NHS
Dorset
Clinical Commissioning Group

MEDICINES STANDARD C1:
PRESCRIBING

The guidance within this document ensures the activities through which medicines are prescribed for supply or administered to a patient are in accordance with 'The Safe and Secure Handling of Medicines' report (2005), Medicines Act (1968), Health Service Circular 2000/026 and Misuse of Drugs Act (1971) and Regulations (and subsequent amendments).

DEFINITIONS

Definitions of terms used within the context of this document:

Patient Group Direction (PGD)
A written instruction for the supply and/or administration of a licensed medicine (or medicines) in an identified clinical situation, signed by a doctor or dentist and a pharmacist. It applies to groups of patients who may not be individually identified before presenting for treatment.

Patient Specific Direction (PSD)
A PSD is a direct instruction and does not require an assessment of the patient by the healthcare professional instructed to supply and / or administer, unlike a PGD. It is the responsibility of the person issuing the PSD to ensure that the individual supplying or administering the medicine is competent to do so.

WHO CAN PRESCRIBE AND WHAT CAN BE PRESCRIBED?

Medical prescribers

Doctors can prescribe any medicine for any medical condition with their competence, including controlled drugs

Dentists can prescribe from a limited list of products, for dental related conditions only. Refer to BNF.

Non-medical prescribers (nurses, pharmacists, podiatrists, optometrists, chiropodists, radiographers and physiotherapists)

Independent non-medical prescribers can prescribe any medicine for any medical condition, including controlled drugs. Nurses, pharmacists and optometrists may become independent

prescribers. Independent nurse and pharmacist prescribers (but not optometrists) may prescribe unlicensed and off label medication.

Community Practitioner nurse prescribers may prescribe a limited set of items from the non-medical prescribers' formulary. They may not prescribe controlled drugs and may not prescribe medicines 'off-label' / 'off-license' apart from one exception – nystatin for oral thrush in neonates.

Supplementary prescribing is defined as a voluntary partnership – between a medical prescriber (doctor or dentist) and a supplementary prescriber. Within this partnership, the supplementary prescriber may prescribe any medicine for any medical condition (including controlled drugs and unlicensed medicines), in accordance with an agreed patient-specific, written Clinical Management Plan (CMP). Supplementary prescribing may be undertaken by nurses, pharmacists, podiatrists, optometrists, chiropodists, radiographers and physiotherapists.

Both medical and non-medical prescribers must only prescribe drugs that are within their area of expertise, and level of competence and should only prescribe for children if they have the expertise and competence to do so.

METHODS OF PRESCRIBING

Recognised and approved methods of prescribing medicines in NHS Dorset Clinical Commissioning Group are as follows:

FP10 prescription forms
Patient Specific Direction (PSD)
Patient Group Direction (PGD)

PRESCRIBING FORMULARY, 'TRAFFIC LIGHTS' AND SHARED CARE GUIDANCE

Prescribing of medication within NHS Dorset Clinical Commissioning Group should reflect best practice and take an evidence-based approach, including adherence to the local formularies and associated guidance from Dorset Medicines Advisory Group (DMAG).

The "traffic light" system defines where responsibility for prescribing between primary and secondary care should lie through categorising individual drugs as red, amber or green. The system is intended to encourage appropriate shifts in prescribing between hospital clinicians and general practitioners (GPs) consistent with clinical responsibility and supported by shared care arrangements.

The Dorset formulary lists drugs approved for prescribing locally, together with their traffic light status, at: www.dorsetformulary.nhs.uk. Associated DMAG guidance is also available via this site.

Prescribing practice will be monitored and against local formularies. If individual prescribers are prescribing outside the local formulary and/or local and national guidance, then their decisions should be justifiable and supported by a body of evidence and take into

consideration the cost effectiveness and impact on the wider health community of such decisions.

REQUIREMENTS FOR PRESCRIPTION WRITING

General requirements

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

- Name of the patient;
- Age of the patient or date of birth, use patient addressograph if possible;
- NHS Number;
- The patient's weight must be included where doses are weight dependent;
- Approved generic name of the product. This should be written clearly and not abbreviated. The brand name must be used for medicine brands which differ in bioavailability, including ciclosporin, lithium, and sustained release formulations of calcium channel antagonists and theophylline.
- The dose

When decimal points are unavoidable a zero should be written in front when there are no other figures (e.g. 0.5 ml not .5 ml).

For liquid oral medicines, the dose should be prescribed by weight (e.g. milligrams) whenever possible, with some drugs e.g. magnesium hydroxide, there is no mg/mcg dose and 'ml' is acceptable.

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

The words: micrograms, nanograms, or units **must not** be abbreviated.

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

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

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

Quantities less than one milligram should be written in micrograms (e.g. 500 micrograms not 0.5 mg).

In their Rapid Response Report on insulin, the National Patient Safety Agency (NPSA) has highlighted that the abbreviation 'U' for units of insulin, can be mistaken for another 0, and has led to serious errors involving doses ten times higher than intended. The NPSA recommends that the word 'units' should not be abbreviated, and this is also stated in the BNF.

Frequency of administration

In the case of preparations to be taken 'as required' a minimum dose interval should be specified, and an indication for its use. Although directions should preferably be in English, without abbreviation, the following Latin abbreviations are permitted for dose frequency and routes of administration:

b.d. = twice a day
o.d. = once a day
o.m. or mane = in the morning
o.n. or nocte = at night
p.r.n. = when required
t.d.s. = three times a day
q.d.s. = four times a day
stat = immediately
PO = oral
PR = rectally
PV = vaginally
IV = intravenously
IM = intramuscularly
NG = nasogastric
PEG = via percutaneous endoscopic gastrostomy
SL = sublingually

Abbreviations should not be used for intradermal, intrathecal, intraperitoneal or transdermal routes, and these routes of administration should always be specified in full.

Signature of the prescriber and date

It is a legal requirement that all prescriptions must be signed in the prescribers own handwriting. However, it is acceptable for the date to be computer generated. (For electronic prescriptions, the prescriber's signature is transmitted electronically).

Duration of prescriptions

FP10 prescriptions for controlled drugs in schedules 1, 2 and 3 and 4 are only valid for a duration of 28 days from the appropriate date on the prescription. Where a prescriber wishes the 28 day period to start on a date later than the date of signing, he/she may specify a start date.

The prescribed quantity of schedules 2, 3 and 4 Controlled drugs should not exceed 30 days supply. Further guidance on prescribing controlled drugs is available in the relevant Medicines Code chapter on management of controlled drugs.

Antibiotic prescriptions

Antibiotics should only be prescribed where there is clear clinical benefit and should be given for the shortest duration appropriate to treat the underlying condition. Avoid using antibiotics unnecessarily. Only prescribe after careful consideration i.e. clinical evidence of infection, and prescribe in line with the local antibiotic formulary and guidance.

Use simple generic antibiotics first whenever possible. Avoid broad-spectrum antibiotics when narrow spectrum antibiotics remain effective, as broad-spectrum antibiotics increase the risk of Clostridium difficile, MRSA and resistant UTIs.

Additional instructions to be specified on the prescription

Ensure that any additional instructions necessary are entered on the prescription (for example, patients prescribed weekly bisphosphonate drugs or weekly methotrexate should have the day of the week included on the prescription).

Patients prescribed medicines to be taken 'when required' should have clear instructions about the indication for use and maximum dose, for example for paracetamol containing analgesia "*two tablets to be taken up to four times a day for pain, up to a maximum of 8 tablets per day*".

Supplementary instructions are required on controlled drug instalment prescriptions. For more information, please refer to the medicines standard document on prescribing and management of controlled drugs.

NON-MEDICAL PRESCRIBING

Specific issues relating to prescribing by nurses, pharmacists and allied health professionals are addressed in the Medicines Standard on non-medical prescribing.

CLINICAL INCIDENTS

Any clinical incidents arising from prescribing are to be reported in accordance with the standard NHS Dorset Clinical Commissioning Group adverse incident reporting processes outlined in the Adverse Incident policy and the Serious Untoward Incident Policy.

In addition, where an adverse reaction occurs in response to prescribing a particular medication, the procedures described in Medicines Code chapter on reporting adverse drug reactions, must be followed.

DUTIES/RESPONSIBILITES AND ACCOUNTABILITY

All prescribers are responsible for:

- Ensuring they only prescribe medicines that fall within their areas of clinical competence;

- Taking, or referring to, an accurate patient medication history before prescribing medication for a patient under their care;
- Checking and recording patient allergies and sensitivities;
- Deciding the drug, dose, route, frequency and appropriate duration of treatment;
- Checking clinically significant drug interactions;
- Ensuring instructions for the administration of medicines are clear and easy to interpret;
- Providing a legal, legible, signed and dated prescription giving all the detail necessary to enable the drug to be taken safely and correctly;
- Maintaining their competence in prescribing in accordance with their code of conduct and employment contract.

REFERENCES

'The Safe and Secure Handling of Medicines' report (2005)
Medicines Act (1968)
Health Service Circular 2000/026
Misuse of Drugs Act (1971)
Misuse of Drugs Regulations (2001)
Dorset formulary: www.dorsetformulary.nhs.uk
National Patient Safety Agency (NPSA) Rapid Response Report on insulin (June 2010)