POLICY NO. CLN. P2

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.

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.