All Wales Prescription Writing Standards

These standards should be read in conjunction with completing the All Wales Medication Chart e- learning package, available on the Learning@NHSWales internet site (www.mle.wales.nhs.uk). Instructions to access may be found at http://www.learningindustries.com/content/659/all-wales-drug-chart/ They are based on national guidelines and legislation,

Section 1 : General Requirements

These apply to ALL prescriptions including in-patient charts, outpatient and take home prescriptions; and to any communications to General Practitioners regarding medication

- **All prescriptions must be written:**
  CLEARLY LEGIBLY INDELIBLY
  Out-patient and Take Home prescription forms should have only one item written on each line and additional prescription forms used if necessary.
  Any unused space on the prescription form should be deleted manually

- **Patient Identification & Details**
  The patient's full **name, address, date of birth and hospital number** must appear on all prescriptions.

  Age and weight must be stated on all **paediatric** (under 12 years) prescriptions.

- **Drug Name**
  The international approved drug name (rINN) must be printed in clearly, legibly and indelibly **so that each individual letter can be read.**

  Do not use chemical descriptions or abbreviations for drug names as they increase the risk of medication errors (*e.g. FeSO4, ISMN are not acceptable)*

  The bioavailability of some medications may vary between different brands, and should be prescribed by brand **name**; these drugs include:

Anti-epileptics (as per MHRA advice)		Ciclosporin	Diltiazem long acting formulations
Lithium	Mycophenolate	Nifedipine	Theophylline modified release
Tacrolimus			

  NB This list is not exhaustive.

  It will sometimes be appropriate to use the brand name, in addition to or instead of the approved name, for other medicines to avoid confusion (examples include insulin, some combination products and opioids with particular emphasis on transdermal preparations).

- **Formulation / Strength**
  Where different formulations and/or strengths of a preparation are available, it is important that details are correctly stated on the prescription e.g. modified release vs. immediate release tablets/capsules; transdermal opioid preparations.

- **Device**

  It is important to state the device required for medication such as insulin and inhalers to ensure the patient receives the correct product.

- **Drug Dose**

  The dose must be stated on all prescriptions
  Avoid unnecessary use of decimal points. e.g. 3mg (*not 3.0mg*)
  Quantities of 1 gram or more must be written as 1g etc.
  Quantities less than 1 gram must be written in milligrams e.g. 500mg *(not 0.5g)*
  Quantities less than 1 milligram must be written in micrograms e.g. 100micrograms *(not 0.1mg)*

  When decimal points are unavoidable, a zero must be put in front of the decimal point where there is no other figure e.g. 0.5ml *(not .5ml)*

  Micrograms, nanograms and **units** must be **written in full** and not abbreviated

  g (grams), **mL**(millilitres), and **mg** (milligrams) are acceptable abbreviations

  Doses of liquid preparation MUST be written as mg etc unless there is no equivalent. The **concentration** of liquid preparations must always be stated (e.g. Furosemide 20mg in 5ml, 40mg in 5ml or 50mg in 5ml). This is particularly important when prescribing for children.

  N.B. Be aware that there may be unlicensed preparations available in different strengths e.g. Phenytoin

- **Route**

  Specify the route of administration. Take care when prescribing for different routes as doses may not be equivalent, in which case separate prescriptions for each route must be written. (e.g. The intravenous dose of Morphine is one quarter to one half of the intramuscular dose, therefore separate prescriptions are required)

  Acceptable abbreviations are:

IV	intravenous	IM	intramuscular
SC	subcutaneous	PO / O	oral
NG	nasogastric	PEG	via peg tube
JEJ	via jejunostomy tube	S/L	sublingual
PR	rectal	PV	vaginal
Top	topical	INH	inhaled
NEB	nebulised	BE	both eyes
LE	left eye	RE	right eye

- **Directions**

  The dosage frequency must be stated on all prescriptions.

  For "as required" medications**,** a minimum dose interval must be specified, and where appropriate a maximum dose
  (e.g. Paracetamol 500mg tablets, one to two tablets every four to six hours when required, maximum 8 tablets in 24 hours, for the relief of pain or fever)

  The indication for any "as required" medication should also be stated..

  Directions should be in English without abbreviation; however the following Latin abbreviations are acceptable:

o.d.	daily	o.m. or mane	in the morning
b.d.	twice daily	o.n. or nocte	at night
t.d.s.	three times daily	stat	immediately
q.d.s.	four times daily		
p.r.n.	when required		

Where a limited course of treatment is required (e.g. steroids, antibiotics) this must be stated on the prescription.

Particular care must be taken when prescribing medication to be taken weekly, monthly etc. It is good practice to cross through the administration boxes on the In-patient chart to emphasise that the dose must only be administered on certain days.

When a drug is only administered monthly or 3 monthly, it is good practice to record when the last dose was given to ensure an accurate medicines trail.

- **Prescriber's Signature & Date**

  All prescriptions must be signed and dated by the prescriber with a bleep number or contact details supplied. Non-medical prescribers must annotate their signatures appropriately.

Section 2: Requirements for Prescribing and Recording Administration on the All Wales In-patient Medication Record charts

In addition to the above standards, the following apply to the All Wales Acute and Long Stay and Paediatric In-patient Medication Record charts.

A new chart must be written for each admission, and the chart discontinued (by crossing through the front page) when the patient is discharged.
(Local policies may allow for the continued use of the chart for weekend leaves and respite care)

Charts that are no longer in use (e.g. administration record is full) must be crossed through; signed and dated ensuring information on the chart is not obscured.

Patient's name and health record number must be stated on each page of the chart to reduce the risk of prescribing and administration error.

- **Allergy box**

  This section **must** be completed, signed and dated prior to administration of medicines.
  When an allergy is recorded, document as much information as possible regarding the details of allergy or reaction.
  Medication should not be administered if this section is not completed – refer back to the prescriber **immediately** to avoid doses being delayed or omitted.
  In exceptional circumstances, if unable to ascertain allergy status, this must be documented, signed and dated in the allergy box **and** the medical notes.

  Remember to update the box should any new reactions occur.

- **Hospital / ward / consultant**

  Details must be completed and kept up to date when changes are made.

- **Weight / Height / Body surface area**

  Current weight must be stated on all paediatric charts.
  Current weight should be included on adult charts when it is appropriate for medication dosage; e.g. low molecular weight heparins, IV paracetamol.
  Height should be stated when body surface area is used to calculate dosage.

- **Supplementary charts & multiple medication charts**

  Use these sections to record other medication charts in use. As a general rule, drugs prescribed on supplementary charts (e.g. Warfarin) should also be recorded on the main chart, with a reference to the supplementary chart on the prescription (see local policy)

  Multiple charts must be recorded as **1 of 2, 2 of 2 etc**

- **Venous Thromboembolism Assessment (VTE)**

  All patients must have the VTE section completed on the front of the medication chart. This section MUST be completed even if a separate assessment form has already been completed.

- **Once only medicines**

  All sections must be completed appropriately.
  Record times using 24-hour clock format.

- **As required medicines**

  All sections must be completed appropriately, including the indication, dose frequency; and where appropriate, the maximum dose in 24 hours should be identified.

- **Prescribing Regular Medications**

  Date

  Complete the month and year at the top of the chart.
  Date each prescription using the **original start date during this admission** (not the date when a chart is re-written)

  Route, dose & dose change

  Follow guidelines under general requirements above for prescribing doses and using abbreviations.

  The route of administration must be specified. Dual routes are NOT allowed e.g. IV/oral as the doses are frequently different for different routes.

  Prescribe the dose in the blue box next to the appropriate administration time.

  When specific times are required (e.g. antibiotics), write the times of administration in the beige boxes (adult chart) and pale green boxes (paediatric chart), using 24-hour clock format.

  When a dose change is required, cross through the whole original dose box and write the date of change, new route and new dose(s) in “dose change” column and initial the change.

  Only one change (dose and/or route) is allowed for each chart entry.

  Special instructions

  Details of administration, indication or special monitoring parameters may be entered here. This box should also be used to identify the reason for temporarily withholding doses.

- **Oxygen Section**

  This section must be completed when a patient requires oxygen therapy. Oxygen is a prescription only medicine and must be prescribed. Circle the required saturation range as per the instructions on the chart.

- **Discontinuation**

  When a medicine is discontinued this must be clearly indicated by marking a Z through the drug name and the end of the treatment. The discontinuation order must be signed and dated.

  Limited courses of treatment (e.g. antibiotics, steroids) should have a bar line marked on the chart to indicate the end of treatment, and when the course is finished the prescription should be crossed through as above.

- **Pharmacist check box**

  A pharmacist's signature in this box indicates that the prescription has been screened for accuracy and appropriateness. The pharmacist must date their entry. Any annotations must comply with the All Wales standards document.
  The supply box is used to record details of dispensing.

- **Administration and non-administration codes**

  If a dose of medication is not administered for any reason, the appropriate code must be entered on the chart, and an entry made in the patient's records as appropriate. (See local policy regarding obtaining supplies of unavailable medication)
  If the prescriber requires a dose to be omitted, a cross must be entered in the appropriate box, and the reason documented in the medical notes.

- **Intravenous & subcutaneous infusions**

  Each section allows for up to three administrations against one prescription for continuous infusions. The prescriber must initial the appropriate box (blue on adult chart, white on the new paediatric chart) to indicate that a continuous infusion is required. If the prescriber does not initial this section, the infusion must not be repeated.

Quality and Safety group of Welsh Chief Pharmacists Committee January 2014