213878 068380 Admin Record.qxp_Layout 1 01/08/2016 16:41 Page 1

	itivities and other e.g diet (tl ping/administering)	nis section should be completed	Patient details
NO KNOWN DRUG	Medication (or other):	Reaction:	Name Dob:
ALLERGY	Sign: PRINT name	Date: Designation	Use Addressograph Label once available

AGREED LIST OF MEDICINES WHICH MAY BE ADMINISTERED ON THE AUTHORITY OF A REGISTERED NURSE

REGISTERED NURSE TO CONFIRM WITH DOCTOR IF IN DOUBT
ALL PAGES OF CHART MUST BE CHECKED BEFORE ADMINISTRATION OF DRUGS

NOTE TO DOCTORS: Cross out and initial any item NOT to be administered GAVISCON ADVANCE SUSPENSION SIMPLE LINCTUS SODIUM CHLORIDE 0.9% NEBULISER INSTILLAGEL SODIUM CHLORIDE 0.9% BLADDER WASHOUT SENNA tablets 7 5mg or syrup 7 5mg/5ml Two tablets or 10ml PO at night	<u>AUTI</u>	HORISED FOR THIS PATIENT BY:(Drs Sig.)	Date	
2 SIMPLE LINCTUS 5 - 10ml PO four hourly 3 SODIUM CHLORIDE 0.9% NEBULISER 5ml neb PRN 4 INSTILLAGEL 6ml or 11ml per urethra PRN 5 SODIUM CHLORIDE 0.9% BLADDER WASHOUT 100ml per catheter PRN		NOTE TO DOCTORS: Cross out and initial any i	tem NOT to be administe	ered
3 SODIUM CHLORIDE 0.9% NEBULISER 5ml neb PRN 4 INSTILLAGEL 6ml or 11ml per urethra PRN 5 SODIUM CHLORIDE 0.9% BLADDER WASHOUT 100ml per catheter PRN	1	GAVISCON ADVANCE SUSPENSION	5 - 10ml PO after meals and a	t bedtime
4 INSTILLAGEL 6ml or 11ml per urethra PRN 5 SODIUM CHLORIDE 0.9% BLADDER WASHOUT 100ml per catheter PRN	2	SIMPLE LINCTUS	5 - 10ml PO four hourly	
5 SODIUM CHLORIDE 0.9% BLADDER WASHOUT 100ml per catheter PRN	3	SODIUM CHLORIDE 0.9% NEBULISER	5ml neb PRN	
· · · · · · · · · · · · · · · · · · ·	4	INSTILLAGEL	6ml or 11ml per urethra PRN	
6 SENNA tablets 7 5mg or syrup 7 5mg/5ml Two tablets or 10ml PO at night	5	SODIUM CHLORIDE 0.9% BLADDER WASHOUT	100ml per catheter PRN	
Two tablets of form of a syrup 7.5mg/offit	6	SENNA tablets 7.5mg or syrup 7.5mg/5ml	Two tablets or 10ml PO at nigh	nt
7 GLYCERIN SUPPOSITORY 4g (Adult) One or two PR daily	7	GLYCERIN SUPPOSITORY 4g (Adult)	One or two PR daily	
8 BISACODYL SUPPOSITORY 10mg One PR daily	8	BISACODYL SUPPOSITORY 10mg	One PR daily	
9 PHOSPHATE ENEMA Single dose PR daily	9	PHOSPHATE ENEMA	Single dose PR daily	
10 MICROENEMA One or two PR daily	10	MICROENEMA	One or two PR daily	
	11	PARACETAMOL (tablets or soluble or syrup)	1 gram 4 hourly PRN qds max	NB: only if weig
12 PARACETAMOL SUPPOSITORY 1 gram 4 hourly PRN qds max is more than 5	12	PARACETAMOL SUPPOSITORY	1 gram 4 hourly PRN qds max	is more than 50l
13 LACTULOSE 10ml - 15ml BD	13	LACTULOSE	10ml - 15ml BD	
14 PEPPERMINT WATER 10mls TDS	14	PEPPERMINT WATER	10mls TDS	_

Date & Time	Medication	Dose	Route	Reason	Given by RN (signature)

For Pharmacy Use Only:

MEDICINES RECONCILIATION

Record of discrepancies found during medicines reconciliation on admission:

Drug	Issue	Outcome

Completed by	Pharm / Pharm tech	Date
· · · · · · · · · · · · · · · · · · ·		

<u>rey</u>

A. Drug omitted
Dose increased

C. Dose decreasedE. New drug commenced

F. Drugs stopped immediately

6. Other (with details)

THIS AREA CUTS AWAY

Northamptonshire Healthcare NHS Foundation Trust

PALLIATIVE CARE PRESCRIPTION AND ADMINISTRATION CHART

☐ Cransley Hospice		Admission date	Consultant	Date	Weight					
☐ Cynthia Spencer Hos	spice	Chart start date	Chart cancelled date							
□ Danetre Chart										
Details of supplementary charts in use										
Blood transfusion	Blood transfusion Nutrition Abstral® Methadone (enteral/PEG feed etc)									
Intolerances and other us	seful info	rmation								

	ONCE ONLY MEDICATION										
Date	Medication	Dose	Route	Special Directions	Doctor	Given					
				Directions	Signature	Date	Time	Signature	Pharmacy		
					_						

drugchart:palliativecareJuly2016 CSP068380 07/16

REGULAR PRESCRIPTIONS

	KE	JULAK I	PRESCRIPTIC	DINO		
Notes						
Our and Drawning tion		la ali a a			41	
Oxygen Prescription Target oxygen saturation	no (cirolo)	Date	ate wnetner patie	ent is receiving O2	Time '	▼ Date ▶
88-92%	94-98%	Date		Stop date	Time	▼ Date ►
Other%	Saturation not indicated	Signatu	ıre			
	(circle)	7				
CONTINUOUS	PRN	Notes				
Starting flow rate	Device					
Drug	Date		Stop date	Pharmacy	,	
Diag	Date		Stop date	i namacy		
Dose	Indication					
Route	Signature					
Frequency	Signature					
Drug	Date		Stop date	Pharmacy	/	
	Indication					
Dose	Indication					
Route	Signature					
Frequency						
Drug	Date		Stop date	Pharmacy	/	
		١ ١				
Dose	Indication					
Route						<u> </u>
Frequency	Signature					
Drug	Date		Stop date	Pharmacy	1	
				1		
Dose	Indication					
Route	Signature					
Frequency	Olgridiaio					
Drug	Date		Stop date	Pharmacy	/	
Door	Indication					
Dose	- Indication					
Route	Signature					
Frequency						

DO NOT alter written prescription. To change dose, route or frequency, you must re-write prescription.

	itivities and other e.g diet (this	section should be completed	Patient details
NO KNOWN DRUG	Medication (or other):	Reaction:	Name Dob:
ALLERGY	Sign: PRINT name	Date: Designation	Use Addressograph Label once available

Prescribers Notes	*00
Complete if more than one syringe pump	2 L
	of

24hr Syringe pump prescription to be reviewed by doctor on a daily basis

SYRINGE PUMPS	McKir	nley	T34	conti	nuous	subcu	taneou	s infu	sion o	ver 24	hours
	DATE										
	TIME										
DRUG	DOSE										
	Signature										
DRUG	DOSE										
	Signature										
DRUG	DOSE								\		
	Signature										
DRUG	DOSE										
	Signature			4							
Asset/ME no. of SYRIN	GE PUMP										
LOCATION OF CAN	NULA										
Eg: R arm											
DILUENT USE	D										
VOLUME (ml) / RATE											
RATE CHECKE (2 sigs)	ED										
TIME STARTE	D				l .						
REGULAR SYRINGE PU		С	L	С	L	С	L	С	L	С	L
RN must document every 4											
(Indicate ✔ YES or X NO or NS · see example)	C LX	С	L	С	L	С	L	С	L	С	L
Cannula (C) ok? Line (L) ok?	38ml										
(if 'no' state and date reason be	low) 1700hrs										
ml remainingTime of check (24 hour clo		С	L	С	L	С	L	С	L	С	L
Initials of RN	,										
RNs Notes:		С	L	С	L	С	L	С	L	С	L
		С		С		С		С		С	·····
			L		L		L		L		L
		С	L	С	L	С	L	С	L	С	L
IF DISCARDING	ml										
	ml SIG. 1										
State reason under RNs Notes above	SIG. 1										
O NOT alter written presc								41			

DO NOT alter written prescription. To change dose, route or frequency, you must re-write prescription



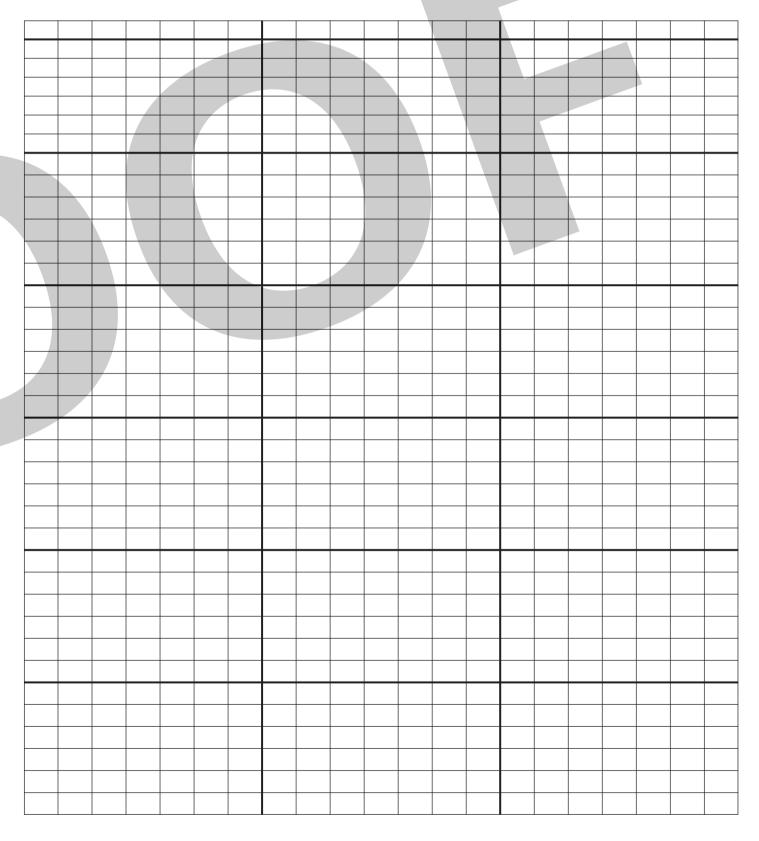
**SD

24hr Syringe pump prescription to be reviewed by doctor on a daily basis

SYRINGE PUMPS	6 McKir	iley T	34	conti	nuous	subcu	taneous	infu	sion o	ver 24	nours
	DATE										
	TIME										
DRUG	DOSE										
	Signature										
DRUG	DOSE										
	Signature										
DRUG	DOSE										
	Signature										
DRUG	DOSE										
	Signature										
Asset/ME no. of SYRII											
LOCATION OF CA Eg: R arm											
DILUENT US											
VOLUME (ml) / RAT	ΓE (ml/hr)								7		
RATE CHECK (2 sigs)	ŒD										
TIME START	ED										
REGULAR SYRINGE P	1	С	L	С	L	С	L	С	L	С	L
RN must document every ← (Indicate ✔ YES or X NO or N											
e see example)	C LX	С	L	С	L	С	L	С	L	С	L
Cannula (C) ok?	38ml										
 Line (L) ok? (if 'no' state and date reason b 	17007										
 ml remaining Time of check (24 hour c Initials of RN 		С	<u> </u> L	С	L	С	L	С	<u> </u> L	С	L
RNs Notes:					·····						
		С	L	С	L	С	L	С	L	С	L
		С	L	С	L	С	L	С	L	С	L
		С	II	С	II	С		С		С	·····
					L						L
IF DISCARDING	ml										
State reason under	SIG. 1										
RNs Notes above	SIG. 2										

REGULAR PRESCRIPTIONS

Notes	Codes but no initials to be entered if drug is not given as prescribe	∍d:
110100	Patient not on ward Incomplete or impossible pres	escription
	2. Drug omitted for clinical reason 6. Out of stock on ward	
	3. Patient opted not to take drug 7. Other documented reason	
	4. Patient self-medicating 8. Transdermal patch checked	





REGULAR PRESCRIPTIONS

Notes					
Drug	Date	Stop date	Pharmacy	Time ▼	Date ▶

Drug	Date	Stop date	Pharmacy	Time ▼	Date ▶
Dose	Indication				
Route	Signature				
Frequency					
Drug	Date	Stop date	Pharmacy		
Dose	Indication				
Route	Signature				
Frequency					
Drug	Date	Stop date	Pharmacy		
Dose	Indication				
Route	Signature				
Frequency	Signature				
Drug	Date	Stop date	Pharmacy		
Dose	Indication				
Route	Signature				
Frequency	Signature				
Drug	Date	Stop date	Pharmacy		
Dose	Indication				
Route	Signature				
Frequency	organication				
Drug	Date	Stop date	Pharmacy		
Dose	Indication				
Route					
Frequency	Signature				
1.104401103					

DO NOT alter written prescription. To change dose, route or frequency, you must re-write prescription.

Prescribers Notes

*Complete if more than one syringe pump

*SD

24hr Syringe pump prescription to be reviewed by doctor on a daily basis

SYRINGE PUMPS	McKir	iley 7	Г34	conti	nuous	subcu	taneou	ıs infu	sion o	ver 24	hours
	DATE										
	TIME										
DRUG	DOSE										
	Signature										
DRUG	DOSE										
	Signature										
DRUG	DOSE								\		
	Signature										
DRUG	DOSE										
	Signature			4							
Asset/ME no. of SYRIN											
LOCATION OF CA											
Eg: R arm											
DILUENT USE	ED										
VOLUME (ml) / RAT	E (ml/hr)										
RATE CHECK (2 sigs)	ED										
TIME STARTE	ΞD										
REGULAR SYRINGE PL	JMP CHECK	С	L	С	L	С	L	С	L	С	L
RN must document every 4											
Indicate ✓ YES or X NO or N : see example)		С	IL	С	L	С	L	С	L	С	L
Cannula (C) ok?	C ~ LX				-						-
Line (L) ok? (if 'no' state and date reason be	38ml 1700hrs										
ml remaining	JB	С	L	С	L	С	L	С	L	С	L
Time of check (24 hour cl Initials of RN	ock)										
RNs Notes:		С		С	<u> </u>	С	IL .	С	TL	С	L
		С	L	С	L	С	L	С	L	С	L
		С	L	С	L	С	L	С	L	С	L
IF DISCARDING	ml										
State reason under	SIG. 1										
RNs Notes above	SIG. 2										
	1	1									

DO NOT alter written prescription. To change dose, route or frequency, you must re-write prescription



SYRINGE PUMP TO COMMENCE FROM THIS PAGE

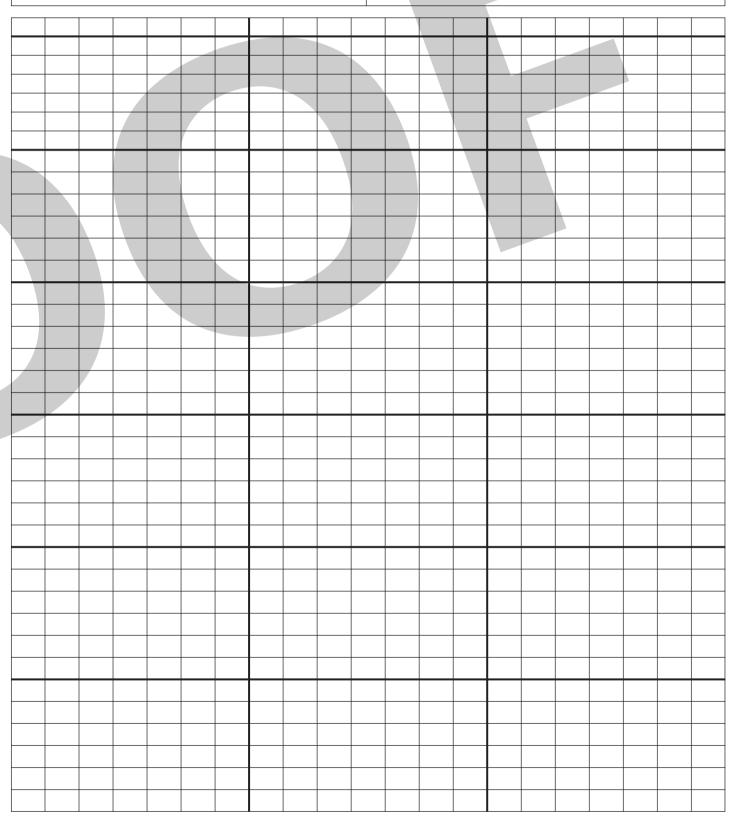
Prescribers Notes *Complete if more than one syringe pump *SD of

24hr Syringe pump prescription to be reviewed by doctor on a daily basis

SYRINGE PUMPS	McKir	nley T	34	contin	nuous	subcu	itaneous	infus	ion ov	/er 24 l	nours
	DATE										
	TIME										
DRUG	DOSE										
	Signature										
DRUG	DOSE										
	Signature										
DRUG	DOSE										
	Signature										
DRUG	DOSE										
	Signature										
Asset/ME no. of SYRIN	NGE PUMP										
LOCATION OF CA Eg: R arm											
DILUENT US	ED										
VOLUME (ml) / RAT	E (ml/hr)		1						7		
RATE CHECK (2 sigs)	ŒD										
TIME STARTE	ED										
REGULAR SYRINGE PL		С	L	С	L	С	L	С	L	С	L
RN must document every 4 (Indicate • YES or X NO or N											
- see example)	C LX	С	TL	С	L	С	L	С	L	С	L
Cannula (C) ok?Line (L) ok?	38ml										
(if 'no' state and date reason be	elow) 1700hrs								1		
ml remainingTime of check (24 hour clInitials of RN	lock)	С	<u>L</u>	С		С	L	С	<u>L</u>	С	<u> </u> L
RNs Notes:		С	TL	С	L	С	L	С	L	С	L
		С	L	С	L	С	L	С	L	С	L
		С	L	С	L	С	L	С	L	С	L
	1										
IF DISCARDING	ml										
State reason under	SIG. 1										
RNs Notes above	SIG. 2										

REGULAR PRESCRIPTIONS

Notes	Codes but no initials to be entered	if drug is not given as prescribed:
	Patient not on ward	5. Incomplete or impossible prescription
	2. Drug omitted for clinical reason	6. Out of stock on ward
	3. Patient opted not to take drug	7. Other documented reason
	4. Patient self-medicating	8. Transdermal patch checked



DO NOT alter written prescription. To change dose, route or frequency, you must re-write prescription

REGULAR PRESCRIPTIONS

Notes			

Drug	Date	Stop date	Pharmacy	Time ▼ Date ▶
Dose	Indication			
Route	Signature			
Frequency	Oignataro			
Drug	Date	Stop date	Pharmacy	
Dose	Indication	,		
Route	Signature			
Frequency	Oignature			
Drug	Date	Stop date	Pharmacy	
Dose	Indication			
Route	Signature			
Frequency	- Oignature			
Drug	Date	Stop date	Pharmacy	
Dose	Indication			
Route	Signature		_	
Frequency	Olgridadio			
Drug	Date	Stop date	Pharmacy	
Dose	Indication	'		
Route	Signature			
Frequency	Gignataro			
Drug	Date	Stop date	Pharmacy	
Dose	Indication			
Route	Signature			
Frequency	Oignature			
				'

DO NOT alter written prescription. To change dose, route or frequency, you must re-write prescription.

AS REQUIRED DRUGS

Notes	

Drug	Dose	Date							
	Route	Time							
Indication	Freq/Min Interval	Dose							
	Pharm	Route							
Sig.	Date	Sig							
Drug	Dose	Date							
	Route	Time			1				
Indication	Freq/Min Interval	Dose							
	Pharm	Route		7					
Sig.	Date	Sig	7						
Drug	Dose	Date							
	Route	Time							
Indication	Freq/Min Interval	Dose							
	Pharm	Route							
Sig.	Date	Sig							
Drug	Dose	Date							
	Route	Time							
Indication	Freq/Min Interval	Dose							
	Pharm	Route							
Sig.	Date	Sig							
Drug	Dose	Date							
	Route	Time							
Indication	Freq/Min Interval	Dose							
	Pharm	Route							
Sig.	Date	Sig							
Drug	Dose	Date							
	Route	Time							
Indication	Freq/Min Interval	Dose							
	Pharm	Route							
Sig.	Date	Sig							

DO NOT alter written prescription. To change dose, route or frequency, you must re-write prescription.





AS REQUIRED DRUGS

Notes			

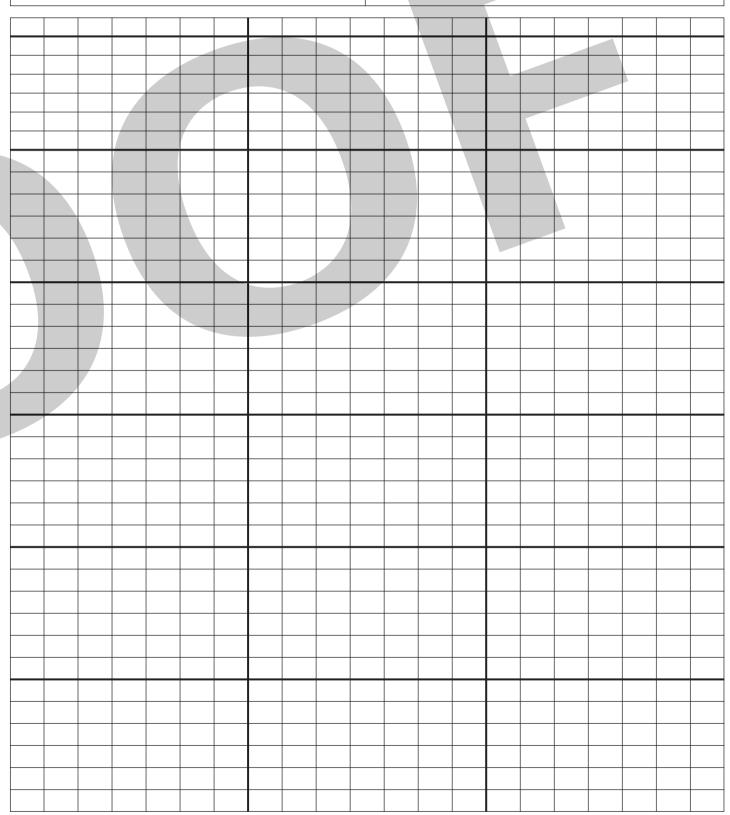
Drug	Dose	Date							
	Route	Time							
Indication	Freq/Min Interval	Dose							
	Pharm	Route							
Sig.	Date	Sig							
Drug	Dose	Date							
	Route	Time							
Indication	Freq/Min Interval	Dose							
	Pharm	Route							
Sig.	Date	Sig							
Drug	Dose	Date							
	Route	Time							
Indication	Freq/Min Interval	Dose							
	Pharm	Route					7		
Sig.	Date	Sig							
Drug	Dose	Date							
	Route	Time							
Indication	Freq/Min Interval	Dose							
	Pharm	Route							
Sig.	Date	Sig							
Drug	Dose	Date							
	Route	Time							
Indication	Freq/Min Interval	Dose							
	Pharm	Route							
Sig.	Date	Sig							
Drug	Dose	Date							
	Route	Time							
Indication	Freq/Min Interval	Dose							
	Pharm	Route							
Sig.	Date	Sig							

DO NOT alter written prescription. To change dose, route or frequency, you must re-write prescription.

REGULAR PRESCRIPTIONS

Codes but no initials to be entered if drug is not given as prescribed:

1. Patient not on ward
5. Incomplete or impossible prescription
2. Drug omitted for clinical reason
3. Patient opted not to take drug
4. Patient self-medicating
5. Incomplete or impossible prescription
6. Out of stock on ward
7. Other documented reason
8. Transdermal patch checked





INSULIN PRESCRIPTIONS

Notes					
REGULAR PRE	SCRIPTIONS	3			
			f the day, eacl	h dose to be prescri	bed separately
INSULIN		Date	Stop date	Pharmacy	Time ▼ Date ▶
Dose		Notes			
Dose	UNITS	Notes			
Route	S/C	Signature			
Frequency					
INSULIN		Date	Stop date	Pharmacy	Time ▼ Date ▶
INSOLIN		Date	Stop date	Filailliacy	Time V Date V
Dose	UNITS	Notes			
Route	S/C	Signature			
Frequency					
INSULIN		Date	Stop date	Pharmacy	Time ▼ Date ▶
Dose		Notes			
	UNITS				
Route	S/C	Signature			
Frequency					
INSULIN		Date	Stop date	Pharmacy	Time ▼ Date ▶
Dose	UNITS	Notes			
Route	S/C	Signature			
Frequency					
When required					1
INSULIN		Date	Stop date	Pharmacy	NOTES
Dose	UNITS	Notes			
Route	S/C	Signature			
Frequency					

AS REQUIRED DRUGS

	AS REGULED DROOT
Notes	

	1_						1		
Drug	Dose	Date							
LORAZEPAM	Route Sublingually	Time		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \					
Indication	Freq/Min Interval 1hr	Dose							
	Pharm	Route							
Sig.	Date	Sig							
Drug	Dose	Date							
MIDAZOLAM	Route Subcutaneous	Time							
Indication	Freq/Min Interval 15min	Dose							
	Pharm	Route		7					
Sig.	Date	Sig							
Drug	Dose	Date							
MIDAZOLAM	Route Intramuscular	Time							
Indication	Freq/Min Interval 2min	Dose							
CRISIS	Pharm	Route							
Sig.	Date	Sig							
Drug	Dose	Date							
MORPHINE	Route Oral	Time							
Indication	Freq/Min Interval 30min	Dose							
	Pharm	Route							
Sig.	Date	Sig							
Drug	Dose	Date							
MORPHINE	Route Subcutaneous	Time							
Indication	Freq/Min Interval 15min	Dose							
	Pharm	Route							
Sig.	Date	Sig							
Drug	Dose	Date							
	Route	Time							
Indication	Freq/Min Interval	Dose							
	Pharm	Route							
Sig.	Date	Sig							
	1				 		 		

DO NOT alter written prescription. To change dose, route or frequency, you must re-write prescription.

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AS REQUIRED DRUGS

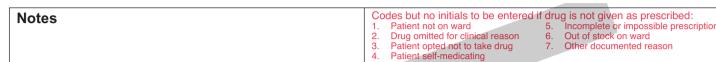
Notes			

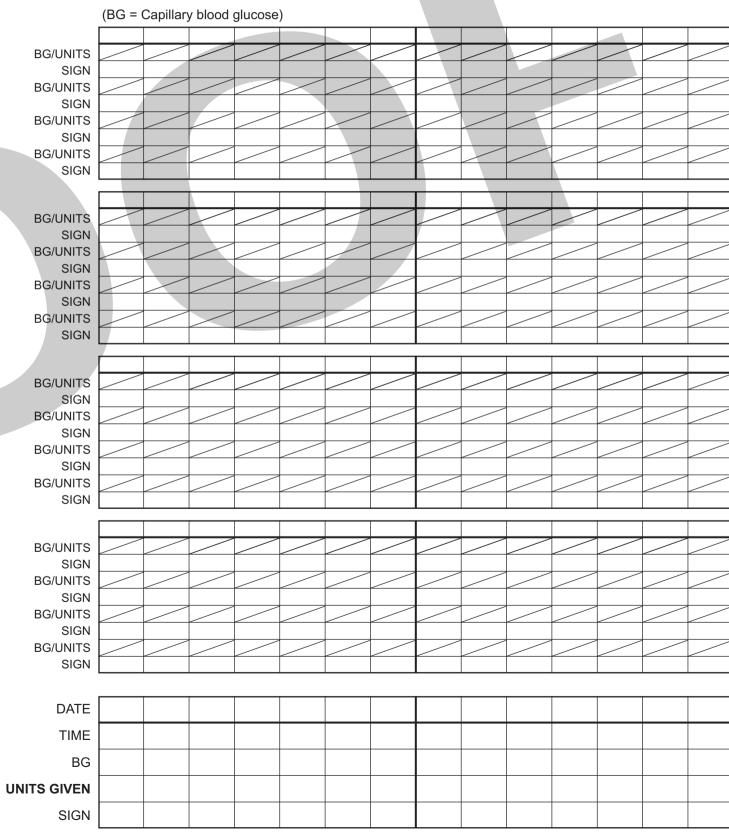
Drug	Dose	Date							
DIAMORPHINE	Route Subcutaneous	Time							
Indication	Freq/Min Interval 15min	Dose							
	Pharm	Route							
Sig.	Date	Sig							
Drug	Dose	Date							
GLYCOPYRRONIUM	Route Subcutaneous	Time							
Indication	Freq/Min Interval 30min	Dose							
	Pharm	Route							7
Sig.	Date	Sig							
Drug	Dose	Date							
HALOPERIDOL	Route Oral	Time							
Indication	Freq/Min Interval	Dose							
	Pharm	Route					7	7	
Sig.	Date	Sig							
Drug	Dose	Date							1
HALOPERIDOL	Route Subcutaneous	Time							
Indication	Freq/Min Interval 15min	Dose							
	Pharm	Route							
Sig.	Date	Sig							
Drug	Dose	Date							
LEVOMEPROMAZINE	Route Oral	Time							
Indication	Freq/Min Interval 1hr	Dose							
	Pharm	Route							
Sig.	Date	Sig							
Drug	Dose	Sig Date							
	Dose	<u> </u>							
Drug	Dose Route Subcutaneous Freg/Min Interval	Date							
Drug LEVOMEPROMAZINE	Dose Route Subcutaneous	Date Time							

DO NOT alter written prescription. To change dose, route or frequency, you must re-write prescription.

12

INSULIN PRESCRIPTIONS







9

PARENTERAL FLUID THERAPY PRESCRIPTION

Notes			

Date	Fluid + any additive	Volume	Duration	Route	Prescribers Signature & printed name		Comm	nenced		Finished		
					·	Date	Time	Batch	Nurses Sig	Date	Time	Nurses Sig

FLUSH PRESCRIPTION

Drug WATER FOR	Dose 0.2ml	Date							
INJECTION	Route Subcutaneous	Time							
Indication Flush for short line	Freq/Min Interval PRN	Dose							
1 lustrior short line	Pharm	Route							
Sig.	Date	Sig		\					
Drug WATER FOR	Dose 0.2ml	Date							
INJECTION	Route Subcutaneous	Time							
Indication Flush for short line	Freq/Min Interval PRN	Dose							
riddir for differ mile	Pharm	Route							
Sig.	Date	Sig							
Drug WATER FOR	Dose 0.2ml	Date							
INJECTION	Route Subcutaneous	Time							
Indication Flush for short line	Freq/Min Interval PRN	Dose							
	Pharm	Route							
Sig.	Date	Sig							
Drug SODIUM CHLORIDE 0.9%	Dose 10 - 20ml	Date							
	Intravenous	Time							
Indication Flush (specify device)	Freq/Min Interval	Dose							
	Pharm	Route							
Sig.	Date	Sig							
Drug SODIUM CHLORIDE 0.9%	Dose 10 - 20ml	Date							
	Intravenous	Time							
Indication Flush (specify device)	Freq/Min Interval	Dose							
	Pharm	Route							
Sig.	Date	Sig							
Drug	Dose	Date							
	Route	Time							
Indication	Freq/Min Interval	Dose							
	Pharm	Route							
Sig.	Date	Sig							

DO NOT alter written prescription. To change dose, route or frequency, you must re-write prescription.

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10