POLICY NO CL11

PORTSMOUTH HEALTHCARE NHS TRUST

CLINICAL POLICY

PRESCRIPTION WRITING

1.0 The Purpose

1.1 The purpose of this policy is to have an agreed, consistent, safe and professional standard of prescription writing across the Trust.

1.2 The secondary purposes are;

- A source document for teaching or reminding doctors of the standards expected
- A source document for audit and risk management
- A reference document for other Health Care Professionals who have prescription writing queries
- A source document for teaching or reminding other Health

Care Professionals, who may have certain prescribing rights, of the standards that the Trust expects

- A means of ensuring accurate prescription and administration records for legal procedures.

2.0 Scope/Definition

This policy does cover all prescriptions written by doctors and nurses but excludes some specific issues which are handled separately. These exclusions are:

a) The timing of drug therapy policy
b) Computerised Prescriptions policy
c) Controlled drugs prescribing policy
d) Policy on the administration of Intravenous Drugs

3.0 Responsibility

3.1 It is the responsibility of every member of staff involved in the medication process to acquaint themselves with this policy.

3.2 It is the responsibility of;

Consultants to ensure all junior doctors are aware of the policy and their responsibilities. Senior nurse managers to ensure all nurses are aware of the policy and their responsibilities..
The Senior Pharmacist to ensure all pharmacists are aware of this policy.
General Managers to ensure the above happens and the policy is available in all settings where prescribing takes place frequently.

4.0 Requirements

Shared Care: In its guidance on responsibility for prescribing between hospitals and general practitioners, the Department of Health has advised that legal responsibility for prescribing lies with the doctor who signs the prescription.

Prescriptions should be written legibly in ink or otherwise so as to be indelible, should be dated, should state the full name and address of the patient and should be signed in ink by the prescriber. The age of the patient should preferably be stated, and is a legal requirement in the case of prescription-only medicines for children under 12 years of age.

The following should be noted;

a) For solids, quantities of 1 gram or more should be written as 1 g etc.
Quantities less than 1 gram should be written in milligrams eg 500 mg, not 0.5 g.
Quantities less than 1 mg should be written in micrograms eg 100 micrograms, not 0.1 mg.
When decimals are unavoidable a zero should be written in front of the decimal point where there is no other figure, eg 0.5 ml, not .5 ml.
Use of the decimal point is acceptable to express a range eg 0.5 to 1 g.
For mixed compound drugs which come in a single dose, the number of tablets should be stated as 1 tab. 2 tabs etc

b) 'Micrograms' and 'nanograms' should **not** be abbreviated.
Similarly 'units' should **not** be abbreviated.

c) The term 'millilitre' (ml or mL) is used in medicine and pharmacy, and cubic centimetre, c.c or cm^3 should not be used

d) Dose and dose frequency should be stated; in the case of preparations to be taken 'as required' a **minimum dose interval** should be specified.

When doses other than 5 or 10 mL, are prescribed for *oral liquid preparations the dose-volume will be provided by means of an* ***oral syringe*** (except for preparations intended to be measured with a pipette)

Suitable quantities;
Elixirs; Linctuses and Paediatric mixtures (5-mL dose) 50, 100, or 150 mL
Adult Mixtures (10-mL dose) 200 or 300 mL
Ear Drops, Eye drops and Nasal drops
10-mL (or the manufacturer's pack)
Eye Lotions, Gargles, and Mouth-washes, 200 mL
Liniments, 100 mL

e) For suitable quantities of dermatological preparations, see introduction to BNF Chapter 13.

f) The names of drugs and preparations should be written clearly and **not** abbreviated, using approved generic titles **only**. The trade name may be used for multi-ingredient products not given a title by the BNF and must be used for those products where generic prescribing is inappropriate (warfarin, lithium, phenytoin, aminophylline, theophylline, carbamazepine and cyclosporin)

g) The quantity to be supplied may be stated by indicating the number of days of treatment required in the box provided on NHS forms. In most cases the exact amount will be supplied. This does not apply to items directed to be used as required - if the dose and frequency are not given the quantity to be supplied needs to be stated.

When several items are ordered on one form the box can be marked with the number of days of treatment providing the quantity is added for any item for which the amount cannot be calculated.

When there is no box on the prescription form each drug should be followed by an indication of the quantity to be supplied as above.

Trust Guidelines on duration of supply are;

14 days for prescriptions for Outpatients or to complete the course of treatment

7 days for prescriptions (TTO's) for Inpatients or sufficient to complete the course of treatment

[NB: If hospital to GP communication of medication takes longer than six days then discharge medication, duration of supply needs to take this into account].

h) Although directions should preferably be in English without abbreviation, the following Latin abbreviations will be allowed. It should be noted that the English version is not always an exact translation.

a.c	=	ante cibum (before food)
b.d	=	bis die (twice daily)
o.m	=	omni mane (in the morning)
o.n	=	omni nocte (at night)
p.c	=	post cibum (after food)
p.r.n	=	pro re nata (when required) [PLEASE STATE INDICATIONS CLEARLY]
q.d.s	=	quater die sumendus (four times daily)
t.d.s	=	ter die sumendus (three times daily)

If precise times are needed these should be stated explicitly.

i) The route of administration should always be stated unambiguously. For inhaled medications the device used should be stated.

j) When using prescriptions charts for inpatients the same rules (a - j) apply however there is some additional guidance necessary:

i) The times of the drug therapy should be clearly marked and accompanied with a tick in the boxes provided.

ii) When a drug dose is changed the drug should be rewritten with the new dose, date, frequency etc

iii) When a drug is stopped the prescription should be deleted with a large Z, countersigned and dated.

iv) When a dose or several doses of a drug are withheld for clinical reasons those dosage boxes should be filled with a small Z and countersigned by the doctor making the decision. The reasons for the decision should be documented in the medical record.

v) If a review date is known this should be stated.

vi) The Patients Identification Number (when available) should always be on the prescription chart.

vii) If a drug dose is missed or refused write X in the box provided and give the reason in the Exceptions to prescribed orders.

viii) Ensure the allergies and drug sensitivities section is completed.

ix) Ensure that ward or department is stated.

x) Ensure that the Consultant's name is stated.

xi) Record the weight for children, and adults where the dose is weight-related.

5.0 **Audit**

It is expected that this policy will be used as the basis of audit in every clinical area where prescribing takes place. This will be on a rolling programme.

6.0 **Review Date**

This policy will be reviewed by the Medical Director and the Lead Consultants for Drugs and Therapeutics activities in July 1996.

7.0 **Reference Documentation**

This policy is based on

i) British National Formulary guidance
ii) Portsmouth HealthCare Trust Prescription charts
iii) FP 10 prescription pads
iv) Portsmouth Hospitals TTO sheets

8.0 **Accountable Person**

Dr M P Severs MEDICAL DIRECTOR

Policy produced on: October 1995

Produced by: Dr M P Severs, Medical Director

Approved by: Trust Board/Operational Management Group - November 1995

To be reviewed: July 1996