Protocol for Transcribing and Amending Inpatient Medication Charts by Powys Teaching Health Board Pharmacists

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The latest approved version of this document is online.
If the review date has passed please contact the Author for advice.

Version Control

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	Dec 2016
2	Version 2 Changed from policy to protocol. Minor amendments and more examples added	Feb 2025
3	Version 3 POM additions added for pharmacists with an independent prescribing qualification to make changes within this protocol/scope of practice/professional competency	Aug 2026

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ENGAGEMENT & CONSULTATION

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Pharmacists

Circulated to the following for Consultation

Date	Role / Designation
June 2016	Lead Nurses
	Senior Sisters
	Care of the Elderly Consultant
	SAS Doctors
	GP Clinical Leads
	Medical Director
	Assistant Director of Nursing
	Head of Safety & Quality
	Assistant Director of Quality and Safety
	Clinical Lead for Mental Health
	Lead Nurse for Mental Health
Jan 2025	PTHB Pharmacists (including Chief Pharmacist)
Jun 2026	PTHB Community Services Pharmacists
Jul 2026	PTHB Area Prescribing Group

Evidence Base
Please list any National Guidelines, Legislation or Health and Care Standards relating to this subject area? The Human Medicines Regulations 2012 and associated amendments.

IMPACT ASSESSMENTS

Equality Impact Assessment Summary					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement** Please remember policy documents are published to both the **intranet** and **internet.** The version on the internet must be translated to Welsh.
Age	x				
Disability	x				
Gender	x				
Race	x				
Religion/ Belief	x				
Sexual Orientation	x				
Welsh Language	x				
Human Rights	x				

Risk Assessment Summary
Have you identified any risks arising from the implementation of this policy / procedure / written control document? If yes, note the risk/s and action taken to mitigate. If no please state no risks identified No risks identified
Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document? No risks identified
Have you identified any training and / or resource implications as a result of implementing this? Please record any training or resource issues /requirements associated with the implementation of your document The medicines management team will provide training on the use of this policy.

1. Introduction

This is an enabling protocol that facilitates transcribing, amending and prescribing by pharmacists within the scope of this protocol; where a pharmacist feels it is appropriate to do so and they are competent and confident to undertake the task.

Nothing within this protocol is mandated and a pharmacist may consider a more appropriate approach is required for an individual patient.

1.1. Transcribing

The Human Medicines Regulations 2012 No 1916 confirm that hospitals have an exemption within the regulations and may supply and administer POMs (in the course of their business) in accordance with a direction rather than a prescription. The regulations (s227) continue to state that the direction must be: (a) in writing; (b) relate to the particular person to whom the prescription only medicine is to be administered; (c) given by a person who is an appropriate practitioner in relation to that prescription only medicine.

A widely accepted interpretation of the above regulation is that providing there is a clear direction from an appropriate practitioner, then the medication can be written by a pharmacist non-prescriber by a process called transcribing. Transcribing is used only in the patient's best interest to ensure safe and continuous care, ensuring the medication is administered accurately, without undue delay.

It is important to distinguish between transcribing and prescribing. Transcribing must accurately duplicate the details of a prescription of therapy that has already been prescribed by a registered prescriber. Since transcribing is the copy of medicines information for the purposes of administration, it cannot be used in place of prescribing to issue or add new medicines or alter/change original prescriptions.

Prescription only medication (POM) within the scenarios in Appendices A and B can be **transcribed** under this policy.

1.2. Additions/Deletions and Amendments

The Human Medicines Regulations 2012 No 1916 (schedule 26 part 2) repealed the requirement for a pharmacist to contact the prescriber to make amendments to clarify or optimise medication use. Pharmacists may use their expertise and professional judgment to make changes to a prescription relating to the name or the product or its common name, directions for use of the product, and precautions relating to the use of the product. This allows pharmacists to change prescriptions to optimise patients' use of medicines, for example by changing the dose or duration for which the medicine is taken but keeping within the overall ceiling of the dosage or timeframe originally prescribed.

Using pharmacists' skills to transcribe or make the exempted amendments helps to avoid medication errors, reduce the number of doses missed due to unclear or

incorrect directions and number of calls to medical staff to clarify or amend medication charts.

1.3. Pharmacist Exceptions

The addition or alteration of P or GSL classified medicines is within the legal scope of a pharmacist and therefore continues to be enabled through this protocol.

In date Serious Shortage Protocols (SSPs) can be applied in accordance with the nationally agreed protocol and without the need to seek authorisation from the prescriber. An SSP would only be used in the case of a serious shortage, if it is considered that it would help manage the supply situation.

1.3.1 Agenda for Change Banding

Transcribing and amending, as exampled in Appendices A and B, is enabled for any qualified pharmacist (band 6 and above) who is competent and confident to undertake and has line manager agreement to do so.

Pharmacist Independent Prescribers – this protocol enables IP pharmacists band 7 and above to undertake prescribing activity.

Prescribing by newly qualified/band 6 pharmacists will be supported by future policy based on All Wales guidance and regulatory body advice GPhC Advice for newly qualified prescribing pharmacists June 2026.

1.4 Pharmacist Independent Prescribers

This protocol enables pharmacists who are qualified as independent prescribers, with a current GPhC Independent Prescribing qualification annotation and inclusion of independent prescribing within their PTHB job description, to perform POM therapeutic switches, add POM medication as agreed with the MDT, and to deprescribe POM medication as appropriate.

Example scenarios are included in Appendix C, these are not exhaustive and working within the The Royal College of Pharmacy Competency Framework for all Prescribers; prescribers may use their prescribing qualification to support and optimise patient care within other scenarios.

Where prescribers are developing or extending their scope of prescribing practice the Royal College of Pharmacy guidance must be followed see Expanding prescribing scope of practice.

2. Objective

This protocol enables pharmacists employed by PTHB to transcribe medicines that have previously been prescribed by an appropriate practitioner. It includes transcribing the patient's existing treatment (e.g. those prescribed by the patient's GP) onto an inpatient medication chart, and also for the medication chart to be rewritten once the original one is full. Transcribing of medication to a discharge prescription is also allowed and covered by the Medicines Transcribing electronic Discharge (MTeD) or ePMA system policy and procedures.

This policy also allows a pharmacist employed by PTHB to amend inpatient medication charts to correct or clarify missing information, directions for use, the name or common name of the medicine or the route of administration. In this case the pharmacist must use their professional skill and judgment, use of medical notes, and clinician and patient communication to ensure that any discrepancies are not intentional and that any change is appropriate. Where there is any doubt about the intention of the prescriber then they must be contacted before any amendment is made.

The pharmacist may also supplement directions where details are missing e.g. 'after food' or optimise the timing of doses.

Pharmacists are enabled to add, discontinue or formulary switch any medicines legally classified as P or GSL medicines, within their competency, on the inpatient medication chart or discharge prescription without a direction from an appropriate practitioner.

This may be for medicines the patient has been taking over the counter (OTC) and still required, or where there is a clinical need for a medicine that is classified as a P or GSL medicine. The pharmacist must be satisfied that the P or GSL medicine is appropriate for the patient's current condition, allergies (including excipients) and other medicines.

Likewise, if a P or GSL medicines is no longer required, indicated or contraindicated this can be discontinued by a pharmacist.

The reason for addition or discontinuation will be clearly documented by the pharmacist in the patient's clinical notes (paper or WNCR).

This protocol also enables a pharmacist with an independent prescribing qualification, working at band 7 or above, to utilise their qualification for PTHB inpatients. Suggested scenarios for use are outlined in appendix C.

3. Definitions

- Appropriate Practitioner - The following are appropriate practitioners in relation to any prescription only medicine (doctor, dentist, supplementary prescriber, authorised independent prescriber, community practitioner nurse prescriber (for a limited list of items))
- BNF – British National Formulary - BNF (British National Formulary) | NICE
- DOAC - direct oral anticoagulants
- ePMA – electronic prescribing and medicines administration
- GPhC – General Pharmaceutical Council – Registration body governing Pharmacy Professionals.
- GSL – General Sales List medicine
- IP – Independent Prescriber
- IVOS - intravenous-to-oral switch
- MAR – medication administration record (may be paper based or electronic)
- P – pharmacy medicine

- POM – prescription only medicine
- PTHB – Powys Teaching Health Board
- RCP – Royal College of Pharmacy
- SPC – Summary of Product Characteristics – available Home - electronic medicines compendium (emc)
- SSP – Serious Shortage Protocols
- WNCR – Welsh Nursing Care Record

4. Responsibilities

Chief Pharmacist – responsible for ensuring that PTHB has an up-to-date protocol to enable pharmacists to transcribe, prescribe, deprescribe and make agreed amendments to medication charts.

Head of Service – responsible for monitoring any transcribing, prescribing, deprescribing and amendments made are within accordance with this protocol or highlighting where the protocol needs updating.

Ward pharmacists – responsible for ensuring that medicines are transcribed safely, and any amendments are made in accordance with this protocol. Where there is any doubt, the appropriate prescriber must be referred to. The pharmacist must always act within their level of competence and must refer to a senior pharmacist if they feel at any time that they are being asked to act outside of their competency.

Independent Prescriber Qualified Pharmacist – where a pharmacist has an independent prescribing qualification, retains current GPhC register independent prescribing annotation and independent prescribing is an activity required by their PTHB job description – then the pharmacist is enabled to utilise their prescribing qualification through this protocol, with suggested scenarios outlined in Appendix C.

Pharmacy Technicians – pharmacy technicians trained to undertake medicines reconciliation should treat the transcribing by the pharmacist in the same way as directions written by a prescriber.

4.1. Staff Group or Specific Role

This protocol only applies to GPhC registered pharmacists employed or engaged by PTHB when providing a pharmaceutical service to PTHB inpatients. The pharmacist must always work within their competency and have full access to medical, nursing notes and the patient's current MAR and medication history.

Any errors or omissions caused by the use of this protocol must be reported via Datix incident reporting system.
All other members of the MDT should treat the transcribing by the pharmacist in the same way as directions written by a prescriber.

5. Process

All changes or additions to the MAR made by a pharmacist:

Paper MAR: -

- Must be clearly written (using capital letters if that improves legibility);
- Transcribing or additions must be made in black ink;
- Amendments or endorsements must be made in approved green ink;
- Should be dated.
- Signed and name printed (amendments may be initialled)
- If an essential amendment to a direction written by a prescriber is likely to obscure the original direction, then the whole entry must be rewritten (incorporating the amendment) and the original direction crossed through. Care must be taken to ensure that the administration side of the medication chart is annotated to eliminate risk of duplication of administration.

Electronic MAR:-

- An addition of a new medication entry.
- An amendment of an existing medication entry
- Discontinuation of an existing medication, replaced with a new updated entry.
- The reason for the addition, change, amendment should be added to the MAR entry or medical notes, or both at the discretion of the pharmacist.

If transcribed - both paper and electronic MARs:-

- Include the phrase "Transcribed by Pharmacist" in the special instructions/additional information or comments box.
- The above comment is not needed if the change or addition is made by an independent prescribing pharmacist unless they specifically want to distinguish transcribing and not prescribing activity.

The pharmacist should consider discussing with prescribers, clinical or senior colleagues for support where they find that errors or omissions are common, frequent or recurrent, in order to facilitate awareness and change in practice.

5.1 Inclusions

See Appendices A, B or C. Specific endorsements not included in Appendix B should be added as per BNF or SPC.

5.2 Exclusions

A Pharmacist must not transcribe or make an amendment to a medicine where:

- there are concerns about the appropriateness, dose, frequency, route of administration of the medicine for the patient;
- there is any doubt about the intention of the prescriber;
- there is any doubt that the medication is still current or being taken;
- any possibility the medicine could have contributed to the admission;
- it is not clear if the patient has any medication allergies.

Where there is any doubt, an appropriate prescriber must be contacted before any alterations are made.

5.3 Cautions

High risk drugs such as controlled drugs, anticoagulants, insulin, and cytotoxic drugs (including methotrexate for rheumatoid arthritis) must only be transcribed, prescribed or amended if the pharmacist is completely satisfied with the information provided and they are appropriate to continue.

5.4 Independent Prescribing

Independent prescribing includes prescribing of new medication and deprescribing or amending existing prescriptions. It also includes the prescribing of controlled drugs and unlicensed medicines as appropriate to the scenario.

Suggested scenarios, applying to the inpatient setting, are outlined in appendix C. The independent prescribing pharmacist may also have a scope of practice agreed for prescribing in other clinical settings.

In general, prescribers should adhere to accepted prescribing etiquette including shared decision making with patients. Pharmacists should avoid making prescribing decisions in isolation and communicate all changes with the relevant prescriber/MDT in advance of prescribing (where possible).

6 Monitoring Compliance, Audit & Review

Pharmacist transcribing, prescribing or amendment of medication charts will be audited by the Medicines Management Team each year.
Information collected will be shared with hospital prescribers to help improve quality of inpatient medication charts.

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within PTHB indicate otherwise.

7 References / Bibliography

- Human Medicines Regulations 2012
- Royal Pharmaceutical Society. Medicines, Ethics and Practice. Edition 47, July 2025.
- A Competency Framework for all Prescribers - Royal College of Pharmacy
- Expanding prescribing scope of practice - Royal College of Pharmacy
- Understanding transcribing for medicines administration – NHS SPS - Specialist Pharmacy Service

Appendix A

Transcribing, Adding, Deleting or Temporarily Stopping Medicines by a Pharmacist

For ePMA processes follow ePMA SOPs.

Transcribing or Adding Medication

General Principles – ePMA or Paper

- If transcribing on admission, ensure that the most accurate medication history is available for the patient – using at least two sources of information (in accordance with NICE guidance) and discussion with the patient/carer if appropriate. Refer to PTHB Medicines Policy. A pharmacy technician trained in Medicines Reconciliation may have already gathered this information.
- Approved (generic) drug names must be used, unless it is recommended for clinical or other reasons that a brand name should be used.
- Review all items for appropriateness while transcribing.
- For added medicines, record in the patient's notes that a medication has been amended or clarified and the reason why.

Paper Medication Charts

- Write in indelible black ink and print clearly (do not transcribe or add in green ink).
- If transcribing or adding to a new chart, ensure that the chart is fully completed including patient details, number of charts in use, allergy box and any supplementary charts.
- 'Micrograms' and 'units' must be written in full.
- Clearly mark all items already administered that day with an 'X' in the administration box.
- Check for 'once only' doses, 'prn' as required drugs/doses previously administered, and fluids to be administered and transcribe as appropriate.
- For rewritten charts, annotate in the prescribers signature section with "drug chart re-written by pharmacist" followed by initials and date.
- Cross through each page of the original chart(s) clearly. Use two diagonal parallel lines, write 'rewritten', sign and date the front of each chart.
- File the superseded chart(s) in the patient's notes.

Deleting Medication

General Principles – ePMA or Paper

- The pharmacist must be completely confident that the medication is no longer to be continued, contacting the prescriber as necessary.
- The pharmacist must write in the patient's notes that the medication has been stopped and indicating the reason for this and outcome of any discussion with the prescriber.

Paper Medication Charts

- The medication must be crossed through, and any remaining administration boxes also must be crossed through.

Temporary stop of medication

General Principles – ePMA or Paper

- A temporary stop to a medication must be evidence-based and established practice e.g. stopping statins during a clarithromycin course.
- The prescriber must be contacted if there is any concern about the clinical effects of a temporary stop to the medication.
- The prescriber must also be contacted if it becomes apparent the stop may need to be more than temporary.
- Consideration should be given to using alternative medications that do not interact.
- The pharmacist must discuss with nursing staff the reason for the temporary stop and when the medication can restart.
- The pharmacist must write in the patient's notes and under the "special instructions" box on the medication chart that medication has been temporarily stopped, indicating the reason for the stop.

Paper Medication Charts

- A temporary stop should be indicated by 'X' marks for the doses to be missed on the administration side of the medication chart.

Protocol for Transcribing and Amending Inpatient Medication Charts – Appendix B

Where there is any doubt, an appropriate prescriber must be contacted before any alterations are made. Any changes must be added to the patient's notes.

Issue	Powys THB Pharmacist Action	Comments
Transcribing		
Medication chart(s) with full administration side	Transcribe fully to new medication chart(s).	
Transcribing onto a paper medication chart if there is an ePMA system outage and the ePMA contingency plan can't be enacted.	Transcribe the latest information available onto a paper medication chart.	Enact if instructed by senior colleagues.
Newly admitted patient medication chart not yet completed	Complete all details on the medication chart and transcribe all medicines where there is a previous clear direction from an authorised practitioner.	Ensure medicine reconciliation principles are used. See above guidance and exclusion criteria.
Missing information previously directed by an authorised practitioner	Transcribe missing information e.g: • Strength of medication; • Route of administration; • Timing/frequency of medication. • Missing medication – if the pharmacist is clear this is an unintended omission (contacting prescriber/GP for confirmation if required).	Refer to transfer information such as GP records, previous discharge letters, and specialist letters.
'When required' (PRN) items	Transcribe: • PRN items identified in medicines reconciliation that the patient is prescribed by the GP; • GTN spray; • Salbutamol (inhalers or nebules);	

Issue	Powys THB Pharmacist Action	Comments
	• All PRN items prescribed and/or administered in the past 5 days. • Anticipatory medication – e.g. just in case, end of life or antiseizure medication. Do not transcribe: Any PRN items prescribed and not administered for >5 days (except for the items above).	
Additions		
Formulary P and GSL classified medicines	Add any P or GSL classified medicines the patient may have been taking at home and still appropriate to continue. The pharmacist may also work with nursing staff to support provision of P or GSL medication that assist in patient care.	Medical staff should be contacted if there is any doubt about the suitability of P or GSL medication for a patient. Use in conjunction with Powys Discretionary Homely Medicines policy which allows nursing staff to administer a limited range of P or GSL medicines for a defined period of time.
Oral Nutritional Supplements	Sip feeds recommended by a PTHB dietitian may be added.	Note the medicines policy allows dietitians to add these items to the medication chart.
Medicines prescribed on a supplementary chart	Add an entry to the inpatient medication chart e.g warfarin or insulin.	As an extra reminder to nursing staff to look for a supplementary chart. Care must be taken if the administration of the item is to be recorded on the supplementary chart, the administration boxes must be crossed through on the inpatient medication chart to ensure the medicines will not be administered from both charts.
Insulin dose	Transcribe dose units when known.	Ensure 'units' is written in full

Issue	Powys THB Pharmacist Action	Comments
Glyceryl trinitrate spray/tablets not on medication chart and patient usually on at home	Add to medication chart unless contra-indication apparent from medical notes or other resources (e.g. aortic stenosis).	
Salbutamol inhalers	Previously prescribed. Add to medication chart in 'as required' section unless contra-indication apparent from medical notes.	
Spacer devices	To enable better patient compliance.	
Nicotine Replacement Therapy (NRT)	Patient attempting to quit smoking, or requires withdrawal management during their in-patient stay, the pharmacist would assess the patient for the most appropriate NRT product and add to the chart.	Refer to MMP 453 – Nicotine Replacement Therapy
Formulary Switches		
P or GSL legally categorised medicines	These can be switched by a pharmacist to the agreed formulary options: - • Calci-D to Calceos other calcium +/- vitamin D) preparations can be switched if P or GSL. • Ferrous fumarate to ferrous sulphate • Macrogol preparations	The examples are not exhaustive and the pharmacist can use professional judgement to amend medication charts to optimise medicines use. Consider and document any dosing changes as a result. Consider excipient as well as drug allergies.
Deletions		
Medicines the patient is no longer taking	Delete medicine if confident that the item is no longer required.	
Duplicated medicines	Delete one entry as appropriate.	
Antibiotics beyond their course length	Check administration side of chart to ensure all course has been given.	

Issue	Powys THB Pharmacist Action	Comments
	Check notes for any indication of patient condition. Stop antibiotic if appropriate.	
Medicines beyond their stop date	Assess according to medication and delete if appropriate.	
Potassium supplements in hyperkalaemia	Stop potassium supplement if potassium levels ≥ 5mmol/L.	Sando K is a P medicine. Check for other potassium increasing medicines such as potassium infusions, ACE inhibitors or ARBs, and potassium-sparing diuretics.
Multiple paracetamol preparations e.g. co-codamol and paracetamol	If the pharmacist is confident about the most suitable option, delete the preparation not to be used.	If the patient is alternating preparations, ensure the chart is clearly endorsed, identifying the preparations and total maximum dose.
Temporary Discontinuation		
Temporary drug interactions or therapeutic duplications e.g. • clarithromycin and statins • tiotropium whilst ipratropium nebules used	Temporarily stop the appropriate medication	
Medication which could cause harm if continued e.g. amoxicillin in penicillin allergic patient, metformin in rapidly declining renal function	All cases must be discussed with the medical team, but the pharmacist may discontinue the medication if directed by the medical team.	If an alternative medication is required and is a POM classified medicine, then an authorised prescriber will need to attend the ward to add to the inpatient chart.
Amendments		
Optimise timing of medicines	Adjust the entry to reflect the most appropriate timing for the drug, using professional judgment. Examples: • Statins taken at night (unless atorvastatin or rosuvastatin, which may be taken any time of the day);	If an amendment cannot be made clearly, rewrite the entry with correct timing and delete the existing entry. The examples are not exhaustive and the pharmacist can use professional

Issue	Powys THB Pharmacist Action	Comments
	• Oral bisphosphonates in the morning or adjusting day of the week; • levothyroxine or diuretics in the morning; • zopiclone at night; • to avoid food--drug or drug-drug interactions; • asymmetric dosing (isosorbide mononitrate); • Anti-diabetic drugs to meal times; • Parkinson's disease medicines; • Quinolones (ciprofloxacin, levofloxacin) and times in relation to magnesium, indigestion mixtures, iron and sucralfate. • Colestyramine (in relation to other drugs); • To facilitate drug level monitoring • Divide doses to improve oral bioavailability (eg. Calcium tablets, thiamine)	judgement to amend medication charts to optimise medicines use.
Regular medication written 'as required' that require regular administration e.g. steroid inhalers, laxatives in opioid use, clotrimazole cream, nystatin suspension	Rewrite in the regular section of the medication chart.	
Multi-ingredient preparations that are not stock or not available but separate components are, e.g. co-codamol	Rewrite each of the separate ingredients at equivalent doses. Delete the multi-ingredient preparation.	

Issue	Powys THB Pharmacist Action	Comments
Most appropriate formulation of medication e.g tablets to liquid, tablets to orodispersible tablets (and vice-versa), MDI to DPI (and vice-versa)	Providing the change in formulation does not alter the overall dosage or clinical response the formulation may be amended. Any change in preparation e.g. ferrous sulphate tablets to ferrous fumarate liquid requires a new drug to be written; if the dose is clinically equivalent, the pharmacist can make the switch. Switches to different inhalator type (DPI, MDI) as required for better patient's compliance or on formulary recommendation.	Discuss choice of appropriate formulation with nursing staff of SALT as appropriate. Consideration to the 'green agenda' with choice of inhalers. Use of NEWT or Drug Administration via Enteral Feeding Tubes (Medicines Complete) via Medicines Information - e-Library for Health SPS resources SPS - Specialist Pharmacy Service – The first stop for professional medicines advice
Medication incorrectly transcribed e.g. wrong dose or formulation	Correct the information if confident a mistake has been made and not an intentional change.	
Antibiotic course lengths	The pharmacist may annotate a course length if the intended course is clear from the notes or from MDT or ward round. Antibiotic stop dates may also be amended if the course does not start at the intended time, to ensure the full course is given.	
Inappropriate dose units used e.g 0.125mg instead of 125mcgs	Change dose to appropriate unit to avoid use of decimal point	
Incorrect dose stated with change in formulation e.g IV to oral metronidazole 500mg tds or IV to oral ciprofloxaxin 400mg bd	If confident about route of administration intended amend dose to correct dose for route.	If any doubt about route of administration intended contact the prescriber.

Issue	Powys THB Pharmacist Action	Comments
Liquid medicines inappropriately entered by volume	If more appropriate amend to dose	Some medicines, e.g. lactulose, may appropriately be entered by volume
Eye, ear or nose drops	Amend to: • Eyes - 1 drop (per affected eye) • Nose – 2-3 drops (per nostril) • Ear – 3-4 drops (per affected ear)	
Medicines prescribed not in accordance with standard frequency e.g. amoxicillin qds, clarithromycin tds	Adjust to recommended dosing if confident the dose difference is not intentional e.g. dose reduction in renal impairment.	
Preparations taken once weekly, monthly or every 3 months	Discuss with patient or carer if possible normal or most suitable day to be taken and amend the medication chart appropriately.	Consider any administration that may have already occurred and adjust the administration as appropriate.
Transdermal patches	Adjust medication chart to ensure the correct number of days for the brand of patch. Contact the prescriber if any concerns the difference may be intentional.	
Optimising inhaler device	After consultation with patient and nursing staff, pharmacist may alter the inhaler device, without changing the drugs/doses being administered.	In accordance with PTHB formulary, green agenda.
Paracetamol	Amend dose based on patient's body weight.	All Wales Pharmacological Management of Pain Guidance p23 for paracetamol dosing
Steroid doses	Make clear any reducing courses, length of treatment and maintenance doses.	
Stock and formulary stop/switches	Pharmacist may stop/switch after consultation with patient: - Dry eye preparations (e.g. carbomer, carmellose, or sodium hyaluronate) to hypromellose;	Noting PTHB formulary choices.

Issue	Powys THB Pharmacist Action	Comments
	- Ferrous fumarate to ferrous sulfate; - Emollients, including shower/bath preparations, to zerobase; - Omeprazole orodispersible to lansoprazole orodispersible if appropriate; - Sudocream to metanium; - Biotene and Glandosane to Oralieve. - Aymes Shakes to Complan; - Fortisip brand to Ensure brand; - Peptac to Gaviscon Advance; - Calcium/colecalciferol preparations to Calceos; - Prednisolone EC tablets to plain tablets; - Stop multivitamins preparations, e.g. forceval.	
Endorsements		
Critical time medicines	Endorse 'critical time medication'.	Please use pre-printed stickers for Parkinson's Disease medicines "Get It On Time"
Timings around food	For example, endorse 'before food' or 'with or after food' as appropriate.	
Devices e.g. inhalers	Specify device type and how to use, e.g. 'inhale slow and steady'.	
Antibiotics	Indication, start date (e.g. if transferred), duration, micro approved (if required)	Use pre-printed sticker.
Liquids	State strength of liquid.	
Split tablets	If a tablet needs to be split to give dose, e.g. 'halve 60mg tablet'	
Controlled drugs	Endorse with strength and form	

Issue	Powys THB Pharmacist Action	Comments
Cytotoxic drugs	'CYTOTOXIC drug'	
Bisphosphonates	Directions for administration	Use Powys pre-printed sticker.
Maximum doses and frequencies for 'as required' medicines	Endorse as appropriate	
Abbreviations used e.g. $FeSO_4$	Endorse with appropriate approved name.	
Enteric coated	'Swallow whole'	
Fridge items	'Store in the fridge'	
Insulin	Specify device being used	
Orodispersible	'Allow tablet to dissolve on the tongue then swallow' or 'dissolve in water'	
Low molecular weight heparins	Add indication and, if required, duration until next review	
NG/PEG/Swallowing difficulties	Endorse form of medication and any administration details e.g. crush tablet, open up tablet	NEWT Guidelines MedicinesComplete – Drug Administration via Enteral Feeding Tubes
Steroids – oral	Indication and care plan – maintenance or acute.	
Steroids – topical	'Apply thinly'	
Patients at risk of falls	Endorse high risk medicines as appropriate e.g. antihypertensives, opioids, benzodiazepines and antidepressants	
Covert administration	State on chart with a start date.	Link to Covert Medicines Policy
Brand names	Endorse brand names where required for clinical reasons or otherwise recommended	See SPS document
Medication Specific Endorsements (examples)		
Atorvastatin	'Avoid grapefruit juice'	

Issue	Powys THB Pharmacist Action	Comments
Carbimazole	'Watch for signs of infection e.g. sore throat'	
Clindamycin	'Medical advice needed if diarrhoea occurs'	
Colchicine	'Medical advice needed if vomiting or diarrhoea occurs'	
Colestyramine	'Give other medicines 1 hour before or 4 – 6 hours after colestyramine'	Alter timings under 'amendments' if necessary
Doxycycline	'With food and plenty of water whilst sitting or standing'	
Finasteride / Dutasteride	'Women of childbearing age should not handle broken tablets'	
Flucloxacillin	"Take 1 hour before or 2 hours after meals. Take with a full glass of water"	
Osmotic laxatives	'Ensure good liquid intake'	
Methotrexate	'Only use 2.5mg tablets to make up dose.' 'ONCE WEEKLY' 'CYTOTOXIC'	Cross through any days not to be given on the administration side of the chart.
Simvastatin	'Avoid grapefruit juice'	
Steroid inhalers	'Rinse mouth after use'	

Use of Independent Prescribing Qualification Scenarios for Inpatient Settings – Appendix C

Scenarios – not exhaustive – examples of types of activity	Any Specific Action
Undertaking POM formulary switches to ensure PTHB formulary is met (switch protocols or guidelines may be available) such as: - • Edoxaban to Apixaban or Rivaroxaban – switching tool AF patients. • Low molecular weight heparins • SGLT2 switch to dapagliflozin • Brand to generic switches – unless requires brand prescribing • Implementation of PTHB formulary switch promotions. • Biosimilar switches e.g. denosumab • Review of low value for prescribing medications	Follow PTHB InForm formulary https://powformulary.wales.nhs.uk/ PTHB Clinical Guidance and Prescribing Resources Items identified as low value for prescribing in NHS Wales - AWTTC
Adjusting doses or durations of pre-existing medicines based on clinical parameters and co-morbidities: - • LMWH - prophylaxis or treatment • Renal impairment • Hepatic impairment • Drug interactions. • Route of administration potency adjustments • To reduce side effects. • DOAC doses • Duration of clopidogrel post MI.	
Inhaler switches to meet formulary/green agenda	Ensure patient is able to effectively use new device. Consider writing to GP about change or ensure the DAL includes any required information. Asthma Toolkit - Greener Practice

Decision made in MDT or ward round to add/alter/discontinue medication.	Prescribing pharmacist may agree to be the member of the MDT to undertake the prescribing activity, if in agreement with the clinical decision.
Prescribing of medicines for discharge via the discharge advice letter (DAL).	Once discharge plan agreed.
Prescribing MRSA decolonisation – see EOLAS (search for MRSA)	Pharmacist is satisfied of requirement. Pharmacist prescribes components.
Combination creams	To separate components. [note if P or GSL then non-IP pharmacists can undertake).
Therapeutic substitution to optimise medication: - • Reduction in anticholinergic burden swapping to a lower impacting agent. • Switch to an equivalent medicine requiring less frequent dosing to aid compliance/care package.	Medicines optimisation guidance, resources and data - AWTTC
Deprescribing: - • No longer required medication e.g. PPI after NSAID discontinued. • Reducing anticholinergic burden (therapeutic substitution may be required). • Implementation of AWMSG Polypharmacy in Older People recommendations	Polypharmacy in older people: A guide for healthcare professionals - AWTTC
Antimicrobial stewardship • Antibiotic choice for empiric treatment • Antibiotic choice review in light of sensitivities information/Microbiologist advice. • IV to oral switching for highly bioavailable drugs or following review with MDT/as per IVOS tool as part of de-escalation • Discontinuation of antibiotics following review of clinical signs/ symptoms/ investigations/ microbiology results (e.g.	Prescribing in accordance with PTHB Eolas prescribing guidance. Prescribing in line with Microbiologist recommendations. Antimicrobial intravenous-to-oral switch: criteria for prompt switch - GOV.UK – IVOS tool

no growth on culture/ no symptoms of infection/ CRP/WCC NAD) • Ensuring appropriate course length/review date – including stopping or amending if appropriate.	
Optimising medicines for chronic conditions – in line with NICE, AWMSG or nationally or locally recognised guidance agreed for use within PTHB.	Plan should be agreed with the MDT.
Specialist pharmacist receives referral to review patient on an inpatient ward within their specialism. Pharmacist decides to start new medication/change existing medication/discontinue medication within agreed scope of practice.	Pharmacist makes amendment to ePMA system/paper MAR, updates medical notes around consultation and outcome and discusses with MDT as appropriate. Pharmacist may also write to GP to update as appropriate or ensure the DAL includes any required information.