Attach ALLERGY Sticker

ALLERGIES & ADVERSE DRUG REACTIONS (ADR)

DRUG / OTHER ALLERGENS	REACTION	SOURCE	INITIAL & DATE
Nil Known Drug (or other) ☐	Not Possible to Ascertain ☐ (Confirm ASAP)		

Condition(s) where medications are contraindicated? _____

HOSPITAL NO.		
SURNAME		
FORENAME		
DATE OF BIRTH	SEX M ☐ F ☐	
Weight (kg)	Height (cm)	BSA (m^2)

IN-PATIENT MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD

Barts Health NHS
NHS Trust

Consultant	Trainee Dr. Name and Bleep no.	Date of admission	Date chart reboarded	Estimated date of discharge
This chart is no. ..... of	Transcribing Check by Pharmacy Sign..... Date.....	Ward 1..... 2.....		

Supplementary Medication charts in use: Other (please specify): 1 ..... 2 .....

Syringe driver ☐ TPN ☐ Chemotherapy ☐ Diabetic treatment chart ☒

Once only medications - loading doses, pre-medication, PGDs or surgical antibiotic prophylaxis

Date	Time to be given	Medicine (approved name)	Dose	Route	Signature and bleep no.	Pharmacy	Time given	Given by	Checked by

Guidance for prescribers

a) Write prescriptions legibly
b) When prescribing medication sign & print your name/use name stamp
c) Ensure demographic details have been completed
d) Use approved names unless brand name essential
e) Avoid decimal points e.g. 500 micrograms not 0.5mg. Write doses less than 1mg in micrograms, and less than 1 microgram in nanograms
f) Discontinue medicine(s) with a vertical line through the prescribing and administration records. Sign and date the discontinuation
g) All intravenous flush solutions must be prescribed, administered and recorded according to local policy
h) Prescribe antifungals, antibiotics and antivirals in the anti-infectives section, stating the duration of the prescription. Prescribe long-term antibiotic prophlaxis and antituberculosis medications in the regular medications section

Guidance for recording administration

Nurse initials to indicate medicine administered. When medicine(s) are not given as prescribed, record the appropriate code in the administration box and initial. Ensure appropriate action is taken as a result of drug delay/omission to promote continuity.

X. Omitted on instruction of doctor or pharmacist
1. Patient away from ward
2. Patient unable to receive e.g. vomiting, NBM (see Trust policy)
3. Patient refused
4. Self medicating: witnessed
6. Self medicating: not witnessed
7. Other - state reason in 'Drugs not administered/delayed administration' section
8. Delayed administration - state reason in 'Drugs not administered/delayed administration' section

Routes of administration

IV = intravenous | IM = intramuscular | SC = subcutaneous | PO = oral | TOP = topical | SL = sublingual
PV = vaginal | PR = rectal | INH = inhalation | NEB = nebulisation | All other routes must be written in full

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Weight (kg) Height (cm) BSA(m²)

THROMBOPROPHYLAXIS ASSESSMENT IS REQUIRED ON ADMISSION AND AT 24hrs

1

PROPHYLAXIS REQUIRED IF

☐ **ONGOING REDUCED MOBILITY RELATIVE TO NORMAL STATE OR** ☐ **SURGICAL PATIENT** } **+ ONE OR MORE OF THE FOLLOWING RISK FACTORS**

- ☐ Age > 60
- ☐ Significantly reduced mobility for ≥ 3days
- ☐ BMI > 30kg/m²
- ☐ Active Cancer or Cancer treatment
- ☐ Previous PE / DVT
- ☐ Known thrombophilia / family history of DVT
- ☐ Significant medical comorbidity
- ☐ Acute illness / infection / inflammation
- ☐ Dehydration
- ☐ Surgical procedure, anaesthesia time > 60 mins
- ☐ Varicose veins with phlebitis
- ☐ Oestrogen therapy (HRT, OCP)
- ☐ Pregnant / post partum (see pregnancy booklet)
- ☐ **No risk factors. No prophylaxis required.**

2 IF PROPHYLAXIS REQUIRED PRESCRIBE LMWH (OR SUITABLE ANTICOAGULANT) UNLESS CONTRA-INDICATED:

Contra-indications to LMWH/other anticoagulants

- ☐ Active bleed (if intracranial liaise with consultant)
- ☐ On anticoagulants (caution with dual antiplatelets)
- ☐ Significant procedure related bleeding risk
- ☐ Acute stroke: haemorrhagic or large infarct
- ☐ Inherited bleeding disorder eg. haemophilia
- ☐ Severe / acute liver disease / caution if CrCl < 30ml/min
- ☐ Platelets < 75 or abnormal clotting screen
- ☐ BP > 230 systolic, or > 120 diastolic
- ☐ Lumbar puncture / epidural / spinal in previous 4 hours or within next 12 hours (for anticoagulants other than LMWH contact haematology SpR)
- ☐ Heparin induced thrombocytopenia
- ☐ **None. Prescribe LMWH / other anticoagulant**

3 ALL AT RISK SURGICAL PATIENTS REQUIRE GRADUATED COMPRESSION STOCKINGS (GCS) AND / OR INTERMITTENT PNEUMATIC COMPRESSION (IPC) UNLESS CONTRA-INDICATED:

For medical patients in whom LMWH is Contraindicated consider GCS and / or IPC.

Contra-indications to GCS

- ☐ Peripheral arterial disease, suspected/proven
- ☐ Previous / planned revascularisation surgery
- ☐ Severe leg or pulmonary oedema
- ☐ Leg conditions worsened by stockings eg dermatitis, recent skin graft, gangrene, fragile skin, wounds, ulcers, cellulitis
- ☐ Major limb deformity / unusual leg shape or size
- ☐ Acute stroke
- ☐ Peripheral neuropathy / sensory impairment
- ☐ Allergy to GCS material
- ☐ **None of the above. Prescribe GCS.**

The VTE assessment is not complete until it is registered within the patient's record on CRS.

On admission
Sign ..... Date.....

At 24 hrs and clinical situation change
Sign ..... Date.....

Thromboprophylaxis *please prescribe treatment regimens in the regular medications section*

Choice of mechanical prophylaxis and leg(s) to be applied to

Graduated elastic compression stockings	Intermittent pneumatic compression device (IPC)	Leg: Left	Leg: Right	Leg: Both	Start date:	End Date	Signature & bleep no.
☐	☐	☐	☐	☐			
☐	☐	☐	☐	☐			

Enter times — Enter dates below

Medication 2 | Dose | Dose change

Please ensure you have completed the VTE risk assessment form

	Dose	Dose change
Date		
Route		
Signature		
Bleep no.		

Enter time — Enter dates below

Instructions

Pharmacy ☐

Regular prescriptions

Oral anticoagulation *follow the anticoagulation guidelines available on the intranet*

Indication	Target INR	Baseline INR (if applicable)	Duration of therapy / Date therapy started	Date of anticoagulation follow-up appointment (clinic or other)*	Anticoagulant record book given or updated. Sign & date	Date patient counselled & sign

*A follow-up appointment must be booked with the anticoagulant clinic or enhanced provider of primary care services. If not, the TTA will **not** be dispensed

Initiating warfarin : Perform baseline coagulation screen, LFTs, U&Es and FBC ⇒ Prescribe initiation dose as per guidelines ⇒ CHECK INR DAILY ⇒ FOLLOW DOSING ALGORITHM IN GUIDELINE

Continuing warfarin : Maintenance therapy ⇒ FOLLOW MAINTENANCE DOSING ALGORITHM IN GUIDELINE

Do not use the initiation protocol for patients already on warfarin. More frequent INR monitoring may be required for patients on interacting drug(s)

Medication 1

Route	Frequency	Time	Start date	Stop date
	OD	18:00		

Signature | Bleep no. | Pharmacy ☐

Date	
INR	
Dose	
Dr sign	
Given	

Initiating Warfarin – please contact haematology team for advice outside of these parameters

Day	One	Two	Three					Four								
INR	< 1.3	No Test	< 1.5	1.5 - 2.0	2.1 - 2.5	2.6 - 3.0	> 3.0	< 1.6	1.6 - 1.7	1.8 - 1.9	2.0 - 2.3	2.4 - 2.7	2.8 - 3.0	3.1 - 3.5	3.6 - 4.0	> 4.0
Dose mg	5	5	10	5	3	1	0	10	7	6	5	4	3	2	1	0

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Condition(s) where medications are contraindicated? _____

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DATE OF BIRTH	SEX M ☐ F ☐
Weight (kg)	Height (cm) BSA (m^2)

Prescriptions in Diabetes Mellitus

Please See Separate Adult Diabetes Chart

Medications requiring frequent regular administration e.g. nebulisers, eye drops, nimodipine, emolients etc.

Medication 6				Enter times	Enter dates below
Dose	Route	Frequency	Start date		
			Stop date		
Signature			Bleep no.		
Instructions			Pharmacy ☐		

Oxygen

Target saturation ☐ 88-92% ☐ 94-98%
Other (specify) _____
Target saturation not applicable ☐

If oxygen saturation falls below target range on prescribed oxygen, patient needs urgent clinical review.
If oxygen saturation is above target range on prescribed oxygen, ask for review.

*Device : N = nasal cannula, SM = Simple face mask, V = venturi, H = humidified, RM = reservoir mask, OTH = other eg. NCPAP/NIPPV

Pharmacy ☐

	Date started	Date changed	Date changed	Enter times	Enter dates below
*Device					
% or L/min (specify a range e.g. 1-21 L/min)					
Signature & bleep no.					

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Weight (kg) Height (cm) BSA(m^2)

Regular prescriptions continued

Anti-infectives prescription *prescribe long term prophylaxis and anti-tuberculosis medications in regular medications section*

Medication 8 | Indication | For ..... days | Signature | Pharmacy ☐ | Date | Bleep | Route | Enter dates below | Times | Dose | 06 | 09 | 12 | 18 | 22 | 24

Medication 9 | Indication | For ..... days | Signature | Pharmacy ☐ | Date | Bleep | Route | Enter dates below | Times | Dose | 06 | 09 | 12 | 18 | 22 | 24

Medication 10 | Indication | For ..... days | Signature | Pharmacy ☐ | Date | Bleep | Route | Enter dates below | Times | Dose | 06 | 09 | 12 | 18 | 22 | 24

Medication 11 | Indication | For ..... days | Signature | Pharmacy ☐ | Date | Bleep | Route | Enter dates below | Times | Dose | 06 | 09 | 12 | 18 | 22 | 24

Medication 12 | Indication | For ..... days | Signature | Pharmacy ☐ | Date | Bleep | Route | Enter dates below | Times | Dose | 06 | 09 | 12 | 18 | 22 | 24

Medication 13 | Indication | For ..... days | Signature | Pharmacy ☐ | Date | Bleep | Route | Enter dates below | Times | Dose | 06 | 09 | 12 | 18 | 22 | 24

Medication 14 | Indication | For ..... days | Signature | Pharmacy ☐ | Date | Bleep | Route | Enter dates below | Times | Dose | 06 | 09 | 12 | 18 | 22 | 24

Medication 15 | Indication | For ..... days | Signature | Pharmacy ☐ | Date | Bleep | Route | Enter dates below | Times | Dose | 06 | 09 | 12 | 18 | 22 | 24

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Regular prescriptions continued

Regular medications

	DOSE			Date														
	START	Change	Change															
Date				Medication 16						Instructions				Signature and bleep no.			Pharmacy	
Route																		
Signature																		
06																		
09																		
12																		
18																		
22																		
24																		
Date				Medication 17						Instructions				Signature and bleep no.			Pharmacy	
Route																		
Signature																		
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Date				Medication 18						Instructions				Signature and bleep no.			Pharmacy	
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Date				Medication 19						Instructions				Signature and bleep no.			Pharmacy	
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Date				Medication 20						Instructions				Signature and bleep no.			Pharmacy	
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Regular prescriptions continued

Regular medications

	DOSE			Date														
	START	Change	Change															
Date				Medication 16						Instructions				Signature and bleep no.			Pharmacy	
Route																		
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Date				Medication 20						Instructions				Signature and bleep no.			Pharmacy	
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HOSPITAL NO.

SURNAME

FORENAME

DATE OF BIRTH SEX M ☐ F ☐

Weight (kg) Height (cm) BSA (m^2)

Regular prescriptions continued

Regular medications

	DOSE			Date														
	START	Change	Change															
Date				Medication						Instructions				Signature and bleep no.				Pharmacy
Route				16														
Signature																		
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Date				Medication						Instructions				Signature and bleep no.				Pharmacy
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Date				Medication						Instructions				Signature and bleep no.				Pharmacy
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Weight (kg) Height (cm) BSA(m²)

As required medications

Medication 31

Indication

Dose | Route | Maximum frequency/dose | Start date | Stop date | Bleep no.

Signature

Date | Time | Dose | Route | Given

Additional instructions:

Pharmacy ☐

Medication 32

Indication

Dose | Route | Maximum frequency/dose | Start date | Stop date | Bleep no.

Signature

Date | Time | Dose | Route | Given

Additional instructions:

Pharmacy ☐

Medication 33

Indication

Dose | Route | Maximum frequency/dose | Start date | Stop date | Bleep no.

Signature

Date | Time | Dose | Route | Given

Additional instructions:

Pharmacy ☐

Medication 34

Indication

Dose | Route | Maximum frequency/dose | Start date | Stop date | Bleep no.

Signature

Date | Time | Dose | Route | Given

Additional instructions:

Pharmacy ☐

Medication 35

Indication

Dose | Route | Maximum frequency/dose | Start date | Stop date | Bleep no.

Signature

Date | Time | Dose | Route | Given

Additional instructions:

Pharmacy ☐

Infusion prescriptions

SC = subcutaneous

IVC = intravenous central
IVP = intravenous peripheral

Date & time	Route	Infusion Fluid		Medication		Duration	Rate	Prescriber's signature & bleep no.	Date Given	Given by/ Added by	Check by	Start time	Finish time	Pharmacy
		Name & strength	Volume	Approved name with expiry and batch / unit number	Dose									
		Exp: Batch/unit no:												
		Exp: Batch/unit no:												
		Exp: Batch/unit no:												
		Exp: Batch/unit no:												
		Exp: Batch/unit no:												
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Medicines management

Medicines reconciliation	Signature	Bleep or extension	Date
Medication history checked on admission			
Medication history source (circle all that apply)	GP / Pts own medicines / eTTA / Patient / Carer / Community pharmacist / Other (specify):		
Relevant contact details (e.g. GP/comm.pharm)			

Medication history charted correctly ☐ No regular medication prior to admission ☐

Details of discrepancies:

Medicine	Dose	Strength	Route	Directions	Pharmacy comments	Doctor's comments

Monitoring Parameters e.g. Creatinine Clearance, potassium etc.

Date	Parameter	Comment	Date	Parameter	Comment
	Pregnant?	Y / N Trimester 1 / 2 / 3			

Multidisciplinary Communications e.g. details of changes/additions to medications or recommendations during in-patient stay

Date	Medicine	Dose & Directions	Changes in therapy				Comment	Signature
			New	Dose change	Witheld	Stopped		

Take Home Medicines (TTAs)

Date & time	Line numbers (Whipps Cross use only)	TTAs verified by - Signature Date & time

Pharmaceutical needs assessment

Communication concern (eg visual/hearing/ language/dementia)	Signature: Designation: Date:	Counselling required	Signature: Designation: Date:	Compliance aids needed or used	Signature: Designation: Date: