

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

Training Presentation
Mental Health 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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For the purposes of this training, we are going to refer to all Mental Health facilities as 'the hospital'.

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/areas e.g. in prescribing medication used in Parkinson's Disease . '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) (18)
- Regular depot injections (3)
- 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, 37 if the depot section is not included.

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

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

Record: _____ of _____
 Rewritten on (date): _____

Allergies / Medicine Sensitivities

THIS SECTION MUST BE COMPLETED

Date	Medicine (generic) / allergies	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: _____
 DOB: _____

Check identity

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)

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This is the first page

Multiple Kardexes and Rewriting the Kardex

Medicine Prescription and Administration Record (Long Stay)

Record: 1 of 1
Rewritten on (date): NA

Allergies / Medicine Sensitivities

THIS SECTION MUST BE COMPLETED

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

Write in CAPITAL LETTERS or use addressograph

Surname: JONES
First Names: MARY
Hospital no: DOH1234
DOB: 6/4/1927
Hospital: HOLBY Ward: 8
Date of admission: 20/10/08 Consultant: SMITH

Weight (kg)	Height (cm)	Date

DR
No known allergies Please tick
Signature: A. Doctor Date: 20/10/08

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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)

Record: 1 of 1
Rewritten on (date): NA

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: A. Doctor Date: 20/10/08

Write in CAPITAL LETTERS or use addressograph

Surname: JONES
First Name: MARY
Hospital no.: DOH1234
DOB: 6/4/1927
Hospital: HOLBY Ward: B
Date of admission: 20/10/08 Consultant: SMITH

Weight (kg)	Height (cm)	Date

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Patient information

Use the addressograph or if your facility does not use addressographs, 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 penicillin allergy

LOGO **Medicine Prescription and Administration Record (Long Stay)** NDV Card
 Record: 1 of 1
 Rewritten on (date): NA

Allergies / Medicine Sensitivities

THIS SECTION MUST BE COMPLETED

Date	Medicine (generic) / allergen	Type or reaction e.g. rash	Signature
20/10/08	PENICILLIN	RASH	A.Doctor

OR
 No known allergies Please tick
 Signature: Date:

Write in CAPITAL LETTERS or use addressograph
 Surname: JONES
 First Names: MARY
 Hospital no: DOH1234
 DOB: 6/4/1927
 Hospital: HOLBY Ward: B
 Date of admission: 20/10/08 Consultant: SMITH
 Weight (kg) Height (cm) Date

- Patient with no known allergies

LOGO **Medicine Prescription and Administration Record (Long Stay)** NDV Card
 Record: 1 of 1
 Rewritten on (date): NA

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: A.Doctor Date: 20/10/08

Write in CAPITAL LETTERS or use addressograph
 Surname: JONES
 First Names: MARY
 Hospital no: DOH1234
 DOB: 6/4/1927
 Hospital: HOLBY Ward: B
 Date of admission: 20/10/08 Consultant: SMITH
 Weight (kg) Height (cm) Date

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Allergy documentation

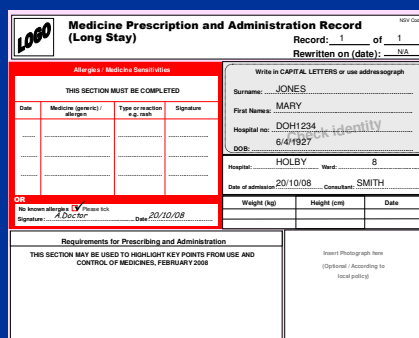
This is a compulsory section that must be completed, as it is essential for patient safety. If the allergy box is not completed then no medication should be prescribed or administered unless in an emergency.

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)

Record: 1 of 1
Rewritten on (date): NA

Allergies / Medicine Sensitivities

THIS SECTION MUST BE COMPLETED

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

Write in CAPITAL LETTERS or use addressograph

Surname: JONES
First Name: MARY
Hospital no.: D0H1234
DOB: 6/4/1927
Hospital: HOLBY Ward: 8
Date of admission: 20/10/08 Consultant: SMITH

Weight (kg) Height (cm) Date

CC: No known allergies Please tick
Signature: Doctor Date: 20/10/08

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)

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

As required medicines

Prescription and administration

AS REQUIRED MEDICINES
Check patient identity and allergy status

Write in CAPITAL LETTERS or use addressograph
Surname: JONES

First Name: MARY
Hospital no.: DQM1234
DOB: 6/4/1927

Medicine	Strength	Route	Frequency	Start Date	Stop Date	Time	Day	Time	Day	Time	Day	Time	Day	Time	Day	Time	Day	Time	Day
PARACETAMOL	1g	PO	Birly																
Special Instructions / Directions: For pain																			
Signature: A. Doctor Date: 25/7																			
SENAVA		PO	OD																
Special Instructions / Directions: None																			
Signature: A. Doctor Date: 25/7																			
HALOPERIDOL TABLETS	5mg	PO	2hrly																
Special Instructions / Directions: Max 30mg/day																			
Signature: A. Doctor Date: 25/7																			
HALOPERIDOL INJECTION	5mg	IM	2hrly																
Special Instructions / Directions: Max 15mg/day																			
Signature: A. Doctor Date: 25/7																			

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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 anxiolytics, medications used in rapid tranquilisation or in treating extra pyramidal symptoms, painkillers, anti-emetics, night sedation.

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. Where a range is prescribed for both a dose and a frequency, then the maximum dose in 24hrs should be noted in the Special instructions/Directions box.

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.

This is important where the different formulations are non-equivalent, and therefore should be written up separately for each route. For example, haloperidol, as shown here, should be written for the oral route and intramuscular route separately, to avoid wrong dose errors occurring.

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 re-prescribed 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

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

REGULAR MEDICINES
Check patient identity and allergy status

Patient Name:
Hospital Number: (complete if prescribing only once)
D.O.B:

CODES FOR RECORDING OMITTED DOSES

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

Year: 2008 Day and month: →

Circles times or enter variable dose / time →

Medicine: **PRIADEL TABLETS**

Dose: 400mg PO Start date: 2010/08

Signature: **A. Doctor** Bleep: 257 Pharmacy: CH-CH-AM-CH

Prescription

State the medicine name in capitals

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

Different formulations

Where more than one formulation of the medicine exists, then the form should also be stated. For example, Priadel Tablets or Priadel Liquid.

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

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.

Regular medicines

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

REGULAR MEDICINES
Check patient identity and allergy status

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

Not to issue Patient not available Missing Prescribed collection Other (please state reason on page 1/2)
 Patient refused Unable to swallow Drug not available Patient on leave

Year: 2008 Day and month: → 01 02 03 04 05 06 07 08 09 10 11 12

Circle times or enter variable dose / time

Medicine	Dose	Route	Start date	Stop date	Time	01	02	03	04	05	06	07	08	09	10	11	12
PRIADEL TABLETS	400mg	PO	26/10/08														
Special instructions / Directions	Signature: A. Doctor Stop: 257 Pharmacy: CH CH AM CH																
RISEDRONATE	35mg	PO	26/10/08														
Special instructions / Directions	Signature: A. Doctor Stop: 257 Pharmacy: CH CH AM CH																
ADCAL D3	2 tabs	PO	26/10/08														
Special instructions / Directions	Signature: A. Doctor Stop: 257 Pharmacy: CH CH AM CH																

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, BuTrans patch once a week, 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. Write the desired time in the blank box alongside the pre-printed column of times, and circle it.

Regular medicines

Prescription – changes in treatment

REGULAR MEDICINES
Check patient identity and allergy status

REGULAR MEDICINES
Check patient identity and allergy status

Year: 2008 Day and month: 1 2 3 4 5 6 7 8 9 10 11 12

Check times or enter variable dose / time

Medicine: PRIADEL TABLETS
Dose: 400mg PO Start date: 20/10/08 Stop date: 12/11/08
Special instructions / Directions: Tuesdays
Signature: A. Doctor Date: 25/10/08 Pharmacy: CH CH AM CH PE

Medicine: RISEDRONATE
Dose: 35mg PO Start date: 20/10/08 Stop date: 12/11/08
Special instructions / Directions: Tuesdays
Signature: A. Doctor Date: 25/10/08 Pharmacy: CH CH AM CH PE

Medicine: ADCAL D3
Dose: 2 tabs PO Start date: 20/10/08 Stop date: 12/11/08
Special instructions / Directions:
Signature: A. Doctor Date: 25/10/08 Pharmacy: CH CH AM CH PE

Medicine: MIRTAZAPINE
Dose: 30mg PO Start date: 23/10/08 Stop date: 12/11/08
Special instructions / Directions:
Signature: A. Doctor Date: 25/10/08 Pharmacy: CH CH AM CH PE

Medicine: MIRTAZAPINE
Dose: 45mg PO Start date: 24/10/08 Stop date: 12/11/08
Special instructions / Directions:
Signature: A. Doctor Date: 25/10/08 Pharmacy: CH CH AM CH PE

Medicine: AQUEOUS CREAM
Dose: Apply TOP Start date: 24/10/08 Stop date: 12/11/08
Special instructions / Directions:
Signature: A. Doctor Date: 25/10/08 Pharmacy: CH CH AM CH PE

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Changes in treatment

Existing prescriptions must not be altered. Changes in treatment must be made by discontinuing the prescription and re-prescribing as a new prescription as shown with mirtazapine

The mirtazapine 45mg at night must be written up as a new prescription as shown here, clearly stating the start date.

Regular medicines

Prescription – doses to be withheld

REGULAR MEDICINES
Check patient identity and allergy status

Patient Name: _____
Hospital Number: _____ (complete if photographing page)
A.C.B.

CODES FOR RECORDING DATES/TIME

= Nil by mouth = Patient not available = Stopping = Prescribed combination = Other (please state reason on page 1/2)
 = Patient refused = Unable to swallow = Drug not available = Patient on leave

Year: 2008 Day and month: →

Check times or enter variable dose / time

Medicine	Dose	Route	Start date	Stop date	Signature	Pharmacy	Time
PRIADEL TABLETS	400mg	PO	20/10/08				
Special instructions / Directions	Twice daily						
Signature	A. Doctor		257				
Pharmacy	CH CH AM CH PE PE AM AM PE DR						
Medicine	RISEDRONATE						
Dose	35mg	PO	20/10/08				
Route	Twice daily						
Signature	A. Doctor		257				
Pharmacy	CH CH AM CH PE PE AM AM PE DR						
Medicine	ADCAL D3						
Dose	2 tabs	PO	20/10/08				
Route	Twice daily						
Signature	A. Doctor		257				
Pharmacy	CH CH AM CH PE PE AM AM PE DR						
Medicine	MIRTAZAPINE						
Dose	30mg	PO	23/10/08				
Route	Once daily						
Signature	A. Doctor		257				
Pharmacy	CH CH AM CH PE PE AM AM PE DR						
Medicine	MIRTAZAPINE						
Dose	45mg	PO	24/10/08				
Route	Once daily						
Signature	A. Doctor		257				
Pharmacy	CH CH AM CH PE PE AM AM PE DR						
Medicine	AQUEOUS CREAM						
Dose	Apply	TOP	24/10/08				
Route	Once daily						
Signature	A. Doctor		257				
Pharmacy	CH CH AM CH PE PE AM AM PE DR						

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Withheld medicines

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 here using Priadel as an example where the dose is intentionally withheld at 21.30 on 29/10/08 due to concerns about fluid balance and electrolyte disturbance following diarrhoea.

Regular medicines

Prescription - increasing doses / cross titration

REGULAR MEDICINES
Check patient identity and allergy status

Legend:
 Will be mouth
 Patient refused
 Patient not indicated
 Unable to swallow
 Not taking
 Drug not available
 Prescribed correction
 Patient on leave
 Other (please state reason on page 12)

Medicines:
OLANZAPINE 10mg PO 29/10/08 - 22/10/08
 For 3 days
 Rescriber: A. Doctor 257
RISPERIDONE 2mg PO 29/10/08 - 22/10/08
 For 3 days
 Rescriber: A. Doctor 257
OLANZAPINE 20mg PO 23/10/08 - 22/10/08
 Continue on 20mg
 Rescriber: A. Doctor 257
RISPERIDONE 2mg PO 23/10/08 - 22/10/08
 For 3 days with stop
 Rescriber: A. Doctor 257

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Increasing/decreasing doses, cross titration

Often it can be difficult to prescribe doses which are to be either increased or decreased, in advance of those dates when the dose actually changes.

If we consider a different patient, the example here demonstrates an increasing dose of olanzapine from 10mg after 3 days to 20mg thereafter.

The prescriber endorses the prescription in the 'Special instructions/Directions' box with the information that the 10mg dose is 'for 3 days' only, enters the 'Stop date', and the remainder of the administration section is cancelled.

The Risperidone prescription is decreasing in dose, this time for 2 specified durations. Once again, the start date and stop date indicate the duration of administration for both the 2mg BD dose and the 2mg nocte dose. The remainder of the administration section is cancelled to avoid administration continuing in error.

Regular medicines

Prescription - variable doses at different times

REGULAR MEDICINES
Check patient identity and allergy status

Legend:
 Will be used
 Patient refused
 Patient not indicated
 Unable to swallow
 Not taking
 Drug not available
 Prescribed correction
 Other (please state reason on page 12)
 Patient on leave

Year: _____ Day and month: _____

Circle times or enter variable dose / time

CHLORPROMAZINE

Form: PO 25/10/08

Signature: A. Doctor 257

Time	08.30	12.30	17.30	21.30
08.30	100mg			
12.30		100mg		
17.30			150mg	
21.30				200mg

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Variable doses at different times

When prescribing variable doses of the same medication across different times of the day. Again for a different patient, the example shown here with chlorpromazine 100mg 08.30, 100mg at 12:30, 150mg at 17:30 and 200mg at 21.30 demonstrates how each different dose is entered in the variable dose / time column beside the prescribed time.

Alternatively this may be prescribed using three separate prescription sections, one for chlorpromazine 100mg at 08.30 and 12.30, one for chlorpromazine 150mg at 17.30 and a third one for 200mg at 21.30 should the prescriber be unable to write the dose legibly in the variable dose / time column as shown.

Regular medicines Administration

REGULAR MEDICINES
Check patient identity and allergy status

Patient Name: _____
Hospital Number: _____ (complete if photographing page)
B.D.S.

Codes for recording administration

= Nil by mouth = Patient not available = Withholding = Prescribed omission = Other (please state reason on page 1/2)
 = Patient refused = Unable to swallow = Drug not available = Patient on leave

Year: 2008 Day and month: →

Check times or enter variable dose / time

Medicine	Dose	Route	Start date	Stop date	Signature	Time	01	02	03	04	05	06	07	08	09	10	11	12
PRIADEL TABLETS	400mg	PO	20/10/08															
Special instructions / Directions																		
Signature: A. Doctor																		
Pharmacy: A. Doctor																		
RISEDRONATE	35mg	PO	20/10/08															
Special instructions / Directions																		
Signature: A. Doctor																		
Pharmacy: A. Doctor																		
ADGAL D3	2 tabs	PO	20/10/08															
Special instructions / Directions																		
Signature: A. Doctor																		
Pharmacy: A. Doctor																		
MIRTAZAPINE	30mg	PO	20/10/08															
Special instructions / Directions																		
Signature: A. Doctor																		
Pharmacy: A. Doctor																		
MIRTAZAPINE	45mg	PO	24/10/08															
Special instructions / Directions																		
Signature: A. Doctor																		
Pharmacy: A. Doctor																		
AQUEOUS CREAM	Apply	TOP	24/10/08															
Special instructions / Directions																		
Signature: A. Doctor																		
Pharmacy: A. Doctor																		

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Administration record

Now if we return to our original patient, 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 be 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

The image shows two pages of a 'Regular Medicines Administration' form. The left page is partially filled with handwritten data, while the right page is blank. Both pages feature a grid for recording medication administration over an 8-week period. The form includes sections for patient details, medication details, and a grid for recording administration over an 8-week period. The text 'Developed by The Northern Ireland Medicines Governance Team' and a logo are visible at the bottom of the form.

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

REGULAR MEDICINES
Check patient identity and allergy status

Patient Name: _____
Responder Number: _____ (appendix 3 pharmacology sheet)
D.O.B: _____

Year: 2008 Day and month: 29 10 08

Circle times or enter variable dose / time

Medicine	Time	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
PRIADEL TABLETS																		
Dose: 400mg	Route: PO	Stop date: 28/10/08																
Special instructions / Directions: Thursdays	Signature: A. Doctor	Pharmacy: 257																
Medicine	Time <td>08</td> <td>09</td> <td>10</td> <td>11</td> <td>12</td> <td>13</td> <td>14</td> <td>15</td> <td>16</td> <td>17</td> <td>18</td> <td>19</td> <td>20</td> <td>21</td> <td>22</td> <td>23</td> <td>24</td>	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
RISEDRONATE																		
Dose: 35mg	Route: PO	Stop date: 28/10/08																
Special instructions / Directions: Thursdays	Signature: A. Doctor	Pharmacy: 257																
Medicine	Time <td>08</td> <td>09</td> <td>10</td> <td>11</td> <td>12</td> <td>13</td> <td>14</td> <td>15</td> <td>16</td> <td>17</td> <td>18</td> <td>19</td> <td>20</td> <td>21</td> <td>22</td> <td>23</td> <td>24</td>	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
ADCAL D3																		
Dose: 2 tabs	Route: PO	Stop date: 28/10/08																
Special instructions / Directions:	Signature: A. Doctor	Pharmacy: 257																

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 Adcal D3 is not administered at 12:30 on 29.10.08. The reason is 'O', other.

Where 'O' is used for other, the reason for non-administration must be recorded on the last page.

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	P = Patient not available	V = Vomiting	PO = 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	

Documentation of non-administration of medicines coded **O**

Date	Time	Medicine	Reason	Signature
29/10/08	12 th	ADCAL D3	Patient has diarrhoea	M White

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Documentation of omitted doses coded 'O'

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 Adcal D3 not administered at 1200 hours on 29.10.08 and coded 'O' is documented as shown.

Regular medicines

Administration – Non-administration of medicines using codes

REGULAR MEDICINES
Check patient identity and allergy status

Legend for recording omitted doses:
 = Nil by mouth
 = Patient refused
 = Patient not available
 = Unable to swallow
 = Vomiting
 = Drug not available
 = Prescribed cessation
 = Patient on leave
 = Other (please state reason on page 12)

Year: 2008 Day and month: 29/10

Medicine: **PRIADEL TABLETS**
 Dose: 400mg PO Start date: 20/10/08 Stop date: 12/11/08
 Special instructions / Directions: Signature: A. Doctor Date: 25/10/08 Pharmacy: CH CH AM CH CH PE AM AM PE

Medicine: **RISEDRONATE**
 Dose: 35mg PO Start date: 20/10/08 Stop date: 12/11/08
 Special instructions / Directions: Thursdays Signature: A. Doctor Date: 25/10/08 Pharmacy: CH CH AM CH CH PE AM AM PE

Medicine: **ADCAL D3**
 Dose: 2 tabs PO Start date: 20/10/08 Stop date: 12/11/08
 Special instructions / Directions: Signature: A. Doctor Date: 25/10/08 Pharmacy: CH CH AM CH CH PE AM AM PE

Administration at a later time than prescribed

This example also shows a dose of Adcal D3 not administered at 12:30 on 29/10/09, for a reason that has been documented in the non-administration of medicines section just shown.

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 as shown here.

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.

Doses to be withheld

The prescriber has also entered 'DR' in the administration section for the dose of Priadel to be withheld at 21.30 on 29/10/08 following diarrhoea.

Any questions?

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