Form; Dose; Route; Signature/Print Name in the appropriate boxes, as previously detailed. **Example 7.**

Further specific instructions for 'As Required Therapy' **Example 16.**

Start Date

- Write the date the medicine is to start.

Frequency & Indication

- Prescribe the time interval that the medicine can be given.
- The indication for the medicine must be entered. Some medicines are used to treat more than one indication, e.g. codeine for pain or diarrhoea.

Maximum Dose in 24hrs

- Wherever appropriate, the Maximum Dose in 24 hours must be entered.
- The prescriber must make it clear if the maximum dose in 24 hours is the maximum dose of 'As Required Therapy' ONLY, or a combination of 'Regular Therapy' and 'As Required Therapy'.

Additional Instructions

- Instructions entered by pharmacist, prescriber or nurse, e.g. administration in relation to food, special instructions, storage, etc.
- If the medicine is also prescribed in the 'Regular Therapy' section, a note of this must be made in the 'Additional instructions'.

Example 16: Specific Instructions for 'As Required Therapy'

AS REQUIRED THERAPY			
Medicine/Form DIHYDROCODEINE		Date	
Dose 30mg		Time	
Route ORAL		Dose	
Frequency & Indication EVERY 4-6 HOURS FOR PAIN		Initials	
MAX Dose in 24hrs 120mg		Date	
Signature/Print name A Doctor A. DOCTOR		Time	
Start Date 07/04/21		Dose	
Pharmacy	Additional Instructions SEE REGULAR THERAPY	Initials	

3.5. Discontinuation of a Medicine

To discontinue a medicine:

- Draw diagonal line through section in which medicine is prescribed, a vertical line through the rest of the day's administration and a double diagonal line through remaining boxes in administration section for that medicine. **Example 17**
- The prescriber must then sign and date next to the double diagonal line. Ideally, the reason the medicine has been discontinued should also be recorded. **Example 17**
- It is important that the lines only delete the intended prescription and do not encroach on other prescriptions rendering them unclear and invalid.
- If a medicine requires to be amended, for example, a dose or frequency change is required, discontinue the entire entry and write a new entry. **Example 18**

Never alter prescriptions; always discontinue and write a new entry.

Example 17: Discontinuation of a Medicine

REGULAR THERAPY			Date	07/04/21	08/04/21														
			Time																
Medicine/Form			08	LQ	LQ														
Dose			12																
Route			14																
Signature/Print name			18																
Pharmacy			20																
Start Date			22																
Frequency																			
Additional Instructions																			

RAMIPRIL
2.5mg **ORAL**
A. DOCTOR
07/04/21 MORNING
WITHHOLD – RENAL IMPAIRMENT
A. Doctor 08/04/21

Example 18: Amendment to a Prescription

REGULAR THERAPY			Date	07/04/21	08/04/21														
			Time																
Medicine/Form			08	LQ	LQ														
Dose			12																
Route			14																
Signature/Print name			18																
Pharmacy			20																
Start Date			22																
Frequency																			
Additional Instructions																			

OMEPRAZOLE
20mg **ORAL**
A. DOCTOR
07/04/21 MORNING
DOSE INCREASED **A. Doctor 08/04/21**

REGULAR THERAPY			Date	07/04/21	08/04/21	09/04/21													
			Time																
Medicine/Form			08																
Dose			12																
Route			14																
Signature/Print name			18																
Pharmacy			20																
Start Date			22																
Frequency																			
Additional Instructions																			

OMEPRAZOLE
40mg **ORAL**
A. DOCTOR
09/04/21 MORNING

3.6. Cancelling a Medicine Written in Error

If a medicine has been written in error, the entry should be cancelled. In addition, the words 'written in error' should be entered adjacent to the prescriber's signature and the date. **Example 19**

Example 19: Cancelling a Medicine Written in Error

REGULAR THERAPY		Date											
		Time											
Medicine/Form BISOPROLOL		08											
Dose 5mg	Route ORAL	12											
Signature/Print name ADoctor A. DOCTOR		14											
Pharmacy	Start Date 07/04/21	18											
	Frequency MORNING	20											
Additional Instructions		22											
WRITTEN IN ERROR ADoctor 07/04/21													

3.7. Rewriting of a PAR

A new PAR should be prescribed before all administration recording boxes have been completed, or if the PAR becomes unusable for other reasons.

Re-writing a PAR should be carried out in a timely manner to reduce the risk of errors.

When a PAR is re-written all prescriptions must be cancelled by writing 'Rewritten' and recording the date the PAR was rewritten diagonally across ALL pages. The prescriber must then sign next to this. **Example 20**

All relevant prescription details, including patient demographics, allergy status, other medicine charts in use and new prescription number, must be transferred on to the new PAR.

The original dates on which the medicine was commenced should be written on the new PAR. The original date must be used to:

- Prevent confusion.
- Ensure medicines which are prescribed as a course can be discontinued on the correct date, e.g. antibiotics.
- Ensure medicines which are being gradually increased/decreased are adjusted on the correct date.
- Ensure that medicines which are being assessed are reviewed at the correct time interval.

All cancelled PARs must be retained in the patient's health records.

Example 20: Rewriting of a PAR

NHS Grampian		PRESCRIPTION & ADMINISTRATION RECORD					
Patient Name: JOHN SMITH		Date of admission <u>02/04/21</u>					
CHI number: XXXXXXXXXX		Prescription number <u>1</u>					
Date of Birth: XXXXXX (Attach printed label here)		Date re-written _____					
Hospital / Ward: ARI WARD 1		Weight: 75 kg	Height: 1.85m				
Consultant: A. CONSULTANT		Date recorded: 02/04/21	Gender: <input checked="" type="radio"/> M <input type="radio"/> F				
KNOWN MEDICINE ALLERGIES/SENSITIVITIES (If NONE confirmed write NKDA in Box 1)							
Must be documented before prescription/administration except in exceptional circumstances							
1. NKDA	2.	3.	4.				
VENOUS THROMBOEMBOLISM RISK ASSESSMENT HAS BEEN UNDERTAKEN ON ADMISSION sign A. DOCTOR							
OTHER MEDICINE CHARTS OR TREATMENT PLANS IN USE (Please tick)							
CHART TYPE		CHART TYPE					
1. Diabetes prescription sheet	5. Anaesthetic Record	9. Mental Health Care and Treatment (Scotland) Act 2003 - T2/T3 form					
2. Intravenous Patient-controlled analgesia prescription sheet	6. Oral anticoagulant prescription sheet	10. Adults with Incapacity (Scotland) Act 2000. (Section 47 Certificate and Treatment Plan)					
3. Fluid (additive medicine) prescription and recording sheet	7. Dermatology sheet	11. Syringe Driver					
4. Chemotherapy prescription sheet	8. Ophthalmology sheet	12. Other					
ONCE ONLY PRESCRIPTIONS							
Date	Time	Medicine	Dose	Route	Prescribed By (signature / print name)	Time Given	Given By
					REWRITTEN 10/04/21		
					ADoctor A. DOCTOR		

3.8. Prescriptions Ordered Verbally (e.g. by Telephone)

In very exceptional circumstances, excluding controlled drugs, a medicine ordered verbally may be given but the following procedure must be adhered to:

- A nurse takes the message, repeating it to the prescriber to ensure accuracy.
- A written direction should be emailed by the prescriber.
- An entry can then be made by the nurse taking the message in the 'Once Only Prescriptions' section of the PAR.
- The name of the prescriber, the nurse who received the verbal prescription order and the time of the call should be documented in the nursing notes.
- The prescriber must sign the prescription at the earliest possible opportunity, in any event, within 24 hours.

For more information, see the joint Royal College of Nursing and Royal Pharmaceutical Society documents ["Professional guidance on the safe and secure handling of medicines"](#) and ["Professional Guidance on the Administration of Medicines in Healthcare Settings"](#)

Note: In community hospitals, there is not always a prescriber present therefore it may be necessary to email prescriptions using the 'Temporary GMED/GP Prescription Sheet'. Only in very exceptional circumstances should a prescription be ordered verbally.

Controlled Drugs must NEVER be prescribed verbally, see Policy and Procedure for Secondary Care and Community Hospitals in NHS Grampian on the Safe Management of Controlled Drugs.

4. Administration of Medicines

4.1. General Guidance

- Medicines will normally be administered by either a nurse or suitably qualified practitioner (see glossary) in accordance with a written prescription.
- In some wards/departments and for some medicines, e.g. intravenous drugs, **two** suitably qualified practitioners must be involved in checking and administration.
- In paediatrics, **two** suitably qualified practitioners must be involved in all medicine administration, unless signed up to the 'Single Nurse Administration of Oral, Topical and Inhaled Medication in the Paediatric Setting' register.
- Effective preparation and planning are key to safe administration.
- Staff must not interrupt the person carrying out medicine administration for a patient, other than in exceptional circumstances (i.e. wait until they have completed administration for that patient).
- Care should be taken to ensure that the maximum recommended dose of a medicine is not exceeded. Some medicines may have been prescribed in more than one section of the PAR therefore checks should be completed of all the relevant sections prior to medicine administration.
- If a patient has been to another department, e.g. theatre, check whether any medicines have been given during that time and consideration should be given as to any impact this may have on subsequent medicines administered that day. For example, if paracetamol was given in theatre and recorded on the anaesthetic record, check that the **maximum dose in 24 hours** will not be exceeded if it is also prescribed in a different section of the PAR.
- Prior to medicine administration check that all aspects of the prescription are complete. The administration times circled should also be checked to ensure they match the frequency stated in the frequency box. If any aspects of the prescription are incomplete or illegible, the prescriber must complete or rewrite the prescription.
- Where medicine(s) are to be given covertly, practitioners must follow the NHSG Guideline on Covert Administration of Medicines (Adult) https://www.nhsgrampian.org/globalassets/foidocument/foi-public-documents1---all-documents/Policy_CovertMeds.pdf

4.2. Administration Process

Once the process of administration has started, it is important to complete all administrations for that patient and complete all documentation immediately and without interruption.

- **Check all patient details** and information on front page are complete and on each page of the PAR in use.
- **Identify the patient** by:
 - Asking the patient to state their full name and date of birth, where possible.
 - Checking their identification bracelet:
 - Check that the patient's full name, date of birth and CHI on their identification bracelet corresponds with their PAR.
 - Where in use they must be checked each time a medicine is to be administered.
 - Extreme care must be exercised with highly dependent patients and in locations where there is an agreed policy not to use identification bracelets.
 - Where the identification bracelet is not used, the patient's identity must be confirmed by another appropriate means, as per NMC guidance or local procedure.

Non-identification or mis-identification of patients is a common source of medicine errors

- **Check the Known Medicine Allergies/Sensitivities section** has been completed, even with 'NKDA' if none. If the section is blank, do not administer and refer to prescriber immediately.

Ensure no medicine is administered where there is a known allergic reaction or sensitivity to that particular medicine

- **Identify the medicines** due to be given by checking all sections of the PAR. If there is any doubt about the prescription, an appropriate senior colleague should be consulted.
- **Check the dose has not already been administered.**
- **Select the medicine** required. Before selecting the medicines required, it is essential to ask the patient if they are willing and able to take the

medicines at that time. If the patient refuses or is unable to take a medicine, see 'Recording the Non-Administration of Medicines'.

Example 25

- **Check the medicine container against the prescription.** Where there is outer packaging, for example strip packed tablets the medicine must be removed from the outer packaging and checked against the prescription. Ensure there is no uncertainty about the identity or quality of the medicine.
- **Check the following:**
 - **Medicine name**
 - **Form** (appropriate for route). Special care should be taken to ensure that the correct formulation is selected, e.g. modified release preparations.
 - **Strength** (appropriate for dose)
 - **Expiry date**
- **If the patient's own medicines are to be administered**, confirm the patient's name on the label is correct and check that the medicine is fit for use.
- **Place the required dose in an appropriate container** for the patient to take the medicine.
- **Witness the patient administering the medication.**
- **Record administration** as detailed below.

4.3. Other Medicine Charts or Treatment Plans in Use

Always check if there are other medicine charts/treatment plans in use as these may contain additional instructions.

All medicine charts for a patient should be located together to ensure all staff are aware of current medicines in use. This helps prevent missed or delayed doses and acts as a prompt for review of medicines on transfer or discharge.

Particular attention must be paid to any medicine administered in the 'Once Only Prescriptions' section as it may affect a medicine due to be administered

4.4. Specific Instructions for Administering and Recording Administration of 'Once Only Prescriptions'

- Check that all columns from 'Date' through to 'Prescribed By' have been completed and that the remaining two columns are blank, i.e. 'Time Given' and 'Given By'.
- Follow 'Administration Process' as previously detailed.
- Record the administration by initialling the 'Given By' column and complete the 'Time Given' column. **Example 21**
- A delay in administering a 'Once Only Prescriptions' medicine may be unavoidable and when this happens, if the nurse considers the prescription still to be appropriate, the actual time that the medicine is given should be entered in the 'Time Given' column. In all other cases, the prescription must be re-written.
- Any medicine prescribed in the 'Once Only Prescriptions' section which cannot be administered, must be discussed with the prescriber who should cancel and write a new prescription as appropriate.

Example 21: Specific Instructions for Administering and Recording Administration of 'Once Only Prescriptions'

ONCE ONLY PRESCRIPTIONS							
Date	Time	Medicine	Dose	Route	Prescribed By (signature / print name)	Time Given	Given By
07/04/21	13.30	AMOXICILLIN	1G	IV	ADoctor A. DOCTOR	13.40	LQ JR
07/04/21	15.00	BISOPROLOL	2.5mg	ORAL	ADoctor A. DOCTOR	CANCELLED	ADoctor 07/04/21

4.5. Specific Instructions for Administering and Recording Administration of 'Regular Therapy'

- Check the date at the top of each 'Regular Therapy' section and look down the column in conjunction with the 'Time' row, establish which medicines are due to be administered.
- If it is the first administration of the day, write the date in the 'Date' column at the top of the page.
- Check for medicines to be given less than once daily, e.g. weekly.
- Additional instructions - it is important to note any instructions which have been entered in the 'Additional Instructions' column.

- Follow 'Administration Process' as previously detailed.
- Record the administration by initialling the top half of the box that corresponds to the appropriate date and time. **Example 22**
- Where a choice of route has been prescribed, the route used should be recorded in the lower half of the administration box.
- Most medicines can be administered up to 1 hour before or 1 hour after the prescribed time. The reason for early or late administration should be documented in the nursing record. Staff who do not feel competent administering medicines outwith the prescribed times should discuss this with a senior colleague on the ward.
- Where Antibiotics are prescribed follow the Antibiotics Policy: 'Antimicrobial Documentation Policy for Staff Working in NHS Grampian Acute and Community Hospitals'
<http://nhsgintranet.grampian.scot.nhs.uk/depts/GrampianMedicinesManagementGroup/MedsGuidelinesandPolicies/Medicines%20Guidelines%20and%20Policies/Policies/AbDocPol.pdf>

Example 22: Specific Instructions for Administering and Recording Administration of 'Regular Therapy'

REGULAR THERAPY			Date	07/04/21																	
			Time	08	12	14	18	20	22												
Medicine/Form ONDANSETRON			08	LQ																	
Dose 8mg			12	JR IV																	
Route ORAL/IV			14	LQ																	
Signature/Print name A Doctor A. DOCTOR			18	JR IV																	
Pharmacy			20	LQ																	
Start Date 07/04/21			22	JR IV																	
Frequency 3 X DAILY																					
Additional Instructions																					

4.6. Specific Instructions for Administering and Recording Administration of 'As Required Therapy'

- Medicines should be administered only for the indication identified.
- Where a choice of dose is prescribed, the lower dose should usually be selected first and the effects evaluated before increasing to the higher dose. Staff who do not feel competent to make this decision should discuss this with a senior colleague on the ward.

- Additional instructions - It is important to note any instructions which have been entered in the 'Additional Instructions' column.
- Follow 'Administration Process' as previously detailed.

Take into account the prescribed frequency, maximum dose, date and time last administered in the previous 24 hours. Check that this dose will not exceed the maximum in the previous 24-hour period by checking other prescriptions including 'Once Only Prescriptions' and 'Regular Therapy'

- Record the administration as follows: Enter the date, time, dose and initials in the relevant boxes. **Example 23**
- Where a choice of route has been prescribed, the route used should be recorded along with the dose in the dose box.

Example 23: Specific Instructions for Administering and Recording Administration of 'As Required Therapy'

AS REQUIRED THERAPY			
Medicine/Form DIHYDROCODEINE		Date	07/04/21
Dose	Route	Time	11.00
30mg	ORAL	Dose	30mg
Frequency & Indication EVERY 4-6 HOURS FOR PAIN	MAX Dose in 24hrs 240mg	Initials	LQ
Signature/Print name A Doctor A. DOCTOR	Start Date 07/04/21	Date	
Pharmacy	Additional Instructions	Time	
		Dose	
		Initials	

4.7. Recording the Administration of Controlled Drugs

A high level of security/recording is applied to Controlled Drugs because of the potential for abuse.

Local procedures relating to Controlled Drugs must be adhered to (see 'Policy and Procedure for Secondary Care and Community Hospitals in NHS Grampian on the Safe Management of Controlled Drugs'
https://www.nhsgrampian.org/globalassets/foidocument/foi-public-documents1---all-documents/Policy_CDs_Hospitals.pdf)

All Controlled Drugs must be checked, administered and recorded **in the presence of a witness. Example 24**

The details of any Controlled Drugs administered must also be entered in the Ward Controlled Drugs Record Book which **must be** signed in full, both by the person administering the medicine and by the witness.

Example 24: Recording the Administration of Controlled Drugs

AS REQUIRED THERAPY			
Medicine/Form SHORTEC CAPSULES		Date	07/04/21
Dose 10mg	Route ORAL	Time	15.00
Frequency & Indication EVERY 4-6 HOURS FOR PAIN		Dose	10mg
MAX Dose in 24hrs 60mg		Initials	LQ JR
Signature/Print name ADoctor A. DOCTOR		Date	
Start Date 07/04/21		Time	
Pharmacy	Additional Instructions	Dose	
		Initials	

4.8. Recording the Non-Administration of Prescribed Medicines

Medicine doses may be omitted or delayed in hospital for a variety of reasons. The reasons for the non-administration are detailed in the PAR.

If a medicine cannot be administered it is the responsibility of that nurse to take appropriate follow-up action. Actions taken to resolve the issue(s) should be documented in the patient’s medical/nursing notes to ensure that all staff are aware.

It is important to recognise that harm can arise from the omission or delay of medicines

If a medicine is not administered, the top of the box should be initialled and the appropriate ‘Non-Administration Code’ should be entered in the lower half of the administration box with a circle drawn round it. **Example 25**

If a medicine has been recorded as not being administered and is subsequently required, the prescriber should be contacted to prescribe the medicine as a ‘Once Only Prescriptions’ dose.

Example 25: Recording the Non-Administration of Prescribed Medicines

CODES FOR NON-ADMINISTRATION OF PRESCRIBED MEDICINES		
If a dose is not administered, initial and enter the appropriate code in the administration box with a circle drawn round it:		
1. Patient refused	6. Once only/as required	11. No intravenous access
2. Patient unavailable	7. Dose withheld - Prescriber's instructions	12. Anaesthetist requested omission
3. Medicine out of stock	8. Self administered by patient	13. Other... <i>No. N.G. time over table</i>
4. Instructions not clear/legal	9. Nausea/vomiting	14. Other.....
5. Nil by mouth	10. Unable to swallow	15. Other.....
General Comments:		16. Other.....

REGULAR THERAPY			Date	07/04/21	08/04/21	09/04/21												
			Time	08	12	14	18	20	22									
Medicine/Form			SENNA															
Dose		Route		15mg			ORAL											
Signature/Print name			ADoctor A. DOCTOR															
Pharmacy	Start Date	Frequency	07/04/21			NIGHT												
Additional Instructions				LQ	LQ	LQ	①											

4.9. Recording the Administration of Medicines When Patients Are ‘On Pass’

When a patient goes ‘on pass’ from the ward any medicine doses due to be administered during the ‘on pass’ period should be recorded as follows:

- Enter the initials of the nurse(s) undertaking the medicine round into the top half of the administration box.
 - Write ‘On Pass’ against one of the ‘Other’ code numbers, e.g. ‘13’, and enter that code number into the bottom half of the administration box.
- Example 26**
- This code number should then be entered at every medication round during the period that the patient is ‘on pass’.

On the day the patient returns from being ‘on pass’, start recording administration again from the first medication given.

Example 26: Recording the Administration of Medicines When Patients Are ‘On Pass’

REGULAR THERAPY			Date	07/04/21	08/04/21	09/04/21	10/04/21	11/04/21										
			Time	08	12	14	18	20	22									
Medicine/Form			SENNA															
Dose		Route		15mg			ORAL											
Signature/Print name			ADoctor A. DOCTOR															
Pharmacy	Start Date	Frequency	07/04/21			NIGHT												
Additional Instructions				LQ	LQ	LQ	LQ	LQ	⑬	⑬	⑬							

4.10. Recording the Administration of a Medicine Given Under a Patient Group Direction (PGD) or NHS Grampian Approved Protocol

Staff using a PGD or an NHS Grampian Protocol to administer medicines to a patient should document the administration as directed in the relevant PGD or protocol.

4.11. Procedure in the Event of a Medicine Incident or Suspected Medicine Incident

A medicine incident is defined as:

‘any incident where there has been an error in the process of prescribing, dispensing, preparation, administration, monitoring, recording, storage or provision of information, regardless of whether any harm occurred or was possible.’

National Patient Safety Agency; 2007

Understanding of and adherence to policies and procedures greatly reduces the risk of errors.

In the event of medicine incident, the following actions should be taken to ensure patient safety:

- Patient safety is paramount, therefore the patient should be observed closely and any appropriate treatment prescribed and administered.
- The doctor/prescriber and senior nurse on duty must be informed.
- The patient/the patient’s relatives should also be informed.
- The incident should be recorded in the patient’s medical notes and nursing notes.
- A DATIX incident report should be completed as soon as possible after the event and staff should be encouraged to provide a full and accurate description of events. The reporting of medicine incidents helps to reduce risk to patients and staff. Lessons can be learned by recording and analysing errors.

5. Medicines Care Plan

Any member of staff may use this section to record medicine-related care issues. **Example 27**

The medicines care plan should be completed as follows:

- Details of presenting complaint and past medical history (PMH) should be entered. Specific medications are contra-indicated in certain medical conditions.
- Confirmation that [medicines reconciliation](#) has been undertaken and that the patient's own medicines have been checked should be recorded.
- Information on whether a patient has a compliance aid and whether they are resident in a care home should be entered. This will facilitate the discharge process and highlight, where appropriate, arrangements which must be made to ensure the patient is able to take their medicines safely on discharge.
- Where a patient receives Level 3 Medicines Management support from carers, this must be identified. On discharge all medicines must be provided along with a Medicine Administration Record (MAR) chart to allow carers to administer medicines. Arrangements must be made with the Care Manager/Local Area Co-ordinator to ensure appropriate care is in place to allow medicine administration as needed after discharge.
- Pharmaceutical care issues identified should be detailed. Examples would be: patients with poor inhaler technique; medicines requiring therapeutic drug monitoring; medicines which have been stopped on admission which may need to be re-instated prior to discharge; patients with swallowing difficulties.

Example 27: Medicines Care Plan

MEDICINES CARE PLAN		Patient name	JOHN SMITH	CHI	XXXXXXXXXX
Presenting Complaint: EXAC. OF COPD		PMH: COPD TYPE 2 DIABETES HYPOTHYROID			
	Tick	Details			
Patient's own medicines checked	<input checked="" type="checkbox"/>				
Medicines reconciled	<input checked="" type="checkbox"/>	ECS + PODS + COMMUNITY PHARMACY			
Compliance Aid?	<input checked="" type="checkbox"/>	MDS: ABC PHARMACY TEL/FAX: 01224 123456			
Resident in Care Home	<input checked="" type="checkbox"/>				
Level 3 medicines management at home?	<input checked="" type="checkbox"/>	PP 07/04/21			
CARE ISSUES		Action / Outcome	Initials	Date	
Relvar Ellipta inhaler		Counselled on inhaler use	PP	07/04/21	
commenced – needs to be		– able to use effectively			
counselled					

6. Consultation Group – Prescription and Administration Records Group

Karen McKessack	Specialist Clinical Pharmacist, ARI
Morag Lyall	Specialist Clinical Pharmacist, ARI
Elaine Neil	HSCP Lead Pharmacist
Sarah O'Beirne	Medicines Information Pharmacist, ARI
Lindsay Cameron	Medication Safety Advisor, ARI
Leona Pottinger	Senior Charge Nurse, High Dependency Unit, RACH
Martina Freeman	Specialist Clinical Pharmacist, RACH
Valerie Dick	Clinical Pharmacist, ARI
Olubunmi Okhuoya	Lead Practice Educator
Dayni McConnell	HEPMA Pharmacist, ARI

7. Glossary

PAR – Prescription and Administration Record.

Medicine – this is a generic term which includes medicinal and pharmaceutical products.

Prescriber – person with a prescribing qualification recognised by NHS Grampian.

Health professional / suitably qualified practitioner – all registered health professionals, including doctors, dentists, nurses, midwives, health visitors, pharmacists, pharmacy technicians, registered ophthalmic or dispensing opticians (working in a hospital setting) and members of professions allied to medicine and dentistry.

Nurse – this refers to Registered Nurses and Midwives, and Student Nurses and Midwives at the appropriate stage of their training (refer to the [Practice Education](#) intranet pages for up to date information).