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**Document Abstract**

Prescribing carries a high level of risk for patients so the primary purpose of this policy is to have an agreed, consistent, safe and professional standard of prescribing and prescription writing across the trust. This policy details the requirements for all prescriptions written by both medical and non-medical prescribers.

**Who should read this policy?**

Do you ever prescribe or administer medicines to adults or children?  
or  
Are you a member of pharmacy staff who screens prescriptions or gives advice about medicines?

Yes

Read the full policy

No

Not applicable
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# Chapter M2: Prescribing Policy

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1. **Introduction**

1.1 Prescribing carries a high level of risk for patients so the primary purpose of this policy is to have an agreed, consistent, safe and professional standard of prescribing and prescription writing across the trust.

1.2 This policy details the requirements for all prescriptions written by both medical and non-medical prescribers. An additional Trust Policy for non-medical prescribing is available in chapter M7.

1.3 Prescribing medicines for children can be considered complex because of the need to take body weight or surface area into account and also because of the variation in metabolism or elimination of drugs by the body.

1.4 Weight based dosing is common in paediatrics and so more calculations need to be made during the prescribing, dispensing and administration processes.

1.5 Additional complicating factors for prescribing of medicines in paediatrics include lack of readily available information on doses of some medicines, the frequent use of off label and unlicensed medicines, non-availability of convenient dosage forms requiring calculations, part use of dosage forms intended for adults, and administration difficulties that can vary with the age and co-operation of the child.

1.6 Errors in prescribing for children commonly arise because of poor handwriting, misinterpretation of decimal points and calculation errors.

1.7 The impact of errors in children, especially neonates, may be more clinically significant as they may not have the metabolic reserves to buffer the consequences of any error.

2. **Purpose and Scope**

2.1 To ensure that all prescriptions are safe, legible, and unambiguous and contain all the information required for a medicine to be administered.

2.2 This chapter forms the overarching policy for prescribing of medicines and should be read in conjunction with the administration of medicines policy and standard operating procedure which details the policy and procedural information that must be followed when administering prescribed medicines.

3. **Definitions**

3.1 **Prescriber**

(a) A prescriber is a person who is authorised to write a prescription. They may be medical (registered medical staff, foundation doctors), dentists or non-medical prescribers (trained and accredited nurses, optometrists, pharmacists, physiotherapists, podiatrists and radiographers, working within their clinical competence as either independent and/or supplementary prescribers).

3.2 **Prescription**

(a) A prescription is an order to another practitioner to administer a medicine. It must be clear & unambiguous. It must contain sufficient information for the correct medicine to be supplied and to enable the administering practitioner to give the medicine safely and effectively.

3.3 **A child**

(a) For the purposes of this policy, a child is defined as in The Children Act as under the age of sixteen years.
4. **Duties, Roles and Responsibilities**

4.1 The prescriber is responsible for:

(a) Deciding the drug, dose, route, rate of administration and appropriate duration of treatment.

(b) Taking, or referring to, an accurate patient medication history and reconciling those medicines.

(c) Checking and recording patient allergies and sensitivities.

(d) Checking clinically significant drug interactions and ensuring instructions for the administration of intravenous drugs are appropriate.

(e) Providing a legal, legible, signed prescription giving all the detail necessary to enable the drug to be administered safely and correctly.

(f) Ensuring that where medicines are to be mixed it is safe to do so.

(g) Maintaining their competence in prescribing in accordance with their code of conduct and employment contract and acting in accordance with the national prescribing competencies;

1. Knowledge. The prescriber has up to date clinical pharmacological and pharmaceutical knowledge relevant to their own area of practice.

2. Options. The prescriber makes or reviews a diagnosis, generates management options for the patients and follows up management.

3. Shared decision making (with parents, care givers or advocates where appropriate). The prescriber establishes a relationship based on trust and mutual respect and recognises patients as partners in the consultation.

4. Safe. The prescriber is aware of their own limitations and does not compromise patient safety.

5. Professional. The prescriber ensures that their prescribing practice is consistent with the scope of practice, organisational, professional and regulatory standards, guidance and codes of conduct.

6. Always improving. The prescriber actively participates in the review and development of prescribing practice to optimise patient outcomes.

7. The healthcare system. The prescriber understands and works within local and national policies, processed and systems that impact on prescribing practice. The prescriber sees how their own prescribing impacts on the wider healthcare community.

8. Information. The prescriber knows how to access relevant information and can use and apply information in practice.

9. Self and others. The prescriber works in partnership with colleagues for the benefit of patients is self-aware and confident in their own ability as a prescriber.

(h) Paediatric prescribers
(i) All prescribers should demonstrate competence to calculate paediatric drug doses prior to prescribing medicines.

(ii) All prescribers must be aware of the additional complicating factors of prescribing medicines for children. Advice and information is available via the local pharmacy department, who can refer to the specialist paediatric pharmacists if necessary.

(iii) If, in exceptional circumstances, children are being cared for on an adult ward (e.g. The Eye Hospital and the Dental Hospital) it is the responsibility of the caring team to seek advice from paediatric specialists where doubt exists concerning drug dosages.


5.1 Requirements for Prescription Writing

(a) General requirements

(i) Prescriptions must be written legibly in block CAPITALS, in indelible ink or computer generated, and should state the following:

(A) Name of the patient.

(B) Age of the patient or date of birth, use patient addressograph if possible.

(C) Hospital or NHS number

(D) The patient’s weight in kilograms. This is mandatory for all children and is good practice for adults. It must be included where doses are weight related (for example in paediatrics, some chemotherapy regimens or for administration of low molecular weight heparins) and prior to anaesthesia. The date the weight was measured must be recorded.

(E) Height and surface area (where appropriate). The date on which the height was measured and surface area was calculated should be recorded.

(F) Approved (generic) name of the product (where one exists). This should be written clearly and not abbreviated.

(G) The trade name may be used for multi-ingredient products

(H) The trade name must be used for medicine brands which differ in bioavailability, including ciclosporin, lithium, tacrolimus, sustained release formulations of calcium channel antagonists, beclometasone inhalers and theophylline

(I) Trade names for prescribing heparin, such as Hepsal, Hep-lock and Hepflush should be avoided. The generic name should be used and strength of heparin sodium recorded for each prescription.

(b) The dose

(i) Use standard numerals (1, 2 etc.) rather than symbols (i, ii etc.)

(ii) The unnecessary use of decimal points should be avoided (e.g. 3 mg not 3.0 mg)

(iii) Quantities of 1 gram should be written as 1 gram.

(iv) Quantities less than 1 gram should be written in milligrams (e.g. 500 mg not 0.5g).

(v) Quantities less than 1 milligram should be written in micrograms (e.g. 500 micrograms not 0.5 mg)
(vi) When decimal points are unavoidable a zero should be written in front when there are no other figures (e.g. 0.5ml not .5ml)

(vii) For liquid oral medicines, the dose should be prescribed by weight (e.g. milligrams) whenever possible. If the dose is written by volume, the strength of the oral liquid must also be specified on the prescription. There are a small number of medicines e.g. magnesium hydroxide where there is no milligram / microgram dose and ‘ml’ is acceptable.

(viii) For mixed compound preparations which come as a single dose, the number of tablets should be stated (e.g. co-dydramon).

(ix) The words: micrograms, nanograms, or units must not be abbreviated. The word ‘units’ must not be abbreviated in the medical notes either.

(x) When prescribing for children consideration must be given as to how the prescribed dose will be measured and given. Providing it is safe and effective to do so, doses should be rounded up or down by the prescriber to enable convenient administration. The prescriber must clearly state the rounded dose, it is not acceptable for a nurse administering the medicine to give a different dose from the one prescribed. For medicines where there is a wide safety margin then prescribing by age range may be adequate e.g. some oral antibiotics.

(xi) Prescriptions for intravenous infusions in children involve more than one calculation since both the dose and the rate of administration need to be calculated. Prescriptions should specify the drug, concentration, dose/kg/time, actual dose/time, route and rate per unit time so that the prescription can be thoroughly checked.

(c) Frequency of administration

(i) In the case of preparations to be taken ‘as required’ a minimum dose interval should be specified, and an indication if not obvious. Although directions should preferably be in English, without abbreviation, the following Latin abbreviations are permitted;

(A) b.d. - twice a day

(B) o.d. - once a day

(C) o.m. or mane - in the morning

(D) o.n. or nocte - at night

(E) p.r.n. - when required

(F) t.d.s. - three times a day

(G) q.d.s - four times a day

(H) stat - immediately

(d) The route of administration should be specified in all cases.

(i) Abbreviations should be written in CAPITALS and should include:

(A) IM = intramuscular

(B) IV = intravenous

(C) PO = oral

(D) PR = per rectum
(E) PV = per vagina
(F) S/CUT = subcutaneous
(G) S/LING = sublingual
(H) TOP = topical
(I) INH = inhaled via inhaler
(J) NEB = nebulised.

(ii) Any other route prescribed should be written in full. (Intrathecal must never be abbreviated).
(iii) Sites of topical application must be specified, e.g. to eczema on left hand (L hand); drops to right eye (R eye).
(iv) For inhaled medicines and subcutaneous insulin, the administration device should also be stated.

(e) Signature of the prescriber;
(i) This should be accompanied by the name printed in CAPITALS to ensure that the prescriber is identifiable. Stamps with the prescriber name and GMC number may be used in place of printing the name by hand. The prescriber’s bleep number should be used for additional identification wherever possible.

(f) Date and year

5.2 Duration and formulary status of prescribed medicines
(a) Medicines must be prescribed in accordance with the BNSSG joint formulary (the formulary does not apply to paediatrics)
(b) Prescribing responsibilities are detailed on the joint formulary website
(c) The standard prescription duration is 28 days, but on-going prescribing is required for drugs classified as ‘red’, drugs classified as ‘amber’ prior to establishing GP shared care arrangements, and unlicensed medicines for which the GP has not accepted prescribing responsibility.
(d) Shared care protocols are available on the shared care page on the BNSSG website.

5.3 Inpatient prescriptions
(a) The following additional requirements are to be entered onto the inpatient prescription chart
(i) Ward
(ii) Consultant’s name.
(iii) Completion of drug allergies / sensitivities section. (State “not known” or “history unobtainable” if these are the case. If unobtainable on admission this should be completed as soon as it practical). Do not prescribe medication until this has been checked
(iv) Times of administration for regular and once only drug therapy should be clearly annotated on the drug chart.
(v) When required, ‘prn’ prescriptions should include
(A) Dose. If the dose is a range, guidance on how to choose which dose should be given if possible

(B) Administration frequency

(C) Maximum daily dose (if relevant)

(D) Indication for administration

(vi) The method of intravenous injection must be specified under additional instructions in writing, i.e. bolus, tubing, burette, and diluting volume stated.

(A) Stability data should be checked when contemplating the dilution of drugs in infusions. The period of administration must not exceed the “life” of the infusion or the manufacturer’s recommendations

5.4 Changing prescriptions

(a) Amendments that clarify a prescription may be made to both adult and paediatric prescriptions.

(b) Dose changes should be made by cancelling the old prescription and rewriting a new one.

5.5 Stopping a drug

(a) When a drug is discontinued the prescription should be deleted with a large ‘Z’ across the drug name, dose and administration sections, countersigned and dated by the doctor

5.6 Dose deliberately withheld

(a) For adult patients, the prescriber should annotate the dose administration box with an ‘X’. The reason for the decision should be documented in the medical notes.

(b) For paediatric patients, the prescriber should annotate the dose administration box with the relevant non-administration code and document the reason for the decision in the medical notes.

5.7 Rewriting prescription charts

(a) When rewriting a chart for continuation of treatment, the ‘start date’ should be the date on which that particular medication was commenced in the hospital and not the date on which the chart was rewritten.

5.8 Antibiotic prescriptions

(a) When a prescription for an antibiotic has been written, the date of review (or stop date if known at this time) must be entered in the appropriate review or stop date box on the treatment chart. Prescriptions for antibiotics must also include the indication in the relevant indication box on the prescription chart.

(b) Where an antibiotic is to be reviewed on a daily basis, the term ‘review daily’ may be written in the review date box.

(c) If there is no information on the prescription regarding the review or stop date for an antibiotic the nursing and Pharmacy staff are to contact the prescriber to incorporate the required information.

(d) Therapeutic Drug Monitoring
(i) For adult patients, draw a box around the time of the appropriate dose and annotate with the word ‘level’. Add a specific instruction to await the result if appropriate.

(ii) For paediatric patients, prescribers should use the appropriate coloured sticker (where used) according to whether they wish a level to be taken and the dose held or given. If stickers are not used, the same process as that defined in 5.8.d.(i) should be followed.

5.9 Additional instructions

(a) Space is provided for specific instructions about the drug administration and best practice includes completion when intravenous and topical applications are prescribed.

(b) Additional instructions such as ‘before food’ may be entered in this space.

5.10 Exceptions to prescribed orders

(a) Prescribed dose omitted: Details of all medicines omitted, together with the reason using the appropriate codes shown on the front of the drug chart, should be recorded at the time prescribed for administration. It is never appropriate to leave administration boxes on the drug chart blank.

5.11 ‘Label’ generated prescriptions

(a) Some departments prepare labels and attach these to inpatient prescription charts as individual prescriptions. In such circumstances the prescription must still be checked and signed by the prescriber. The master labels must be retained as a read-only file which is password controlled and each label must be version controlled. All new ‘label’ prescriptions must be approved by Pharmacy before use.

(b) Printing quality must be of good standard and each label must contain legible, clear and complete text. Any substandard labels must be destroyed.

(c) The size of the label must be appropriate to fit on the drug chart.

(d) Lower case may be used on pre-printed labels.

5.12 Pre-printed prescription charts

(a) Some departments prepare pre-printed prescriptions. These separate charts must still be checked and signed by the prescriber. All new pre-printed prescriptions must be approved by pharmacy before use.

(b) Printing quality must be of a high standard and the drug details should be complete, legible and clear. The paper on which the prescription is printed must be of similar quality to that of the main drug chart.

(c) The pre-printed chart must be stapled to the main drug chart

(d) The main drug chart must carry a comment on the front to reflect the fact that a separate pre-printed chart is in use.

5.13 Multiple Prescription Charts

(a) In the event of more than one inpatient prescription chart being required for a patient, the charts must be clearly labelled at the top ‘1 of 2’ etc., and attached to each other with a treasury tag.

5.14 Prescribing Controlled drugs

(a) See the controlled drug policy, chapter 5 of the medicine code.
5.15  **Medication ‘To Take Away’**

(a) For the purpose of this policy document “to take aways” (TTAs) mean to provide medication, including dressings, upon discharge, for the patient until seen by their General Practitioner.

(b) TTA’s should be ordered and delivered to the ward or department on or before the discharge date.

(c) If delivered to the pharmacy department, the TTA prescription must always be accompanied by the prescription chart, unless previously screened (and signed) on the ward by a pharmacist.

(d) Ward-supply of TTAs should be according to agreed protocols and use pharmacy-dispensed pre-packed drugs. A patient name must always be present on the label; it is good practice to include dosage and administration directions. A patient information leaflet should always be given for each medicine.

5.16  **Prescriptions for Outpatient, Accident and Emergency, Day Case Surgery or Day Attenders**

(a) Patients attending as day cases, for day surgery, or for accident and emergency treatment are liable for prescription charges for any medication prescribed to take out of the hospital.

(b) The consultant responsible for the episode must be identified on each prescription.

5.17  **Non-Medical Prescribing**

(a) Specific issues relating to prescribing by nurses, pharmacists and allied health professionals are addressed in the separate medicines code chapter ‘Non-medical prescribing policies and procedures’.

5.18  **Verbal orders**

(a) Verbal orders are not permitted unless written policy has been approved by the Director of Pharmacy or are needed for a life threatening emergency

5.19  **Clinical Incidents**

(a) Any clinical incidents arising from prescribing are to be reported via the online incident report form

6.  **Standards and Key Performance Indicators**

6.1  **Applicable Standards**

(a) All medicines are prescribed in accordance with section 5.1 of this policy.

(b) Inpatient medicines charts will contain all of the additional required information as detailed in section 5.3.

(c) No verbal orders are accepted unless written policy has been approved by the Director of Pharmacy or are needed for a life threatening emergency

(d) Paediatric prescribing will incorporate all additional requirements as determined in this policy.

6.2  **Measurement and Key Performance Indicators**

(a) Medicines prescribing will be audited on a regular basis, at least once every three years

(b) Prescribers take responsibility for their actions and must comply with the prescribing competencies.
7. References


8. Associated Documentation

BNSSG Hospital Trusts’ Prescribing Policy 2003

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**Prescribing remains with the Trust when preparations:**
- Are part of a hospital trial
- Are used outside the terms of the product licence unless GP has agreed otherwise
- Are unavailable to GPs
- Are Red Category in the Traffic Light System²
- Are Amber Category in the Traffic Light System, until prescribing by GP agreed under shared care Arrangement²

**No prescriptions will be provided by the Trust:**
- For Outpatients where preparations are unrelated to the current episode
- On Discharge for medicines unrelated to the reason for admission where the patient already has sufficient supplies

9. Appendix A – Monitoring Table for this Policy

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¹28 days as per ‘patient packs’, unless the course is shorter. Minimum 14 days TTA when ‘patient pack’ initiated for inpatient treatment.

² See BNSSG Traffic Light System for Prescribing Responsibility and shared care guidance.
### 10. Appendix B – Dissemination, Implementation and Training Plan

10.1 The following table sets out the dissemination, implementation and training provisions associated with this Policy.

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<td>Training is required:</td>
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**Additional Comments**
## 11. Appendix C – Document Checklist

11.1 The checklist set out in the following table confirms the status of ‘diligence actions’ required of the ‘Document Owner’ to meet the standards required of University Hospitals Bristol NHS Foundation Trust Procedural Documents. The ‘Approval Authority’ will refer to this checklist, and the Equality Impact Assessment, when considering the draft Procedural Document for approval. All criteria must be met.

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**Additional Comments**

Not Applicable