Prescribing in hospitals and NHS Lothian Healthcare premises

Purpose of this procedure:

To ensure that prescriptions are written on an appropriately approved prescribing document in an approved manner.

The Procedure:

1.0 Prescribing documents

1.1 Not more than one main prescribing and administration chart should be in use at any time for each patient. Where specific therapy is prescribed on an approved supplementary chart, it is also documented on the main chart.

1.2 When a patient is re-admitted, or transferred from another hospital out with NHS Lothian, a new medicine chart must be used. When a patient is transferred from another hospital within NHS Lothian, or returns from pass or re-attends hospital for planned procedures at short intervals, the original medicine chart may be used.

1.3 Electronic prescribing systems must provide at least the same level of detail and safety as the paper system.

2.0 Supplementary prescription and administration charts

2.1 A supplementary prescription and administration chart is a chart used to prescribe and record the administration of medicines, instead of, or in addition to, the main hospital Prescription and Administration Record.

2.2 Supplementary charts are used when it is not possible to record the administration instruction and/or record to the required level of detail on the main Prescription and Administration Record. Supplementary charts are also used in protocols, treatment plans, integrated care pathways etc. that are used to record information for individual patients.

2.3 Supplementary charts must comply with relevant national guidance, where available, from professional bodies and government agencies for the medicine or category of medicine for which is it used.

2.4 As far as possible, in order to minimise risk, there should be one approved supplementary chart for a medicine or category of medicine. Therefore, before a new supplementary chart is developed for use, the person developing the chart must check to ensure that a suitable approved supplementary chart is not already available.

2.5 In order to minimise risk, the layout of a supplementary chart must be consistent as far as possible with the layout of the main Prescription and Administration Record, and with other supplementary charts.

2.6 The terminology used must be consistent with the main Prescription and Administration Record.

2.7 The minimum standards for information that must be recorded on supplementary charts are as follows. The chart must include prompts where appropriate, and adequate space to record the information.

- Patient details – name, CHI number, date of birth, weight for paediatric patients, hospital and ward or department
- If the chart has more than one page, the patient name and date of birth must be included on every page
- Instructions – date prescribed, start date, administration times, prescribed by signature
- Administration record – dates and times administered, administered by signature, reason for non-administration (consistent with the main Prescription and Administration Record)
- If it is the only chart that any adverse reactions to medicines must be listed.

2.8 The Medicines Policy Subcommittee must approve all supplementary charts. Approved supplementary charts are published on the NHS Lothian intranet.

2. 9 All supplementary charts must be controlled to ensure only the current approved version is used. The clinical director is responsible for ensuring that the current approved version is used within the directorate.

3.0 Prescription writing in prescribing documents

3.1 Prescriptions must be written clearly in block capitals, using a black ballpoint pen.

3.2 For inpatient prescriptions, enter the following patient details

Hospital
Ward or department
Name
CHI Number
Date of birth
Height
Weight
Known drug sensitivities

3.3 Name and date of birth must be recorded on each page of the record.

3.4 For discharge and outpatient prescriptions, the following information must be included.

Hospital
Ward or department
Name
CHI Number
Date of birth
Known drug sensitivities
Patients address
GP name and address
Consultant

3.5 The approved (generic) drug names should be used when prescribing. However in some cases prescribers may use proprietary names for prescribing certain items such as dressings and appliances. Where there is a possible difference in bioavailability of drugs made by different pharmaceutical companies, then the proprietary name must be used, for example lithium or sustained release preparations. Special care should be taken to avoid errors when prescribing compound preparations; in particular the hyphen in the prefix 'co-' should be retained.

3.6 The form of the medicine should be specified e.g. ointment, type of inhaler, mixture and where there is more than one form available e.g. tablet and capsule and either there is a clinical need to use a specific form or different forms are not bioequivalent. Where no form is stated then it is assumed that the solid dose form is prescribed for the oral route.

3.7 The dose of the medicine must be specified. Prescribing a dose range e.g. 10-20mg, is not acceptable.

3.8 The dose must be written in metric units. Only the following abbreviations may be used.

g = gram
mg = milligram
mL = millilitre

3.9 All other dose units must be written in full.

3.10 The use of decimal points must be avoided. For example, 0.1mg must be written as 100micrograms. If the use of the decimal points is unavoidable, a zero must be written in front of the decimal point, for example 0.5mL, not .5mL.

3.11 For 'as required' medicines, the symptoms to be relieved, the minimum time interval between doses, and the maximum daily dose or the maximum number of doses per day,

must be specified, for example paracetamol 1g every 6 hours as required for pain relief to a maximum of 4g per day.

3.12 The route of administration must be written in full except for the following approved abbreviations. Note that oral and intrathecal must be written in full.

ETT	=	endotracheal
TOP	=	topical
INHAL	=	inhaled
IV	=	intravenous
IM	=	intramuscular
ID	=	intradermal
SC	=	subcutaneous
SL	=	sublingual
NG	=	nasogastric
NJ	=	nasojejunal
PR	=	per rectum
PV	=	per vagina
PEG	=	percutaneous endoscopic or other gastrostomy

3.13 The times, and day(s) where appropriate, of administration must be specified.

3.14 Prescriptions must not be altered or amended. If a change is required, the medicine must be cancelled completely and a new prescription must be written.

3.15 Outpatient and discharge prescriptions for controlled drugs must comply with legal requirements.

3.16 All prescriptions must be signed by the prescriber, and the name printed beside the signature. Initials are not acceptable.

4 Prescriptions for inpatients

4.1 The start date must be clearly documented. When rewriting the prescription, the original start date must be carried forward.

4.2 For a course of treatment a cross should be put in the box after the last dose due for each time slot prescribed and a line drawn through the remaining time slots. See the "Golden Rules for Prescription Writing".

http://intranet.lothian.scot.nhs.uk/Directory/MedicinesManagement/Documents/Golden%20Rules%20for%20Prescribing.pdf

4.3 For alternate day treatment, draw a cross through the boxes on the administration section on the dates the medicine is not to be given.

4.4 Medicines intended to be given once only must be prescribed in the once only section of the medicine chart.

4.5 Medicines that are to be given once weekly must be prescribed in the regular section of the chart. A cross must be drawn through the days that the medicine is not to be given, and an instruction must be written in the notes section 'Once a week on a ….day'.

4.6 As required medicines must be prescribed in the as required section of the medicine chart.

4.7 When a medicine is discontinued, this must be done by drawing a line across the prescription box without obliterating what has been written, and by drawing a vertical line down the last administration time, then a double diagonal line, the date of discontinuation and the signature. A brief rationale for stopping the medicine should be documented in the patient's notes.

4.8 When re-writing medicine charts the following steps must be taken:

- Any item no longer required must be cancelled, and a diagonal line drawn across each page of the old chart
- The original start date for each medicine must be written in the new chart
- The word 're-written' and the date of re-writing, must be written at the top of the new chart
- All medicines reviewed for appropriateness

Associated materials/references:

The Safe Use of Medicines Policy

http://intranet.lothian.scot.nhs.uk/Directory/BoardCommittees/AreaDrugTherapeutics/Medicines%20Governance%20Policies%20and%20ADTC%20Policy%20Stat/SOP%20line%20through%20discontinued%20prescriprions%20v1%20(Dec%202014).pdf

Prescribing for older people Procedure

Prescribing for children Procedure

Prescribing in a multi-cultural, multi-faith society Procedure

Prescriptions for intravenous injections Procedure