1. Answer **ALL** parts (a) to (d).

BM is an inpatient following recent surgery. Their hospital medical notes are as follows:

Patient: BM
Hospital number: 776778
DoB: 14/05/1954
Gender: F
Address: 25 Shrublands, Flatplace

Day 1
Allergies: Penicillin
Weight: 64kg

Occupation: Retired teacher
Alcohol: Nil
Smoking status: Non-smoker

MHx: Osteoarthritis (1995)

DHx: Morphine sulphate modified release tablets – 10mg BD
Morphine sulphate 10mg/5mL solution – 2.5mL QDS PRN
Ibuprofen 400mg TDS
Paracetamol 1g QDS
Zacin® 0.025% cream QDS

Plan: Elective admission for knee replacement (left) due to severe osteoarthritis of the knee impairing mobilisation and causing severe pain.

Operation to take place this afternoon.

Plan for immediate post-op pain relief – Morphine sulphate PCA (dose = 1mg, up to every 5 minutes).

Oral step-down analgesia plan from day 3:
Paracetamol 1g QDS,
Naproxen 500g BD,
Morphine modified release 15mg BD,
Gabapentin 300mg TDS

Patient for VTE prophylaxis – dalteparin 5000 units OD

T. Halliday Dr Halliday Bleep-0989

Day 2 – AM ward round

Operation successfully completed, patient back on the ward. Patient sleeping and nursing staff report patient has been very drowsy and nauseous, sick x1.

Patient to have full set of bloods today, no new blood tests to review.

Overnight patient complained of pain around cannula site.
OE: Area red, warm to touch and inflamed.

Area marked to monitor spread. Cannula removed and swab taken. New cannula in other hand for PCA.
Start antibiotics – Clarithromycin 500mg BD for 7 days.

T. Halliday Dr Halliday Bleep-0989

Day 3 – on-call junior doctor - call from microbiology

Patient confirmed MRSA positive.
Switch antibiotic to - vancomycin 1g BD, daily review.

B Chilvers Dr Chilvers Bleep-0345

Monitoring:

Reference	Day 1 - Day 2 Monday	- Day 3 -	Day 4 - range	Friday	Saturday	Sunday
Patient observations		**(TPR chart)**				
BP (mmHg)	130/70			138/82	140/85	139/80
Temperature (°C)	36.8	37.5		38	37.9	
Pulse (BPM)	60			64	67	68
Urine (mL/Hr) Daily	49	27	25	19 **average**		
Stool Type 1-7	Small type 3	Small Type 4		type 3	Small type 2	
Pain (0-10)	6 on			5	4	4 mobilisation
Respiratory rate	**12-20** 16	13	11	8		

Biochemistry and Haematology

Cr	**µmol/L** 98			175	195	230
Urea	**1.7 – 7.1** 6.1 9.2 12.0 25.5 **mmol/L**					
eGFR	**ML/min/** ^{2} >90 **1.73m**			27	24	19
Sodium	**134 – 145** 141	140	140	140 **mmol/L**		
Potassium	**3.6 – 5.00** 4.0	4.8	5.1	5.7 **mmol/L**		
LFT	NAD			NAD	NAD	NAD
WBC	**4-11 x 10^{9}/L** 8.3			15.9	18.8	18.2
Hb	**13.0 – 18.0 g/dL** 14.3	13.0		13.0	13.0	13.0
CRP	**<10 mg/L** 87			168	183	195
Vancomycin	**10 – 20** - - 17 22 **mg/L**					

NAD = Nothing abnormal detected

(a) With reference to the medical notes, review, and comment on BM's renal function since admission. Describe potential contributory factors to the current situation and how these could be managed.

Contributory Factors:

- Infection - Patient was positive to MRSA (hospital infection)
- Age - Pt is 70 yrs old - as people age Renal Function decreases
- Drugs: multiple drugs prescribed are excreted renally, affecting kidney function, (also naproxen & ibuprofen are nephrotoxic)

Management of renal impairment causes:

- Infection: Antibiotic - patient is receiving Vancomycin
- Age: Adjust Drug dose
- Drugs: Pt renal impairment - stage 2 AKI (Check RENAL HANDBOOK) (Adjust doses)
    - Morphine: Reduce to 50% original dose - give 7.5 mg according to renal handbook
    - Naproxen: is nephrotoxic can avoid change to gel formulation, benefits due to localised treatment + lower dose in gel form
    -
    - Ibuprofen: is nephrotoxic so avoid it if possible.
    - NSAIDs affect bone healing as patient just had knee surgery.
    - Vancomycin: reduce dose to 0.5 - 1 g for 24-48 h as per renal handbook must be IV, monitor serum levels.
    - Gabapentin Start at low dose and increase dose according to response

Management of respiratory depression:

- Morphine causes respiratory depression: Give Naloxone IM, 200 mg - 400 mg,
- Start at low dose and increase dose according to response

(b) With regards to the post-op step down analgesia, critique the appropriateness of the drug therapies for BM. For any issues identified, describe how these should be managed. [25%]

- According to the pain workshop, NSAIDs are contraindicated in post operative pain treatment if the operation involved bone e.g., hip, knee or pelvis surgery. it affects bone recovery

- PATIENT IS IN RESPIRATORY DEPRESSION. Give NALOXONE to reverse opiod activity.

- Hold Opiod until patient is table and respiratorary rate is back up.
- Monitor RR closely.

if patient becomes stable,

- PCA is good for pain but change morphine to FENTANYL as patient is severely renally impared
- Change ORAL morphine dose to patches. total oral morphine is 30mg daily but needs to be reduced by 50% due to renal impairment according to The Renal Handbook.
- Original dose was 30mg daily, reduced to 15mg daily. CHANGE TO Buprenorphine '5' patches.
-

8. Answer **BOTH** parts.

JH is attending their routine out-patient clinic appointment – they are reviewed by their consultant who makes the following record in their notes:

Patient: JH
Hospital number: 642758

DoB: 24/04/1956
Gender: F

Address: 13, Clover, Flatplace

Allergies: NKDA

Weight:62Kg

Occupation: Retired teacher

Alcohol: Nil

Smoking status: Non-smoker

SH: Lives with partner, independent

PMH: Type 1 DM (since childhood)
ESRF (secondary to diabetic nephropathy) – on

haemodialysis 3 x a week Hypertension 15 years

DH: Atorvastatin 20mg ON
Amlodipine 10mg OM
Ramipril 5mg ON
Calcium acetate 1-2 tablets with each meal

Erythropoietin injection (Eprex®) 4000IU IV whilst on haemodialysis
Lantus® Solostar® insulin 15IU ON
NovoRapid® Flexpen® insulin – variable dose TDS with meals

JH
788993 24/04/1956

F
13 Clover Hill, Flatplace

NKDA 62kg

Retired teacher
Nil
Non-smoker
Lives with partner, independent

Type 1 DM (since childhood)
ESRF (secondary to diabetic nephropathy) – on

haemodialysis 3 x a week Hypertension 15 years

Atorvastatin 20mg ON
Amlodipine 10mg OM
Ramipril 5mg ON
Calcium acetate 1-2 tablets with each meal

OE:

BP: Temperature: Pulse:

Blood tests:

7 **PHA-6020Y**

Erythropoietin injection (Eprex®) 4000IU IV whilst on haemodialysis
Lantus® Solostar® insulin 15IU ON
NovoRapid® Flexpen® insulin – variable dose TDS with meals

129/80 mmHg
36.2 degrees Celsius 66 BPM

HbA1c
eGFR:
Phosphate: Correctedcalcium: Hb:

Ferritin:

46.4mmol/mol / 6.8%
9 ml/min/1.73m2
1.43 mmol/L (Ref: 0.8-1.45) 1.75mmol/L(Ref:2.1-2.6) 13.5g/dL (Ref: 13.0-18.0)

243 µg/L

Describe and explain any interventions you

(a) Critique JH's current drug therapy.
would like to make regarding their treatment.

According to nice guidelines

Antihypertensives

-Amlodipine 10 mg OM -used to manage hypertension , by lowering the blood pressure ,good in patients with renal impairment so (NO CHANGES)
-Ramipril 5mg ON -ACE inhibitor used also to manage hypertension .it also provide renal protection .However this is a ESRF stage which meaning it needs to be carefully monitored due to the risk of hyperkalemia and further renal decline(NO CHANGES)

Atorvastatin 20mg ON -used for cardiovascular risk with patients with diabetes and renal disease(NO CHANGES)

Calcium acetate (1-2 tablets with meal)-used in the management of hyperphosphatemia in ESRF .(CHANGES) The phosphate levels are within the range however the calcium is low which means we have to adjust the dose of calcium acetate or switch to sevelamer which is a different phosphate binder and avoid hypercalcemia but still needs monitoring

Erythropoietin injection (Eprex®) 4000IU IV- (NO CHANGES) - This because for anemia management ,the Hb levels are within range for dialysis patients

Lantus® Solostar® insulin 15IU ON
NovoRapid® Flexpen® insulin - (NO CHANGES) HbA1c is well controlled at 46.4mmol/mol

(b) Describe the underlying pathophysiology and potential clinical consequences of the condition(s) you have recommended intervention(s) for in part (a).

2. Answer **ALL** parts (a) to (c).

You have a new patient, CR, admitted to the cardiology ward. Their medical notes and drug chart are as follows:

Patient: CR
Hospital number: 0357912
DoB: 1.1.1954
Gender: F
Address: Ivy Lane, Flatplace

PC: Uncontrolled AF

HPC: Admitted via GP with uncontrolled AF (picked up when attended surgery for routine appointment)

PMH: Epilepsy (since childhood)

DH: Carbamazepine MR 400mg bd
Sodium valproate MR 500mg bd

Allergies: NKDA

OE:

BP: 150/100 mmHg
Pulse: 120 BPM, irregular

SH: Retired, active – walks 2-3 miles/day
Alcohol: 1-2 Units/week
Smoking status: Non-smoker

Diagnosis: Uncontrolled AF

Plan: P 155/95
Pulse 125bpm (irregular)

UEA Training Prescription Chart

Number of drug charts in use: 1

Date	Surname	Forename	Sex	D/O/B	Hosptial No.	Weight (kg)	Height (cm)	Surface Area (m^2)	SAM?
Day 1	**R**	**C**	F	01/01/1954	357912	Estimate / Actual			Yes / **No**

Ward/ward change:	**Cardio**	**Patient address:**	
Consultant(s)	**Dr P Nair**		

DRUG SENSITIVITIES/ALLERGIES MUST BE ENTERED. If no allergies/sensitivites you must write 'NKDA' and sign and date.

Medicine/Substance	Description of allergy/sensitivity	Signature	Date
	NKDA	*P Nair*	*Day 1*

PRE-MEDICATION AND ONCE ONLY DRUGS

Pharm	Date	Drug (approved name)	Dose	Directions/ route/ other	Time to be given	Signature	Administered by	
							Initials	Date
	Day 1	*Digoxin*	*500mcg*		**1400**	*P Nair*		
	Dai 1	*Digoxin*	*500mcg*		**2000**	*P Nair*		

Thromboprophylaxis Risk Assessment

Drug thromboprophyaxis recommended			
Drug thromboprophlaxis NOT recommend	X		

Prescribing

- Write clearly in black, indelible ink.
- Use approved drug names.
- All prescriptions must be signed and dated.
- If a drug is to be intentionally omitted by a prescriber or pharmacist, indicate this with an 'X' in the drug administration box.
- If a drug is being stopped, or a dose altered, draw a line through the whole prescription, sign and date.
- Doctors to re-write charts as required. Start dates should be transferred to new chart. Include cross-reference to drugs on other charts.

Drug omissions

If a drug is omitted, one of the below codes must be entered into the drug administration box.

1. Nil by mouth
2. Not required
3. Patient refused
4. Drug unavailable
5. Vomiting/nausea
6. Patient off ward
7. No IV access
9. Contra-indicated
8. Other - reason must be recorded in notes

Self administration of medicines (SAM)

If a patient is suitable for SAM they can initial in the relevant drug administration box or a nurse can write 'SAM' in the box.

Prescribers

Signature	*Dr P Nair*
Bleep no.	5893
Print name	Doctor P NAIR
Signature	
Bleep no.	
Print name	
Signature	
Bleep no.	
Print name	
Signature	
Bleep no.	
Print name	
Signature	
Bleep no.	
Print name	

Pharmacy codes

Pharm: Signature confirms checked/date

TTO ✔ = from locker; **H** = at home; **R** = relabel; ★ = new supply at discharge

Supply: S = ward stock; **T** = dispensing, see date and quantity; **P** = POD, see date and quantity

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REGULAR MEDICINES 1

CHECK PAGE 1 FOR ALLERGY STATUS

Tick box to indicate time of admission or add other times ↓	Date →	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10
1. Drug (approved name): Apixaban; Start date: Day 1; End date	06:00										
	08:00	✓	X								
Dose: 5mg; Route: Po; Frequency: BD	12:00										
	14:00										
Indication; Pharm check	18:00	✓									
	22:00										
Prescriber's signature: P Nair; Supply	00:00										
2. Drug (approved name): Digoxin; Start date: Day 2; End date	06:00										
	08:00	✓	X								
Dose: 125mcg; Route: Po; Frequency: OD	12:00										
	14:00										
Indication; Pharm check	18:00										
	22:00										
Prescriber's signature: P Nair; Supply	00:00										
3. Drug (approved name); Start date; End date	06:00										
	08:00										
Dose; Route; Frequency	12:00										
	14:00										
Indication; Pharm check	18:00										
	22:00										
Prescriber's signature; Supply	00:00										
4. Drug (approved name); Start date; End date	06:00										
	08:00										
Dose; Route; Frequency	12:00										
	14:00										
Indication; Pharm check	18:00										
	22:00										
Prescriber's signature; Supply	00:00										
5. Drug (approved name); Start date; End date	06:00										
	08:00										
Dose; Route; Frequency	12:00										
	14:00										
Indication; Pharm check	18:00										
	22:00										
Prescriber's signature; Supply	00:00										

CHECK PAGE 1 FOR ALLERGY STATUS

Question 2 continues...

(a) With reference to current evidence-based guidelines, critique CR's current drug therapy. Describe and explain any interventions you would like to make regarding her treatment.

- NICE recommends Beta Blocker has 1st line in uncontrolled AF to control the rate, however this patient is not on any beta blockers so should be preferably started on Bisoprolol 2.5mg OD and titrate according to response
- Patient is on DOAC which would be good because according to NICE guidelines they recommend anyone with a CHAD score of 2 or more/1 if male to be considered for any anticoagulation (assessment of bleeding risk with ORBIT). Although we don't know the CHAD score because the patient has uncontrolled AF and a high blood pressure, they might qualify but as an intervention CHAD score should be done
- Digoxin is only appropriate for monotherapy if the patient is living a sedentary lifestyle however this patient is wa;lking 2-3 miles a day which does not classify as sedentary! If monotherapy doesn't work (beta blocker) then digoxin can be used in combination therapy, so digoxin should be replaced with a beta blocker for now.
- Carbamazipine and Sodium Valporate if appropriate for their current treatment of epilepsy should be on the drug chart, however they are not and should be added ASAP because they run the risk of having seizures etc. SO ADD!
- Discuss carbamazepine with pt & IM specialist as can exacerbate seizures in myoclonic

3. Answer **ALL** parts (a) to (c).

You have a new patient, HY, admitted yesterday to the cardiology ward. Their medical notes and drug chart are as follows:

Patient: HY
Hospital number: 476321
DoB: 12.10.1941
Gender: M
Address: 23 Lime Ave, Flatplace

Day 1:

PC: Admitted via GP with severe SOB

HPC: Over past week has become increasingly SOB whilst mobilising. Now needing 4 pillows at night to sleep.

PMH: Gout (10 years)
Hypertension (6 years)
Heart failure (2 years)

DH: Furosemide 40mg om
Perindopril 2mg od
Bisoprolol 2.5mg om
Allopurinol 200mg od

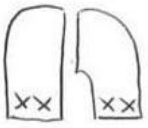
NKDA

SH: Lives in sheltered accommodation

Alcohol: Nil
Smoking status: Non-smoker

OE: Patient short of breath, struggling to speak. Patient also reporting extremely painful, red, hot toe on right foot.

BP: 155/95 mmHg
Temperature: 36.2 degrees Celsius
Pulse: 78 BPM (regular)
Weight: 86kg (normally around 75kg)
Lungs: Bibasal crackles +++



Investigations: Chest x-ray – pulmonary oedema
Echo – EF 30%

Diagnosis: Acute LVF + acute flare of gout

Plan: IV furosemide 80mg bd + ibuprofen 400mg tds

A Tsung Bleep 4670

Day 2:

Weight still 86kg, patient still SOB +++

A Tsung Bleep 4670

UEA Training Prescription Chart

Number of drug charts in use: 1

Date	Surname	Forename	Sex	D/O/B	Hosptial No.	Weight (kg)	Height (cm)	Surface Area (m^2)	SAM?
Day 1	Y	H	M	12/10/1941	476321	86 Estimate / Actual			Yes / No

Ward/ward change:	Cardio	Patient address:	
Consultant(s)	Dr P Nair		

DRUG SENSITIVITIES/ALLERGIES MUST BE ENTERED. If no allergies/sensitivites you must write 'NKDA' and sign and date.

Medicine/Substance	Description of allergy/sensitivity	Signature	Date
	NKDA	P Nair	Day 1

PRE-MEDICATION AND ONCE ONLY DRUGS

Pharm	Date	Drug (approved name)	Dose	Directions/ route/ other	Time to be given	Signature	Administered by	
							Initials	Date
			Thromboprophylaxis Risk Assessment					
Drug thromboprophyaxis recommended								
Drug thromboprophlaxis NOT recommend								

Prescribing

- Write clearly in black, indelible ink.
- Use approved drug names.
- All prescriptions must be signed and dated.
- If a drug is to be intentionally omitted by a prescriber or pharmacist, indicate this with an 'X' in the drug administration box.
- If a drug is being stopped, or a dose altered, draw a line through the whole prescription, sign and date.
- Doctors to re-write charts as required. Start dates should be transferred to new chart. Include cross-reference to drugs on other charts.

Drug omissions

If a drug is omitted, one of the below codes must be entered into the drug administration box.

1. Nil by mouth
2. Not required
3. Patient refused
4. Drug unavailable
5. Vomiting/nausea
6. Patient off ward
7. No IV access
9. Contra-indicated
8. Other - reason must be recorded in notes

Self administration of medicines (SAM)

If a patient is suitable for SAM they can initial in the relevant drug administration box or a nurse can write 'SAM' in the box.

Pharmacy codes

Pharm: Signature confirms checked/date

TTO ✔ = from locker; **H** = at home; **R** = relabel; ★ = new supply at discharge

Supply: S = ward stock; **T** = dispensing, see date and quantity; **P** = POD, see date and quantity

Prescribers

Signature	Dr P Nair
Bleep no.	5893
Print name	Doctor P NAIR
Signature	
Bleep no.	
Print name	
Signature	
Bleep no.	
Print name	
Signature	
Bleep no.	
Print name	
Signature	
Bleep no.	
Print name	

Version 001-19

REGULAR MEDICINES 1

CHECK PAGE 1 FOR ALLERGY STATUS

Date → / Tick box to indicate time of admission or add other times ↓		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10
1. Drug (approved name): Furosemide; Start date: Day 1; End date:	06:00										
Dose: 80mg; Route: IV; Frequency: BD	08:00	✓	X	RA							
Indication:	12:00										
Pharm check:	14:00	✓	RA								
	18:00										
	22:00										
Prescriber's signature: P Nair; Supply:	00:00										
2. Drug (approved name): Perindopril; Start date: Day 1; End date:	06:00										
Dose: 2mg; Route: Po; Frequency: ON	08:00										
Indication:	12:00										
Pharm check:	14:00										
	18:00										
	22:00	✓	RA								
Prescriber's signature: P Nair; Supply:	00:00										
3. Drug (approved name): Bisoprolol; Start date: Day 1; End date:	06:00										
Dose: 2.5mg; Route: PO; Frequency: OM	08:00	✓	X	RA							
Indication:	12:00										
Pharm check:	14:00										
	18:00										
	22:00										
Prescriber's signature: P Nair; Supply:	00:00										
4. Drug (approved name): Allopurinol; Start date: Day 1; End date:	06:00										
Dose: 200mg; Route: PO; Frequency: OM	08:00	✓	X	RA							
Indication:	12:00										
Pharm check:	14:00										
	18:00										
	22:00										
Prescriber's signature: P Nair; Supply:	00:00										
5. Drug (approved name): Ibuprofen; Start date: Day 1; End date:	06:00										
Dose: 400mg; Route: PO; Frequency: TDS	08:00	✓	X	RA							
Indication:	12:00	✓	RA								
Pharm check:	14:00										
	18:00	✓	RA								
	22:00										
Prescriber's signature: P Nair; Supply:	00:00										

CHECK PAGE 1 FOR ALLERGY STATUS

(a) With reference to current evidence-based guidelines, critique HY's current drug therapy. Describe and explain any interventions you would like to make regarding their treatment. Your answer should make reference to both acute and chronic management.

Increasing the dose of furosemide to 80 mg BD is appropriate for the pulmonary odeoma. This is appropriate for managing pulmonary odeoma due to the fact that acute LVF provides rapid diuresis.

It is important to monitor the input and output to assess the effectiveness of diuretic therapy and prevent dehydration. It is important to regularly monitor electrolytes, especially potassium and magnesium due to the high risk of hypokalemia with high dose furosemide.

The perindopril 2mg OD is relatively low dose. Increasing the dose will aid a better afterload reduction but it is important to monitor the renal function and blood pressure. I will recommend 2.5mg once daily for 2 weeks then increase to 5 mg once daily, dose to be taken in the morning.

Gout is the first line for the ibuprofen 400mg TDS as it is an NSAID which causes harm to the kidney and exacerbates CVD attacks like heart so as a result you will have to swap the ibuprofen with colchicine 500 mcg QDS for the treatment of gout.

Review the dose of allopurinol for the long term management of gout where it is important to assess their ongoing renal function and uric acid levels

Perinodpril should be swapped with ramipril as it is the first choice drug for hypertension and can be used as an ace inhibitor to treat heart failure.

Titrate the dose of the bisoprolol to 3.75mg once daily for a week then increase to 5mg once daily for 4 weeks, then increase if tolerated to 7.5 mg once daily for 4 weeks, then increase if tolerated to 10mg once daily which is the target dose

Add a mineralocorticoid receptor antagonist so adding spironolactone to improve the outcomes of the ejection fraction.

Talk to the patient about dietary sodium restriction and daily weight monitoring to detect fluid retention early.

4. Answer **ALL** parts (a) to (c).
You have a new patient, KL, admitted in the early hours of this morning to the coronary care unit. Their medical notes and drug chart are as follows:

Patient: KL
Hospital number: 156709
DoB: 15.7.1965
Gender: M
Address: 2 Salt Road, Flatplace

Day 1 04:00:

PC: Admitted via ambulance from home with severe chest pain (aspirin 300mg STAT given by paramedics)

HPC: Woken up during night with severe central chest pain

PMH: Hypertension (2 years)

DH: Amlodipine 10mg od NKDA

SH: Warehouse manager. Independent.

Alcohol: 30-35 units/week
Smoking status: Smokes 15-20/day

OE: Chest pain 9/10, clammy, anxious +++

BP: 145/95 mmHg
Temperature: 36.2 °C
Pulse: 88 BPM (regular)
Weight: 96kg (BMI 31)

Investigations: ECG: ST-elevation
Troponin >50,000

Diagnosis: STEMI

Plan: For PPCI

05:30: PPCI complete – DES inserted into RCA and LAD

Day 2 09:00:
No further chest pain. Patient very tearful – reports increasing low mood over past few months. Recently divorced and stress at work.

UEA Training Prescription Chart

Number of drug charts in use: 1

Date	Surname	Forename	Sex	D/O/B	Hosptial No.	Weight (kg)	Height (cm)	Surface Area (m^2)	SAM?
Day 1	L	K	M	15/07/1965	156709	96 Estimate / Actual			Yes / No

Ward/ward change:	Cardiology	Patient address:	2 Salt Rd, Flatplace
Consultant(s)	Dr A Tsung		

DRUG SENSITIVITIES/ALLERGIES MUST BE ENTERED. If no allergies/sensitivites you must write 'NKDA' and sign and date.

Medicine/Substance	Description of allergy/sensitivity	Signature	Date
	NKDA	Dr A Tsung	Day 1

PRE-MEDICATION AND ONCE ONLY DRUGS

Pharm	Date	Drug (approved name)	Dose	Directions/ route/ other	Time to be given	Signature	Administered by	
							Initials	Date
	Day 1	Ticagrelor	180mg	STAT	5am	Dr A Tsung	AB	Day 1
	Day 1	Diamorphine	2.5mg	STAT IV	5am	Dr A Tsung	AB	Day 1

Thromboprophylaxis Risk Assessment

Drug thromboprophyaxis recommended								
Drug thromboprophlaxis NOT recommend			X					

Prescribing

- Write clearly in black, indelible ink.
- Use approved drug names.
- All prescriptions must be signed and dated.
- If a drug is to be intentionally omitted by a prescriber or pharmacist, indicate this with an 'X' in the drug administration box.
- If a drug is being stopped, or a dose altered, draw a line through the whole prescription, sign and date.
- Doctors to re-write charts as required. Start dates should be transferred to new chart. Include cross-reference to drugs on other charts.

Drug omissions

If a drug is omitted, one of the below codes must be entered into the drug administration box.

1. Nil by mouth
2. Not required
3. Patient refused
4. Drug unavailable
5. Vomiting/nausea
6. Patient off ward
7. No IV access
8. Other - reason must be recorded in notes
9. Contra-indicated

Self administration of medicines (SAM)

If a patient is suitable for SAM they can initial in the relevant drug administration box or a nurse can write 'SAM' in the box.

Prescribers

Signature	Dr A Tsung
Bleep no.	4670
Print name	Doctor A Tsung
Signature	
Bleep no.	
Print name	
Signature	
Bleep no.	
Print name	
Signature	
Bleep no.	
Print name	
Signature	
Bleep no.	
Print name	

Pharmacy codes

Pharm: Signature confirms checked/date

TTO ✓ = from locker; **H** = at home; **R** = relabel; ★ = new supply at discharge

Supply: S = ward stock; **T** = dispensing, see date and quantity; **P** = POD, see date and quantity

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AS REQUIRED DRUGS

CHECK PAGE 1 FOR ALLERGY STATUS

1. Drug (approved name): *Diamorphine*	Start date: *Day 1*	Date	Day 1										
Dose: *2.5mg*	Route: *IV*	Max Frequency	Time	04:45									
Indication		Pharm check	Dose	2.5mg									
			Route	IV									
Prescriber's signature: *A Tsung*		Supply	Given by	GN									
2. Drug (approved name): *Ondansetron*	Start date: *Day 1*	Date	Day 1										
Dose: *8mg*	Route: *Po*	Max Frequency: *BD*	Time	04:40									
Indication		Pharm check	Dose	8mg									
			Route	Po									
Prescriber's signature: *A Tsung*		Supply	Given by	GN									
3. Drug (approved name): *GTN (400mcg) spray*	Start date	Date	Day 1										
Dose: *1-2 sprays*	Route: *SL*	Max Frequency: *PRN*	Time	04:15									
Indication		Pharm check	Dose	[illegible]									
			Route	SL									
Prescriber's signature: *A Tsung*		Supply	Given by	GN									
4. Drug (approved name)	Start date	Date											
Dose	Route	Max Frequency	Time										
Indication		Pharm check	Dose										
			Route										
Prescriber's signature		Supply	Given by										
5. Drug (approved name)	Start date	Date											
Dose	Route	Max Frequency	Time										
Indication		Pharm check	Dose										
			Route										
Prescriber's signature		Supply	Given by										

CHECK PAGE 1 FOR ALLERGY STATUS

(a) With reference to current evidence-based guidelines, critique KL's current drug therapy. Describe and explain any interventions you would like to make regarding their treatment. Your answer should make reference to both acute and chronic management. [50%]