

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

<b>Co-ordinators:</b>  [Redacted] Chair, Record Standards Group	<b>Consultation Group:</b>  Record Standards Group	<b>Approver:</b>  [Redacted] Chair, Record Standards Group
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<b>Signature:</b>  [Redacted]		<b>Signature:</b>  [Redacted]
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<b>Identifier:</b>  Identifier: NHSG/Guid/Inst/MGPGxxx x	<b>Review Date:</b>  January 2020	<b>Date Approved:</b>  January 2018
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**Version 2**

**Executive Sign-Off**

**This document has been endorsed by the Director of Pharmacy and Medicines  
Management**

[Redacted]  
**Signature:** \_\_\_\_\_

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

**Unique Identifier:** NHSG/Guid/Inst/MGPGxxxxx

**Replaces:** NHSG/Guid/Inst/MGPG446, Version 1

Across NHS Boards	Organisation Wide	Directorate	Clinical Service	Sub Department Area

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**Lead Author/Co-ordinator:** As per front cover

**Subject (as per document registration categories):** Prescribing and prescription

**Key word(s):** Kardex, instructions, prescribing, administration, charts, medicines, prescription record, administration record, Medication Administration Record, drug chart

**Process Document: Policy, Protocol, Procedure or Guideline** Guideline

**Document application:** NHS Grampian

**Purpose/description:** To promote the safe use of the NHS Grampian Prescription and Administration record.

**Responsibilities for implementation:**

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

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

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

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**Responsibilities for review of this document:** As per front cover

**Responsibilities for ensuring registration of this document on the NHS Grampian Information/ Document Silo:** Pharmacy and Medicines Directorate

**Physical location of the original of this document:** Pharmacy Department, ARI

**Job/group title of those who have control over this document:** Records Standards Group

**Responsibilities for disseminating document as per distribution list:** Records Standards Group

**Revision History:**

<b>Revision Date</b>	<b>Previous Revision Date</b>	<b>Summary of Changes (Descriptive summary of the changes made)</b>	<b>Changes Marked* (Identify page numbers and section heading )</b>
December 2015		Redesign of document to add in more accurate information and clarity.	Throughout Document

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

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

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

## Introduction

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

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

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

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

## Prescription and Administration Record (PAR)

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

2-page        ZOP 112;

Standard     ZOP 105;

Long stay (only to be used following discussion with Pharmacy Department)  
ZOP 109.

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

## General Guidance

- A PAR should be generated for all inpatients on admission. Other approved medicine charts for specialist use are also available.
- All medicine prescription charts for an individual patient should be kept in a single location. This will reduce the risk of medicine errors, in particular those involving duplication and omission. The designated location should be in close proximity to the patient, ideally co-located with the other patient information, according to individual ward policy. It is the responsibility of Department/Line Managers to ensure all staff are aware of the location of prescription sheets within their clinical area.
- All PAR entries must be written in English and in BLOCK CAPITAL LETTERS using indelible black ink. Some medicines have similar names and writing in capital letters

helps to avoid confusion, therefore reducing the likelihood of errors in administration. Latin abbreviations such as 'p.r.n.' must not be used.

- All PARs generated during an admission must be filed in the patient's health records on completion/discharge whether or not any entries have been made. PARs must be kept in the patient's appropriate health records from which they **originated**, e.g. acute, psychiatry or community hospital.
- A new PAR must be used for patients who are readmitted regardless of the time that has elapsed since last admission.
- PARs belonging to patients transferred within NHS Grampian may continue to be used in the receiving ward/hospital if appropriate.
- All medicines must only be prescribed by practitioners who have a recognised prescribing qualification, approved by NHS Grampian.
- Prescribers must comply with current prescribing legislation, relevant NHS Grampian prescribing policies, together with the procedures detailed in this document.
- Healthcare professionals 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 (<http://www.nhsgrampian.org/gjf>), NHSG Non-medical Prescribing Policy (<http://tinyurl.com/NHSGNMRx>) and the NHSG Medicines Reconciliation Protocol ([http://www.nhsgrampian.org/grampianfoi/files/Med\\_Rec\\_711\\_0115.pdf](http://www.nhsgrampian.org/grampianfoi/files/Med_Rec_711_0115.pdf)).
- Medicines that may be given in accordance with NHS Grampian's approved Protocols/Patient Group Directions (PGDs) should be recorded on the PAR as detailed in the protocol or PGD.

## Completion of the Prescription and Administration Record (PAR)

### 1 Patient Demographics

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

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

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

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

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

**NHS Grampian** **PRESCRIPTION & ADMINISTRATION RECORD**

[illegible]



## 1.1 Known Medicine Allergies/Sensitivities

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

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

All serious adverse drug reactions should be recorded by the doctor on the Master Registration Card at the front of the patient's health records.

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

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

## 1.2 Venous Thromboembolism Risk Assessment Has Been Undertaken On Admission

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

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

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

### 1.3 Other Medicine Charts or Treatment Plans in Use

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

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

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

#### Example 3: Other Medicine Charts or Treatment Plans in Use

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

#### Example 4: 'Regular Therapy' Entry

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

SEE ANTICOAGULANT PRESCRIPTION

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

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

## Example 6: Discontinuation of 'Regular Therapy' Entry

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

SEE ANTICOAGULANT PRESCRIPTION

STOPPED A Doctor 3/9/17

## 2 Instructions for Prescribers

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

### 2.1 General Instructions for All Sections

#### Medicine/Form: Example 7

- The full name of the medicine should be printed clearly in BLOCK CAPITAL LETTERS. Some medicines have similar names and printing helps to avoid confusion, reducing the likelihood of errors when administering.
- Most medicines have approved (non-proprietary or generic) names. The use of non-proprietary names is good practice and can facilitate economical use of medicines.
- Where bioavailability varies between brands or between formulations, the brand (proprietary) name must be specified. For example, Beclometasone inhalers, lithium products, theophylline, some immunosuppressants (e.g. tacrolimus, to prevent organ transplant rejection), certain epilepsy medicines and modified release preparations.
- Brand (proprietary) names can be used where this would reduce the risk of an administration error. For example, oxycodone should be prescribed by brand name to distinguish between immediate or sustained release products, Shortec and Longtec respectively.
- Insulin should be prescribed using brand names.
- The following link provides guidance on which medicines should be prescribed by brand: <https://www.sps.nhs.uk/articles/which-medicines-should-be-considered-for-brand-name-prescribing-in-primary-care/>
- Where more than one strength of multi-ingredient preparation exists the strength must be specified as part of the medicine name, e.g. Seretide 500 Accuhaler; co-codamol 30/500 tablets.
- Formulation must be specified when it is essential to assist in administration of the correct medicine, e.g. modified release, enteric coated, inhaler type (e.g. MDI, Accuhaler), etc.
- Form must be specified on ALL paediatric prescriptions.

## Dose: Example 7

- Prescribe dose of medicine using metric system:  
milligram = mg  
gram = g  
millilitre = mL
- Do not abbreviate micrograms or nanograms - 'mcg' and 'µg' are not acceptable.
- Do not abbreviate units to 'u' – 'units' must be written in full.
- Doses of less than one milligram must be expressed in micrograms, e.g. 62.5 micrograms and not 0.0625 mg. A leading zero should be added for numbers less than 1, e.g. 0.5mL and not .5mL. Whole numbers should not be followed by a decimal point and zero, e.g. 1 and not 1.0.
- Doses of liquid preparations should be expressed as milligrams or micrograms of the active ingredient. Doses in millilitres (mL) should only be used for multi-ingredient preparations.
- Where more than one strength combination of a multi-ingredient preparation exists, the dose to be administered must be stated, e.g. Seretide 500 Accuhaler, one inhalation (puff) in the morning and at night.
- A choice of dose may be prescribed where appropriate in the 'As Required Therapy' section only, e.g. Dihydrocodeine tablets, 30-60mg every 6-8 hours for pain.

**The dose of a medicine must be expressed in terms that are explicit, e.g.**

**Furosemide dose - '60 mg'**

**or**

**Seretide 500 Accuhaler dose - 'One inhalation'**

## Route of Administration: Example 7

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

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

## Signature and Print Name: Example 7

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

## Example 7: General Instructions for All Sections

<b>REGULAR THERAPY</b>			Date												
			Time												
Medicine/Form <b>SIMVASTATIN</b>			08												
Dose <b>40mg</b>	Route <b>ORAL</b>		12												
Signature/Print name <b>ADoctor A. DOCTOR</b>			14												
Pharmacy	Start Date <b>1/9/16</b>	Frequency <b>NIGHT</b>	18												
Additional Instructions			20												
			22												

## 2.2 Specific Instructions for 'Once Only Prescriptions'

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

### Example 8

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

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

### Example 8: Specific Instructions for 'Once Only Prescriptions'

ONCE ONLY PRESCRIPTIONS							
Date	Time	Medicine	Dose	Route	Prescribed By (signature / print name)	Time Given	Given By
1/9/16	13.30	AMOXICILLIN	1G	IV	ADoctor A. DOCTOR	13.40	LQ
<del>2/9/16</del>	<del>15.00</del>	<del>BISOPROLOL</del>	<del>2.5mg</del>	<del>ORAL</del>	<del>ADoctor A. DOCTOR</del>	<del>CANCELLED</del>	<del>JR</del>
						ADoctor 2/9/16	

## 2.3 Specific Instructions for 'Regular Therapy'

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

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

### Start Date

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

### Example 9: Start Date

REGULAR THERAPY			Date																	
			Time																	
Medicine/Form <b>AMIODARONE</b>			08																	
Dose <b>200mg</b>		Route <b>ORAL</b>	12																	
Signature/Print name <b>ADoctor A. DOCTOR</b>			14																	
			18																	
Pharmacy	Start Date <b>1/9/16</b>	Frequency <b>3 X DAILY</b>	20																	
Additional Instructions <b>FOR 7 DAYS ONLY</b>			22																	
REGULAR THERAPY			Date																	
			Time																	
Medicine/Form <b>AMIODARONE</b>			08																	
Dose <b>200mg</b>		Route <b>ORAL</b>	12																	
Signature/Print name <b>ADoctor A. DOCTOR</b>			14																	
			18																	
Pharmacy	Start Date <b>8/9/16</b>	Frequency <b>TWICE DAILY</b>	20																	
Additional Instructions <b>FOR 7 DAYS ONLY</b>			22																	
REGULAR THERAPY			Date																	
			Time																	
Medicine/Form <b>AMIODARONE</b>			08																	
Dose <b>200mg</b>		Route <b>ORAL</b>	12																	
Signature/Print name <b>ADoctor A. DOCTOR</b>			14																	
			18																	
Pharmacy	Start Date <b>15/9/16</b>	Frequency <b>MORNING</b>	20																	
Additional Instructions			22																	



## Time of Administration / Alternative Times / More Than Six Administrations

- To prescribe a medicine to be given at regular times, circle the time of each administration in the 'Time' column, i.e. 08, 12, 14, 18, 20, 22. **Example 10**

### Example 10: Time of Administration

REGULAR THERAPY			Date															
			Time															
Medicine/Form <b>SIMVASTATIN</b>			08															
Dose <b>40mg</b>		Route <b>ORAL</b>	12															
Signature/Print name <b>A. DOCTOR</b>			14															
Pharmacy	Start Date <b>1/9/16</b>	Frequency <b>NIGHT</b>	18															
Additional Instructions			20															
			22															

- Medicines can be prescribed at alternative times by entering and circling alternative times in the adjacent column. **Example 11**

### Example 11: Alternative Times

REGULAR THERAPY			Date															
			Time															
Medicine/Form <b>NIMODIPINE</b>			08 (02)															
Dose <b>60mg</b>		Route <b>ORAL</b>	12 (06)															
Signature/Print name <b>A. DOCTOR</b>			14 (10)															
Pharmacy	Start Date <b>1/9/16</b>	Frequency <b>6 X DAILY</b>	18 (14)															
Additional Instructions			20 (18)															
			22 (22)															

- There may be instances when more than six administrations a day of a medicine are necessary. In these circumstances, the medicine should be prescribed in two consecutive boxes. In the adjacent time column, enter and circle the administration times, using the 24 hour clock, in chronological order. **Example 12**

## Example 12: More Than Six Administrations

REGULAR THERAPY			Date																
			Time																
Medicine/Form <b>SODIUM CHLORIDE 0.9%</b>			08	00															
Dose <b>5ml</b>			12	02															
Route <b>NEB</b>			14	04															
Signature/Print name <b>ADoctor A. DOCTOR</b>			18	06															
Pharmacy	Start Date <b>1/9/16</b>	Frequency <b>EVERY 2 HOURS</b>	20	08															
Additional Instructions			22	10															

  

REGULAR THERAPY			Date																
			Time																
Medicine/Form <b>SODIUM CHLORIDE 0.9%</b>			08	12															
Dose <b>5ml</b>			12	14															
Route <b>NEB</b>			14	16															
Signature/Print name <b>ADoctor A. DOCTOR</b>			18	18															
Pharmacy	Start Date <b>1/9/16</b>	Frequency <b>EVERY 2 HOURS</b>	20	20															
Additional Instructions			22	22															

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

## Example 13: Medicine Prescribed in 'Regular Therapy' and 'As Required Therapy'

REGULAR THERAPY			Date																
			Time																
Medicine/Form <b>DIHYDROCODEINE</b>			08																
Dose <b>30mg</b>			12																
Route <b>ORAL</b>			14																
Signature/Print name <b>ADoctor A. DOCTOR</b>			18																
Pharmacy	Start Date <b>1/9/16</b>	Frequency <b>4 X DAILY</b>	20																
Additional Instructions <b>SEE AS REQUIRED THERAPY</b>			22																

  

AS REQUIRED THERAPY									
Medicine/Form <b>DIHYDROCODEINE</b>			Date						
Dose <b>30mg</b>			Time						
Route <b>ORAL</b>			Dose						
Frequency & Indication <b>EVERY 4-6 HOURS FOR PAIN</b>			Initials						
Signature/Print name <b>ADoctor A. DOCTOR</b>			Date						
Start Date <b>1/9/16</b>			Time						
Pharmacy			Dose						
Additional Instructions <b>SEE REGULAR THERAPY</b>			Initials						

## Frequency

- The frequency box must be completed for all prescriptions. This is especially important for dosage regimens that are administered less frequently than daily e.g. Methotrexate which is given once weekly. **Example 14**
- If the medicine is not prescribed on a daily basis, the days on which the medicine is not to be administered should be crossed off to prevent administration

### Example 14: Frequency Less Than Daily

REGULAR THERAPY			Date															
			Time															
Medicine/Form <b>METHOTREXATE</b>			08	X	X	X	X		X	X	X	X	X	X		X	X	X
Dose <b>10mg</b>		Route <b>ORAL</b>	12															
Signature/Print name <b>ADoctor A. DOCTOR</b>			14															
			18															
Pharmacy	Start Date <b>1/9/16</b>	Frequency <b>FRIDAY</b>	20															
Additional Instructions			22															

## Pharmacy Box

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

## Additional Instructions

- Instructions entered by pharmacist, prescriber or nurse, e.g. administration in relation to food, special instructions, storage, etc.
- A duration or stop/review date may be appropriate for some medicines prescribed as a defined course. A line must be drawn across the administration boxes to highlight the course should be complete. **Example 15**
- For all antibiotic prescriptions, the indication and duration/stop/review date must be documented in this box (see antibiotic prescribing guidance <http://intranet.grampian.scot.nhs.uk/foi/files/AbDocPol.pdf>). **Example 15**

### Example 15: Duration/Review Date

REGULAR THERAPY			Date																	
			Time																	
Medicine/Form <b>TRIMETHOPRIM</b>			08																	
Dose <b>200mg</b>		Route <b>ORAL</b>	12																	
Signature/Print name <b>ADoctor A. DOCTOR</b>			14																	
			18																	
Pharmacy	Start Date <b>1/9/16</b>	Frequency <b>TWICE DAILY</b>	20																	
Additional Instructions <b>UTI 3 DAYS</b>			22																	

## 2.4 Specific Instructions for 'As Required Therapy'

Prescriber completes: Medicine/Form; Dose; Route; Signature/Print Name in the appropriate boxes, as previously detailed. **Example 18**

### Start Date

- Write the date the medicine is to start.

### Frequency & Indication

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

### Maximum Dose in 24hrs

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

## Additional Instructions

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

### Example 18: Specific Instructions for 'As Required Therapy'

AS REQUIRED THERAPY									
Medicine/Form <b>DIHYDROCODEINE</b>		Date							
Dose <b>30mg</b>		Time							
Route <b>ORAL</b>		Dose							
Frequency & Indication <b>EVERY 4-6 HOURS FOR PAIN</b>		Initials							
MAX Dose in 24hrs <b>120mg</b>		Date							
Signature/Print name <b>A Doctor A. DOCTOR</b>		Time							
Start Date <b>1/9/16</b>		Dose							
Pharmacy	Additional Instructions <b>SEE REGULAR THERAPY</b>	Initials							

## 2.5 Discontinuation of a Medicine

To discontinue a medicine:

- Draw diagonal line through section in which medicine is prescribed, a vertical line through the rest of the day's administration and a double diagonal line through remaining boxes in administration section for that medicine. **Example 16**
- The prescriber must then sign and date next to the double diagonal line. Ideally, the reason the medicine has been discontinued should also be recorded. **Example 16**
- It is important that the lines only delete the intended prescription and do not encroach on other prescriptions rendering them unclear and invalid.
- If a medicine requires to be amended, for example, a dose or frequency change is required, discontinue the entire entry and write a new entry. **Example 17**

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

### Example 16: Discontinuation of a Medicine

REGULAR THERAPY		Date	1/9/16	2/9/16															
		Time	1/9/16	2/9/16															
Medicine/Form		08	LQ	LQ															
RAMIPRIL																			
Dose	Route	12																	
2.5mg	ORAL																		
Signature/Print name		14																	
ADoctor A. DOCTOR																			
Pharmacy	Start Date	Frequency	18																
	1/9/16	MORNING																	
Additional Instructions		20																	
		22																	

WITHHOLD - RENAL IMPAIRMENT  
ADoctor 3/9/17

### Example 17: Amendment to a Prescription

REGULAR THERAPY		Date	1/9/16	2/9/16															
		Time	1/9/16	2/9/16															
Medicine/Form		08	LQ	LQ															
OMEPRAZOLE																			
Dose	Route	12																	
20mg	ORAL																		
Signature/Print name		14																	
ADoctor A. DOCTOR																			
Pharmacy	Start Date	Frequency	18																
	1/9/16	MORNING																	
Additional Instructions		20																	
		22																	

DOSE INCREASED ADoctor 3/9/17

  

REGULAR THERAPY		Date	1/9/16	2/9/16	3/9/16														
		Time	1/9/16	2/9/16	3/9/16														
Medicine/Form		08																	
OMEPRAZOLE																			
Dose	Route	12																	
40mg	ORAL																		
Signature/Print name		14																	
ADoctor A. DOCTOR																			
Pharmacy	Start Date	Frequency	18																
	3/9/16	MORNING																	
Additional Instructions		20																	
		22																	

## 2.6 Cancelling a Medicine Written in Error

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

**Example 19**

### Example 19: Cancelling a Medicine Written in Error

[illegible]

## 2.7 Rewriting of a PAR

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

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

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

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

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

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

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



### Example 20: Rewriting of a PAR

[illegible]



## 2.8 Prescriptions Ordered Verbally (e.g. by Telephone)

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

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

For more information, see NMC Standards for Medicine Management, Standard 11 <https://www.nmc.org.uk/standards/additional-standards/standards-for-medicines-management/>.

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

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

### 3 Administration of Medicines

#### 3.1 General Guidance

- Medicines will normally be administered by either a nurse or suitably qualified practitioner in accordance with a written prescription.
- In some wards/departments and for some medicines, e.g. intravenous drugs, **two** nurses or suitably qualified practitioners must be involved in checking and administration.
- In paediatrics, **two** nurses or suitably qualified practitioners must be involved in all medicine administration, unless signed up to the 'Single Nurse Administration of Oral, Topical and Inhaled Medication in the Paediatric Setting' register.
- Effective preparation and planning are key to safe administration.
- Staff must not interrupt the person carrying out medicine administration for a patient, other than in exceptional circumstances (i.e. wait until they have completed administration for that patient).
- Care should be taken to ensure that the maximum recommended dose of a medicine is not exceeded. Some medicines may have been prescribed in more than one section of the PAR therefore checks should be completed of all the relevant sections prior to medicine administration.
- If a patient has been to another department, e.g. theatre, check whether any medicines have been given during that time and consideration should be given as to any impact this may have on subsequent medicines administered that day. For example, if paracetamol was given in theatre and recorded on the anaesthetic record, check that the **maximum daily dose** will not be exceeded if it is also prescribed in a different section of the PAR.
- Prior to medicine administration check that all aspects of the prescription are complete. The administration times circled should also be checked to ensure they match the frequency stated in the frequency box. If any aspects of the prescription are incomplete or illegible, the prescriber must complete or rewrite the prescription.
- Where medicine(s) are to be given covertly, practitioners must follow the NHSG Guideline on Covert Administration of Medicines (Adult) [http://www.nhsgrampian.com/grampianfoi/files/Covert\\_700\\_0215.pdf](http://www.nhsgrampian.com/grampianfoi/files/Covert_700_0215.pdf).

### 3.2 Administration Process

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

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

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

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

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

- **Identify the medicines** due to be given by checking all sections of the PAR. If there is any doubt about the prescription, an appropriate senior colleague should be consulted.
- **Check the dose has not already been administered.**
- **Select the medicine** required. Before selecting the medicines required, it is essential to ask the patient if they are willing and able to take the medicines at that time. If the patient refuses or is unable to take a medicine, see 'Recording the Non-Administration of Medicines'. **Example 23**

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

### 3.3 Other Medicine Charts or Treatment Plans in Use

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

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

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

### 3.4 Specific Instructions for Administering and Recording Administration of 'Once Only Prescriptions'

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

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

ONCE ONLY PRESCRIPTIONS							
Date	Time	Medicine	Dose	Route	Prescribed By (signature / print name)	Time Given	Given By
1/9/16	13.30	AMOXICILLIN	1G	IV	ADoctor A. DOCTOR	13.40	LQ
<del>2/9/16</del>	<del>15.00</del>	<del>BISOPROLOL</del>	<del>2.5mg</del>	<del>ORAL</del>	<del>ADoctor A. DOCTOR</del>	<del>CANCELLED</del>	<del>JR</del>

### 3.5 Specific Instructions for Administering and Recording Administration of 'Regular Therapy'

- Check the date at the top of each 'Regular Therapy' section and look down the column in conjunction with the 'Time' row, establish which medicines are due to be administered.
- If it is the first administration of the day, write the date in the 'Date' column at the top of the page.
- Check for medicines to be given less than once daily, e.g. weekly.
- Additional instructions - it is important to note any instructions which have been entered in the 'Additional Instructions' column.
- Follow 'Administration Process' as previously detailed.
- Record the administration by initialling the top half of the box that corresponds to the appropriate date and time. **Example 22**



- Record the administration as follows: Enter the date, time, dose and initials in the relevant boxes. **Example 25**
- Where a choice of route has been prescribed, the route used should be recorded along with the dose in the dose box.

### Example 25: Specific Instructions for Administering and Recording Administration of 'As Required Therapy'

AS REQUIRED THERAPY									
Medicine/Form <b>DIHYDROCODEINE</b>		Date	1/9/16						
Dose <b>30mg-60mg</b>		Time	11.00						
Route <b>ORAL</b>		Dose	30mg						
Frequency & Indication <b>EVERY 4-6 HOURS FOR PAIN</b>		MAX Dose in 24hrs <b>240mg</b>	Initials	LQ					
Signature/Print name <b>ADoctor A. DOCTOR</b>		Start Date	1/9/16						
Pharmacy Additional Instructions		Date							
		Time							
		Dose							
		Initials							

## 3.7 Recording the Administration of Controlled Drugs

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

Local procedures relating to Controlled Drugs must be adhered to (see 'Policy and Procedure for Secondary Care and Community Hospitals in NHS Grampian on the Safe Management of Controlled Drugs' [http://intranet.grampian.scot.nhs.uk/foi/files/CD\\_SecCare\\_0912.pdf](http://intranet.grampian.scot.nhs.uk/foi/files/CD_SecCare_0912.pdf)).

All Controlled Drugs must be checked, administered and recorded **in the presence of a witness. Example 26**

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

### Example 26: Recording the Administration of Controlled Drugs

AS REQUIRED THERAPY									
Medicine/Form <b>SHORTEC CAPSULES</b>		Date	1/9/16						
Dose <b>10mg</b>		Time	15.00						
Route <b>ORAL</b>		Dose	10mg						
Frequency & Indication <b>EVERY 4-6 HOURS FOR PAIN</b>		MAX Dose in 24hrs <b>60mg</b>	Initials	LQ JR					
Signature/Print name <b>ADoctor A. DOCTOR</b>		Start Date	1/9/16						
Pharmacy Additional Instructions		Date							
		Time							
		Dose							
		Initials							

### 3.8 Recording the Non-Administration of Prescribed Medicines

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

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

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

If a medicine is not administered, the top of the box should be initialled and the appropriate 'Non-Administration Code' should be entered in the lower half of the administration box with a circle drawn round it. **Example 23**

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

#### Example 23: Recording the Non-Administration of Prescribed Medicines

CODES FOR NON-ADMINISTRATION OF PRESCRIBED MEDICINES		
If a dose is not administered, initial and enter the appropriate code in the administration box with a circle drawn round it:		
1. Patient refused 2. Patient unavailable 3. Medicine out of stock 4. Instructions not clear/legal 5. Nil by mouth General Comments:	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... <i>No IV access</i> 14. Other..... 15. Other..... 16. Other.....

REGULAR THERAPY		Date	1/9/16	2/9/16	3/9/16												
		Time															
Medicine/Form		08															
SENNA																	
Dose	Route	12															
15mg	ORAL																
Signature/Print name		14															
ADoctor A. DOCTOR																	
Pharmacy	Start Date	18															
	1/9/16																
Frequency																	
NIGHT																	
Additional Instructions		20															
		22															



### 3.9 Recording the Administration of Medicines When Patients Are 'On Pass'

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

- Enter the initials of the nurse(s) undertaking the medicine round into the top half of the administration box.
- Write 'On Pass' against one of the 'Other' code numbers, e.g. '13', and enter that code number into the bottom half of the administration box. **Example 24**
- This code number should then be entered at every medication round during the period that the patient is 'on pass'.

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

#### Example 24: Recording the Administration of Medicines When Patients Are 'On Pass'

REGULAR THERAPY			Date	1/9/16	2/9/16	3/9/16	4/9/16	5/9/16											
			Time																
Medicine/Form			08																
SENA																			
Dose		Route	12																
15mg		ORAL																	
Signature/Print name			14																
ADoctor A. DOCTOR																			
Pharmacy			18																
Start Date		Frequency																	
1/9/16		NIGHT	20	LQ	LQ	LQ	LQ	LQ											
Additional Instructions			22																

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

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

### 3.11 Procedure in the Event of a Medicine Incident or Suspected Medicine Incident

A medicine incident is defined as:

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

National Patient Safety Agency; 2007

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

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

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

## 4 Medicines Care Plan

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

The medicines care plan should be completed as follows:

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

### Example 27: Medicines Care Plan

MEDICINES CARE PLAN		Patient name	CHI
Presenting Complaint:			XXXXXXXXXX
PMH:			
	Tick	Details	
Patient's own medicines checked	✓		
Medicines reconciled	✓	ECS + PODS + COMMUNITY PHARMACY	
Compliance Aid?	✓	MDS: ABC PHARMACY TEL/FAX:	
Resident in Care Home	X		
Level 3 medicines management at home?	X	PP 1/9/16	
CARE ISSUES	Action / Outcome	Initials	Date
Relvar Ellipta inhaler commenced – needs to be counselled	Counselled on inhaler use – able to use effectively	PP	1/9/16

## Consultation Group - Records Standards Group

- [REDACTED], Specialist Clinical Pharmacist, ARI
- [REDACTED], Specialist Clinical Pharmacist, ARI
- [REDACTED], Specialist Clinical Pharmacist, RACH
- [REDACTED], Specialist Clinical Pharmacist, RCH
- [REDACTED], LCHP Lead Pharmacist, Aberdeenshire CHP
- [REDACTED], Medicines Information Pharmacist, ARI
- [REDACTED]ron, Medication Safety Advisor, ARI
- [REDACTED], Practice Educator, Roxburghe House
- [REDACTED] Nursing Professional Development, CHP
- [REDACTED], Clinical Effectiveness Facilitator, Inverurie Hospital
- Medication Safety Group
- Mental Health Operational Medicines Management Group

## Glossary

**PAR** – Prescription and Administration Record.

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

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

**Nurse** – this refers to Registered Nurses and Midwives.

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