NHS
Mid and South Essex
NHS Foundation Trust

Document Title:	**PRESCRIBING OF MEDICINES FOR INPATIENT USE**		
Document Reference/Register no:	08084	**Version Number:**	5.0
Document type: (Policy/ Guideline/ SOP)	Policy	**To be followed by:** (Target Staff)	Clinical Staff
Ratification Issue Date: (Date document is uploaded onto the intranet)	1 April 2020	**Review Date:**	31 March 2023
Developed in response to:	Department of Health Medicines Regulations NHSLA Risk Management Standards		
Contributes to HSC Act 2008 (Regulated Activities) Regulations 2014(Part 3); and CQC Regulations 2009 (Part 4) **CQC Fundamental Standards of Quality and Safety:**			9
Issuing Division/Directorate:	Pharmacy		
Author/Contact: (Asset Administrator)	Maria Richards, Principal Clinical Pharmacist, Emergency Care		
Hospital Sites: (tick appropriate box/es to indicate status of policy review i.e. joint/ independent)	✓ Mid Essex Hospital Services NHS Trust (MEHT) □ Basildon and Thurrock University Hospitals NHS Foundation Trust (BTUH) □ Southend University Hospital NHS Foundation Trust (SUHT)		
Consultation:	(Refer to page 2)		
Approval Group / Committee(s):	Medical Optimisation & Medicines Safety Group	**Date:**	26 February 2020
Professionally Approved by: (Asset Owner)	Alison Felton, Head of Pharmacy	**Date:**	14 January 2020
Ratification Group(s):	DRAG Chair's Action	**Date:**	26 March 2020
Executive and Clinical Directors (Communication of minutes from Document Ratification Group	**Date:** April 2020	**Distribution Method:**	Trust Intranet/ Internet

Consulted With: *this must include **Pharmacy** if the document has any reference to medication*	**Post/ Approval Committee/ Group:**	**Date:**
Jo Myers	ADoN Burns, Plastics and Outpatients	26 February 2020
Dr Subrahmanyam Peddasomayajula	Rheumatology Consultant	26 February 2020

Related Trust Policies (to be read in conjunction with)	Investigating & Learning from Incidents Policy, Reporting of Medication errors Near misses and Adverse drug reactions 06021 Injectable Medicines Policy 09060 Controlled Drug Policy 08083 Non Medical Prescribing Policy 07049 Risk Management Policy Self Prescribing Policy 10034

Document Review History:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ Record documents superseded by:**	**Issue Date:**
1.0	Rosemary Oakley		June 2009
2.1	Lesley Stuart		May 2012
3.0	Lesley Stuart	Appendix 1 added	November 2012
3.1	Lesley Stuart	Section 5.23 amended	January 2013
4.0	Lesley Stuart		March 2013
4.1	Lesley Stuart	6 month extension request due to MSB standardisation	April 2013
4.2	Sarah Ferguson	4 month extension request due MSE standardisation	22 November 2019
5.0	Maria Richards	Full review	1 April 2020

Contents

1 Introduction

1.1 This policy describes the requirements for prescribing medicines for administration to in-patients.

2 Scope

2.1 Medicines for administration to patients within the Trust can only be prescribed by persons authorised to do so and who are employed by the Trust to undertake this role. Those authorised include doctors, dentists, independent and supplementary prescribers (refer to the policy for non-medical prescribing for specifics of what may be prescribed by whom in this category).

2.2 Provisionally registered medical practitioners may prescribe for in-patients and medicines for leave or discharge, but may not prescribe for private patients, A&E patients, out-patients, themselves, colleagues or members of their families.

2.3 Medical students are not permitted to prescribe under any circumstances. Refer also to the Controlled Drugs Policy for prescribing restrictions.

3 Definitions

TERM	DEFINITION
A & E	Accident and Emergency
PMAR	Patient medication administration record
NKDA	No known drug allergy
NICU	Neonatal intensive care unit
PRN	When required
rINN	Recommended International Non-proprietary Name
EDL	Electronic discharge letter
MO & MSG	Medicines Optimisation and medication safety group
TTA	To take away

4 Roles and Responsibilities

4.1 **Role & Responsibilities of Individuals within the Trust**
Duties Are:

- Deputy Chief Pharmacist/ Head of Pharmacy to oversee the implementation;
- Pharmacists and pharmacy technicians to ensure adherence to the policy and raise any issues as appropriate;
- Nurses are to ensure adherence to policy;
- Clinicians are to ensure adherence to policy;

5 Process for prescribing medicines for inpatients

5.1 All prescriptions for medicines for administration to inpatients must be written on the Trust approved *Prescription and Medication Administration Record* (PMAR) card i.e. drug chart (paediatric and neonatal specialities see separate chart). The PMAR must be fully completed. All patient details including hospital number, surname, first name, date of birth, allergy status, name of consultant and current ward must be completed on the front page. Name and allergy information must be completed on pages 2 and 15 (plus 16 if in use). This will ensure that patient details can be seen whenever prescribing or administering medication.

5.2 Every attempt should be made to establish the allergy status of every patient; this should be recorded on the PMAR on pages 1, 2 and 15 (16 if in use) except babies in the Neonatal Intensive Care Unit (NICU) and maternity wards. In the event of a neonate in NICU/maternity wards exhibiting an adverse reaction to a particular drug, the drug sensitivity box must be completed immediately. If the patient has no known allergies this should also be recorded (the abbreviation NKDA is acceptable). Where a patient reports an allergy to a medicine, the nature of this allergy should be recorded. ***In all cases the practitioner completing the allergy status box should sign and date.*** Except in emergency situations, medications should not be administered to the patient unless the allergy status has been completed on the PMAR.

5.3 Regular subcutaneous insulin is to be prescribed on p10. Intravenous insulin is to be prescribed on p11. Tick variable rate (most clinical areas) or fixed rate (currently GICU/GHDU only). Sign and date initial insulin prescription. Decide on frequency of blood tests. Ensure usual long-acting insulin is prescribed on p10 even when intravenous insulin is prescribed.

5.4 Bolus doses of heparin for vascular or plastic surgery patients should be prescribed in the allotted space on the infusion chart if required; additional doses should be prescribed on the front as a “once only dose” or on the PRN medications with specific instructions. Heparin infusions should be prescribed on p14.

5.5 The prescription must be signed and dated by the prescriber in indelible ink (blue or black) to legalise the prescription. For further information on prescribing by non-medical prescribers see the Trust policy for non-medical prescribers.

5.6 Where possible, prescribers should use the recommended International Non-proprietary Name (rINN).

5.7 Prescriptions must be legible and in BLOCK CAPITALS or type written. If there is any doubt about the intention of a prescription, the nurse will not attempt to guess and will not administer the medication.

5.8 Great care must be taken when specifying strengths. Note the following:

- The unnecessary use of decimal points should be avoided;
- Never use a terminal zero (e.g. 5g not 5.0g);
- Quantities of 1 gram or more should be written as 1g etc;

- Quantities less than 1 gram should be written in milligrams (e.g. 500mg, not 0.5g);
- Quantities less than 1mg should be written in micrograms (e.g. 100microgram, not 0.1mg);
- Micrograms and nanograms must be written in full;
- When the use of a decimal is unavoidable, a zero should always be written in front of the decimal point where there is no other figure (e.g. 0.5ml not .5ml).

5.9 When calculations are involved in determining a dose, the calculation must always be double-checked by a second person (e.g. doctor, nurse or pharmacist).

5.10 For children, the age, weight and intended dose in mg/kg should be included on all prescriptions for medicines of high risk.

5.11 English must be used unless there is an accepted Latin abbreviation.

5.12 Instructions about the route, dose and frequency must be specific and not left as alternatives i.e 1 or 2, except for PRN medications where it may be appropriate to prescribe a dose range.

5.13 Where appropriate, the intended duration of treatment should be stated.

5.14 Prescriptions for antibiotics **must** give an intended duration of treatment, and an annotation must be made in the patient's medical notes and on the antibiotic section of the drug chart stating indication and duration of treatment. Antimicrobials should be prescribed in accordance with the hospital formulary, which may be found on the Trust Intranet. Prescriptions for antimicrobials are valid for 5 days only and should be rewritten if still indicated after this time.

5.15 "As required" prescriptions must be dated, and state a maximum frequency and minimum dose interval.

5.16 Medication must be reviewed every two weeks or sooner if necessary, and a new PMAR written.

5.17 When a medication is to be stopped, the prescription must be cancelled clearly, signed and dated and an explanation written in the patient's medical records detailing the decision for stopping the medicine.

5.18 Ideally, a prescription **must not** be changed without completely re-writing it, as this has been demonstrated to be a major source of error. It may be appropriate in some circumstances for a prescription to be changed without rewriting it. If this is deemed necessary, the prescription **must** be clear (see points above) and the date of change must be documented alongside the initials of the practitioner making the change. It must be clear what has been received for any doses already administered prior to the change/amendment.

5.19 A new PMAR must be written on each occasion that a patient is admitted or re-admitted after discharge. Patients going on home leave (e.g. over a weekend) are not discharged but have their admission suspended.

5.20 Medicines for patients to take home (TTAs) will only be supplied against a prescription presented on an appropriately completed Electronic Discharge Letter (EDL) and signed by either:

- The responsible medical practitioner;
- An independent prescriber;
- Supplementary prescriber (with CMP attached).

5.21 Medication will normally only be supplied or administered on the direction of an authorised prescriber. Nurses may supply or administer some medicinal products within the terms of an agreed patient group direction (PGD) or a local protocol. Other clinicians may also operate under the terms of a PGD or local protocol.

5.22 There **must be NO** verbal orders for sedatives or antipsychotics, with the exception of ITU patients. (See appendix 2).

5.23 All chemotherapy (oral, intravenous, intramuscular, intrathecal or intravescial) intended for the treatment of malignant disease, may only be prescribed or administered by an appropriately trained consultant or non medical prescriber. For further information on prescribing chemotherapy for malignant disease, please contact the oncology pharmacist.

5.25 Provisionally registered (FY1) medical practitioners **must** not prescribe, transcribe or administer oral, intravenous, intramuscular, intrathecal or intravescial chemotherapy intended for the treatment of malignant disease.

5.24 Where medicines are prescribed in the form of a skin patch, the prescriber should state the frequency of change. Each patient with a skin patch should have a 'transdermal patch application record' (see Appendix 1) and this should be completed as per the directions on the form.

5.25 Abbreviations of medicine names **must not** be used as interpretations can differ.

5.26 When a medicine is prescribed in ***standard units*** (e.g. insulin, heparins, some vitamins) *units* should be written in full, and not abbreviated in any way.

6 Monitoring and Audit

10.1 Each document must outline the Trust's process of monitoring compliance with, and the effectiveness of the document's main points.

10.2 Significant prescribing errors identified which have caused or have potential for serious harm or death will also be reported in accordance with the Trust's Incident Policy via the Datix system and reported to MO&MSG.

10.3 Key learning points will be disseminated by a Drug Safety Bulletin every 2 months.

Aspect of compliance or effectiveness being monitored	Monitoring Method	Individual department responsible for the monitoring	Frequency of the monitoring activity	Group / Committee / forum which will receive the findings/monitoring report	Committee / individual responsible for ensuring the actions are completed
Prescribing and administration of medicine	Routine ward visits and reviewing charts in the pharmacy dispensary	Pharmacy	Ongoing	Medicine optimisation and medication safety group	Clinical Pharmacist

7 Implementation and Communication

7.1 Once professionally approved and ratified by DRAG this policy will be placed on the Trust's intranet and highlighted via the Trust's staff newsletter.

7.2 This policy will be referred to during the medicines management session delivered to junior doctors by the pharmacy department at their induction.

7.3 Areas of this policy relevant to nursing staff will be addressed at the mandatory medicines management training for nurses delivered by the pharmacy department.

8 Equality Impact Assessment

8.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.
(Refer to Appendix 2)

9 References

Adult drug prescription and administration booklet launched 2013

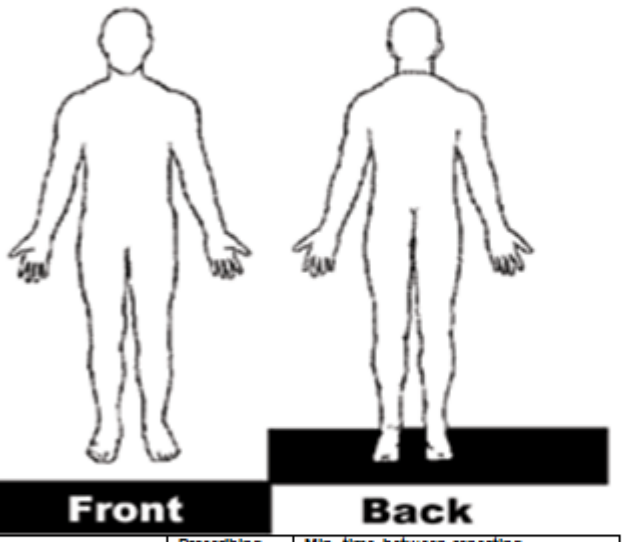
Appendix 1: Transdermal patch record

Transdermal Patch Application Record

WARD	
SURNAME	First Name
DOB	
NHS/ HOSPITAL NUMBER	
Name and strength of patch prescribed on drug chart	

INSTRUCTIONS FOR USE

1. Write the date of application on the patch prior to application.
2. Check the patient information leaflet inside the box for individual patch placement instructions/requirements.
3. Record the site of application on the body diagrams below.
4. Clearly number each site 1 to 14
5. Record and sign the date and time of application in the corresponding numbered boxes opposite marked 'on'. Record and sign the date and time of removal in the corresponding number boxes opposite marked 'off'.



Application		On	Off
1	Initials		
	Date		
	Time		

Application		On	Off
2	Initials		
	Date		
	Time		

Application		On	Off
3	Initials		
	Date		
	Time		

Application		On	Off
4	Initials		
	Date		
	Time		

Application		On	Off
5	Initials		
	Date		
	Time		

Application		On	Off
6	Initials		
	Date		
	Time		

Application		On	Off
7	Initials		
	Date		
	Time		

Patch	Prescribing frequency	Min. time between repeating application site
Fentanyl	72 hourly	7 days
Buprenorphine - BuTrans	Weekly	3 weeks
Buprenorphine - Transtec	96 hourly	1 week
Rivastigmine - Exelon	Daily	14 days
Rotigotine - Neupro	Daily	14 days
HRT	Depends on patch. Check SPC.	7 days.
NRT	16hourly or 24hourly	Consult product literature (2-7 days)
Oxybutynin - Kentera	Twice weekly	7 days
GTN	24 hourly	7 days (NB. If using to reduce phlebitis whilst administering PN, repeated site usage is appropriate)
Lidocaine	12 hours on/12 hours off	No need to rotate the site of application
Hyoscine	72 hourly	Apply to hairless area behind ear every 3 days (alternate ear). (NB. can be applied to the abdomen if a decrease in absorption is desirable)

Appendix 2 – Verbal policy exceptions (sections 5.23) applicable to GICU only

1.0 Verbal Instruction Policy

1.1 Verbal instructions may be used to authorise the administration or discontinuation (permanent or temporary) of a prescribed treatment.

1.2 Verbal instructions should be infrequent and can only be accepted in exceptional circumstances; faxed instructions are preferable to verbal instructions, but when received they should initially be treated as verbal instructions.

1.3 Verbal instructions are **not** acceptable for discharge medication (TTAs). In exceptional circumstances, if the prescriber is not available, a verbal instruction may be given directly by the prescriber to a pharmacist for dispensing

1.4 Verbal instructions are acceptable for schedule 2 or 3 controlled drugs within Critical Care.

1.5 Verbal instructions are acceptable for sedative and antipsychotic drugs within Critical Care.

1.6 An exceptional circumstance is one where it is critical that the patient receives the medication immediately and the prescriber is detained or unable to complete a prescription due to treating the patient.

1.7 Verbal instructions are subject to the following conditions:

- The person receiving the verbal instruction and acting on it must be a senior nurse (band 6 or above) within Critical Care
- The verbal instruction must be recorded as a “verbal order” event on Metavision.

2.0 Verbal instructions for the administration of a medicine

2.1 The registered nurse taking the verbal instruction should repeat the order back to the consultant/doctor clearly stating the patient’s name, drug and dose. When administering the drug, the RN should clearly state the drug, concentration in mg/ml, and the dose being administered.

2.2 Following administration of medication, a verbal order ‘event’ should be used on Metavision and the time, drug, dose, nurse's name and name of doctor who gave the verbal order should be included in the comments section in order to provide documentation of the verbal instruction. The prescription should be written as soon as practically possible.

2.3 A verbal instruction initiating the administration of a medicine is valid for **one** dose only.

2.4 The time, date and initials of the person administering the medicine must be recorded in the normal way.

2.5 The prescriber must sign the prescription as soon as possible and always within 24hours.

3.0 Verbal instructions for the cancellation or suspension of the administration of a drug

3.1 If the verbal instruction is for the temporary suspension of administration, a verbal order ‘event’ should be completed and the prescription cancelled as soon as possible but within 24 hours by a medical practitioner.

3.2 The instruction must be read back to the prescriber confirming the patient’s name, the medicine, the dosage, and the duration for which the discontinuation is valid.

Appendix 3: Preliminary Equality Analysis

This assessment relates to: Prescribing of medicines to inpatients / 08084

A change in a service to patients		A change to an existing policy	X	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	Answers
1. What are you proposing to change?	Pharmacy may supply medicines even if allergy status has not been completed. Verbal orders for sedative, antipsychotic, and schedule 2 and 3 controlled drugs in critical care only.
2. Why are you making this change? **(What will the change achieve?)**	Prescriptions may be altered in some cases if the intention is clear and the change is dated and signed. Allows timely administration of all drugs in ITU.
3. Who benefits from this change and how?	Prevents delay in supply of treatment. Allows pharmacists to amend prescriptions when deemed necessary (e.g. to complete medicines reconciliation). Prevents delays in critical medicines in ITU.
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	Patients will benefit by receiving the correct treatment in a timely manner.
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Yes; Refer to pages 1 & 2

Preliminary analysis completed by:

Name	Maria Richards	**Job Title**	Principal Pharmacist	**Date**	24 January 2020