NHS Grampian

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

Author:	Consultation Group (see relevant page within the document)	Approver:
Chair of Prescriptions and Administration Records Group		Grampian Area Drugs and Therapeutics Committee (GADTC)
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Identifier: Identifier: NHSG/Guid/Inst/1660	**Review Date:** May 2028 This guideline will be reviewed in three years or sooner if current treatment recommendations change.	**Date Approved:** May 2025

Policy Statement:
It is the responsibility of all staff to ensure that they are working to the most up to date and relevant guideline, policies, protocols and procedures.

Version 4.1

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Executive Sign-Off

This document has been endorsed by the Director of Pharmacy

Signature: _____

Replaces: NHSG/Guid/Inst/1660 Version 4

Document application: NHS Grampian Acute / Primary Care

Revision History:

Revision Date	Summary of Changes (Descriptive summary of the changes made)	Changes Made (Identify page numbers and section heading)
Mar 25	**3 yearly update.** Changed to a guide following roll out of HEPMA since minimal wards continue to use paper PARs and paper PARs may be used wide scale as part of a contingency if HEPMA down. Separated Medicines Administration process into a separate Policy (not specific to the type of record used)	Throughout Document

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1. Introduction

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

NHS Grampian in-patient areas use Hospital Electronic Prescribing and Medicines Administration (HEPMA) to prescribe and record administration of most medicines. Guidance on how to use HEPMA to prescribe and administer medicines can be found on the North of Scotland HEPMA Webpages. HEPMA live areas may need to move to using PAR in the event of a major incident resulting in HEPMA being down for a prolonged period of time. Refer to local HEPMA contingency plans for what to do during major incidents/HEPMA downtimes.

Some locations continue to use a paper Prescription and Administration Record (PAR) and some medicines require an approved paper PAR for specialist use to be completed e.g. Subcutaneous Insulin Prescription and Administration Record (SIPAR) or the Vancomycin Prescription and Administration Record.

All paper PARs in use within NHS Grampian must be approved by the NHS Grampian Prescription and Administration Records Group.

1.1 Objectives

This document aims to give general guidance to all prescribers and Healthcare Professionals who administer medicines on the completion of all paper PARs.

While not all sections/examples given below will be relevant for every paper PAR in use the general principles in this document apply. Specific guidance for specialist PARs will be noted on the specialist PAR itself or in an associated instruction document.

1.2 Definitions

Prescription and Administration Record (PAR): a combined prescription and administration record (the paper prescription/medicines administration record).

Specialist Prescription and Administration Record (PAR): A prescription and administration record for a specific medicine e.g. insulin, warfarin, gentamicin, vancomycin.

Medicine: a generic term which includes medicinal and pharmaceutical products.

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

Hospital Electronic Prescription and Medicines Administration (HEPMA): the electronic prescribing and medicines administration chart.

1.3 Clinical Situations

This document applies to any areas where a patient has a paper Prescription and Administration Record in use.

1.4 Staff Groups to Which This Document Applies

This document applies to Prescribers and Healthcare Professionals who prescribe and administer medicines using a paper Prescription and Administration Record.

1.5 Patient Groups to Which This Document Does Not Apply

Patients with a HEPMA record – refer to HEPMA Standard Operating Procedures.

2. Evidence Base

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.

3. Process Document Main Components and Recommendations

3.1 General Guidance

- All PARs 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.
- HEPMA users must also check for any paper PARs in use for their patient.
- 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.
- All PAR entries must be written in English and in BLOCK CAPITAL LETTERS using indelible black ink.
- Latin abbreviations such as ‘p.r.n.’ and symbols such as must not be used.
- PARs belonging to patients transferred within NHS Grampian may continue to be used in the receiving ward/hospital if appropriate.

- On discharge PARs generated during an admission must be uploaded into the patients EPR as per Health Records policies and procedures.

- A new PAR must be used for patients who are readmitted regardless of the time that has elapsed since last admission.

- 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.

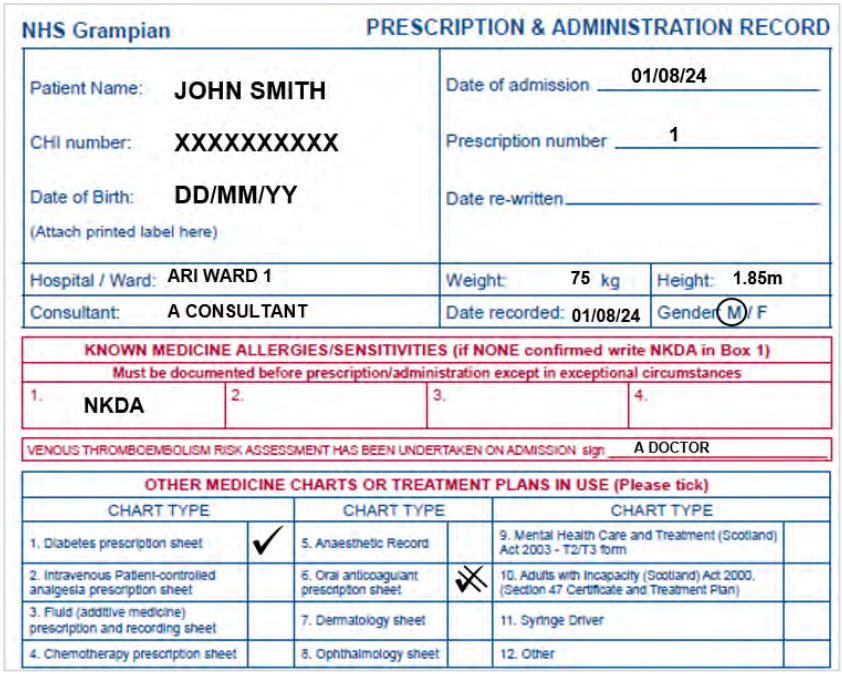
- Resources are available to support prescribing and prescribers should familiarise themselves with these, namely, NHSG Joint Formulary, NHSG Non-medical Prescribing Policy and the NHSG Medicines Reconciliation Protocol.

- 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.

3.2 Completing Demographics, Medicines Allergies, VTE Risk Assessment and Other Medicines Charts Sections

Patient Demographics
Complete before prescribing any medicines.

Attach addressograph label where possible, if not write details in full.



NHS Grampian — PRESCRIPTION & ADMINISTRATION RECORD

Patient Name: JOHN SMITH		Date of admission: 01/08/24	
CHI number: XXXXXXXXXX		Prescription number: 1	
Date of Birth: DD/MM/YY (Attach printed label here)		Date re-written:	
Hospital / Ward: ARI WARD 1		Weight: 75 kg	Height: 1.85m
Consultant: A CONSULTANT		Date recorded: 01/08/24	Gender: (M) / F

KNOWN MEDICINE ALLERGIES/SENSITIVITIES (if NONE confirmed write NKDA in Box 1)
Must be documented before prescription/administration except in exceptional circumstances

1.	2.	3.	4.
NKDA			

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	

Hospital / Ward
Abbreviations may be used (e.g. ARI/209). Update if the patient moves Ward or Hospital.

Consultant
PRINT in full surname of consultant or GP (doctor responsible for care in hospital).

Date of Admission
Enter as DD/MM/YY

Prescription Number
The number of same PARs in use. If more than one the number should be amended to “1 of 2” “2 of 2”.

A maximum of two general PARs should be in use at any one time.

Date re-written
Should be entered when the previous PAR(s) have been re-written and replaced with a new PAR.

Weight
Record on admission using kilograms.

Height
Record when necessary using metres

Date recorded
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 should be circled as appropriate.

Known Medicines Allergies/Sensitivities
Must be completed by the prescriber prior to prescribing.

Use generic name of any known medicine allergies/sensitivities.

If it has been confirmed that the patient has 'No Known Drug Allergies', write 'NKDA'.

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.

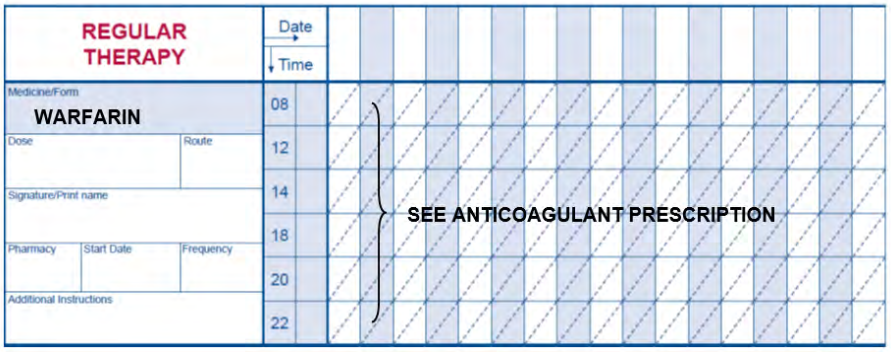
All serious adverse drug reactions should be recorded in the appropriate section within the patient's health records.

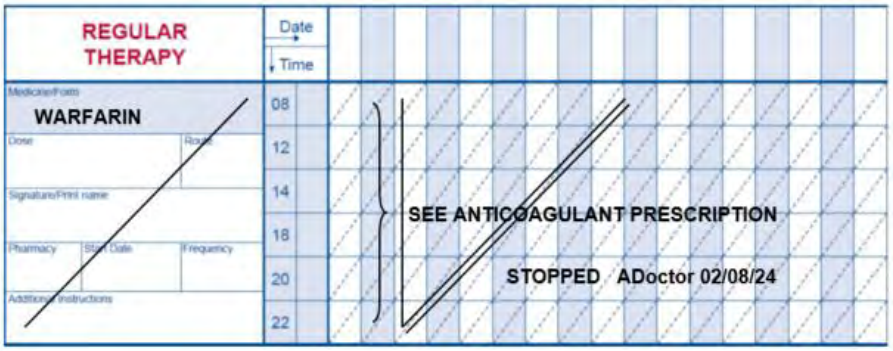
Adverse Drug Reactions should be reported to Yellow Card.

VTE Risk Assessment
This should be signed by the person completing the assessment.

Other Medicines Charts or Treatment Plans in Use
The prescriber should tick the box of the appropriate chart if in use. Medicines on other charts should be written in the Regular Therapy Section as a reminder to staff.

Any other charts that have been discontinued should be scored out with two lines across the tick.

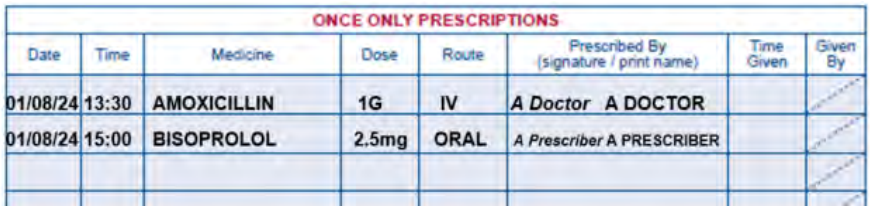




3.3 Prescribing Medication

3.3.1 Date, Time, Medicine/Form

Date/Start Date



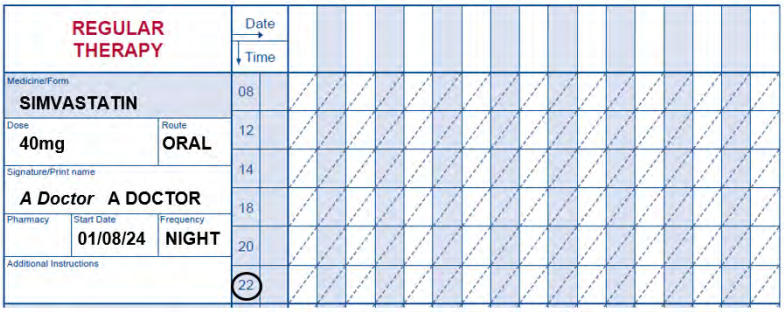
ONCE ONLY PRESCRIPTIONS

Date	Time	Medicine	Dose	Route	Prescribed By (signature / print name)	Time Given	Given By
01/08/24	13:30	AMOXICILLIN	1G	IV	*A Doctor* A DOCTOR		
01/08/24	15:00	BISOPROLOL	2.5mg	ORAL	*A Prescriber* A PRESCRIBER		

Date the dose is to be given (once only prescriptions) or the date the medicine is to be started (regular therapy and as required therapy).

Use DD/MM/YY format

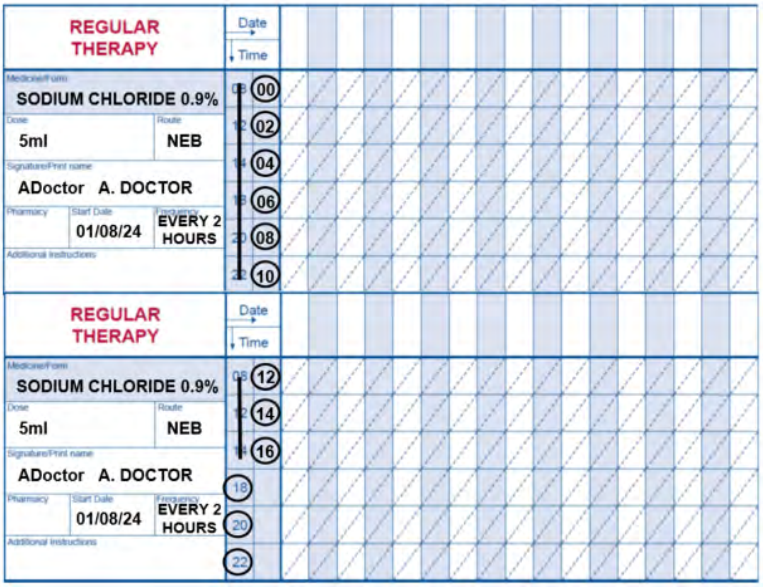
Time



Use 24 hour clock (once only prescriptions) or circle appropriate time(s) (regular therapy).

Additional or alternative times for regular therapy may be written and circled in the adjacent time column. Score out the pre-printed times not used with a line. For more than six administration in 24 hours prescribe the medicine in two consecutive boxes.

Medicine/Form



Full generic name of medicine in BLOCK CAPITAL LETTERS

Some medicines have similar names and writing in capital letters helps to avoid confusion, therefore reducing the likelihood of errors in administration.

Brand name can be used when:

- bioavailability between brands or formulations exists
- this would reduce the risk of an administration error
- Prescribing Insulin

Specify strength for multi-ingredient preparations when more than one strength exists e.g. Revlar 92/22 Ellipta.

Formulation must be specified when it is essential to assist the administration of the correct medicine. Form must be specified on ALL paediatric prescriptions.

3.3.2 Dose, Route, Signature, Frequency and Pharmacy Box

Dose

Prescribe using metric system:

- milligram = mg
- gram = g
- millilitre = mL

Do not abbreviate micrograms, nanograms or units.

Express doses of less than one milligram in micrograms e.g. 62.5 micrograms.

Use a leading zero for numbers less than 1 e.g. 0.5mL.

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.

Route

Method of administration must be appropriate to the medicine prescribed and may be abbreviated as per User Notes on PAR chart.

5. Method of administration should be abbreviated as follows:

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

All other routes must be written in full.

More than one route e.g. IV/ORAL must only be used if the dose of the medicine is the same for BOTH routes.

Signature and Print Name

Each medicine 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.

Initials are not acceptable.

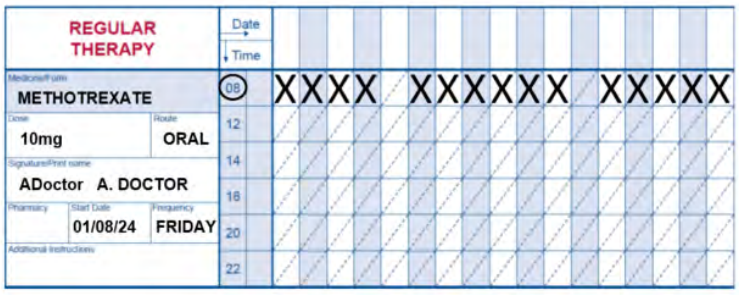
Non-medical prescribers should annotate the prescription accordingly:

- Non-medical prescriber: NMP
- Independent Prescriber: IP
- Supplementary Prescriber: SP

Frequency

Must be completed for all prescriptions.

Especially important for dosage regimens that are administered less frequently than daily.



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.

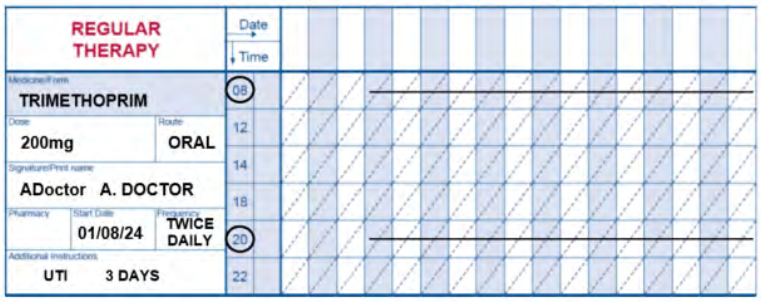
Pharmacy Box

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

3.3.3 Additional Instructions Box

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.

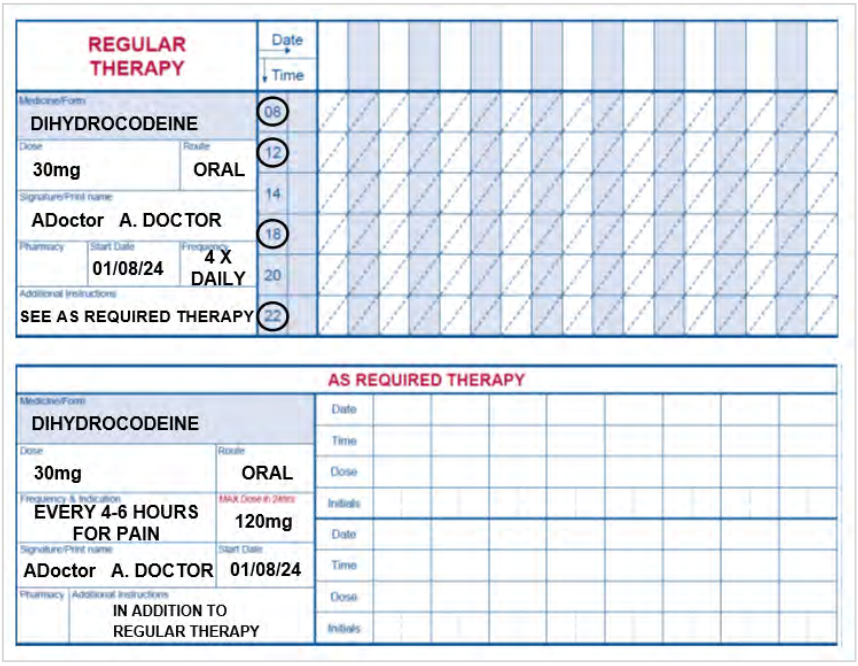
For all antibiotic prescriptions, the indication and duration/stop/review date must be documented in this box.

3.3.4 Further Instructions for ‘As Required Therapy’

Frequency
Prescribe the interval time that medicine can be given

Indication
Must be entered. Some medicines are used to treat more than one indication.

Dose
A choice of doses may be prescribed where appropriate in the ‘As Required Therapy’ section only.



Maximum Dose in 24 hours
Wherever appropriate, the Maximum Dose in 24 hours must be entered.

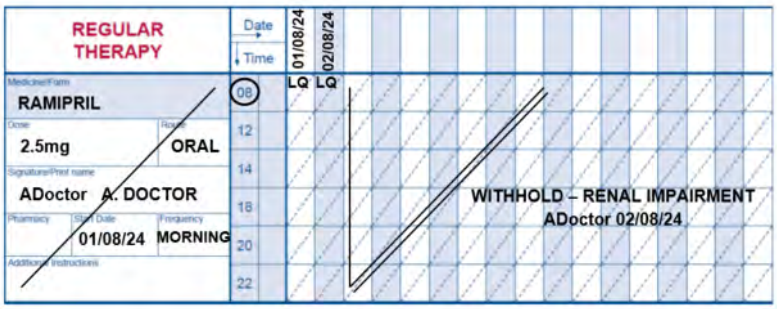
Prescriber must make it clear if the maximum dose in 24 hours is the maximum dose of As Required Therapy ONLY, or a combination of Regular Therapy and As Required Therapy.

Additional Instructions Box
Use this box to indicate when the same medicine is prescribed as both Regular Therapy and As Required.

3.4 Discontinuing a Medicine or Cancelling a Medicine Written in Error

To Discontinue a Medicine the following should be done

Draw a line through the section in which the medicine is prescribed.



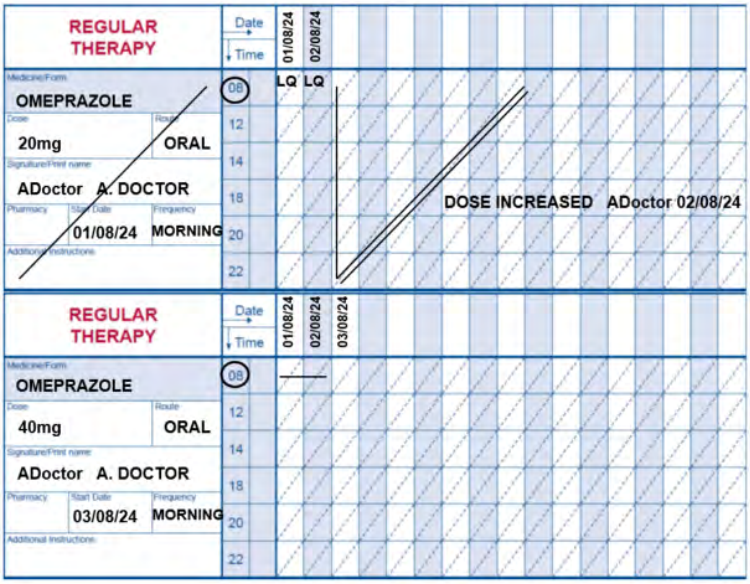
Draw a vertical line through the rest of the day's administration

Draw a double diagonal line through the remaining boxes in the administration section for that medicine.

Prescriber signs and dates next to the double diagonal line.

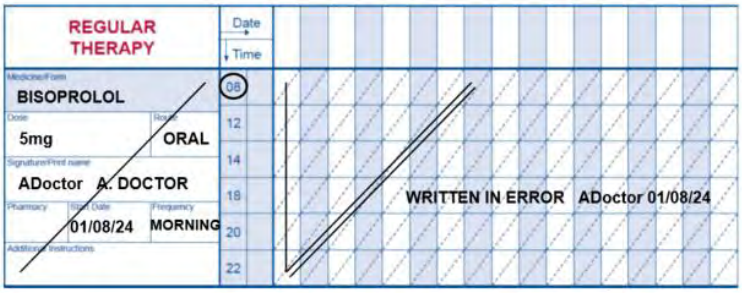
The reason the medicine has been discontinued should be recorded.

Never alter prescriptions. If a medicine requires to be amended, e.g. a dose or frequency change is required, discontinue the entire entry and write a new entry.



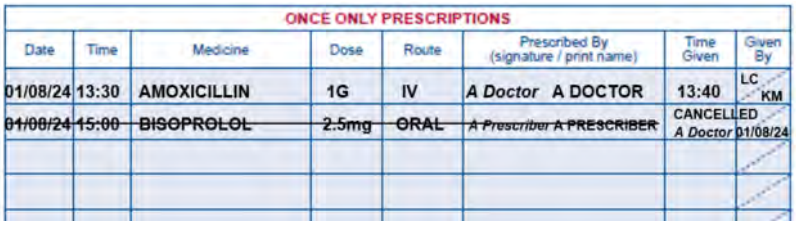
To cancel a medicine written in error

For Regular Therapy and As Required Therapy follow instructions above and record 'written in error'.



To cancel a once only prescription that no longer requires to be given or is written in error

Draw a line through the prescription



ONCE ONLY PRESCRIPTIONS

Date	Time	Medicine	Dose	Route	Prescribed By (signature / print name)	Time Given	Given By
01/08/24	13:30	AMOXICILLIN	1G	IV	*A Doctor* A DOCTOR	13:40	LC KM
~~01/08/24~~	~~15:00~~	~~BISOPROLOL~~	~~2.5mg~~	~~ORAL~~	~~*A Prescriber* A PRESCRIBER~~	CANCELLED *A Doctor* 01/08/24	

Write 'Cancelled' or 'written in error' as appropriate

Sign across the 'Time Given and 'Given by' boxes.

3.5 Rewriting a PAR

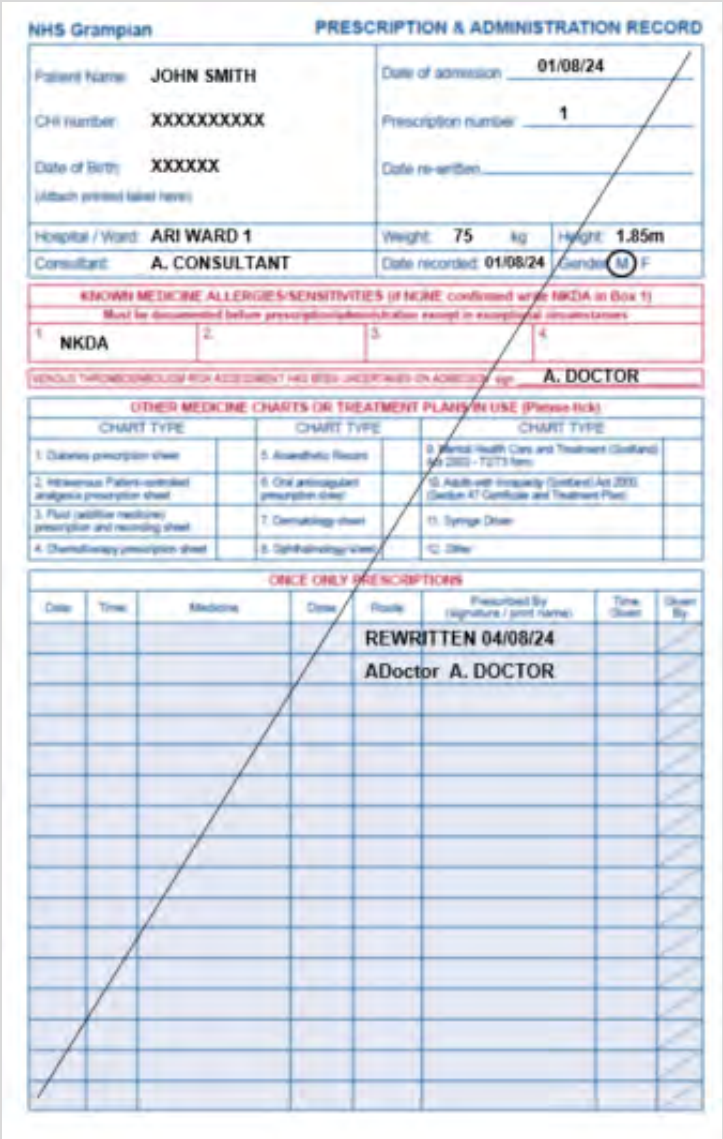
A new PAR should be prescribed before all administration recording boxes have been completed, or if the PAR becomes unusable for other reasons.

All prescriptions must be cancelled by writing ‘Rewritten’ and recording the date the PAR was rewritten diagonally across ALL pages.

The prescriber must sign next to this.

The original dates on which the medicine was commenced should be written on the new PAR.

All cancelled PARS must be retained in the patient’s health records.

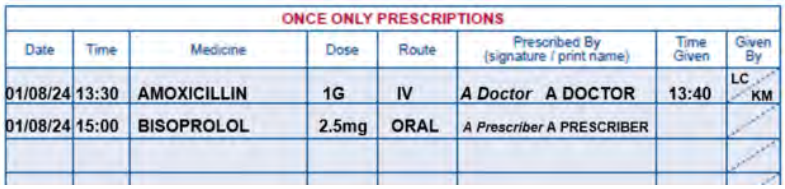


3.6 Recording Administration

3.6.1 Once Only Prescriptions, Regular Therapy, As Required Therapy and PGDs

Once Only Prescriptions

Record the administration of the medicine by initialling the 'Given By' column.



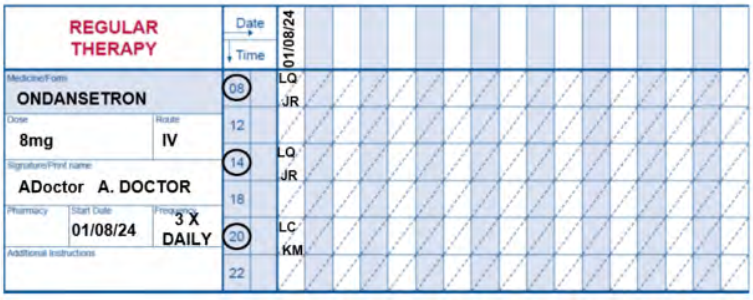
ONCE ONLY PRESCRIPTIONS

Date	Time	Medicine	Dose	Route	Prescribed By (signature / print name)	Time Given	Given By
01/08/24	13:30	AMOXICILLIN	1G	IV	*A Doctor* A DOCTOR	13:40	LC KM
01/08/24	15:00	BISOPROLOL	2.5mg	ORAL	*A Prescriber* A PRESCRIBER		

Record the actual time given in the 'Time Given' column.

Regular Therapy

Enter date at the top of the 'Date' column if it is the first administration of the day (DD/MM/YY).



REGULAR THERAPY

Date 01/08/24

Time

ONDANSETRON

8mg — IV

ADoctor A. DOCTOR

01/08/24 — 3 X DAILY

Time	01/08/24
06	LQ
12	JR
14	LQ
18	JR
20	LC
22	KM

Record administration by initialling the top half of the box that corresponds to the appropriate date and time.

Where a choice of route has been prescribed, the route used should be recorded in the lower half of the administration box.

As Required Therapy

Record the following:

- Date (DD/MM/YY)
- Time (11:00)
- Dose administered
- Your initials

AS REQUIRED THERAPY

DIHYDROCODEINE

30mg — ORAL

EVERY 4-6 HOURS FOR PAIN — 240mg

ADoctor A. DOCTOR — 01/08/24

Date	01/08/24
Time	11.00
Dose	30mg
Initials	LQ
Date	
Time	
Dose	
Initials	

Where a choice of route has been prescribed, the route should be recorded along with the dose in the dose box.

Witness

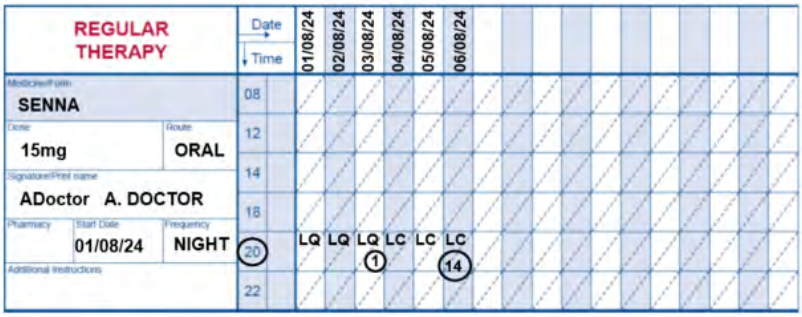
Any medicines that require a witness e.g. intravenous (IV) medicines or controlled drugs (CDs) for administration, the witness should also sign the appropriate box.

Recording Administration of a Medicine under a PGD or NHS Grampian Approved protocol

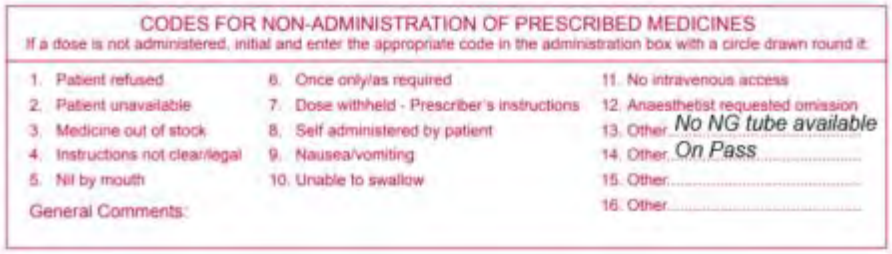
Document as directed in the relevant PGD or protocol.

3.6.2 Non-administration of Prescribed Medicines

The top of the administration box should be initialled and the appropriate 'Non-administration Code' should be entered in the lower half of the box with a circle drawn round it.



Non-administration codes are found on the PAR.



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
2. Patient unavailable
3. Medicine out of stock
4. Instructions not clear/illegal
5. Nil by mouth
6. Once only/as required
7. Dose withheld - Prescriber's instructions
8. Self administered by patient
9. Nausea/vomiting
10. Unable to swallow
11. No intravenous access
12. Anaesthetist requested omission
13. Other *No NG tube available*
14. Other *On Pass*
15. Other
16. Other

General Comments:

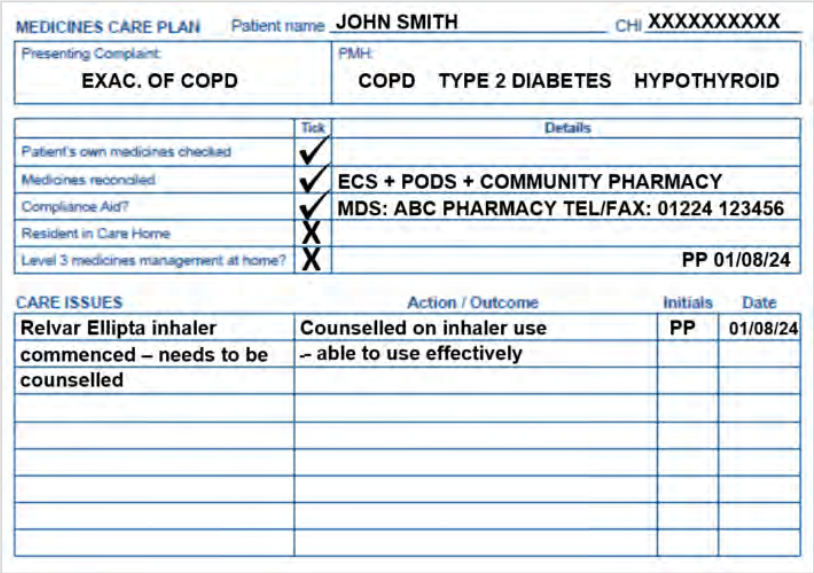
If an appropriate code cannot be found additional reasons can be written in the 'Other' code numbers.

When a patient goes 'on pass' from the ward any medicine doses due to be administered during the 'on pass' period should be recorded with a non-administration code.

3.7 Medicines Care Plan

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

Completing this section ensures communication of any medicines related care issues and facilitates an effective discharge.



MEDICINES CARE PLAN Patient name JOHN SMITH CHI XXXXXXXXXX

Presenting Complaint:	PMH:
EXAC. OF COPD	COPD TYPE 2 DIABETES HYPOTHYROID

	Tick	Details
Patient's own medicines checked	✓	
Medicines reconciled	✓	ECS + PODS + COMMUNITY PHARMACY
Compliance Aid?	✓	MDS: ABC PHARMACY TEL/FAX: 01224 123456
Resident in Care Home	X	
Level 3 medicines management at home?	X	PP 01/08/24

CARE ISSUES	Action / Outcome	Initials	Date
Relvar Ellipta inhaler	Counselled on inhaler use	PP	01/08/24
commenced – needs to be	– able to use effectively		
counselled			

To complete

Enter details of presenting complaint and past medical history (PMH).

Mark the relevant box with a tick or cross to indicate whether the patient has any of the following/the following has been undertaken:

- Patient's own medicines checked
- Medicines Reconciliation undertaken
- Uses a compliance aid
- Is resident in a care home
- Receives Level 3 Medicines Management support form carers. (MAR chart must be provided on discharge).

Details relating to the above should be documented in the relevant details section.

Pharmaceutical care issues identified should be detailed in the Care Issues section. The initials of the person who identified these issues and the date should also be recorded.

4 Responsibilities for implementation

Organisational:	Chief Executive and Management Teams
Corporate:	Senior Managers
Departmental:	Heads of Service/Clinical Leads
Area:	Line Managers
Hospital/Interface services:	Group Clinical Directors
Operational Management Unit:	Unit Operational Managers