The Medicines Policy

Chapter 2: Standards of Practice

PRESCRIBING

V3.0

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CHAPTER 2

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6. Standards and Practice

6.1. Prescribing

The General Medical Council principals set out in the 'Good practice in prescribing and managing medicines and devices' (Feb 2013) should be followed.

6.1.1 Patient-Centred Prescribing

- Patients must be at the centre of all prescribing decisions and prescribers must ensure the medicines given are appropriate and person-centred by taking account of their:

  1) age
  2) choices
  3) lifestyle
  4) cultural and religious beliefs
  5) allergies and intolerances
  6) existing medical conditions and prescriptions
  7) adverse drug reactions
  8) recommended prescribing regimes.

- Healthcare professionals should adapt their consultation style to the needs of individual patients so that all patients have the opportunity to be involved in decisions about their medicines at the level they wish.
- Establish the most effective way of communicating with each patient and, if necessary, consider ways of making information accessible and understandable (for example, using pictures, symbols, large print, different languages, an interpreter or a patient advocate).
- Offer all patients the opportunity to be involved in making decisions about prescribed medicines.
- Establish what level of involvement in decision-making the patient would like.
- Be aware that increasing patient involvement may mean that the patient decides not to take or to stop taking a medicine. If in the healthcare professional's view this could have an adverse effect, then the information provided to the patient on risks and benefits and the patient's decision should be recorded.
- Accept that the patient has the right to decide not to take a medicine, even if you do not agree with the decision, as long as the patient has the capacity to make an informed decision and has been provided with the information needed to make such a decision.
- Be aware that patients' concerns about medicines, and whether they believe they need them, affect how and whether they take their prescribed medicines.
- Offer patients information that is relevant to their condition, possible treatments and personal circumstances, and that is easy to understand and free from jargon.
- Recognise that non-adherence is common and that most patients are non-adherent sometimes.
- Routinely assess adherence in a non-judgemental way whenever you prescribe, dispense and review medicines.
- Be aware that although adherence can be improved, no specific intervention can be recommended for all patients. Tailor any intervention to increase adherence to the specific difficulties with adherence the patient is experiencing.

- Review patient knowledge, understanding and concerns about medicines, and a patient's view of their need for medicine at intervals agreed with the patient, because these may change over time.
- Offer repeat information and review to patients, especially when treating long-term conditions with multiple medicines.
- Ensure that prescribing is within the Trust formulary. Any non-formulary prescribing increases the chances of patients missing doses and should be avoided. An application to the Cornwall Area Prescribing Committee should be made to have a medicine added to the formulary before any attempt to prescribe it is made.

6.1.2 Prescription Writing Rules

Electronic prescribing systems are in place across the Trust. Each system has an accompanying training package. Prescribers will need to undertake this training before being given access to the relevant system. Prescribers have a responsibility to maintain their competence on these systems and should contact the relevant prescribing system support team if additional training or refresher training is required.

There remain some areas where electronic prescribing is not yet available. Prescribers should be aware of the inherent risks of handwritten prescriptions namely they are not always legible and unambiguous. The points made in the table below, all of which are **rules**, apply to all prescriptions; compliance will significantly reduce the chance of error and risk of patient harm.

Rule	Rationale
Write in BLACK or BLUE INK or otherwise so as to be indelible.	Spills happen and can easily make a previously clear prescription ambiguous. Black is specified by the RCHT policy for managing health records for all notes and notes-related documents.
Use BLOCK CAPITALS.	This is usually the most legible way of writing by hand and is least capable of misconstruction
Use the approved numerals: 1 2 3 4 5 6 7 8 9 0	Note particularly that there is no upstroke on the numeral one and that the numeral seven is crossed. Confusion between numerals one, two and seven is thus minimised.
Use APPROVED names for drugs except when the brand is significant (e.g. insulins, calcium-channel blockers, theophylline).	This significantly reduces the chance of error when the drug is dispensed or administered and allows the dispenser to give the most cost-effective brand when there is choice.
Never alter a prescription, always cancel it and rewrite.	Alterations frequently change a clear prescription into an ambiguous one.
Always write 'units' in full, never abbreviate.	Abbreviations are DANGEROUS in this case.
Write weights as G or g for grams, mg for milligrams. Write micrograms and nanograms in full.	Although in practice a thousand-fold error is unlikely to be implemented, either in the dispensary or on the ward. Never use μg for microgram, it is very easily confused with mg.
Write volumes as ml for millilitres.	Other units, e.g. decilitres, are uncommon in Britain and are frequently misunderstood.

Never use fractions for weights, for example '500mg' not '0.5g' and NEVER '.5g'	A range such as '0.5 – 1g' is acceptable.
Write fractions of a millilitre with a leading zero: '0.25ml'.	Do not use microlitres, many people do not understand them and syringes are always calibrated in millilitres.
Avoid all abbreviations other than those in Addendum 1.	Abbreviations are a form of code, what is clear to you may well mean something else entirely to the dispenser or nurse. For example, do not use QD for once a day – many professionals think this means four times a day.

6.1.3 Methods of Inpatient and Discharge Prescribing

Inpatient Prescribing and Additional Treatment Sheets

- At the time of writing this policy, all inpatient areas are live on electronic prescribing and administration (EPMA).
- The general wards are using the JAC EPMA system.
- Critical Care is using the CareVue prescribing system.
- Chemotherapy regimens are prescribed on the Aria system (available on Lowen ward).
- There are some elements of prescribing that have not moved over to the JAC EPMA system and additional treatment sheets remain in existence for these e.g. infusions and insulin sliding scales. Using infusions as an example, the prescribers should prescribe 'infusion chart' on the EPMA system and write the details on the additional treatment sheet.
- There is an available form on all wards for the prescribing and administration of urgent medicines. This is to be used where for some reason the EPMA system is not available and a medication is required urgently.
- At times of sort periods of EPMA downtime a paper copy of the EPMA record will be printed off for each patient. These print-outs should be used as regular paper drug charts, remembering to update the EPMA system with any changes once it is back on-line.
- The drug charts must always show a complete record of all drug treatment for the patient, either by containing the prescription and administration record or by making clear reference to the existence of other forms (see below).
- At times of prolonged EPMA down time, the Trust will resort back to the paper drug chart form CHA2827. Pharmacy holds contingency stock of these charts. Full details of how to complete drug chart CHA 2827 can be found in *Appendix 10.*

Discharge prescriptions (TTOs)

- The standards for discharge summaries are set out in the Academy of Royal Colleges & NHS document, 'A Clinician's Guide to Record Standards'.
- All discharge prescriptions must be written using the JAC EPMA TTA system.
- This information then feed through into the Maxims eDischarge letter that goes to the patient on discharge and is automatically sent to their GP.
- The eDischarge is used to tell the patient and their GP about the admission and about changes in drug therapy that have been initiated during admission, drugs given on discharge, drugs stopped during admission and to give advice on continuation therapy. Up to a maximum of 28 days' supply may be prescribed.

In exceptional circumstance more than 28 days may be supplied and in such cases the prescriber must make a note of the reason on the prescription record.

- The eDischarge will usually be the first indication to a GP that their patient has been in hospital. Therefore it is very important that it has been completed fully, accurately and legibly and should include a list of all medicines taken, not just those started while in hospital, any reasons for changes to medication and any follow-up required by the GP. The Trust takes the view that correct and full use of this form is an important contributor to good clinical governance; failure to do so will always increase risk to patients because it will lead to less effective communication between secondary care and primary care.
- An abridged version of the eDischarge is permitted on the medical admissions unit where a patient has been in for less than 24 hours.
- If EPMA is unavailable prescribers should use the discharge prescription form CHA2592.

Pre-printed Discharge Prescription Sheets

- A number of pre-printed discharge prescription sheets have been authorised for use by the Medication Practice Committee, though these are phasing out with the implementation of EPMA. The general points given above apply to these forms, together with the specific rules set out below.

- Each form is solely for use in the treatment patients in the specified unit or on their discharge from the unit.

- If the patient needs drugs not pre-printed on the form, the whole prescription must be dispensed in pharmacy, no part of it may be supplied from ward or department stock by the prescriber.

Oral Surgery and Day Case Surgery (form CHA1812)

- The pre-printed section of this form has entries for several antibiotics, for several analgesics containing paracetamol and for several non-steroidal analgesics. Take great care to avoid inadvertent therapeutic duplication or overdose.
- Sign each line that is to be dispensed and for antibiotics enter the number of tablets to be taken.

Eye Surgery (form CHA1934)

- Prescribe by specifying which eye(s) are to be treated or by entering a number of days' treatment to be dispensed. For cyclopentolate, chloramphenicol or for prednisolone, take care to select the correct dose frequency.

SMH Discharge Prescription / WCH Day Case Prescription (CHA2572)

- Staff working in relevant areas of the Trust will be given specific instruction in the use of this form by a member of the staff of the Pharmacy Department at West Cornwall Hospital.

6.1.3.1 Prescribing and Dispensing TTOs Out of hours

This section sets out the actions to be taken when medicines are to be supplied to patients to take home directly from ward stock, at a time when the pharmacy cannot make a supply. Such supplies may only be made by a doctor and she/he

takes full responsibility for all aspects of the supply notwithstanding that he may have delegated part of the procedure set out below;

- The doctor must complete and sign an out of hours dispensing form (CHA1041). Supplies of the form are kept on all wards.
- The doctor must check whether the patient already has sufficient, correctly labelled supplies (minimum 14 days) of his own medications brought in on admission to last until his next visit to his GP. If he has, relevant items should be clearly marked 'own drugs' on the form so that a duplicate supply is not dispensed.
- Wherever possible, items shall be prescribed and dispensed using the range of ready made discharge medicines ("pre-packs") available in the relevant emergency cupboard.
- The emergency cupboard also contains a supply of empty containers and blank labels to allow items not held as pre-packs to be dispensed, in this case using stock held on the ward. The minimum quantity – 14 days supply – should be dispensed.
- Labels on pre-packs must be completed to show dose size, frequency, patient's name, ward name and date of dispensing.
- The doctor must sign at the bottom of the 'Out of Hours' dispensing form to indicate that he has dispensed the medication and handed it to the patient.
- Details of diagnosis, outcome and follow-up arrangements should be communicated to the GP in the usual way (either electronically or on a TTO/discharge prescription). If a TTO/discharge prescription is used, instead of filling out the drug details, the GP copy of the completed Out of Hours dispensing form should instead be attached to the GP copy of the TTO/Discharge form before sending it to the GP.
- The relevant ward or department manager must ensure that the pharmacy copy of the Out of Hours Dispensing form is returned to the Pharmacy immediately (so that the stock of pre-packs, empty containers and labels can be replenished). The bottom copy of the form is filed in the patient's notes as a record of the therapy on which the patient was discharged.
- Controlled drugs must be dispensed by pharmacy in all circumstances. Similarly, if the prescription is complex, it would be good practice to ask pharmacy (through the on-call pharmacist) to do the work.
- On paediatric wards, labels, containers and a small range of pre-packs specific to children are available.

6.1.4 Outpatient Prescribing

General Principles

- Hospital prescribers should not provide treatment which is unrelated to the current episode.
- All prescribing should adhere to the CIOS Joint Formulary, which categorises medicines into three main groups: first/second choice options, specialist initiated and hospital only medicines. The Trust formulary is available via the intranet. Any non-formulary prescribing will require sign off from the chief pharmacist or appointed deputy before it can be dispensed.

- Prescriptions should only be provided for new treatments and dose changes that are clinically urgent or hospital only medicines. All non-urgent treatments and dose changes should be referred back to the GP via the clinic letter.
- All repeat prescribing should be referred back to the patient's GP unless it is a 'hospital only' drug.

- A maximum of one month's medication can be prescribed for outpatients. The exception to this is home delivery patients, or where the hospital is maintaining the patient's supply, where greater quantities may be prescribed.
- Prescribers must ensure that any repeat prescribing activity for ongoing care is captured by the Trust so expenditure can be appropriately covered by contractual arrangements.
- Clinical trial drugs must be prescribed on the specific trial prescription (and/or via the Aria system for cancer prescribing).
- Where 'shared care guidelines' are to be used, the prescriber must clearly communicate this to the GP and ensure there is agreement with the GP for this shared care.

Choice of Prescription Type

- The electronic outpatient prescribing system should be used as the default for prescribing.
- When a prescription is required, prescribers must use the hospital outpatient prescription in preference to an FP10NHC prescription.
- Using the hospital form ensures the hospital is charged the NHS price for the drug, rather than a potentially more expensive price in community pharmacy (set by the drug tariff)

FP10HNCs (for dispensing in community pharmacies)

- Should only be used for initiating urgent treatment when prescribing away from the RCHT site or out of the outpatient pharmacy opening hours.
- Do not use FP10HNCs to prescribe 'High Cost Drug Exclusion' drugs *(see Department of Health web-site).*
- The use of FP10HNCs to prescribe unlicensed medications is not encouraged. The patients may have difficulty sourcing these medicines in the community and the cost of these preparations is often substantially higher in the community that when procured through the RCHT contracts.
- FP10HNC prescribing is monitored regularly on a clinic and prescriber level basis and information on drugs prescribed is fed back to the Divisions.
- For guidance on safety and storage of FP10HNC prescriptions, see *Appendix 4*.

The points made below, all of which are **rules**, are in addition to the general points made above.

	Hospital Outpatient Prescriptions				FP10HNC's	
	Rule	Rationale			Rule	Rationale
1.	The name, address, date	Full details are needed to		1.	F1 doctors may not	Only registered Drs may

	of birth and hospital or NHS number of the patient must be completed.	safely identify the patient			prescribe on form FP10 (HNC).	prescribe on FP10s
2.	Enter the patient's allergy status in the box provided on the outpatient prescription or write "no known drug allergy" or "NKDA".	The pharmacy will not dispense any prescription for a patient whose allergy status is not known.		2.	The name and address of the patient must be handwritten.	Address labels frequently come off the forms. This is a problem with the quality of the paper used for the forms and is beyond the control of the Trust.
3.	Complete details of the hospital, clinic and consultant responsible for the current episode of care	This information is vital if any queries on the prescription need to be resolved.		3.	The age of a child under 12 years old must be stated.	It is good practice to enter both date of birth and age for all patients.
4.	The weight of a child under 12 years old must be stated.	It is good practice to enter both date of birth and age for all patients.		4.	Use 'the number of days' treatment' box, maximum 28 days, only when the dose is specified.	For 'PRN' prescriptions you will have to give a quantity to be dispensed, see the BNF for details of packs available.
5.	Where possible, enter brief details of indication or other relevant clinical information	This informs the pharmacist when clinically checking the prescription and handing it out to the patient.		5.	For each item write the drug name, the dose-form, the strength and the dose.	See the BNF for dose forms and strengths available.
6.	For each item write the drug name, the dose-form, dose, frequency and period of treatment, and indicate whether the treatment is intended to be continued by the GP.	Full details here should prevent the pharmacist having to contact the prescriber for clarification.		6.	Print your name and give a contact telephone number.	It will help the dispensing pharmacy to contact you. Remember the patient will not present the prescription for dispensing until long after the clinic is over.
7.	Print your name, indicate your status and give a contact telephone or bleep number.	This will help the dispensing pharmacy to contact you.		7.	Do not write in the 'Endorsements' or 'Office use' boxes.	These are for the dispenser and for the NHS Business Services Authority.

8.	When controlled drugs are to be supplied, the prescription requirements of the Misuse of Drugs Regulations 2001 must be followed (see BNF section for full details) The prescriber must write the total number of dose units in words and figures, rather than the total dose in words and figures.	It is a criminal offence to issue a prescription for a controlled drug which does not comply with the rules. This matches GP prescribing practice and reduces the risk of dispensing error.			When controlled drugs are to be supplied, the prescription requirements of the Misuse of Drugs Regulations 2001 must be followed (see BNF section for full details)	It is a criminal offence to issue a prescription for a controlled drug which does not comply with the rules.

*Note- mnay of the requirements are automatically completed when using electronic outpatient prescribing

Electronic Outpatient Prescribing (eOP)

- At the time of writing eOP is deployed across the Treliske site using the JAC EPMA system and Medisoft for ophthalmology.
- At the point of printing, the eOP system will request whether you require a hospital OP prescription, an FP10HNC or a GP referral letter. Choose accordingly.
- The eOP system will also automatically print out a non-formulary request form when a prescriber choses a non-formulary item. This form must be signed off by the chief pharmacist or appointed deputy before it can be dispensed.
- Please complete the eOP training package before using the system.

6.1.5 Transcribing

Transcribing of medicines by nursing or other professional staff must only take place in accordance with a specific transcription policy or procedure for that clinical area. This must be approved by the Medication Practice Committee.

6.1.6 Prescribing of Clinical Trials

All clinical trials should be prescribed on trial specific documentation or on the e-Prescribing system (provided this allows for differentiation between clinical trials and non clinical trials). The prescriber must be named on the specific clinical trial delegation log before prescribing. For further details of prescribing in clinical trials, please refer to the Research and Development Policy available on the document library.

6.1.7 Prescribing of Low Molecular Weight Heparins (LMWH)

Following guidance issued by the NPSA:

- A patient's weight must be used as the basis for calculating the required treatment dose of LMWH. The weight must be accurately recorded in kilograms (kg) in the inpatient medication chart (when in use) and clinical record. Patients should be weighed at the start of therapy and, where applicable, during treatment.
- Renal function is considered when prescribing treatment doses of LMWHs. The renal function test should not delay initiation of the first dose but every effort must be made to base subsequent dosing on these results.
- Essential information such as dose, weight, renal function, indication and duration of treatment should be communicated at transfers of care (e.g. by discharge letters) and used to ensure that future doses are safe.
- Dosing checks based on patient information are made by healthcare professionals who review, dispense or administer LMWHs when this information is readily available to them.

6.1.8 Prescribing for Yourself, Family Members and Members of Staff

Staff are reminded that;

a) They must not take medicines from clinical areas for personal use under any circumstances as this is considered theft and may result in disciplinary action.

b) They must not ask nursing or medical colleagues to give them any medicines from a clinical area for personal use.

c) Medical staff - in line with GMC good practice guidance RCHT does not allow prescribers to prescribe for themselves, members of their family, colleagues or friends except when the consultation is part of a formal episode of care. Any members of staff requesting a prescription should be referred to the Emergency Department (RCHT Medicines Policy Chapter 2: Standards of Practice - Prescribing).

d) Medical Staff wishing to self-prescribe must use a private prescription and are advised to inform their GP as soon as possible, in line with GMC good practice. (GMC - Good practice in prescribing and managing medicines and devices, 2013).