Section 10 – Prescribing

1. General Principles

1. 1 A patient's treatment with medicines must be initiated through a formal process. This will usually be via prescribing by a suitably qualified and authorised prescriber, or may be through an approved patient group direction (PGD).

1. 2 **Medicines may only be prescribed by a suitably qualified practitioner who is recognised and authorised by the organisation to undertake this function.** All prescribers are responsible for:

- Conforming to legal requirements and ensuring the safe and clinically appropriate use of medicines
- Adhering to the NHS Lanarkshire Joint Formulary http://www.medednhsl.com/meded/nhsl_formulary/
- Checking the patient's medical record before a new prescription is written.
- Discussing aims and side effects of drug treatment with the patient or their representative, if possible
- Documenting the treatment plan, including how the response to drug therapy is to be monitored, clearly in the patient's clinical notes

1. 3 Nurses and midwives are not authorised to administer medicines to a patient if they have not been prescribed correctly

1. 4 In certain life-threatening circumstances the process may not be formally initiated in full but retrospective records must be made to detail the treatment given.

1. 5 Where a licensed medicine is available, it should normally be prescribed in preference to any unlicensed alternative.

1. 6 Medicines are prescribed by their Recommended International Non-Proprietary Name (rINN). The exceptions to this are: -

- Modified release oral preparations of drugs where bioavailability may be a problem, e.g. phenytoin, lithium, diltiazem, , theophylline, ciclosporin preparations etc. These medicines should be prescribed using their brand name. See formulary for details.
- Medicines which contain more than one ingredient and for which an approved name has not been designated.
- Biological medicines, including biosimilar medicines, should be prescribed by **both** brand name and the generic name, e.g. infliximab (Remsina).

2. Non-Medical Prescribers

2. 1 All non-medical prescribers must:

- Have successfully completed an accredited non-medical prescribing course and have an annotation signifying their non-medical prescribing status on their professional register entry.
- Have received written confirmation that they are included on the NHS Lanarkshire non-medical prescribers' database. To achieve this they must submit a specimen signature and a copy of their academic result to the appropriate contact as listed below -

  Nursing and AHP's contact = the Practice Development Centre at Beckford Street

  Pharmacists contact = their professional line manager/Head of Pharmacy.
- Agree their role and scope of duties with their line manager and the service manager for the area in which they work, including reference to prescribing within the job description.
- Provide evidence to their line manager that they are up to date and competent within their sphere of prescribing practice each year as part of their annual PDP appraisal and re-validation process.
- Prescribe only within their professional competency.

2. 2 Where a non-medical prescriber changes job roles, has an extended period of absence or is a new NHS Lanarkshire employee with an existing NMP qualification, they must complete a further period of supervised practice. The requirements in each case will differ and agreement must be reached between the individual practitioner, their line manager and the NMP lead as to necessary requirements.

2. 3 It is the responsibility of the non-medical prescriber to inform the NMP Practice development Practitioner if they leave NHSL or are no longer prescribing.

2. 4 Each registered practitioner is accountable for her/his own conduct and practice in accordance with the professional standards of their regulatory body, e.g. NMC Standards of Conduct, Performance and Ethics for nurses and midwives, General Pharmaceutical Council's Standards of Conduct, Ethics & Performance etc.

2. 5 Further info can be found on FirstPort via http://firstport2/staff-support/practice-development-centre/non-medical-prescribing/default.aspx

3. Checks Prior To Prescribing

3. 1 Before the prescription is written a full medicines reconciliation process should have been completed for the patient by the admitting clinician, documentation of continue, stop or withhold must be completed

3. 2 Before the prescription is written on a prescription form or supplementary sheet the identity of the patient must be checked against the personal details on the prescription form.

3. 3 The list of drugs to be avoided due to previous adverse reactions/allergies should be checked and documented

3. 4 A check must be made of any supplementary medication sheets which may be in use, e.g. insulin, warfarin etc.

3. 5 A check should be made of any relevant formulary implications.

4. Prescribing For In-Patients

4.1 Prescription must be written on approved stationary, or prescribed electronically if local procedures for electronic prescribing for in-patient are in place.

4.2 All entries on the prescription sheet must be hand printed legibly in indelible ball point ink (i.e. not fountain pen) preferably in block capitals.

4.3 For in-patient prescriptions the following details are required:-

- Patient's name, CHI number age of the patient must be stated - an addressograph label can be used.
- A record of the known body weight is essential for children and "fragile" patients, and for patients receiving drugs that require therapeutic monitoring (TDM), weight based dosing, dopamine or chemotherapy. This should be entered in the medication prescription form in the weight box.
- Known sensitivities
- The medicine name, strength, form, dose route and time of administration
- Date prescribed
- Prescriber's signature
- Stop or review date for parenteral drugs – especially IV antibiotics.

4.4 **The date must be clearly printed** for each medicine prescribed. For regular medication this is the date the prescription must start. Bracketing of dates is not acceptable. For medicines which are to be administered once only this is the date the medicine is to be administered on. **When a prescription form requires to be rewritten the original prescribing date should be used, unless the medication**

and or dose is changed (in which case an appropriate note should be made in the case record).

4.5 **The dose to be administered must be stated**. The unnecessary use of decimal points should be avoided.

- For solids, quantities of one gram or more must be written as **1g**, etc.
- Less than one gram must be written in milligrams, e.g. **500mg**, not 0.5g.
- Quantities less than one milligram must be written in micrograms e.g. **100micrograms**, not 0.1mg.
- "**micrograms**" and "**nanograms**" must not be abbreviated.
- When decimals are unavoidable, a zero should be written in front of the decimal point where there is no other figure, e.g. **0.5 ml** not .5 ml.
- "**Units**" must not be abbreviated

4.6 **Abbreviations are not acceptable**, for example 'prn' must be written as '**as required**' and '6^{o}' must be written as '**6 hourly**' etc.

4.7 The **red section** of the paper prescription form **'Parenteral Drugs: Regular Prescriptions'** is for prescribing regular parenteral medication only, i.e. IV, SC, IM

4.8 The **blue section** of the paper prescription form **'Oral and Other Drugs: Regular Prescriptions'** is for prescribing regular doses of all other medication, e.g. oral, inhaled, topical treatment.

4.9 The **blue section** of the paper prescription form **'All Routes: As Required Prescriptions'** is for prescribing all 'as required' medication regardless of route.

4.10 **Critical Care Prescription Form** The red section of the critical care prescription form is for prescribing parenteral continuous infusions and the green sections of the critical care prescription form are for prescribing regular parenteral medicines

4.11 **Signatures -** Each entry on the medication prescription form must be signed in ink with the full signature of the prescriber. Initials are not acceptable, except when cancelling prescriptions. Entries must not be bracketed together under one signature.

4.12 **Times of Administration -** The times of administration must be clearly indicated, either by placing a tick in the appropriate section or in writing. If the medicine is to be administered at non-standard intervals, the times of administration must be clearly stated. **The 24hour clock must be used**.

It is the prescriber's duty to familiarise him/herself with the times that medicines are actually administered on the ward so that alternative times can be specified, if necessary.

4.13 **"As Required" Prescriptions** - Prescriptions for medicines which are only administered "as required" must state the symptoms to be relieved, the minimum dose interval and maximum dose allowed in 24 hours which can be administered e.g. Paracetamol Tablets 1 gram every six hours when required for headache, maximum 8 tablets in 24 hours.

4.14 If a drug is prescribed in both the 'regular' and 'as required' sections of the prescription form, this must be emphasised in the 'additional instructions/comments' box in both sections of the prescription form.

4.15 **Oral, IM or IV formulations** of the same medicines must be prescribed as separate items. It is not permitted to write O/IM/IV in the route box.

4.16 **Variable Dose Prescriptions -** can be of two types:

- Prescribed in the regular prescription section and cross-referenced to the appropriate chart, e.g. sliding scale insulin.
- Prescribed in the as required section e.g. analgesics

The prescription must clearly state, or refer to ward protocol, the circumstances under which the person administering the medicines may vary the dose, as well as the frequency of dose.

4.17 **Route Of Administration**

- The route of administration must be clearly written in full, e.g. "oral" or "topical" or by using the following instructions:- IV, SL, PR, SC, IM, PV – see back page of medicine prescription form.
- Eye and ear preparations must be clearly designated. The eye or ear to be treated must be specified.

4.18 **Medicines to be Discontinued**

- Medicines which are to be discontinued must be deleted by an authorised prescriber, using a single straight diagonal line through the prescribing section. The date on which the medicine is discontinued should be entered and initialled by the authorised prescriber. The administration record must not be crossed out.
- The authorised prescriber may annotate the prescription with a stop time and date, e.g. stop after lunch-time dose on 5 May. In this case nursing staff or pharmacist may complete and sign the discontinuation section of the sheet.

- Highlighter pens must not be used to discontinue medicines.

4.19 **Correction of Errors -** Prescriptions which are entered in error should be deleted with a single line "Cancelled" should be written in the times of administration column. The entry should be initialled and dated by the authorised prescriber. Correction fluid must never be used.

4.20 **Alterations to the Original Prescription - p**rescriptions must not be altered. If a prescriber decides to increase or decrease the strength of a preparation, the original entry should be deleted and a new prescription should be entered on the prescription sheet. Ticks, used to annotate times of administration, should not be added or deleted.

5. Additional Prescription Sheets (Continuation Sheets)

5.1 Ideally each patient should have one prescription form. If the first prescription form is full, and additional medicines are required, the entire patient's data from the main prescription form, together with the list of medicines to be avoided and a record of the prescription forms in use, must be entered on the continuation form. A second form bearing only the patient's name is not acceptable. All subsequent sheets should be numbered.

5.2 Sheets must be clearly marked with a discontinuation date and cancelled with a diagonal line fully across the page.

6. Oxygen

This section does not apply to the emergency use of oxygen or to the use of oxygen associated with operations.

Oxygen is a prescription only medicine and, other than for emergency use, must be prescribed on the prescription form. Instructions must include the type of mask and the flow rate to be used entered in the "times of administration" column.

7. Pre and Post-Operative Medicines

7.1 Pre-operative medicines are prescribed on the front page of the medicine prescription form under 'Once Only and Premedication Drugs'

7.2 Post-operative medicines must be prescribed on the main medication prescription form or anaesthetic sheet.

8. Diagnostic Medication

8.1 Medicines used for diagnosis, e.g. Synacthen test, must be entered in the "Once Only and Premedication Drugs" section on the front page of the prescription form

8.2 A record should be made of any radio-opaque preparations, or any radio-pharmaceuticals administered to patients in the "Once Only and Premedication Drugs" section on the front page of the prescription form.

9. Prescribing for Out-Patients

9.1 Hospital Out-Patients are referred back to their G.P. who will provide any medication recommended by the Consultant/Specialist Service the patient was referred to. However, when:-

- The administration of a medicine requires specialist hospital monitoring **and** the Consultant retains responsibility for prescribing treatment for the patient,

or

- The Consultant considers that treatment must start immediately, i.e. the treatment is initiated within the out-patient clinic,

or

- The medicine prescribed is only available to Hospitals.

9.2 The hospital prescriber may prescribe for the patient using an Out-Patient Prescription Form which can be dispensed in the hospital pharmacy

10. Health Board Prescription (HBP) Forms

10.1 When it is not possible to provide medicines by an internal hospital prescription it is permissible for the Consultant to use a Health Board Prescription Form HBP10 – commonly referred to as a 'blue pad prescription'

10.2 Only drugs and medicines may be prescribed on the HBP10 Form. HBP10 forms cannot not be used for appliances, dressings or chemical reagents.

10.3 The HBP10 Form is taken by the patient to a community pharmacy for dispensing.

10.4 HBP10 forms MUST NOT be used for prescribing for hospital staff or family members.

10.5 Pharmacy will audit the use and associated costs of medicines prescribed via HBP10 pads.