Good Prescription Writing Guidelines

1. Highland Joint Formulary (HJF)	• Please use/refer to the Highland Joint Formulary when choosing appropriate prescription. • Prescribers must be aware of the FORMULARY and LICENSE STATUS of any medicine prescribed and must comply with all policies relating to the supply of non-formulary medicines, refer to Formulary website on NHS Highland intranet.
2. Write legibly	Prescriptions should be : • in ink (or otherwise so as to be indelible) • dated • include the full name and address of the patient, and • signed in BLACK ink by the prescriber.
3. Age, Date of Birth and CHI Number	• These should always be stated. In the case of prescription-only medicines, it is a legal requirement to state the age for children under 12 years of age.
4. Dose	• Where possible, the dose must be stated in the International System of Units (SI Units). • Abbreviations for grams (g) ; milligrams (mg), millilitres (mL) and litres (L) may be used. • Micrograms, nanograms and units must be written in full. • The dosage from, dose, route, timing and frequency should be stated.
5. Frequencies and Routes of Administration	• These should be written in FULL.
6. Decimal Points	• AVOID unnecessary zeros and naked decimal points. • Decimal points should always have a number covering in front e.g. 0.5 mg and NOT .5 mg. • Decimal points should be clearly prominent and ideally, centred. • WHOLE numbers should be kept whole e.g. 5mg and not 5.0mg. • Quantities of 1 gram or more should be written as gram/grams. • Quantities less than 1 gram should be written as milligrams e.g. 500 mg. • Quantities less than 1 mg should be written in micrograms e.g. 100 micrograms, not 0.1mg.
7. As directed	AVOID writing 'as directed'.
8. Non-proprietary (Generic) Names	Recommended International Non-proprietary Names (ie generic names as they appear in the British National Formulary) should be used for a medicine and be written in full except for some combination preparations and some modified release preparations.
9. Abbreviations	Abbreviations should be avoided.
10. Weight or surface area	Where the weight or surface area is required to calculate a dose, write this on the prescription.
11. Administration	A medicine that is NOT CORRECTLY PRESCRIBED must not be administered if it is considered that following the prescribing instruction may be harmful to the patient.
12. Drug kardex	The drug *Kardex* MUST include the patient's • name • hospital number (or CHI number) • date of birth, and • weight and/or surface area (where dosage requires it).
13. Prescribers	Medicines must be prescribed on the appropriate PRESCRIPTION SHEET by a registered or provisionally registered medical practitioner, dentist, extended independent or supplementary prescriber.
14. Kardex prescriptions	• These must be DATED and WRITTEN LEGIBLY, TYPED or ELECTRONICALLY produced in indelible ink specifying the DOSAGE FORM, DOSE, ROUTE, TIMING and FREQUENCY with the prescriber's SIGNATURE and printed name for each item prescribed. • CARE must be taken to ensure correct section of form is used e.g. ONCE ONLY and PRE-MED REGULAR THERAPY or AS REQUIRED THERAPY.
15. Capitals	All written prescribing information on the Drug *Kardex* must be in capitals.
16. As required medicines	• For medicines prescribed on an 'as required' basis, abbreviations must NOT be used and DOSE, DOSAGE INTERVAL and INDICATION for the medicine should be clearly stated e.g. 500 mg every four hours for a headache when required. • MAXIMUM DOSE should be indicated, if appropriate.
17. Discontinuation	• To discontinue a medicine, the prescriber must draw a DIAGONAL LINE through the complete entry, enter the date in the 'stop date' box and initial it. • When an amendment to a prescription is needed, the item to be changed must be discontinued in the same way.
18. Prescription Sheets	• Not more than one prescription sheet should be used for each patient. Old prescription sheets should be cancelled by drawing TWO PARALLEL DIAGONAL LINES across them and writing CANCELLED. It should be authorised by the prescriber's SIGNATURE and DATE OF CANCELLATION. • A NEW SHEET should be used for each hospital admission.
19. Rewriting	If it is necessary to rewrite a prescription from the ORIGINAL START DATE for each item must be used.
20. Special Sheets	When special sheets (e.g. oral anticoagulants, insulin and continuous infusions) are in use, items must also be prescribed on the Drug *Kardex* with the dose stated AS CHARTED.
21. Allergy section	• An entry MUST be made in the Allergy/Drug sensitivity section. • Write either DRUG NAME or NIL KNOWN.

Medication Prescription Chart (Short Version)

NHS Highland

Name of Patient:

PATIENT LABEL

Date of Birth : Age:

Hospital Number: CHI :

Date of Admission: Consultant :

Ward : Chart no:.....of.....

Weight: (metric) Height: Surface area:

Additional prescribing Sheets in use (please also document within *Kardex)*

Name	Tick ✔
Warfarin	
Insulin	
Chemotherapy	
Dietary Supplements	
Total Parental Nutrition (TPN)	
Gentamicin	
Diazepam	
Heparin Infusion	
Epidural	
Syringe pump prescribing chart	

KNOWN DRUG SENSITIVITIES Circle below

No -nil known Yes - list below

KNOWN or SUSPECTED ADVERSE REACTION Circle below

No -nil known Yes - list below

MEDICINE	ADVERSE REACTION

ONCE ONLY AND PRE-MED (*NB Time must be in 24 hour format)

Date	Time*	Drug (Approved Name)	Dose	Route	Prescriber's Signature PRINT NAME	Time Given	Given By	Checked by (if app)
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			
					Sig: Print			

Name of Patient: PATIENT LABEL	
Hospital Number:	
CHI :	
Date of Birth :	Age:

REGULAR THERAPY

Weight if applicable.........................(metric)
Height if applicable..........................(metric)

***N.B. Time must be in 24 hour format**

			Date / Time*									
Drug (Approved Name)		Dose										
Route	Indication	Comments										
Start Date	Stop date Initial											
Signature	Name											

Drug (Approved Name)		Dose										
Route	Indication	Comments										
Start Date	Stop date Initial											
Signature	Name											

Drug (Approved Name)		Dose										
Route	Indication	Comments										
Start Date	Stop date Initial											
Signature	Name											

Drug (Approved Name)		Dose										
Route	Indication	Comments										
Start Date	Stop date Initial											
Signature	Name											

Drug (Approved Name)		Dose										
Route	Indication	Comments										
Start Date	Stop date Initial											
Signature	Name											

CODES

If a dose is not administered as prescribed, initial entry and then enter a code in the column with a circle drawn around the entry according to the reason as follows : (***Medical staff or prescriber contacted if appropriate)**

1. Patient refuses *
2. Patient not present on ward*
3. Medicine not available * - ORDER FROM PHARMACY (see table)
4. Instructions not clear or legal* - CLARIFY WITH PRESCRIBER
5. Patient self administered medicine - supervised as per Self Admin Policy
6. Nil by mouth*
7. Asleep/drowsy *
8. Unable to swallow*
9. Vomiting/nausea*
10. Time varied on Dr's instructions
11. Once only/as required medication
12. Dose witheld on Dr's instructions
13. No IV access*
14. Medication not required

To be specified in the Administration Comments section

15. possible drug reaction/side effect * 16. With held for clinical reasons 17. Other reason

Ordered Drugs (code 3)

Date	Drug	Inits

***NB Time must be in 24 hour format**

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date Initial		Date									
			Time*									
Signature	Name		Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date Initial		Date									
			Time*									
Signature	Name		Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date Initial		Date									
			Time*									
Signature	Name		Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date Initial		Date									
			Time*									
Signature	Name		Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date Initial		Date									
			Time*									
Signature	Name		Dose/Route									
			Initial									

Name of Patient: PATIENT LABEL	
Hospital Number:	
CHI :	
Date of Birth :	Age:

AS REQUIRED THERAPY

Weight if applicable.........................(metric)
Height if applicable..........................(metric)

CODES		Ordered Drugs (code 3)		
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***NB Time must be in 24 hour format**

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			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

Drug (Approved Name)			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date		Date									
	Initial		Time*									
Signature		Name	Dose/Route									
			Initial									

Date	ADMINISTRATION COMMENTS	Inits

Name of Patient:

PATIENT LABEL

Hospital Number:

CHI :

Date of Birth : Age:

REGULAR THERAPY

Weight if applicable.....(metric)

Height if applicable.....(metric)

CODES	Ordered Drugs (code 3)		
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***N.B. Time must be in 24 hour format**

***NB Time must be in 24 hour format**

Drug (Approved Name)		Dose	Date / Time*
Route	Indication	Comments	
Start Date	Stop date Initial		
Signature	Name		

Drug (Approved Name)		Dose	Date
			Time*
Dose	Route	Frequency & comments	Dose/Route
			Initial
Start Date	Stop date Initial		Date
			Time*
Signature	Name		Dose/Route
			Initial

Name of Patient: PATIENT LABEL	
Hospital Number:	CHI :
Date of Birth :	Age:

***N.B. Time must be in 24 hour format**

SYMPTOMATIC RELIEF POLICY

DRUGS MAY ONLY BE ADMINISTERED FROM THE SYMPTOMATIC RELIEF POLICY IF:

- **PATIENT IS OVER 16 YEARS OLD**
- **SYMPTOMATIC RELIEF HAS BEEN PRESCRIBED**
- **NURSING STAFF INVOLVED IN ADMINISTRATION HAVE COMPLETED THE TRAINING**

Maximum of two consecutive days per drug - otherwise contact prescriber

Medicine	Code	Main Indication	Dose	Route	Maximum per 24 hours per policy
Paracetamol	A	Mild to moderate pain only	Up to 1 gram, at least 4 hours apart	Oral/rectal	2 doses
Senna	B	Constipation	7.5 to 15 mgs	Oral	2 doses
Glycerol Suppositories	C	Constipation	1 to 2 suppositories	Rectal	2 doses
Sodium Citrate Enema	D	Constipation	1 enema	Rectal	1 enema
Oral Rehydration Salts	E	Diarrhoea	1 sachet	Oral	2 doses
Epaderm® Ointment	F	Dry skin emollient	Apply liberally	Topical	2 doses
Diprobase® Cream	G	Dry skin emollient	Apply liberally	Topical	2 doses
Peptac® Liquid	H	Indigestion	10 to 20 mls	Oral	2 doses

SYMPTOMATIC RELIEF POLICY

Exceptions (please circle)	Start date	Stop date Initial										
No Yes (please list)	Signature		Date									
			Time*									
			Code									
			Dose/Route									
			Initial									
	Name		Date									
	Comments		Time*									
			Code									
			Dose/Route									
			Initial									

AS REQUIRED THERAPY

Weight if applicable.........................(metric) Height if applicable..........................(metric)

***NB Time must be in 24 hour format**

Drug (Approved Name)												
			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date Initial		Date									
			Time*									
Signature	Name		Dose/Route									
			Initial									

Drug (Approved Name)												
			Date									
			Time*									
Dose	Route	Frequency & comments	Dose/Route									
			Initial									
Start Date	Stop date Initial		Date									
			Time*									
Signature	Name		Dose/Route									
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Ordered Drugs (code 3)

Date	Drug	Inits

Date	ADMINISTRATION COMMENTS	Inits

Name of Patient: PATIENT LABEL
Hospital Number:
CHI :
Date of Birth : Age:

REGULAR THERAPY

Weight if applicable.....(metric)
Height if applicable.....(metric)

CODES	Ordered Drugs (code 3)		
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Drug (Approved Name)		Dose	Time* / Date
Route	Indication	Comments	
Start Date	Stop date Initial		
Signature	Name		

Drug (Approved Name)		Dose
Route	Indication	Comments
Start Date	Stop date Initial	
Signature	Name	

Drug (Approved Name)		Dose
Route	Indication	Comments
Start Date	Stop date Initial	
Signature	Name	

Drug (Approved Name)		Dose
Route	Indication	Comments
Start Date	Stop date Initial	
Signature	Name	

Date	ADMINISTRATION COMMENTS	Inits