NHSGGC Safe and Secure Handling of Medicines	
Guidance Section 6	
Prescribing Medicines	
Approved by: ADTC Safer Use of Medicines Committee	April 22
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Please refer to the NHSGGC Therapeutics Handbook "Good Prescribing Practice" section for general information – link here, and to the NHSGGC Medicines Reconciliation Policy – link here (both on the ggcmedicines.org.uk site). The term "Medicines Prescription Form" is used to describe electronic or paper documents used in NHSGGC to instruct and document medicine administration e.g. Hospital Electronic Prescribing and Medicine Administration (HEPMA) record; GGC approved paper-based kardexes etc. For further details on use of the HEPMA system please accesses the relevant Quick Reference guides here and Training Videos here (all held on Staffnet).

6.1 General principles

6.1.1 Medicines are prescribed only for, and supplied to, NHS patients. They will not be prescribed for or supplied to members of staff, patients' relatives or carers unless they are registered patients, for example through the Accident and Emergency Department (except in emergency situations).

6.1.2 Prescriptions can be generated only by suitably qualified prescribers (e.g. registered doctors, dentists, independent prescribers and any nurse / allied health professional (AHP) registered as a supplementary prescriber who is prescribing medicines authorised by the Clinical Management Plan (CMP)). Appropriate local procedures relating to registration with NHSGGC for non-medical prescribers must be followed and job descriptions updated (if necessary).

6.1.3 Prescriptions for in-patients, out-patients, discharge or pass medication must be generated electronically using NHSGGC approved systems or written legibly in black ink or otherwise so as to be indelible using the current appropriate approved prescribing documents. Under no circumstances should any entry be permanently obliterated - any changes required to an already generated / written prescription must be clearly documented and a new prescription generated /written or new entry made on the Medicine Prescription Form (paper kardex or electronic system, as appropriate).

6.1.4 Whenever possible no more than one paper Medicine Prescription Form (Kardex) should be in use for each patient. Where specific therapy is prescribed on an approved supplementary chart, it must also be documented on the Medicine Prescription Form (paper Kardex or electronic) e.g. insulin, warfarin, IV infusions.

6.1.5 Medicine must be prescribed generically using the current British Approved Name (BAN), except where branded products of the same drug are known to have clinically significant differences in bioavailability (e.g. controlled release

formulations of nifedipine, theophylline etc.). For these medicines, the brand in use should be specified when prescribing.

6.1.6 Medicine doses must be specified / selected in metric units. Only the following abbreviations may be used:
g = gram
mg = milligram
ml = millilitre
mmol = millimoles
All other dose units must be written / selected in full, e.g. microgram, litre and Units for Insulin International Units.

6.1.7 The use of decimal points must be avoided. For example, 0.1mg must be written / entered as 100 micrograms. If the use of the decimal points is unavoidable, a zero must be placed in front of the decimal point i.e. “0.5ml”, not “.5ml”.

6.1.8 The route of administration must be selected / written in full except for the following approved abbreviations. N.B. Intrathecal must be written in full.

PO oral	PEG percutaneous endoscopic gastrostomy
IV intravenous	RIG radiologically inserted gastrostomy
IM intramuscular	PEJ percutaneous endoscopic jejunostomy
ID intradermal	NJ nasojejunostomy
SC subcutaneous	ETT endotracheal
SL sublingual	TOP topical
NG nasogastric	INHAL inhaled
PR per rectum	NEB nebulised
PV per vagina	

6.1.9 The times and day(s), where appropriate, of administration must be specified. Particular attention must be paid when prescribing once weekly medicine, e.g. methotrexate for rheumatoid arthritis or bisphosphonates for osteoporosis.

6.1.10 Oxygen (or any other medical gas prescribed for in-patients or out-patients) must be prescribed on the appropriate Medicine Prescription Form (e.g. paper kardex or electronic system, as appropriate).

6.1.11 Medicines given by continuous infusion should be clearly identified in the Medicine Prescription Form. If using the paper Kardex an arrow should be drawn through all the “Time” sections on the entry in the Medicine Kardex and “Continuous Infusion” written on the Other Information section. If the dose is

likely to vary the dose should be annotated as “as per chart” on the Medicine Prescription Form and each dose change recorded on the additional paper Infusion Chart.

6.1.12 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 e.g.:

1g every four-six hours when required for pain, Maximum 4g in 24 hours

6.1.13 If it is necessary to use two paper Kardexes or Discharge Prescriptions for the same patient this should be clearly identified by annotating the Medicine Kardexes / Discharge Prescriptions with “1 of 2” and “2 of 2”.

6.1.14 When a patient is re-admitted, or transferred from another hospital where a shared case note record is not in place, a new Medicine Prescription Form (paper Kardex or electronic system) must be created. When a patient returns from pass or re-attends hospital for planned procedures at short intervals, the original Medicine Prescription Form may be used (as guided by local procedures). A review of the patient’s prescription records must take place on every admission to ensure it is appropriate and up-to-date.

6.1.15 Medicines are prescribed, or authorised for administration or supply, according to agreed local policies, formularies and stock lists.

6.1.16 Medicines used for research and clinical trials will have the appropriate management and ethics committee approval and must be prescribed on appropriate approved documentation or electronically in approved systems.

6.1.17 A record of all medicines prescribed and administered or supplied is maintained in the patient’s records (electronic or paper).

6.1.18 All medication prescribing errors or potentially serious ‘near miss’ events must be reported and investigated following agreed GGC processes.

6.1.19 Use of electronic systems can facilitate “remote” prescribing in certain clinical areas / situations. Local procedures should be followed and remote prescribing must only be used if it is in the patient’s best interests and the prescriber has all the clinical information required to make safe prescribing decisions e.g. –

- the patient’s current and past health status
- clinical evidence for the medicine / treatment being prescribed
- compatibility of any medicine being prescribed with other current medicine / treatment the patient is receiving (including self-purchased / administered medication).

Appropriate documentation must be kept (e.g. in the patient’s medical notes) to support remote prescribing decisions.

Controlled Drugs : Additional Requirements

6.1.20 If electronic prescribing is used then any CD IDL / pass prescription generated will need to meet the requirements for a CD prescription, including the addition of the following handwritten details - Printed name and signature by the prescriber, ward / dept name, hospital name and date.

6.2 Prescriptions for in-patients

6.2.1 Prescriptions must be generated electronically or written on approved stationery (e.g. the NHSGGC Medicine Kardex). The following policy statements apply to clinical areas / wards / theatres / departments using a combined prescription and administration style Medicine Prescription Form (in paper or electronic format). In areas using other styles of kardex local SOPs should be followed (which apply the core principles outlined in this document).

6.2.2 For in-patient prescriptions, the following patient details are required:

- Hospital.
- Ward or department.
- Patient's name.
- CHI number.
- Date of birth.
- Height.
- Weight.
- Known drug sensitivities (allergies and known or suspected adverse drug reactions)
- Medicine name, strength, form, dose route and times of administration.
- Date prescribed.
- Prescriber's name (and signature if paper forms used).
- Stop or review date for parenteral drugs (especially IV antibiotics).

6.2.3 The patient name must be visible on each page of any paper Medicine Prescription forms in use.

6.2.4 The start date for each entry must be clearly documented.

6.2.5 Medicines intended to be given once only must be prescribed in the "Once Only" section of the Medicine Kardex (or electronic equivalent).

6.2.6 'As Required' medicines must be prescribed in the "As Required" section of the Medicine Kardex or electronic equivalent. The indication for the medicine, minimum time interval between doses, dose, and the maximum dose that can be given in an appropriate time period (e.g. 24 hours) must be stated.

6.2.7 When a medicine is discontinued, this must be documented appropriately in electronic or paper systems (e.g. on the Medicine Kardex 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. A diagonal line should be made across the remaining days / columns. The date of

discontinuation should be recorded and the signature / initials of the person responsible for discontinuing the medicine).

6.2.8 When a paper Medicine Kardex has to be rewritten:

- Any item no longer required must be discontinued and a diagonal line drawn across each blank section /page of the old chart.
- For each medicine being continued, the original start date 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.

6.2.9 Individual entries on the paper Medicine Kardex must not be altered or amended. If a change is required, the entry must be cancelled completely and a new prescription entry must be written. The date of cancellation should be noted.

6.3 Prescriptions for discharge or pass medicine

6.3.1 For discharge (IDLs) and pass prescriptions (using approved paper or electronic systems) the following information must be included:

- Name of the hospital.
- Name, address and CHI number (or DOB if appropriate) of the patient.
- Consultant name.
- Ward or department.
- Date prescription written.
- Prescriber’s signature (electronic or “wet” signature as appropriate) and contact details of prescriber (e.g. page / phone number). The prescriber must print his/her name beside their signature if paper documents are used, initials are not acceptable.
- Name and address of the GP (if available).
- If issued by a dentist, the words “For dental use only”.
- Age and weight (if the prescription is for a child under 12).

6.3.2 The IDL / Pass Prescription must include details of all currently prescribed medicines. The information required must be accurately transcribed from the medicine prescription form (paper or electronic) and the patient’s medical notes.

6.3.3 The doctor or authorised prescriber responsible for the patient’s care must ensure that the IDL / Pass Prescription is completed in adequate time, taking account of the patient’s planned time and date of discharge.

6.3.4 Where deliberate changes are made from the entries on the medicine prescription form (paper or electronic) when prescribing medicines for discharge or pass this should be noted in the patient’s medical notes and medicine prescription form (paper kardex or electronic system) e.g. antibiotics discontinued at discharge as the course is complete. If these changes are

recorded it will expedite the discharge process and facilitate accurate communication between hospital and primary care professionals.

6.3.5 At least seven days supply of medicines will be provided, unless a longer or shorter course of treatment is appropriate. Where Patients Own Drugs / Making the Most of Your Medicines (MmyM) systems are in use the patient may receive original packs of dispensed medicines (which may be part-used at point of discharge if they were supplied and used during the in-patient period).

6.3.6 If the patient already has his or her own supply of required medicines at home or stored in the ward, an additional supply should not be issued from the hospital. The nurse / midwife / pharmacist / doctor/ pharmacy technician must annotate the IDL / pass prescription (paper or electronic) with “Patient’s own supply” and attach their initials to each entry, as appropriate. In doing so they are accepting that the patient has supplied reliable and accurate information on the medicines they have at home. If there is any doubt as to the validity of the information provided by the patient a fresh supply of all required medicines should be requested from pharmacy using an IDL / Pass prescription. In these circumstances, the patient (or their carer) should be asked to return all medicines stored at home to their local community pharmacy. All medicines currently prescribed for the patient must be written / added to the IDL / Pass prescription, regardless of whether or not a supply is needed.

6.3.7 If the medicines prescribed on the IDL / Pass Prescription change prior to the patient going home the IDL / pass prescription must be amended (following approved processes). This may include returning the originally dispensed medicines to the pharmacy team for re-dispensing.

6.3.8 If compliance with medication is identified as an issue during the in-patient period the patient should be assessed by medical, nursing, midwifery, pharmacy or AHP staff (following local procedures). If a compliance aid device is assessed as essential a suitable method of ongoing supply post-discharge must be organised (e.g. via a local community pharmacy). The IDL must be annotated appropriately (e.g. “New compliance aid device required. Ongoing supply arranged with XXXXX”). Patients already receiving medicines in compliance aid devices before admission to hospital must also have their IDL/Pass prescription appropriately annotated to ensure medication is dispensed and supplied appropriately.

Controlled Drugs: Additional Requirements

Please refer to the NHSGGC Therapeutics Handbook “Controlled Drug Prescribing” section (on ggcmedicines.org.uk site) for more information – link here.

6.3.9 A separate IDL / pass prescription is required for CD medication. More than one CD can be prescribed on the same IDL / Pass Prescription. This must be completed with all appropriate details as described in the link above, including the form and quantity to be suppled in WORDS AND FIGURES for each CD medicine. A "wet" prescriber name and signature is required on all IDLs / pass prescriptions containing CDs, in addition to the hospital name, ward/dept name and date in "wet" format by the prescriber.

6.3.10 Where possible, the clinical pharmacist should check the IDL/ pass prescription before it is sent to pharmacy to reduce the number of queries regarding prescriptions that are unclear, inaccurate or do not comply with prescribing regulations for CDs.

6.3.11 A pharmacist is allowed to make minor amendments to prescriptions for Schedule 2 and 3 CDs, providing the prescriber's original intention is clear. Minor amendments include correcting typographical or spelling mistakes and adding the quantity in either words or figures (where it is written in only words OR figures).

6.3.12 CDs will be supplied in compliance aid devices if deemed clinically appropriate (local SOPs will apply). IDLs / pass prescriptions must be appropriately annotated if this is required.

6.4 Prescriptions for out-patients / Patient Packs

Please refer to NHS GGC guidance on the Supply of Medicines Following Specialist Service Review or Clinic Appointments – link here (held on ggcmedicines.org.uk site).

6.4.1 Patients attending out-patient clinics will usually have changes in their medication / any new medication initiated by their GP on receipt of a communication from the hospital practitioner. Only in exceptional circumstances, where there is an immediate need to change medication or start new medicine, will the patient receive an initial supply from the hospital pharmacy. Medicines should be requested on approved stationery e.g. a Hospital Discharge Prescription form or electronic equivalent.

6.4.2 If a medicine is designated 'Hospital Supply Only' the patient will be unable to obtain supplies from their community pharmacy. The prescriber should prescribe the medicine on a Discharge Prescription (or electronic equivalent) in the first instance and then contact the local pharmacy department to discuss ongoing supply arrangements. Prescribers may also wish to retain responsibility for prescribing certain medicines (e.g. if the medicine is being used outwith its Product Licence and the GP will not accept prescribing responsibility). In these cases the prescriber should prescribe the medicine on a Discharge Prescription in the first instance and then contact the local pharmacy department to discuss ongoing supply arrangements.

6.4.3 Some clinic areas utilise ‘Patient Packs’ of commonly used medicines. If patient-pack arrangements are in place a Discharge prescription (or electronic equivalent) must be generated for all medication prescribed. This will ensure the patient’s GP receives full details of any medicines prescribed. A local record of patient-pack supplies must also be completed. Local processes will apply.

6.4.4 Hospital doctors, dentists and other suitably qualified prescribers may also prescribe medicines on Health Board Prescriptions (HBPs), which the patient must take to their community pharmacy to be dispensed. Local processes should be followed when using HBPs.

6.5 Prescriptions for clinical trial medicines

6.5.1 For out-patient supply of clinical trial medicines, a trial specific approved prescription form must be used and signed by a trial investigator.

6.5.2 If a patient is admitted on a trial medicine the patient’s own trial medicine should be used (if clinically appropriate) during the in-patient period. If further supplies are required for the patient these should be requested from the centre conducting the trial.

6.5.3 When medicines in clinical trials are prescribed for hospital in-patients the protocol number, patient number, the title of the trial and, if possible, the names of any potential medicines should be recorded on the Medicine Prescription form (paper kardex or electronic system) e.g. “ASA trial, Aspirin or placebo”. Supplies will be obtained by the investigator via the hospital pharmacy using approved clinical trial prescriptions / documentation / processes.

6.5.4 In-patients being discharged on a clinical trial medicine should have supplies organised by the investigator using approved documentation & processes. Trial medication should be included on the IDL / Pass Prescription (annotated as “Trial medicine – supplied by investigator”). Usually supplies will continue to be supplied from hospital, but if it is intended that the patient’s GP continues the trial medicine supplies, ensure that they have been informed via the trial-specific GP letter & process.

6.5.5 Clinical trial supplies can be supplied direct to patients at home e.g., via courier or postal service if the Sponsor permits it and they have risk assessed the product as suitable for this method of supply. The research team must contact the local clinical trials pharmacy team to arrange this.

Controlled Drugs: Additional Requirements

6.5.6 Trial CDs are covered by the same regulations as non-trial Controlled Drugs in addition to the requirements above to cover clinical trial regulations.

6.6 Prescriptions for injections and infusions

6.6.1 The parenteral route is potentially more hazardous than other routes of administration of medicines.

6.6.2 Medicines should be prescribed by injection only if no other route is suitable. For example:

- The medicine is not available for administration by another route, and there is no therapeutically equivalent medicine that could be used by another route, or
- The oral, naso-gastric, rectal or other possible route is not suitable, or
- The medicine needs to be administered by injection to achieve immediate effect or the required therapeutic level.

6.6.3 If an injection needs to be prescribed the prescriber must:

- Write a specific finishing date on the prescription (paper kardex or electronic equivalent or IDL), if appropriate, or
- Review it every 24 hours, if appropriate, and change to a potentially less hazardous route at the earliest opportunity (local SOPs should be adhered to where regular injections are prescribed over defined periods (e.g. depot injections) to ensure safety and continuity of supply and administration).