Remote Prescribing

Subject:	Remote prescribing during COVID-19 Pandemic	
Objective:	To provide guidance to all clinical staff involved in the prescribing or administration of medication	
Category:	Information	
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1. Introduction

This document has been written to detail the changes to remote prescribing during the COVID-19 pandemic within the MCNS and Hospices. These changes are also detailed in two accompanying flow charts.

2. MC Medicines Management Policy Hospice

Verbal orders are permitted for Schedule 2 – 5 CDs during the COVID-19 pandemic

In this situation remote orders for schedule 2-5 CD's may only be taken for a CD:

- That has been prescribed for that patient before and:
  - there is no room left on the medication/MAR chart
  - the route of administration needs to be changed and dose adjusted accordingly
  - the dose needs to be increased or decreased. If increasing the increase must not be more than 50% of the previously prescribed dose
- In exceptional circumstances, for a previously un-prescribed schedule 2-5 where the patient has ongoing symptoms that are not controlled by current medication.
- For a standard anticipatory medication in end of life care

The following procedure should be followed:

1. The authorised prescriber, identifies themselves, specifies the patient's name and gives the verbal order to the first RN. The prescriber should use generic drug names, where appropriate and pronounce numerical digits separately, for example "one six" instead of "sixteen". The dose should be repeated to ensure clarity and abbreviations should be avoided. Before prescribing any medication, the prescriber must ask the nurse if the patient has any allergies.

2. The first RN immediately writes the information on the appropriate medication chart, including the date, time and authorised prescribers name.

The following information should be included; -

- The patients name and date of birth

- The drug name, which should be spelled out to avoid errors due to sound alike drugs
- Dosage form, for example tablets, capsules, injection
- Strength or concentration, pronouncing it in single digits, for example 15mg should be read back as one five.
- The dose. All doses of medication to include units of weight, for example mg or g
- The route
- The frequency, where three times a day should be stated not TID or TDS
- Any other information to ensure that the order makes sense in the context of the patient's condition, for example the indication for the medication.

3. The second RN then repeats the order back to the authorised prescriber to confirm the accuracy of what has been written and checks that the prescriber is aware of any allergies. All the information should be written on the appropriate medication chart before it is read back.

4. The authorised prescriber should then confirm their verbal order by sending an e-mail, which must be received before the administration can take place.
Please note that on all emails the patients name should only be written as INITIALS to maintain confidentiality. The patient's date of birth MUST also be included.

5. The patient's name, date of birth and HNS/CHI number should then be immediately written on the printed email, or if no label is available then the full name and date of birth should be clearly written on the top of the e-mail.

6. One of the RNs should then compare the verbal order given over the telephone with the written confirmation, received by e-mail to check the accuracy of all the details before administration of any medication. If all the details are correct, he/she may administer the medication to the patient in line with the MC Medicine Management policy.

7. The RN should then sign and date the copy of the e-mail to confirm they have checked it and then it should be placed with the medication chart in the patients' medication folder. This documentation should not cause delay in administration to the patient.

8. The verbal order on the appropriate medication chart must be countersigned and dated by an authorised prescriber within 24 hours.

9. If a medication prescribed by telephone is ineffective, then the patient should normally have a medical review prior to further prescribing.

10. The nursing staff should document the initial effect of the telephone prescribing in the patients' electronic record. This should also be documented by the medical staff at the next medical assessment.

11. All remote prescribing incidents should be reviewed by the MD or deputy as part of the incident review meeting or investigation

3. MC Medicine Management Policy MCNS

Remote prescribing is only permitted within the MCNS in:

- The rapid response teams.
- Other MCNS services by RN's during the COVID-19 pandemic

In these situations, RNs may accept remote prescriptions (verbal orders) in exceptional circumstances, for non-controlled drugs where medication has previously been prescribed and the prescriber is unable to issue a new prescription, but where changes to dose are considered necessary and there is a need to prescribe remotely.
The prescription must be signed within 24 hours.

Remote prescriptions are also permitted for Schedule 2 – 5 CDs by RN's during the COVID 19 pandemic

In this situation remote orders for schedule 2-5 CD's may only be taken for a CD:

- That has been prescribed for that patient before and:
  - there is no room left on the medication/MAR chart
  - the route of administration needs to be changed and dose adjusted accordingly
  - the dose needs to be increased or decreased. If increasing the increase must not be more than 50% of the previously prescribed dose
- In exceptional circumstances, for a previously un-prescribed schedule 2-5 where the patient has ongoing symptoms that are not controlled by current medication.
- For a standard anticipatory medication in end of life care

The following procedure should be followed:

1. The authorised prescriber, identifies themselves, specifies the patient's name and gives the verbal order to the RN. The prescriber should use generic drug names, where appropriate and pronounce numerical digits separately, for example "one six" instead of "sixteen". The dose should be repeated to ensure clarity and abbreviations should be avoided. Before prescribing any medication, the prescriber must ask the RN if the patient has any allergies.

2. The RN immediately writes the information on the appropriate medication chart, including the date, time and authorised prescribers name.
The following information should be included; -

- The patients name and date of birth
- The drug name, which should be spelled out to avoid errors due to sound alike drugs
- Dosage form, for example tablets, capsules, injection
- Strength or concentration, pronouncing it in single digits, for example 15mg should be read back as one five.
- The dose. All doses of medication to include units of weight, for example mg or g
- The route
- The frequency, where three times a day should be stated not TID or TDS
- Any other information to ensure that the order makes sense in the context of the patient's condition, for example the indication for the medication.

3. The second person (where available this should be a second RN, however if not available could be an HCA or family member if appropriate. If no other person is available this step can be skipped) then repeats the order back to the authorised prescriber to confirm the accuracy of what has been written and checks that the prescriber is aware of

any allergies. All the information should be written on the appropriate medication chart before it is read back.

4. The authorised prescriber should then confirm their verbal order by sending an e-mail or text, which must be received before the administration can take place.
Please note that on all emails or texts the patients name should only be written as INITIALS to maintain confidentiality. The patient's date of birth MUST also be included.

5. The email/text should be sent to the OOH and CNM to be included in the patients record.

6. The RN should then compare the verbal order given over the telephone with the information received by e-mail/text to check the accuracy of all the details before administration of any medication. If all the details are correct, he/she may administer the medication to the patient in line with the MC Medicine Management policy.

7. The RN should then write in the patient's record to confirm they have checked it and then the email/text should be sent to the OOH and CNM to be included in the patients record. This documentation should not cause delay in administration to the patient.

8. The verbal order on the appropriate medication chart must be countersigned and dated by an authorised prescriber within 24 hours.

9. If a medication prescribed by telephone is ineffective, then the patient should normally have a medical review prior to further prescribing.

10. The RN should document the initial effect of the telephone prescribing in the patients' electronic record. This should also be documented by the medical staff at the next medical assessment.

11. All remote prescribing incidents should be reviewed by the Regional Manager or CNM as part of the incident review meeting or investigation