

**APPITUDE TEST**

**DOCUMENTATION FOR RPN**

**OBJECTIVE STRUCTURED**

**CLINICAL EVALUATION MPAR STATIONS**

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| Insert current Patient Photograph |

**MEDICINES PRESCRIPTION AND ADMINISTRATION RECORD**

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| **Page** | **Index** |
| 1. | Cover Page. |
| 2. | Instructions on how to use this MPAR. |
| 3. | Signature Record and Communication Section. |
| 4. | Once Only STAT. |
| 5. | Variable Dose Medication. |
| 6.  | Depot Medication. |
| 7.  | As required Medication PRN. |
| 8-11. | Regular Medications. |
| 12.  | Antimicrobial Medications. |
| 13.  | Oxygen. |
| 14. | Fluids and Electrolytes. |

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| **PATIENT LABEL OR ADDRESSOGRAPH** |
| NAME: |
| **PATIENT HOSPITAL NUMBER OR MEDICAL RECORDS NUMBER (MRN)** |
| DATE OF BIRTH: |
| ADDRESS:  |

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| **PATIENT PERSONAL DETAILS** |
| **Admission date:** | **Discharge date:** |
| **Consultant’s Name :** | **Ward/Unit:** |
| **Status:** | **Date Medicines commenced :** |
| **Status Change:** | **Date:** | **Status Change** | **Date:** |
| **Measured Height** | **Height (cm)** | **Date** | **Initials** | **DRUG CHART NUMBER**  |  | **OF** |  |

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| **Patient Conditions Affecting** **Oral** **Doses** | **Restricted oral route(e.g. swallowing problems)** **Enteral Feeding (e.g. NG Tube, PEG feeding)****Specify…………………………………………………………………………** |
| **Signature:** | **Date:** |

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| **WEIGHT** |
| **Weight (Kg)** | **Date** | **Initials** |
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| **ALLERGIES/ADVERSE DRUG REACTIONS: Complete below before medication is administered****OR tick if No Known Drug Allergy Signature: Date:**  |
| **Medication/Other** | **Nature of Reaction** | **Signature**  | **Date** |
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**How to use this Medication Prescription and Administration Record (MPAR) for the safety of the patient.**

1. Medicines prescription and administration records must be completed in line with:
	1. The local health governance administration Policy, Protocols, Procedures and Guidelines/Standard operating procedures.
	2. The up to date version of the Mental Health Commissions Judgement Support Framework (2020) (Version 5.1).
	3. Professional Standards: Guidance for Registered Nurses and Midwives on Medication Administration (NMBI, 2020).
2. Print clearly in un-joint **CAPITAL** letters. Use a **black ink** ballpointpen.
3. Complete Allergy Status before prescribing or administering medication.
4. Complete the SIGNATURE LOG RECORD before writing in this Record. Include your Personal Identification Number ( PIN )(Medical Council Number/ Nursing and Midwifery Board of Ireland Number).
5. A numbered record must be placed in the front of each (MPAR), i.e. **DRUG CHART (KARDEX) NUMBER 1 OF 1** or in the event of 2 DRUG CHARTS being used per patient – **1 OF 2 AND 2 OF 2.**
6. Medicine prescription and administration record charts must contain complete details. An addressograph sticker should be placed on each prescription page with the completeness of the patient’s details being the responsibility of the prescriber.
7. All prescriptions have to be signed and dated by, a medical practitioner and include the practitioners medical council number (MCN).
8. To stop/discontinue a prescription, draw a line through the prescription and a line at the end of the last filled in administration section. Enter the stop date, the reason for stopping and sign.
9. To change a prescription or drug therapy, stop it as above and write the new prescription. Do **NOT** alter existing prescriptions.
10. Prescribe by generic drug name, except in cases where the brand name must be specified, e.g. combination of products, modified release products, controlled drugs, insulins, biological medications, anti-epileptics, immunosuppressants etc.
11. The Patient’s NAME and Identification Number (I.D.) must be on each page of the Prescription.
12. The use of abbreviations within prescriptions are NOT permitted e.g. GTN, NSA.
13. Prescription doses should be written in the normal convention as follows:

13.1 **g** for **grams.**  13.2 **mg** for **milligrams.**

 13.3 **Micrograms** should be written **in full**. 13.4 **Nanograms** should be written **in full**.

1. Check that the drug has not already been administered.
2. Check for entries in the Communication Section each time you use this record
3. In the event of the non-administration of a medication base on clinical judgement, please enter the relevant code in theappropriate box. The justification is entered in the comments section of the MPAR and documented in the patient’s notes.
4. If the prescribed dose is variable, e.g. (500 mg-1g of Paracetamol) always note the actual dose.
5. Check the entries in every section, including the variable section, to avoid omissions.
6. In the event of the non-administration of a medication, the administrator should enter the relevant code (from the list below) and initials in the:
	1. Appropriate box.
	2. The comments section of the Medicines prescription and administration records.
	3. The patients clinical notes.
	4. Inform the registered medical practitioner.

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| **APPROVED DRUG ROUTE ABBREVIATIONS** |
| **I.M.** | Intramuscularly | **P.V.** | Per Vagina | **NEB.** | Via Nebuliser | **P.R.N.** | As Required (frequency **MUST BE** stated e.g. 4 hourly P.R.N. and the maximum dose in 24 hrs. |
| **I.V.** | Intravenously | **P.O.** | Orally | **TOP.** | Topically |
| **S.C.** | Subcutaneously | **I.O.** | Intraocularly | **S.L.** | Sublingually |
| **P.R.** | Per Rectum | **STAT** | Immediately | **N.G.** | Naso Gastrically | **P.E.G.** | Percutaneous Endoscopic Gastrostomy |
| **PLEASE NOTE: Any drug route not on this approved list of abbreviations must be written in full**. |

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| **CODES for recording omitted doses in the administration record.** | **Action taken** |
| 1. | Patient away from the ward. | 7. | Medication withheld on doctor’s orders. | Document and Record the specific action taken in the Comments section relating to the CODE used, the date and inform the team if appropriate. |
| 2. | Patient absent without leave. | 8. | Medication not available on ward/unit. |
| 3. | Patient on Leave. | 9. | Medication held due to patient condition. |
| 4. | Patient Refused Medication.. | 10. | Self-administered. |
| 5. | Route not available, e.g. Fasting, vomiting, difficulty swallowing. No IV access. | 11. | Discharge. |
| 6. | Patient Drowsy. | 12 | Other. |

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| DATE OF BIRTH: |
| ADDRESS: |

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| **Allergies/Adverse Drug Reactions** |
| Medicine/Other | Nature of Reaction |
|  |  |
|  |  |
| Or No Known AllergiesSignature ……………………………. Date ………………………………………….MRCN………………………. |

**Signature Record Each health care professional who writes in this chart MUST complete the signature record**

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| --- | --- | --- | --- | --- | --- |
| **Date** | **Name** (Print) | **Initials** | **Signature** | **MCRN/NMBI PIN Number** | **Contact Number** |
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**Medication Issues** **Use this section to document medication-related issues and actions.**

**Communication Record** **In addition, communicate issues directly to the appropriate health professional.**

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| **Date** | **Time** | **Communicated medication issues/actions** | **Signature** | **Contact Number** |
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**Once only Medications: STAT.**

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| **PRESCRIPTION** | **ADMINISTRATION** |
| Date | Drug (Generic Name) | Route | Dose | Special Instructions e.g., Diluent & Volume | Time to be given  | Date to be given | Signature | **Given by** **Checked by** | Date | Time Given (24Hr Clock) |
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| **Allergies/Adverse Drug Reactions** |
| Medicine/Other | Nature of Reaction |
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|  |  |
| Or No Known AllergiesSignature ……………………………. Date ………………………………………….MRCN………………………. |

**Variable Dose Prescription(Reducing dose Steroids, Chlordiazepoxide etc.)**

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| **Drug (Generic Name)** | **Route** | **Special Instructions** | **Reviewed by****Date** |
| Date | Result | Dose | Frequency | Prescribers Sig | Reg No. | Given By | Time | Given By | Time | Given by  | Time  |
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| **Allergies/Adverse Drug Reactions** |
| Medicine/Other | Nature of Reaction |
|  |  |
|  |  |
| Or No Known AllergiesSignature ……………………………. Date ………………………………………….MRCN………………………. |

**Depot Injection.**

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| **PRESCRIPTION** |  | **ADMINISTRATION** |
| Date | Drug (Generic Name) | Route | Dose | Special Instructions e.g., Diluent & Volume | Time to be given  | Date to be given | Signature | MCRN | Given by Checked by | Date | Time Given (24Hr Clock) |
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| Medicine/Other | Nature of Reaction |
|  |  |
|  |  |
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**As Required (PRN) Prescriptions**

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| **Year Month** | **Date**  | **Time Given** | **Route** | **Dose Given** | **Given By** | **Date**  | **Time Given** | **Route** | **Dose Given** | **Given By** |
| **Drug (Generic)** |  |  |  |  |  |  |  |  |  |  |
| **Route** | **Dose** | **Max Frequency** |  |  |  |  |  |  |  |  |  |  |
| **Special Instructions**  |  |  |  |  |  |  |  |  |  |  |
| **Prescriber Sig** | **MCRN**  | **Date** |  |  |  |  |  |  |  |  |  |  |
| **Reviewed By** | **Date** | **Stop Date Reason Signature** |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Year Month** | **Date**  | **Time Given** | **Route** | **Dose Given** | **Given By** | **Date**  | **Time Given** | **Route** | **Dose Given** | **Given By** |
| **Drug (Generic)** |  |  |  |  |  |  |  |  |  |  |
| **Route** | **Dose** | **Max Frequency** |  |  |  |  |  |  |  |  |  |  |
| **Special Instructions**  |  |  |  |  |  |  |  |  |  |  |
| **Prescriber Sig** | **MCRN**  | **Date** |  |  |  |  |  |  |  |  |  |  |
| **Reviewed By** | **Date** | **Stop Date Reason Signature** |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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| **Drug (Generic)** |  |  |  |  |  |  |  |  |  |  |
| **Route** | **Dose** | **Max Frequency** |  |  |  |  |  |  |  |  |  |  |
| **Special Instructions**  |  |  |  |  |  |  |  |  |  |  |
| **Prescriber Sig** | **MCRN** | **Date** |  |  |  |  |  |  |  |  |  |  |
| **Reviewed By** | **Date** | **Stop Date Reason Signature** |

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| **Allergies/Adverse Drug Reactions** |
| Medicine/Other | Nature of Reaction |
|  |  |
|  |  |
| Or No Known AllergiesSignature ……………………………. Date ………………………………………….MRCN………………………. |

YEAR

**Regular Prescriptions** (Prescribe antimicrobials in antimicrobials section)

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| **Prescriber circle time or enter variable time in second column** | Day | Month |  |  |  |  |  |
| **Drug 1** (Generic Name) | **6** |  |  |  |  |  |  |  |  |
| Route  | Dose | Frequency and Prescriber circle time | **8** |  |  |  |  |  |  |  |  |
| **Special Instructions** | Reviewed ByDate | **10** |  |  |  |  |  |  |  |  |
| Prescriber Sig | **Start Date** | **12** |  |  |  |  |  |  |  |  |
| **14** |  |  |  |  |  |  |  |  |
| MCRN |  | **18** |  |  |  |  |  |  |  |  |
| **Stop Date** | Reason | SignatureMCRN | **22** |  |  |  |  |  |  |  |  |

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| **Prescriber circle time or enter variable time in second column** | Day | Month |  |  |  |  |  |
| **Drug 2** (Generic Name) | **6** |  |  |  |  |  |  |  |  |
| Route  | Dose | Frequency and Prescriber circle time | **8** |  |  |  |  |  |  |  |  |
| **Special Instructions** | Reviewed ByDate | **10** |  |  |  |  |  |  |  |  |
| Prescriber Sig | **Start Date** | **12** |  |  |  |  |  |  |  |  |
| **14** |  |  |  |  |  |  |  |  |
| MCRN |  | **18** |  |  |  |  |  |  |  |  |
| **Stop Date** | Reason | SignatureMCRN | **22** |  |  |  |  |  |  |  |  |

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| **Prescriber circle time or enter variable time in second column** | Day | Month |  |  |  |  |  |
| **Drug 3** (Generic Name) | **6** |  |  |  |  |  |  |  |  |
| Route  | Dose | Frequency and Prescriber circle time | **8** |  |  |  |  |  |  |  |  |
| **Special Instructions** | Reviewed ByDate | **10** |  |  |  |  |  |  |  |  |
| Prescriber Sig | **Start Date** | **12** |  |  |  |  |  |  |  |  |
| **14** |  |  |  |  |  |  |  |  |
| MCRN |  | **18** |  |  |  |  |  |  |  |  |
| **Stop Date** | Reason | SignatureMCRN | **22** |  |  |  |  |  |  |  |  |

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| Medicine/Other | Nature of Reaction |
|  |  |
|  |  |
| Or No Known AllergiesSignature ……………………………. Date ………………………………………….MRCN………………………. |

 Day& Month DD/MM

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| **D****R****U****G****1** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | RECHART |
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| **D****R****U****G****2** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | RECHART |
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| **D****R****U****G****3** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | RECHART |
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| **PATIENT LABEL OR ADDRESSOGRAPH** |
| NAME: |
| **PATIENT HOSPITAL NUMBER OR MEDICAL RECORDS NUMBER (MRN)** |
| DATE OF BIRTH: |
| ADDRESS: |

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| **Allergies/Adverse Drug Reactions** |
| Medicine/Other | Nature of Reaction |
|  |  |
|  |  |
| Or No Known AllergiesSignature ……………………………. Date ………………………………………….MRCN………………………. |

YEAR

**Regular Prescriptions (**Prescribe antimicrobials in antimicrobials section)

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| **Prescriber circle time or enter variable time in second column** | Day | Month |  |  |  |  |  |
| **Drug 4** (Generic Name) | **6** |  |  |  |  |  |  |  |  |
| Route  | Dose | Frequency and Prescriber circle time | **8** |  |  |  |  |  |  |  |  |
| **Special Instructions** | Reviewed ByDate | **10** |  |  |  |  |  |  |  |  |
| Prescriber Sig | **Start Date** | **12** |  |  |  |  |  |  |  |  |
| **14** |  |  |  |  |  |  |  |  |
| MCRN |  | **18** |  |  |  |  |  |  |  |  |
| **Stop Date** | Reason | SignatureMCRN | **22** |  |  |  |  |  |  |  |  |

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| **Prescriber circle time or enter variable time in second column** | Day | Month |  |  |  |  |  |
| **Drug 5** (Generic Name) | **6** |  |  |  |  |  |  |  |  |
| Route  | Dose | Frequency and Prescriber circle time | **8** |  |  |  |  |  |  |  |  |
| **Special Instructions** | Reviewed ByDate | **10** |  |  |  |  |  |  |  |  |
| Prescriber Sig | **Start Date** | **12** |  |  |  |  |  |  |  |  |
| **14** |  |  |  |  |  |  |  |  |
| MCRN |  | **18** |  |  |  |  |  |  |  |  |
| **Stop Date** | Reason | SignatureMCRN | **22** |  |  |  |  |  |  |  |  |

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| **Prescriber circle time or enter variable time in second column** | Day | Month |  |  |  |  |  |
| **Drug 6** (Generic Name) | **6** |  |  |  |  |  |  |  |  |
| Route  | Dose | Frequency and Prescriber circle time | **8** |  |  |  |  |  |  |  |  |
| **Special Instructions** | Reviewed ByDate | **10** |  |  |  |  |  |  |  |  |
| Prescriber Sig | **Start Date** | **12** |  |  |  |  |  |  |  |  |
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| **Stop Date** | Reason | SignatureMCRN | **22** |  |  |  |  |  |  |  |  |

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| **PATIENT LABEL OR ADDRESSOGRAPH** |
| NAME: |
| **PATIENT HOSPITAL NUMBER OR MEDICAL RECORDS NUMBER (MRN)** |
| DATE OF BIRTH: |
| ADDRESS: |

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| **Allergies/Adverse Drug Reactions** |
| Medicine/Other | Nature of Reaction |
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|  |  |
| Or No Known AllergiesSignature ……………………………. Date ………………………………………….MRCN………………………. |

Day& Month DD/MM

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| **D****R****U****G****4** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | RECHART |
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| **D****R****U****G****5** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | RECHART |
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| **D****R****U****G****6** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | RECHART |
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| **PATIENT LABEL OR ADDRESSOGRAPH** |
| NAME: |
| **PATIENT HOSPITAL NUMBER OR MEDICAL RECORDS NUMBER (MRN)** |
| DATE OF BIRTH: |
| ADDRESS: |

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| **Allergies/Adverse Drug Reactions** |
| Medicine/Other | Nature of Reaction |
|  |  |
|  |  |
| Or No Known AllergiesSignature…………………………. Date ……………………………MRCN………………………. |

**Antimicrobials requiring Therapeutic Drug Monitoring**

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|  | **Vancomycin** | **Gentamicin** (Once Daily) | **Gentamycin in** (Multiple daily dosing) | **Amikacin** |
|  | **Use local guidelines (=/ local dosing calculator) to determine initial dose. Adjust dose and /or monitoring in renal impairment.** |
| **Timing of 1st level** | Pre-dose at 48hrs | 16-24hrs post first/second dose | Trough level at 24hrs. post-dose (30mins) level at 24hrs | 16-24hrs post first/second dose |
| **Target****range (s)** | 10/15mg/L (or 15 20mg/L) | Trough < 1mg/L | Trough<1mg/L, Peak 3-5mg/L. | Trough<5mg/L |
| **Repeat levels** | Twice weekly (e.g., Mon/Thurs or Tues/Fri) providing level in target range, dose and renal function are stable.If doses are adjusted to optimise levels and /or renal function is unstable, more frequent monitoring is required until they meet the former criteria (see “Antimicrobial Guidelines”) |

**Administered By/Witnessed By**

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| Drug (Approved Name)**Vancomycin IV** | What infection are you treating?Reviewed by: Date: | **Date** |  |  |  |  |  |  |  |  |  |  | **Automatic Stop unless rewritten**  |
| **Time of Level** |  |  |  |  |  |  |  |  |  |  |
| Start Date | Dose | Frequency | Prescribers Signature and MCRN | Stop Date | **Level** |  |  |  |  |  |  |  |  |  |  |
| **Do not hold doses awaiting levels unless specifically advised.** |
|  |  |  |  |  | 06.00 |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | **10.00** |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | 12.00 |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | 14.00 |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | 18.00 |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | 22.00 |  |  |  |  |  |  |  |  |  |  |
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| Drug (Approved Name)**Gentamicin IV** | What infection are you treating?Reviewed by: Date: | **Date** |  |  |  |  |  |  |  |  |  |  | **Automatic Stop unless rewritten**  |
| **Time of Level** |  |  |  |  |  |  |  |  |  |  |
| Start Date | Dose | Frequency | Prescribers Signature and MCRN | Stop Date | **Level** |  |  |  |  |  |  |  |  |  |  |
| **Do not hold doses awaiting levels unless specifically advised.** |
|  |  |  |  |  | 06.00 |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | **10.00** |  |  |  |  |  |  |  |  |  |  |
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**Administered By/Witnessed By**

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| Drug (Approved Name)**Gentamicin IV** | What infection are you treating?Reviewed by: Date: | **Date** |  |  |  |  |  |  |  |  |  |  | **Automatic Stop unless rewritten**  |
| **Time of Level** |  |  |  |  |  |  |  |  |  |  |
| Start Date | Dose | Frequency | Prescribers Signature and MCRN | Stop Date | **Level** |  |  |  |  |  |  |  |  |  |  |
| **Do not hold doses awaiting levels unless specifically advised.** |
|  |  |  |  |  | 06.00 |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | **10.00** |  |  |  |  |  |  |  |  |  |  |
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| **Allergies/Adverse Drug Reactions** |
| Medicine/Other | Nature of Reaction |
|  |  |
|  |  |
| Or No Known AllergiesSignature…………………………. Date ……………………………MRCN………………………. |

**Oxygen Therapy**

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| **Prescriber:** For most chronic conditions, oxygen should be prescribed to achieve a target saturation of 94%-98% (0r 88%-92% for those at risk of hypercapnic respiratory failure i.e., C02 retainers.)**Is the patient a known C0 retainer?** YES . NO**. Prescriber tick here if to continue upon discharge**  |

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| Prescription: | Administration: Check and record flow rate (FR)/device(D) at each medicine round or other times specified and sign.Record oxygen saturations in the patient’s observation chart. |

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| **Year: Day and Month** **Other times** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Continuous oxygen therapy Or “When required” oxygen therapy | **6** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **FR** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **D** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  Target oxygen Saturation 88-92% 94-98%Other saturation range…………………………………………………………………………Tick here if saturation not indicated and state reasone.g., end of life care. | **10** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **FR** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **D** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Starting device and flow rate: | **12** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **FR** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **D** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Prescribers Signature: | **14** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MCRN: | **FR** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Date: | **D** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Stop date: | Reason | Signature | **18** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **FR** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Reviewed by | Date: | **22** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **FR** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Device Codes** |
| **RA:** Room Air (not requiring O2 , weaning or on PRN O2.) | **CP:** Patient on CPAP system | **V24:** Venturi 24%(change figure as appropriate for percentage in use). |
| **SM:** Simple Mask | **NV:** Patient in NIV system |
| **N:** Nasal Cannulae | **OTH:** Other device(specify)………………………………………. |  |
| **RM:** Reservoir mask | **H28:** Humidified oxygen at 28% (change figure as appropriate for percentage in use). |
| **TM:** Tracheostomy Mask |  |
| If a ward patient is requiring high flow oxygen via non rebreathe mask, consider medical review.If target saturations as 88-92%, nebulised drugs should not be driven by oxygen (unless specified by doctor). |

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| **Allergies/Adverse Drug Reactions** |
| Medicine/Other | Nature of Reaction |
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| Or No Known AllergiesSignature ……………………………. Date ………………………………………….MRCN………………………. |

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| **PATIENT HOSPITAL NUMBER OR MEDICAL RECORDS NUMBER (MRN)** |
| DATE OF BIRTH: |
| ADDRESS: |

**Fluid +/- Electrolyte Infusions**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date | Fluid+/- Electrolyte and Dose | Volume | Route | Duration/Rate | Start Time | Prescriber Signature | MRCN | Prepared by Given by | Checkedby | Admin Rate | Time Started |
|  |  |  |  |  |  |  |  |  |  |  |  |
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**References**

This document was developed and complied from the shared data gleamed from the following sources:

1. HSE Medication Record Templates for Adult Acute Hospitals [www.safemeds.ie](http://www.safemeds.ie) and <https://www.hse.ie/eng/about/who/nqpsd/patient-safety-programme/medication-safety/medication-record.html> accessed 19th October 2022.
2. National Medication Safety Programme (Safermeds) HSE Quality Improvement Division March 2017

This project led by Mr Tim Delaney under the guidance of the National Medication Safety Advisory Group chaired by Professor Joe Harbison.

1. Mental Health Commission (2020) Judgement Support Framework: Working together for Quality Mental Health Services. (Version 5.1-January 2020) MHC: Dublin.

END