Long Stay In-patient Medicine Prescription and Administration Record (‘kardex’)

Training Presentation

Elderly Care Version

Developed by The Northern Ireland Medicines Governance Team

Training session

- Learning objectives
- Background
- New Kardex design
- Examples of new Kardex in use

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Learning objectives

- Aim:
  - To reduce risk and improve patient care
- Objectives:
  - To be familiar with prescription writing standards and how to apply them
  - To know how to complete Kardexes correctly
  - To be aware of potentially serious or common errors in prescribing

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• Aim: to reduce the risk of medication incidents and improve patient care by the introduction of a regional standard form following the same design as the in-patient acute kardex.

• Objectives:

Be familiar with the prescription writing standards and how to apply them

Know how to complete the in-patient medication and administration charts correctly

Be aware of potentially serious or common errors in prescribing

Background

- Regional templates for in-patient medicine prescription and administration ('kardex') developed in 2006 – acute template of 2 week duration
- Long stay template follows acute template and is of 8 week duration.
- Closer link between prescription and administration record required

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Regional templates for an in-patient medicine prescription and administration record (frequently referred to as a 'kardex') were distributed to HPSS in 2006. It was acknowledged that the focus for the templates was acute care. A number of Trusts, while welcoming the templates, requested that a template be developed for use in facilities where the length of stay was longer than acute care facilities.

A regional template for a Long Stay In-patient Medicine Prescription and Administration Record ('kardex') has been developed following extensive consultation with staff in longer stay facilities, where it is anticipated that the template will be used. The contribution of staff members on drafts of the template has been invaluable.

The design of the long stay template followed the design used in the acute care templates, where the prescription and administration record are located alongside each other. This is a design favoured in England, Scotland and for the All-Wales prescription. Medication incident reporting and feedback from users indicated a number of problems with the format previously used in Northern Ireland:

1. Current kardex design

- Documentation of administration may occur on the reverse of the prescription chart or on a separate sheet. As a result:
    - Allergy status may not be checked prior to each medicine administration.
    - Medical staff may not check for omitted doses of medication where treatment appears ineffective.
    - Separate sheets have gone missing.
- Kardexes may not have a dedicated space to record patients' weight.
- Fixed administration times do not accommodate all specialities e.g. paediatrics. 'Other times' sections become overcrowded and duplicate administration may occur where documentation is unclear.
- Where medicine administration is recorded using assigned letters or numbers, spaces can become overcrowded, letters may be indistinguishable from nurses' signatures, numbers may be difficult to decipher (e.g. 1,7,11) and thus documentation is not easily audited.
- The administration record of medicines prescribed on an 'as required' basis does not easily allow identification of the last administered dose.
- Some Kardexes do not easily accommodate medicines prescribed on a weekly basis or patches that require to be changed every three days.
- If a medicine is to be withheld for a few doses, it can be difficult to highlight this and verbal communication has proven unreliable in such circumstances.
- Kardexes may not be rewritten for indefinite periods. Such Kardexes can be soiled with spillages and become ambiguous due to numerous cancellations. There is also a concern that they may not be regularly reviewed.

2. Reviewed other designs from England, Scotland and All-Wales kardex

3. Make administration record a more useable document – see at a glance what has/has not been given and where appropriate use the administration record as part of the prescription i.e. doses being withheld.

New Kardex design

- 6 double sided A4 pages Hole punched
- Administration record beside prescription
- New allergy box
- Once only and premedications (including administration under PGD) (37)
- As required (21)
- Regular (18)
- Documentation of non-administration of medicines coded ‘O’

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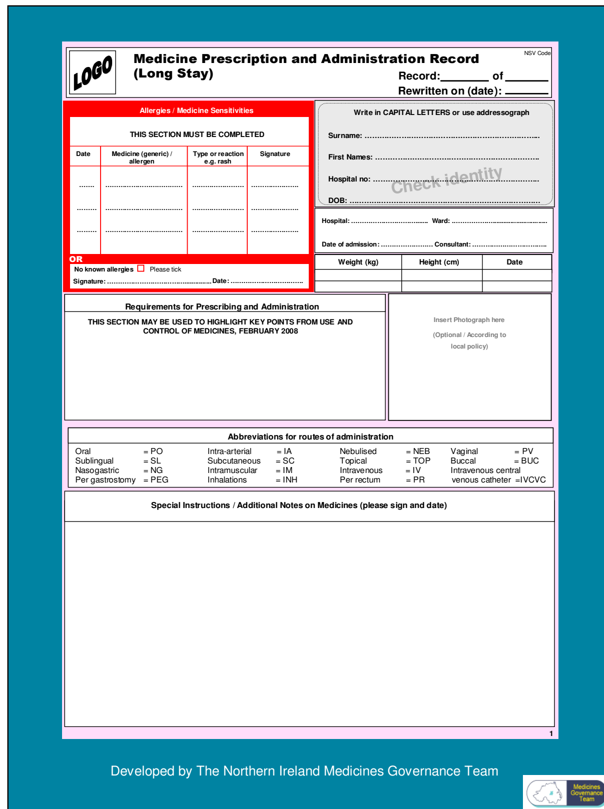
Once only and premedications - 18 if optional depot section included

Current chart has X non-injectable, X injectable, X once only



LOGO

Medicine Prescription and Administration Record (Long Stay)

NSV Code

Record:________ of ________

Rewritten on (date): ________

Allergies / Medicine Sensitivities

THIS SECTION MUST BE COMPLETED

Date	Medicine (generic) / allergen	Type or reaction e.g. rash	Signature
....	....	....	....
....	....	....	....
....	....	....	....

OR

No known allergies ☐ Please tick

Signature: .... Date: ....

Write in CAPITAL LETTERS or use addressograph

Surname: ....

First Names: ....

Hospital no: ....

Check identity

DOB: ....

Hospital: .... Ward: ....

Date of admission: .... Consultant: ....

Weight (kg)	Height (cm)	Date

Requirements for Prescribing and Administration

THIS SECTION MAY BE USED TO HIGHLIGHT KEY POINTS FROM USE AND CONTROL OF MEDICINES, FEBRUARY 2008

Insert Photograph here

(Optional / According to local policy)

Abbreviations for routes of administration

Oral	= PO	Intra-arterial	= IA	Nebulised	= NEB	Vaginal	= PV
Sublingual	= SL	Subcutaneous	= SC	Topical	= TOP	Buccal	= BUC
Nasogastric	= NG	Intramuscular	= IM	Intravenous	= IV	Intravenous central venous catheter	=IVCVC
Per gastrostomy	= PEG	Inhalations	= INH	Per rectum	= PR		

Special Instructions / Additional Notes on Medicines (please sign and date)

1

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This is the first page

Multiple Kardexes and Rewriting the Kardex

LOGO

Medicine Prescription and Administration Record (Long Stay)

NSV Code

Record: 1 of 1

Rewritten on (date): N/A

Allergies / Medicine Sensitivities

THIS SECTION MUST BE COMPLETED

Date	Medicine (generic) / allergen	Type or reaction e.g. rash	Signature
1/2/09	PENICILLIN	RASH	A. Doctor

OR

No known allergies ☐ Please tick

Signature: .... Date: ....

Write in CAPITAL LETTERS or use addressograph

Surname: SMITH

First Names: ANN

Hospital no: 123456

DOB: 14/07/1921

Check identity

Hospital: HOLBY Ward: 4

Date of admission: 1/2/09 Consultant: JONES

Weight (kg)	Height (cm)	Date

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Multiple Charts

Some patients will require more than one medication chart to be in use at one time. The total number of charts in use must be stated.

You must use the format '1 of 1 ' and '1 of 2' so that the complete number of charts is shown.

Without this, vital medication could be missed.

Rewritten on (date)

Where the chart is damaged, messy or 8 weeks of medicines administration are completed the chart will need to be rewritten. You must state the date of re-writing. When re-writing the medicines the start date should remain the original start date and not the date of re-writing. This is particularly important given that the kardex is for long stay patients.

If it is the first Kardex then put N/A as shown.

Patient information and Hospital Details

Medicine Prescription and Administration Record (Long Stay)

NSV Code

Record: 1 of 1

Rewritten on (date): N/A

Allergies / Medicine Sensitivities

THIS SECTION MUST BE COMPLETED

Date	Medicine (generic) / allergen	Type or reaction e.g. rash	Signature
1/2/09	PENICILLIN	RASH	A. Doctor

OR

No known allergies ☐ Please tick

Signature: .... Date: ....

Write in CAPITAL LETTERS or use addressograph

Surname: SMITH

First Names: ANN

Hospital no: 123456

DOB: 14/07/1921

Check identity

Hospital: HOLBY Ward: 4

Date of admission: 1/2/09 Consultant: JONES

Weight (kg)	Height (cm)	Date

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Patient information

Use the addressograph or complete all the patient details, writing clearly in block capitals.

This is a legal requirement.

The patient details should be visible on the front and back covers and on at least one internal page in each plane of vision so that users do not have to refer to the front cover to verify the patient's identification.

A common medication incident reported across Northern Ireland is the use of an incorrect addressograph on medicines kardex and this can result in medicines being administered to the wrong patient.

Hospital & patient details

Hospital: The hospital name can be abbreviated.

Ward: The ward number or name should be printed here.

Consultant: The consultant's name should be printed clearly or written in initials.

Date of admission: The date is compulsory and should be written out in full.

Weight: Weight should be expressed in kg. This information is required for any paediatric patients and for medicines that are prescribed by weight e.g. enoxaparin. The date the patient is weighed should be entered.

Height: Height should be expressed in cm. The date the patient is measured should be entered.

Allergy documentation

- Patient with allergy

- Patient with no known allergy

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Allergy documentation

This is a compulsory section that must be completed, as it is essential for patient safety. If the allergy box is not completed then no medication should be prescribed or administered unless in an emergency.

This section is to be completed after confirming any allergies with the patient. All allergies must be stated – not just medicines allergies e.g., peanut, latex etc.

The type of reaction must be stated e.g. rash, swelling, stomach upset. This can indicate whether the patient has a sensitivity or a true allergy. Drug sensitivity inappropriately documented as an allergy may prevent administration of vital medication. Sign and date the entry.

If there is no known allergy, then tick, sign and date the allergy box as shown

Requirements for prescribing and administration

Medicine Prescription and Administration Record (Long Stay)

LOGO

NSV Code

Record: 1 of 1

Rewritten on (date): N/A

Allergies / Medicine Sensitivities

THIS SECTION MUST BE COMPLETED

Date	Medicine (generic) / allergen	Type or reaction e.g. rash	Signature
1/2/09	PENICILLIN	RASH	A. Doctor

OR

No known allergies ☐ Please tick

Signature: .... Date: ....

Write in CAPITAL LETTERS or use addressograph

Surname: SMITH

First Names: ANN

Hospital no: 123456

DOB: 14/07/1921

Check identity

Hospital: HOLBY Ward: 4

Date of admission: 1/2/09 Consultant: JONES

Weight (kg)	Height (cm)	Date

Requirements for Prescribing and Administration

THIS SECTION MAY BE USED TO HIGHLIGHT KEY POINTS FROM USE AND CONTROL OF MEDICINES, FEBRUARY 2008

Insert Photograph here

(Optional / According to local policy)

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Requirements for prescribing and administration

Trust to complete notes on this section depending on requirements selected from Use and Control of Medicines.

Space for photograph

This is optional depending on the method used to confirm patient identity

Special instructions / Additional notes

LOGO **Medicine Prescription and Administration Record (Long Stay)**

Record: 1 of 1
Rewritten on (date): N/A

Allergies / Medicine Sensitivities

THIS SECTION MUST BE COMPLETED

Date	Medicine (generic) / allergen	Type or reaction e.g. rash	Signature
1/2/09	PENICILLIN	Rash	A. Doctor

OR
No known allergies ☐ Please tick
Signature: .... Date: ....

Write in CAPITAL LETTERS or use addressograph
Surname: SMITH
First Names: ANN
Hospital no: 123456
DOB: 14/3/1921
Check identity
Hospital: HOLBY Ward: 4
Date of admission: 1/2/09 Consultant: JONES

Weight (kg)	Height (cm)	Date

Requirements for Prescribing and Administration
THIS SECTION MAY BE USED TO HIGHLIGHT KEY POINTS FROM USE AND CONTROL OF MEDICINES, FEBRUARY 2008

Insert Photograph here (Optional / According to local policy)

Abbreviations for routes of administration

Oral	= PO	Intra-arterial	= IA	Nebulised	= NEB	Vaginal	= PV
Sublingual	= SL	Subcutaneous	= SC	Topical	= TOP	Buccal	= BUC
Nasogastric	= NG	Intramuscular	= IM	Intravenous	= IV	Intravenous central	
Per gastrostomy	= PEG	Inhalations	= INH	Per rectum	= PR	venous catheter	=IVCVC

Special Instructions / Additional Notes on Medicines (please sign and date)

1

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This section can be used for special instruction or additional notes e.g. medication temporarily withheld

Once Only Medicines and Pre-medications (includes administration under Patient Group Direction)

Prescription and administration

ONCE ONLY MEDICINES
Check patient identity and allergy status

Patient Name:..
Hospital Number:.......................... (complete if photocopying page)

Once Only Medicines and Pre-medications (includes administration under Patient Group Direction)								
Prescription						Administration		
Date	Medicine	Dose	Route	Time to be given (24 hour clock)	Signature and Bleep	Given by	Time given (24 hour clock)	Pharmacy

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Once only medicines and pre-medications (includes administration under patient group direction)

This section will be for 18 or 37 medicine entries depending on whether or not the optional depot section is used.

You must state in this section:

Date

Approved medicine name

Dose

Route

Time to be administered (in 24hr format)

Prescribers signature

The nurse or Doctor who administers the medicine must also record the date and time the medicine was administered and provide initials.

This section may also be use to record administration under patient group direction. Where this occurs, the nurse should insert ‘PGD’ in the prescription signature box.

As required medicines

Prescription and administration

AS REQUIRED MEDICINES
Check patient identity and allergy status

Write in CAPITAL LETTERS or use addressograph
Surname: SMITH
First Names: ANN
Hospital no: 123456
DOB: 14/07/1921
Check identity

Medicine: GLYCERYL TRINITRATE | Start Date: 1/2/09
Dose: TT SPRAYS | Route: S/L | Freq. (max): PRN | Stop Date
Special Instructions / Directions | Signature
Signature: A. Doctor | Bleep | Pharmacy
Print Name: A. DOCTOR 1111
Date | Time | Dose/Route | Given by

Medicine: ZOPICLONE | Start Date: 1/2/09
Dose: 3.75mg | Route: PO | Freq. (max): NOCTE | Stop Date
Special Instructions / Directions: HOSPITAL ONLY | Signature
Signature: A. Doctor | Bleep | Pharmacy
Print Name: A. DOCTOR 1111
Date: 1/2/09 | Time: 21:45 | Dose/Route: 3.75mg PO | Given by: TP

Medicine: CO-CODAMOL 8/500 | Start Date: 1/2/09
Dose: TT | Route: PO | Freq. (max): 4-6 hourly | Stop Date
Special Instructions / Directions: MAX 4 DOSES IN 24 HOURS | Signature
Signature: A. Doctor | Bleep | Pharmacy
Print Name: A. DOCTOR 1111
Date: 2/2/09, 2/2/09 | Time: 16:00, 22:00 | Dose/Route: TT PO, TT PO | Given by: BM, TP

Medicine | Start Date
Dose | Route | Freq. (max) | Stop Date
Special Instructions / Directions | Signature
Signature | Bleep | Pharmacy
Print Name
Date | Time | Dose/Route | Given by

Medicine | Start Date
Dose | Route | Freq. (max) | Stop Date
Special Instructions / Directions | Signature
Signature | Bleep | Pharmacy
Print Name
Date | Time | Dose/Route | Given by

Medicine | Start Date
Dose | Route | Freq. (max) | Stop Date
Special Instructions / Directions | Signature
Signature | Bleep | Pharmacy
Print Name
Date | Time | Dose/Route | Given by

Medicine | Start Date
Dose | Route | Freq. (max) | Stop Date
Special Instructions / Directions | Signature
Signature | Bleep | Pharmacy
Print Name
Date | Time | Dose/Route | Given by

3

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As required medicines

We are now going to cover the as required medicines section of the chart.

In contrast to the acute template this comes before the regular medicines to ensure these medicines are not inadvertently overlooked and to maximise use of space in the layout.

There are 21 spaces for as required medicines over 3 pages.

As you are going to a new page, you must either attach an addressograph or fill in the patient's name and hospital number at the top of the page.

Use this section to prescribe painkillers, anti-emetics, night sedation etc.

State the approved name of the medicine, the dose and the route. State maximum frequency for all as required medicines. A dose range may be specified to allow the medication to be adjusted to the patient's needs and the actual dose administered is recorded. This section does allow for more than one route to be prescribed within the same prescription where the dose is the same for different routes since the actual dose and route administered are recorded in the administration record. However some Trusts may decide that only one route may be prescribed within one prescription in which case, this should be stated in the requirements for prescribing and administration on the first page.

It is good practice to state the indication for any as required medication to ensure it is administered correctly. The special instructions/directions box can be used to facilitate this. Administration is recorded in chronological order, filling from the left hand side. There is space to administer 14 doses against each as required prescription after which the prescription should be represcribed if further doses are required on an as required basis. Frequent use of as required medicines should prompt a review if the medication is effective or required on a regular basis.

Regular medicines

Prescription and administration

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Regular medicines

We are now going to cover the regular section of the chart. In contrast to the acute template, regular injectable and non-injectable medicines are within the same section. This is to maximise use of space in the layout since it is expected that the majority of medicines will be non-injectable for patients where the template will be used.

Only one route of administration may be prescribed in each prescription as the regular section does not permit recording of the route administered. Where the route of administration is changed, the prescription should be rewritten.

Trusts may wish to consider measures to ensure the route of administration for injectable medicines is highlighted, for example by circling this route.

It is important to remember that when you are going to a new page, you must attach an addressograph on the right hand side. If photocopying the kardex, patient details must also be filled in at the top of every left hand page.

Using this chart you can prescribe 18 medicines for 8 weeks, over 3 pages.

As described the administration section is directly beside the prescription. We will begin by focusing on the prescription section with worked examples.

Regular medicines

Prescription

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Prescription

State the medicine name in capitals

State the dose, route and start date for the medicine. The date is a legal requirement.

The prescriber circles the times for administration from the pre-printed times or specifies others as required using the adjacent column. Four pre-printed times have been included although trusts may determine other pre-printed times are more appropriate. Blank fields are also included above and below the pre-printed times where more than four times a day administration is required.

Sign the entry and print your name and bleep or contact number. (Trusts may feel that this is onerous for prescribers writing several medicines at the same time and may agree that prescribers print name and bleep number on the last of multiple entries). It is essential that the prescription is signed as it cannot be processed without a signature. Supplementary prescribers signatures must be followed by the letters 'SP'.

Endorsement by pharmacy

A pharmacist's signature in the pharmacy box indicated the prescription has been screened for accuracy and appropriateness. The pharmacist should date the entry. Pharmacists will often annotate the chart with useful information to ensure appropriate medicine administration and/or monitoring in the special instructions/directions box.

Regular medicines

Prescription – discontinued medicines and changes in treatment

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Discontinued treatment

To show that a medicine is discontinued the prescriber completes the stop date and signs the stop section. The prescriber must also put a diagonal line through the medicine name and cancel the remainder of the administration record, otherwise it may inadvertently be restarted when transcribed or used to write a discharge prescription.

Changes in treatment

Existing prescriptions must not be altered. Changes in treatment must be made by discontinuing the prescription and represcribing as a new prescription as shown with furosemide.

Regular medicines

Prescription – changes in treatment

REGULAR MEDICINES
Check patient identity and allergy status

Patient Name:.......................................
Hospital Number:.................. (complete if photocopying page)
D.O.B ....

CODES FOR RECORDING OMITTED DOSES

(N) = Nil by mouth	(P) = Patient not available	(V) = Vomiting	(DR) = Prescribed omission	(O) = Other (please state reason on page 12)
(R) = Patient refused	(S) = Unable to swallow	(D) = Drug not available	(L) = Patient on leave	

Year: | Day and month: → 3/2

Circle times or enter variable dose / time

Medicine: FUROSEMIDE
Dose: 40mg | Route: PO | Start date: 3/2/09 | Stop date
Special instructions / Directions | Signature
Signature: B Doctor | Bleep | Pharmacy
Print name: B Doctor | 2222
Times: (08³⁰) 12³⁰ 17³⁰ 21³⁰

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This shows a change in furosemide dose from twice a day to once a day.

Regular medicines

Prescription – limited courses of treatment

REGULAR MEDICINES
Check patient identity and allergy status

Patient Name:..........
Hospital Number:.......... (complete if photocopying page)
D.O.B ....

CODES FOR RECORDING OMITTED DOSES

N = Nil by mouth
R = Patient refused
P = Patient not available
S = Unable to swallow
V = Vomiting
D = Drug not available
DR = Prescribed omission
L = Patient on leave
O = Other (please state reason on page 12)

Year: 2009 | Day and month: 2/2, 3/2, 4/2, 5/2
Circle times or enter variable dose / time

Medicine: TRIMETHOPRIM
Dose: 200mg | Route: PO | Start date: 2/2/09 | Stop date: 4/2/09
Special instructions / Directions: 3 DAYS
Signature: A Doctor | Bleep: 1111
Print name: A Doctor
Signature
Pharmacy
Times: 08:30, 12:30, 17:30, 21:30

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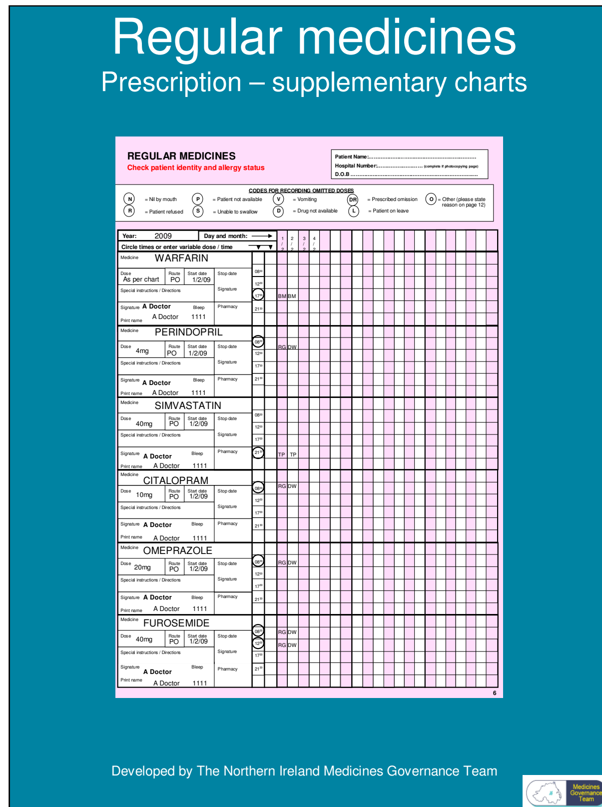
Limited courses of treatment

When prescribing limited courses of treatment e.g. antibiotics, a stop date can be entered in advance and the remainder of the administration record cancelled out as shown for this 3 day course of trimethoprim.



Supplementary charts

A few medicines, usually with variable or complex dosing schedules are prescribed on supplementary charts. These must be referenced on the main kardex and the example of warfarin is shown. For warfarin, administration must be recorded on the kardex and on the supplementary chart. This is to avoid warfarin being overlooked in a patient where a supplementary chart has not been initiated.

Regular medicines

Prescription – less than once a day, times other than pre-printed times, different formulations

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Less than once a day medicines

There are a few medicines administered less than once daily e.g. once weekly or every few days. These commonly presented problems with the old style kardex. This example shows once a week risedronate where the administration record is annotated as part of the prescription to indicate the day of administration. Other medicines administered less than once a day such as fentanyl patches every 72 hours or oral methotrexate for non-malignant conditions once a week. The special instructions/directions box can additionally be used to note the frequency and day of administration.

Administration at times other than pre-printed times

The example of risedronate is given where it is clinically appropriate to administer the medicine at a time other than the pre-printed time.

Different formulations

It is important to state the form of the medicine when different formulations, strengths or devices are available, for example insulin or inhalers.

Regular medicines

Prescription – different doses

Different doses (levothyroxine)

The levothyroxine example shows how the administration record is used as part of the prescription to chart different doses of the same medicine due at the same time on different days.

Regular medicines

Prescription – doses to be withheld

REGULAR MEDICINES

Check patient identity and allergy status

Patient Name:........................
Hospital Number:........................ (complete if photocopying page)
D.O.B ....

CODES FOR RECORDING OMITTED DOSES

(N) = Nil by mouth	(P) = Patient not available	(V) = Vomiting	(DR) = Prescribed omission
(R) = Patient refused	(S) = Unable to swallow	(D) = Drug not available	(L) = Patient on leave

(O) = Other (please state reason on page 12)

Year: 2009 | Day and month: → 1/2, 2/2, 3/2, 4/2, 5/2

Circle times or enter variable dose / time

Medicine: WARFARIN

Dose: As per chart | Route: PO | Start date: 1/2/09 | Stop date

Special instructions / Directions | Signature

Signature: A Doctor | Bleep: 1111 | Pharmacy

Print name: A Doctor

Times: 08^{30}, 12^{30}, 17^{30} (circled), 21^{30}

17^{30}: BM, BM, (DR), (DR), (DR)

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Where the prescriber intends doses of a medicine to be temporarily withheld, this can be done in one of two ways, either:

Discontinue the medicine as previously shown – it is useful to make a note in the additional notes section to avoid the medicine being overlooked when it should be restarted.

Or

The prescriber can enter ‘DR’ and put a circle around ‘DR’ in the administration section for each dose that should be withheld as shown.

Regular medicines

Administration

REGULAR MEDICINES
Check patient identity and allergy status

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Administration record

When administering the medicine, the nurse checks the date the medicine is due to start and then writes the date they are administering it along the horizontal line for date at the top.

The nurse must then check the prescribed time of administration and initial the box for that date and time to document the administration; the analogy of a 'mileage' chart may useful for those unfamiliar with this design, where the row across from the prescribed time and the column down from the date of administration will bring you to the box where the signature for administration should be entered. When a second check is needed, for example controlled drugs, the box can be split to allow 2 signatures.

Regular medicines

Administration

REGULAR MEDICINES
Check patient identity and allergy status

REGULAR MEDICINES
Check patient identity and allergy status

Check identity

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The administration section runs across two pages for the 8 week duration.

It is essential that the original prescribed time is followed to determine medicines due for administration. Medication incidents have occurred where staff have followed a pattern of administration signatures from previous days, for example a medicine prescribed twice a day administered in the evening on the first day following admission but then only administered in the evening from then on.

Regular medicines

Administration – Omitted doses

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Codes for recording omitted doses

If a dose of medication is not administered for any reason, the appropriate code must be entered on the chart. Codes have been assigned to the most commonly occurring reasons for non-administration and are defined on the kardex. A circle must be drawn around the code letter to distinguish the code from someone initials. Any additional notes on action taken are recorded in nursing notes.

In this example, a dose of lactulose is not administered at 08.30 on 3.2.09. The reason is ‘O’, other.

Where ‘O’ is used for other, the reason for non-administration must be recorded on the last page. Where a dose must be given at a later time than prescribed, either re-prescribe as a once only dose or document as shown.

Regular medicines

Administration - Non-administration of medicines coded ‘O’

Patient Name:...
Hospital Number:........................ (complete if photocopying page)

CODES FOR RECORDING OMITTED DOSES

N = Nil by mouth
R = Patient refused
P = Patient not available
S = Unable to swallow
V = Vomiting
D = Drug not available
DR = Prescribed omission
L = Patient on leave
O = Other (please state reason on page 12)

Documentation of non-administration of medicines coded O

Date	Time	Medicine	Reason	Signature
3/2/09	08^{30}	LACTULOSE	Patient has diarrhoea	D White

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This is used as a record for any doses not administered for a reason that does not fall within the defined codes. The dose of lactulose not administered at 08.30 and coded ‘O’ is documented as shown.

Regular medicines

Administration - Non-administration of medicines using codes

REGULAR MEDICINES
Check patient identity and allergy status

Patient Name:
Hospital Number:
D.O.B

CODES FOR RECORDING OMITTED DOSES

Year: 2009 | Day and month:

Circle times or enter variable dose / time

Medicine	Dose	Route	Start date	Signature	Print name
BISOPROLOL	5mg	PO	1/2/09	A Doctor	A Doctor 1111
LACTULOSE	20ml	PO	1/2/09	A Doctor	A Doctor 1111
ADCAL D3	TT	PO	1/2/09	A Doctor	A Doctor 1111
RISEDRONATE (WEDNESDAY)	35mg	PO	1/2/09	A Doctor	A Doctor 1111
NOVOMIX 30 FLEXPEN	80 UNITS	SC	1/2/09	A Doctor	A Doctor 1111
NOVOMIX 30 FLEXPEN	74 UNITS	SC	1/2/09	A Doctor	A Doctor 1111

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This example also shows a dose of Adcal D3 not administered at 12.30 on 3.2.09 due to vomiting.

For some medicines, particularly medicines administered on a once a day basis, where a dose is not administered for a reason but it would be appropriate to administer later in the day, this can either be prescribed as a once only dose or more usually administered later against the regular prescription. Where it is administered against the regular prescription it is important to document this clearly as shown so that it is obvious that this was an unusual time for administration by drawing an arrow down to the actual time of administration and signing. If it falls outside the pre-printed times, then the time should also be handwritten.

Any questions?

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