PRESCRIBING OF MEDICINES POLICY

This is a working document and any changes that become necessary to this policy must be notified in writing to the Medicine Management Group via the Chief Pharmacist, East Cheshire Trust

The Medicines Management Group
Version 2.0: February 2017
Review: August 2019
<table>
<thead>
<tr>
<th>Policy Title:</th>
<th>Prescribing of Medicines Policy</th>
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<tbody>
<tr>
<td>Executive Summary:</td>
<td>This policy provides guidance to all staff in East Cheshire NHS Trust regarding all aspects of prescribing of medicines.</td>
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<tr>
<td>Supersedes:</td>
<td>Version 1 of Prescribing of Medicines Policy</td>
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<tr>
<td>Description of Amendment(s):</td>
<td>No major amendments</td>
</tr>
<tr>
<td>This policy will impact on:</td>
<td>All health professionals involved in the prescribing, supply, administration and handling of medicines</td>
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<tr>
<td>Financial Implications:</td>
<td>Financial impact to release staff time to address training needs.</td>
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**Policy Area:** Medicines Management  
**Document Reference:** ECT002710

<table>
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<tr>
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<td>Effective Date:</td>
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<tr>
<th>Issued By:</th>
<th>Chair of Medicines Management Group</th>
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<table>
<thead>
<tr>
<th>Author:</th>
<th>Chief Pharmacist</th>
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<tr>
<td>Impact Assessment Date:</td>
<td>December 2016</td>
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### APPROVAL RECORD

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<th>Committees / Group</th>
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<tr>
<td><strong>Consultation:</strong></td>
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<tr>
<td>Specialist Advice (if required)</td>
<td>February 2017</td>
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<tr>
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<td>February 2017</td>
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<td>Medical Director</td>
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<td>Director of Nursing, Performance &amp; Quality</td>
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<td><strong>Received for information:</strong></td>
<td>February 2017</td>
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<td>Trust SQS Committee</td>
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# POLICY FOR THE PRESCRIBING OF MEDICINES

<table>
<thead>
<tr>
<th>Table of Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 INTRODUCTION</td>
<td>4</td>
</tr>
<tr>
<td>1.1 Policy Statement</td>
<td>4</td>
</tr>
<tr>
<td>1.2 Definitions</td>
<td>4</td>
</tr>
<tr>
<td>1.3 Organisational Responsibilities</td>
<td>4</td>
</tr>
<tr>
<td>1.4 Planning and Implementation</td>
<td>5</td>
</tr>
<tr>
<td>1.5 Measuring Performance</td>
<td>5</td>
</tr>
<tr>
<td>1.6 Legislation</td>
<td>6</td>
</tr>
<tr>
<td>1.7 Audit</td>
<td>6</td>
</tr>
<tr>
<td>1.8 Review</td>
<td>6</td>
</tr>
<tr>
<td>1.9 Training</td>
<td>6</td>
</tr>
<tr>
<td>1.10 Dignity, Equality and Diversity</td>
<td>7</td>
</tr>
<tr>
<td>2 PRESCRIBING MEDICINES</td>
<td>8</td>
</tr>
<tr>
<td>2.1 Who may prescribe?</td>
<td>8</td>
</tr>
<tr>
<td>2.2 Writing Prescriptions</td>
<td>8</td>
</tr>
<tr>
<td>2.3 Prescribing for In-Patients</td>
<td>10</td>
</tr>
<tr>
<td>2.4 Prescribing Discharge Medicines (TTOs)</td>
<td>11</td>
</tr>
<tr>
<td>2.5 Prescribing for Outpatients</td>
<td>11</td>
</tr>
<tr>
<td>2.6 Prescribing by Non-Medical Prescribers</td>
<td>12</td>
</tr>
<tr>
<td>2.7 Prescribing Controlled Drugs</td>
<td>12</td>
</tr>
<tr>
<td>2.8 Unlicensed Medicines</td>
<td>13</td>
</tr>
<tr>
<td>2.9 Clinical Trials</td>
<td>13</td>
</tr>
<tr>
<td>2.10 Verbal Instruction</td>
<td>13</td>
</tr>
<tr>
<td>2.11 Transcribing</td>
<td>14</td>
</tr>
<tr>
<td>2.12 Clinical pharmacy screening</td>
<td>14</td>
</tr>
<tr>
<td>2.13 Chemotherapy/ Cytotoxic Drugs</td>
<td>15</td>
</tr>
<tr>
<td>2.14 Prescribing Injectable Medicines</td>
<td>16</td>
</tr>
<tr>
<td>2.15 Prescribing Errors</td>
<td>17</td>
</tr>
<tr>
<td>2.16 Prescribing for self/family</td>
<td>17</td>
</tr>
<tr>
<td>2.17 Prescribing thromboprophylaxis</td>
<td>18</td>
</tr>
<tr>
<td>2.18 Prescribing antibiotics</td>
<td>18</td>
</tr>
</tbody>
</table>
1 INTRODUCTION

1.1 Policy Statement

The prescribing of medicines for patients is the most common intervention made as part of the treatment provided to patients during a hospital admission. Medicines are prescribed to promote health, healing and/or well-being of patients. They can, however, be harmful to patients if prescribed, dispensed or administered incorrectly or if patients suffer adverse reactions. Medicines must be prescribed in a manner which is clearly understood by the prescriber, pharmacist and practitioner administering the medication. The prescriber must not prescribe medicines beyond their competence. This policy informs all staff on the principles of prescribing. These should be adhered to by all Trust staff.

Where a referral for an opinion to another team has taken place, the team in charge of the patient should normally prescribe any recommended treatment changes.

Where patient care is devolved to specialist areas such as Critical Care Units, clinicians to whom an opinion has been asked for via a referral must write clinical recommendations in the medical notes and discuss these with the duty doctor who will then amend the prescription charts as appropriate.

1.1.2 The purpose of this policy is to:

- Provide guidance to all Trust staff on the procedures relating to the prescribing of medicines.
- To provide a governance framework for this element of medicines management in the Trust, thereby improving patient safety.

1.2 Definitions

1.2.1 Medicines Management

Medicines Management in hospitals encompasses the entire way that medicines are selected, procured, delivered, prescribed, administered, and reviewed to optimise the contribution that medicines make to producing informed and desired outcomes of patient care (Audit Commission 2001).

1.2.2 Registered Nurse

Throughout this policy a registered nurse is taken to mean any nurse, midwife and specialist community public health nurses who are registered with the NMC (http://www.nmc-uk.org/Registration/Useful-information/Registration-qualifications/)

1.3 Organisational Responsibilities

1.3.1 Chief Executive

Has ultimate responsibility for the implementation and monitoring of the policies in use in the Trust. This responsibility may be delegated to an appropriate colleague.
1.3.2 Medical Director
Has Trust Board responsibility for all aspects of medicines management. The Medical Director is responsible for reporting any medicines management issues identified to the Trust Board.

1.3.3 Chair of Medicines Management Group
The Chair of the Medicines Management Group has responsibility for co-ordinating the activities of the Medicines Management Group to ensure that good practice relating to medicines, as described in this policy, becomes embedded in to everyday working practice across the Trust. The Chair will raise any medicines management issues at the Trust SQS Committee.

1.3.4 Chief Pharmacist
The Chief Pharmacist has responsibility for ensuring the Trust complies with local and national guidance relating to medicines, and to ensure the Business Units are fully informed of their role in maintaining the required standards of practice relating to medicines.

1.3.5 Directorates
It is the responsibility of the Clinical Directors and Associate Directors to ensure that all staff are trained to carry out the tasks required of them in the prescribing, administration and management of medicines.

1.3.6 Ward / Department Managers
Responsibility for the operational implementation of the Medicines Policy, including ensuring staff within their ward / department attends appropriate training.

1.3.7 All Prescribers
This policy applies to all Trust staff involved in the prescribing of medicines.

1.4 Planning and Implementation

2 This policy has been circulated to the Clinical Directors for comment
3 The policy will be approved by the Medicines Management Group (MMG).
4 The policy will be uploaded onto the Trust internet and an email containing a link to the policy will be sent to all staff.
5 It is the responsibility of the ward and department managers to inform their staff of the changes in the policy.
6 All staff groups involved in the prescribing of medicines should receive training related to medicines management. The training should be tailored to the requirements of the staff group involved.

1.5 Measuring Performance

The Trust may be measured for compliance with NHSLA standard C4 criteria 6, and by the Care Quality Commission.
1.6 Legislation

This policy complies with all relevant legislation and guidelines that are considered to be good practice which relate to the prescribing, supply, storage, security and administration of medicines.

1.7 Audit

East Cheshire NHS Trust recognises its responsibility to check practice in adherence to all trust policies including ‘The Safe and Secure Handling of Medicine Policy’ through audit. Aspects to be audited as part of a rolling audit programme should include:

- Prescribing: For example clearly written, use of approved/appropriate brand drug name and clear instructions of dose, route, form, strength
- Patient details: For example name, hospital number, ward, consultant, age, weight, documented hypersensitivities/allergies
- Clinical: Drug prescribing should be audited to ensure compliance with Trust prescribing guidelines
- Non-medical prescribing: Prescribing - as above
  - Registered list of non-medical prescribers
  - Completed approval to practice forms
  - Documented parameters of prescribing

All audits should be registered with the Trust Department for Clinical Effectiveness. Audit results should be discussed by the Medicines Management Group to identify areas of good and poor practice, and to highlight training needs.

A Medicines Management report will be submitted to the Trust SQS Committee twice a year.

1.8 Review

It is the responsibility of the Medicines Management Group to review and amend this policy. This policy will be reviewed and up-dated every 2 years. The review of the policy will include feedback from the performance review, audit and training related to the policy.

1.9 Training

All staff groups involved in the prescribing of medicines should receive training related to medicines management. The training should be tailored to the requirements of the staff group involved. Aspects of training should include:

- All groups of staff involved in the prescribing of medicines should receive a medicines management training session as part of their induction
• Training specifically for medical staff should include sessions about various aspects of medicines management - delivered as part of the F1/F2 training programme
• Training specifically for non-medical prescribers: completion of level 3 / 4 Non-Medical Prescribing Course prior to commencing supplementary / independent prescribing

Training needs specifically tailored to individuals, or departments, may be identified following a review and identification of trends from the Trust Drug Incident Reporting scheme.

1.10 Dignity, Equality and Diversity

This policy has been impact assessed with regards to dignity, equality and diversity with respect to patient’s age, choices, lifestyle and cultural / religious beliefs (see appendix one).
2 PRESCRIBING MEDICINES

2.1 Who may prescribe?

2.1.1 Medical staff, licensed to practice with the General Medical Council, are responsible for the majority of prescribing of medicines for patients. They must comply with appropriate legislation, the Medicines Policy and professional guidance when prescribing.

2.1.2 Nurses and other Healthcare Professionals who have successfully completed the appropriate nationally recognised prescribing course and are registered with their professional body as a person qualified to prescribe, and are Trust approved non-medical prescribers may prescribe according to their designation of supplementary or independent prescriber in accordance with the Trust Non-Medical Prescribing Policy.

2.1.3 Dentists who are licensed to practice by the General Dental Council. Dental practitioners are restricted to prescribing from the Dental Practitioners Formulary contained within the BNF.

2.1.4 Medical students are not permitted to write prescriptions. Medical staff with limited registration are permitted to prescribe only for inpatients within the speciality in which they are employed, under the supervision of a consultant.

2.2 Writing Prescriptions

2.2.1 General

2.2.1.1 Only approved Trust prescriptions may be used, which includes:

- In-patient medicine chart
- Critical Care in-patient prescription chart
- Discharge prescription (including electronic discharge prescriptions)
- Out-patients prescription
- Home Intravenous Therapy Service (HITS) prescription
- Haemodialysis medication chart
- Insulin prescription chart
- Chemotherapy prescriptions (including Chemocare electronic prescriptions)
- Contacts of meningococcal disease
- GUM Clinic/ Antiretroviral prescription
- Alcohol withdrawal prescription chart
- Epidural Chart
- PCA Chart
- TPN prescription
- FP10 forms (community)
- FP10 (HP) forms
- Emergency Department card, major trauma proforma, Acute cardiac (thrombolysis) proforma
- Community prescribing and administration charts

2.2.1.2 All prescribers should remember that they alone take clinical, professional and legal responsibility for all prescriptions they sign.
2.2.1.3 All prescriptions must:

- Be printed clearly in indelible black ink
- Be accurate and unambiguous
- Use English instructions where appropriate
- Avoid abbreviations of medicine names
- State the form, strength, metric dosage (see 2.2.1.4), route of administration, frequency and time (24 hour clock) of doses. The dose interval and maximum number of doses in the treatment period should be specified for ‘as required’ medicines

<table>
<thead>
<tr>
<th>Acceptable abbreviations for frequency of administration</th>
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<tbody>
<tr>
<td>AC</td>
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<tr>
<td>Before food</td>
</tr>
<tr>
<td>BD</td>
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<tr>
<td>BD</td>
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<tr>
<td>OM</td>
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<tr>
<td>OM</td>
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<tr>
<td>PRN</td>
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<td>PRN</td>
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- The patient’s full name (initials for patient’s forename are not acceptable)
- Hospital/ NHS number
- Date of birth
- Known allergy status or hypersensitivity, if no known allergies this must be recorded. Allergy status must be signed and dated
- Ward / Clinical Area
- Consultant
- Weight (kg) (if appropriate)
- Approved generic medicine name, unless differences in bioavailability between preparations dictate a specific brand should be prescribed e.g. anticonvulsants
- Date treatment commenced. The anticipated stop date should be entered where appropriate. Please refer to the Antibiotic Policy (available on the intranet) for treatment lengths for antibiotics
- Prescribers name (printed) and signature
- Non-medical prescribers in community, must put their professional registration number and the GP code on the FP10s they have prescribed on
- Antibiotics must be prescribed according to the Trust Antibiotic Prescribing Guidelines with the indication, the length of the course of treatment clearly specified and a review date. Restricted antibiotics may be prescribed only on the instructions of a Consultant Microbiologist

2.2.1.4 Metric units must be used when prescribing. Decimal points should be avoided where possible. If used when prescribing, the decimal point must be preceded by a zero for doses less than one whole metric unit (e.g. 0.5ml not .5ml). The terms microgram and nanogram must not be abbreviated.

The following abbreviations are acceptable:

<table>
<thead>
<tr>
<th>g – gram</th>
<th>mg – milligram</th>
<th>kg – kilogram</th>
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<tbody>
<tr>
<td>ml – millilitre</td>
<td>mmol – millimole</td>
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</tbody>
</table>
2.2.1.5 When prescribing insulin, the type of insulin, the brand of insulin and the device used by the patient must be clearly annotated on the medicine chart. All doses prescribed must be annotated with the word "units". The abbreviation “U” or I.U. must not be used.

2.2.1.6 Liquid preparations should have the strength of the preparation written against the medicine name, e.g. amoxicillin syrup 250mg/5mL. The dose should state the drug quantity as well as the liquid volume e.g. amoxicillin 250mg (5mL).

2.2.1.7 Roman numerals should not be used.

2.2.1.8 The route of administration must be identified on the prescription. The following abbreviations can be used:

<table>
<thead>
<tr>
<th>Acceptable abbreviations for route of administration (all other routes to be written in full)</th>
</tr>
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<tbody>
<tr>
<td>BUC</td>
</tr>
<tr>
<td>INH</td>
</tr>
<tr>
<td>IM</td>
</tr>
<tr>
<td>IV</td>
</tr>
<tr>
<td>NG</td>
</tr>
<tr>
<td>NEB</td>
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<tr>
<td>PO</td>
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</tbody>
</table>

2.2.1.9 Where appropriate, the site of application should also be specified, e.g. left eye.

2.3 Prescribing for In-Patients

(Please refer to all information in General section 2.2.1).

2.3.1 Where the number of medicines prescribed requires additional charts to be written, each chart must be marked clearly 1 of 2, 2 of 2 etc.

2.3.2 If a prescribed item is unclear or requires an amendment to the dose, the original prescription must be scored through, initialled and dated and a new prescription written.

2.3.3 When a prescription chart is full, it must be completely re-written by the prescriber. They must ensure that the dates entered relate to the dates when therapy commenced, not the date of re-writing.

2.3.4 A pharmacist may alter a prescription in line with a Medicines Management Group approved protocol without contacting the prescriber.

2.3.5 Under a pharmacist’s professional judgement, they may alter a prescription in a situation where the prescriber’s intention is clear or where a risk to the patient receiving the medicine has been identified (i.e. it is unsafe for the patient to receive the medicine as prescribed).
In all other situations the prescription may only be altered after discussion with the prescriber. The alteration must be marked with the notation ‘p.c.’ (prescriber contacted), signed and dated by the pharmacist.

2.3.6 A new medicine chart must be used if a patient is re-admitted to hospital.

2.3.7 Patient’s should have their medicines reconciled within 24 hours of admission during weekdays to ensure that all required medicines are prescribed (see Medicines Reconciliation Policy).

2.3.8 Known allergies or intolerances MUST be recorded on the medicine chart and on the front of the case notes. (Allergies may be to medications e.g. penicillins, complementary medicines or food e.g. nuts, milk or chemicals e.g. latex etc.).

2.3.8.1 The nature/type of the allergy/adverse effect should also be recorded e.g. anaphylaxis, rash etc.

2.3.8.2 It is equally important to record ‘Nil known’ on the chart if this is the case.

2.3.8.3 After completion the allergy/intolerances box should be signed and dated.

2.3.8.4 Nurses, midwives and pharmacists are authorised to complete the allergy / intolerances box of a medicines chart.

2.3.8.5 All persons administering medicines must clarify the allergy status of the patient before administration.

2.3.8.6 All patients with a documented allergy must have a red allergy band fitted on admission, in order to alert the medical staff.

2.4 Prescribing Discharge Medicines (TTOs)

2.4.1 All hospital discharge prescriptions should be prescribed using the Trusts eDNF system.

2.4.2 Where the eDNF system is not available in that clinical area, a Trust approved paper-based discharge prescription should be written (see section 2.2.1.1).

2.5 Prescribing for Outpatients

2.5.1 Outpatient prescriptions should not be used to re-issue routine or repeat medicines.

The consultant should provide the patient with a hand written advice letter (Prescribing Recommendations for GP), which they can take to their GP. In this situation, patients should be advised to allow 14 days for the preparation of their prescription.

Prescriptions should only be issued to outpatients in the following circumstances:-
• The patient requires immediate treatment (e.g. urgent antibiotic treatment)
• The patient requires a medicine that is not available outside the hospital (e.g. clinical trial, hospital-only medicine etc.)
• The patient requires a medicine for which safe and effective prescribing depends on knowledge and experience unlikely to be possessed by the GP (e.g. chemotherapy, TB treatment, certain psychopharmacological preparations for children)
• The patient requires treatment of a disease with a medicine for which it has been agreed that the hospital clinician is responsible (e.g. Hepatitis C infection, HIV etc.)

A record of the medicine including the dose and duration should be entered in the patient's notes.

Where an essential supply of medicine is required, a maximum of 28 days supply will normally be dispensed. However this duration may be increased for specialist areas such as oncology where prolonged courses may be required.

2.5.2 FP10HP prescriptions should not be used when the pharmacy is open. They should be restricted to when the pharmacy is shut or for offsite trust activity.

2.5.3 Known allergies or intolerances MUST be recorded on the out-patient prescription to include the nature of the allergy e.g. anaphylaxis, rash etc. It is equally important to record ‘Nil known’ if this is the case.

2.6 Prescribing by Non-Medical Prescribers

2.6.1 All prescriptions must comply with all legal requirements as outlined above.

2.7 Prescribing Controlled Drugs

See the Safe and Secure Handling of Controlled drugs policy for full details.

2.7.1 To ensure that the supply of controlled drug medicines meets the legal requirements of the Misuse of Drugs Act 1971 (updated regulations 2001), pharmacists are not permitted to dispense an incorrectly written prescription for a controlled drug. However, pharmacists may make certain changes to a controlled drug prescription if the prescriber’s intentions are clear.

For Outpatient and Discharge prescriptions, the prescription must include:-

• The patient’s full name, address and hospital number
• The approved generic medicine name (unless Brand specific), dosage form (e.g. tablets), strength of the preparation and dose
• State in words and figures, either the total quantity of the drug or the total number of dose units
• The prescription must be dated and signed (not just initialled) by the prescriber. The prescriber must also clearly print their name and bleep or contact telephone number.
The doctor will be contacted to amend any prescription for a controlled drug that does not comply with legal requirements, before it is supplied.

Controlled drug medication required on discharge should be prescribed using the eDNF system, and must be handwritten on the controlled drug discharge prescription form if the patient requires a supply of medication.

2.8 **Unlicensed Medicines**

See the Unlicensed Medicines policy for full details

2.8.1 For the purposes of this document, unlicensed medicines are considered to be those which do not hold a UK marketing authorisation. In certain circumstances, it may be necessary to prescribe medicines which do not hold such an authorisation. The prescribing and use of an unlicensed medication should be discussed with the patient and/or their relatives.

2.9 **Clinical Trials**

2.9.1 Trust staff involved in clinical trials will comply with the statutory requirements for the conduct of Clinical Trials. These regulations include the Medicines for Human Use Clinical Trials Regulations 2004 and Amendment 2006 and all other relevant UK and International guidelines and policies as appropriate.

2.9.2 All Chief or Principal Investigators wishing to undertake clinical trials involving investigational medicinal products will obtain Trust approval, through the Clinical Effectiveness, Research and Development Department, prior to committing to the trial.

2.9.3 All Chief or Principal Investigators will contact the Pharmacy Department for advice on Trust pharmaceutical requirements for clinical trials, including pharmacovigilance.

2.9.4 When patients included in a clinical trial are admitted to the Trust, the principal investigator and pharmacy department will be notified as soon as practical by the medical team looking after the patient or the ward pharmacy service.

2.10 **Verbal Instruction**

2.10.1 The following are taken from Nurse Midwifery Council Standards for Medicines Management Section 4, Standard 11).

2.10.2 A verbal order is not acceptable on its own. The fax or email prescription or direction to administer must be stapled to the patient’s existing medicine chart. This should be followed up by a new prescription signed by the prescriber who sent the fax or email confirming the changes within normally a maximum of 24 hours (72 hours maximum – bank holidays and weekends). In any event, the changes must have been authorised (via text, email or fax) by a registered prescriber before the new dosage is administered. The registered nurse should request the prescriber to confirm and sign changes on the patient’s individual medicines administration record (MAR) chart or care plan.
2.10.3 Where a medicine has not been prescribed before, a nurse or midwife independent prescriber may not prescribe remotely if they have not assessed the patient, except in life-threatening situations. See standard 20 of the Standards of Proficiency for Nurse and Midwife Prescribers.

2.10.4 In exceptional circumstances, a medical practitioner may need to prescribe remotely for a previously unprescribed medicine, for example, in palliative care or remote and rural areas. The use of information technology (such as fax, text message or email) must confirm the prescription before it is administered. This should be followed up by a new prescription signed by the prescriber who sent the fax/email confirming the changes within normally a maximum of 24 hours (72 hours maximum – bank holidays and weekends).

2.10.5 Details of the drug, dose and route of administration should be written in the ‘Once Only’ section of the in-patient medicine chart. The entry should be annotated ‘VERBAL MESSAGE’ and signed by the 2 healthcare professionals who received the verbal message. Administration of the medicine must be recorded on the in-patient medicine chart.

2.10.6 The nurse is accountable for ensuring all relevant information has been communicated to the prescriber and s/he may refuse to accept a remote prescription if it compromises care to the patient. In this instance they should document accurately the communication that has taken place. Nurses should note that remote prescribing cannot be undertaken in a care home because they do not have access to a stock of medicines.

2.10.7 A note should be made in the patient’s notes and the nursing records that a verbal request electronic order for a medicine was accepted.

2.11 Transcribing

2.11.1 Transcribing will only occur when duplicating the details of a prescription for therapy that has already been prescribed by a registered prescriber.

2.11.2 Transcribing is restricted to pharmacists deemed competent to prescribe.

2.11.3 Transcribing by nursing staff is not supported within East Cheshire NHS Trust unless there are exceptional circumstances where to not transcribe would compromise patient care.

2.12 Clinical pharmacy screening

2.12.1 Pharmacists under the direction of the Chief Pharmacist are responsible for managing the safe, effective and economic use of medicines in the Trust. This includes the regular monitoring of prescriptions to ensure appropriateness, accuracy, safety and clarity of prescribing.

2.12.2 Clinical pharmacists are responsible for ensuring that the prescription chart is accurately completed to allow medicines to be administered safely. This may include making amendments to the following:
- Patient details
- Allergy box
- Generic medicine name (or trade name if required)
- Timing and frequency of dose
• Maximum dose and frequency for as required medicines
• Diluent and rate of administration for intravenous medicines
• Additional relevant information

2.12.3 The pharmacist must sign and date the ‘pharmacy’ box on the prescription chart according to pharmacy procedures.

2.12.4 The pharmacist will discuss changes with the prescriber.

2.12.5 The pharmacy ward based team will document medicine history taking on the chart (on the “Medicines Reconciliation” Page 12 of the medicine chart) and clarify any changes made with the prescriber.

2.12.6 Certain medicines may be substituted, according to agreed protocols, for the appropriate formulary choice. The medicine chart must be annotated clearly.

2.12.7 In situations where the prescriber cannot be contacted, the pharmacist may make changes to the prescription in order to ensure that nursing staff can administer prescribed medicines safely.

2.13 Chemotherapy/ Cytotoxic Drugs

2.13.1 The vast majority of prescribing of cytotoxics in ECT is by consultant oncologists, the consultant haematologist or their nominated deputies and approved non-medical prescribers for patients attending outpatient clinics in the Macmillan Cancer Resource Centre. All chemotherapy for oncology patients is prescribed according to Greater Manchester and Cheshire Cancer Network (GMCCN) protocols (www.gmccn.nhs.uk).

However, consultants from other specialities may prescribe cytotoxic agents for specific indications, some non-oncology, within their scope of practice, for example:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Cytotoxic Agent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>Mitomycin C bladder washout</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>Methotrexate, cyclophosphamide</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>Methotrexate</td>
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<tr>
<td>Paediatrics</td>
<td>Methotrexate</td>
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<tr>
<td>Neurology</td>
<td>Cyclophosphamide</td>
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<tr>
<td>Gastroenterology</td>
<td>6-mercaptopurine, methotrexate</td>
</tr>
<tr>
<td>Dermatology</td>
<td>methotrexate</td>
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The in-patient prescribing team should liaise with the oncologist to ascertain whether or not it is appropriate to continue with systemic anti-cancer therapy (SACT).

2.13.2 Oral chemotherapy

Increasingly oral chemotherapy forms part or all of a regimen. The principles outlined in NPSA / 2008 / RRR001 Risks of Incorrect Dosing of Oral Anti-cancer Medicines should be followed. As patients are responsible for taking their own oral chemotherapy in their own homes it is of the utmost importance that they are fully informed of potential toxicities and how to manage them,
and when and how to obtain ongoing advice. Patients can obtain information and advice, including out of hours, on the Christie Hotline number: 0161 446 3658.

For oncology patients, the oncologists, specialist nurse, chemotherapy nurse or cancer services pharmacist always undertakes the specific patient counselling necessary with oral chemotherapy.

Many oral chemotherapy drugs are prescribed for non-cancer indications (as above) and a full explanation of the side effects, how to manage them and necessary monitoring is the responsibility of the initiating consultant, although this may be delegated to a clinical nurse specialist. The initiating teams are responsible for providing such information to the patient and GP.

### 2.13.3 Inpatients on oral chemotherapy

With the increasing use of oral chemotherapy, it is possible that patients on a course of oral chemotherapy or SACT may be admitted to Macclesfield District General Hospital (MDGH). The patient may be under the care of an oncologist at MDGH or elsewhere. As soon as possible, advice from the oncology team looking after the patient needs to be sought about the appropriateness of continuing the oral chemotherapy agent; it may be more appropriate to withhold oral chemotherapy. The GMCCN Oral Chemotherapy Handbook can be accessed for further information about necessary dosage adjustments, side effects etc.

### 2.13.4 Parenteral Chemotherapy

For oncology patients attending the Macmillan Cancer Resource Centre, all parenteral chemotherapy must be prescribed on a pre-printed intravenous therapy prescription form or using the electronic prescribing system, Chemocare. The oncologist and chemotherapy nurses hold these forms/ have access to Chemocare. For all other patients an ECT prescription chart must be used.

The prescription forms must be fully completed, legible, unambiguous, annotated with clear instructions where appropriate, dated and signed as outlined in this Policy.

All out-patient chemotherapy prescriptions for oncology patients must be clinically verified by an accredited pharmacist, who will sign the prescription in the appropriate place.

East Cheshire Trust does not prescribe any chemotherapy via the intrathecal route.

### 2.14 Prescribing Injectable Medicines

#### 2.14.1 All guidelines in section 2.2.1 of this policy should be followed.

#### 2.14.2 Before prescribing, the prescriber should read the patient's notes, prescription, relevant protocol / guideline and be aware of any special instruction or investigation required for the therapy.
2.14.3 The prescriber should confirm the parenteral route is the most appropriate route for the patient – consider and exclude oral or other routes of administration.

2.14.4 The prescriber should record any monitoring requirements in the patient’s notes and communicate appropriately to staff.

2.14.5 The prescriber should record the reasons for any deviations from clinical guidelines on the prescription and patient’s notes.

2.14.6 All continuous fluids, e.g. Sodium Chloride 0.9% must be prescribed on the IV/SC fluid section of the medicine chart. Each bag must be separately prescribed. Any additives must be clearly documented.

2.14.7 All short infusions, e.g. Clarithromycin, Metronidazole can be written solely on the regular section of the medicine chart with annotation, if necessary, of the diluent, volume, rate of infusion and infusion device in the additional instructions section.

2.14.8 These IV’s will be prepared and infused in accordance with the UCL ‘Injectable Drug Administration Guide’ that should be available in all clinical areas. If there is a requirement to give the preparation in any other way than this, then each dose will have to be prescribed separately.

2.14.9 All subcutaneous fluids should be charted on the IV /SC section of the medicine chart clearly stating the route of administration.

2.14.10 Continuous infusion via small volume subcutaneous pump, (e.g. diamorphine for palliative care) must be written on the 24 hour subcutaneous syringe driver sheet, annotating the chart with the volume and type of diluent to be used.

2.14.11 All insulin infusions should be prescribed on the SC / IV section of the medicine chart in conjunction with the diabetes guidelines.

2.15 Prescribing Errors

2.15.1 All prescribing errors must be reported using the Trust Incident Reporting system (Datix). Any incidents relating to fraud must also be reported on Datix and also reported to the Chief Pharmacist. These will be forwarded onto the local counter fraud officer accordingly.

2.16 Prescribing for self/family

2.16.1 Medical and non-medical prescribing by ECT staff for themselves, colleagues or their family is not permitted. Trust staff may receive prescriptions from Occupational Health medical practitioners or through accident and emergency in the case of emergency or potential occupational infection/infestation.
2.17 Prescribing of thromboprophylaxis

2.17.1 The patients VTE risk assessment form is embedded within the drug chart. All prescribers should ensure that the VTE risk assessment is completed on admission, within 24 hours and repeated weekly unless the clinical situation dictates an earlier assessment as per the trust Guidelines for the Prevention and Treatment of VTE. The VTE risk assessment form should be signed and completed with the date and time of completion by the responsible clinician.

2.17.2 The prescription for Low Molecular Weight Heparin (LMWH) is embedded within the drug chart. The prescriber should ensure that the eGFR, platelets and weight are documented on the drug chart when prescribing the LMWH.

2.18 Prescribing Antibiotics

2.18.1 The first dose of antibiotics and single doses should be prescribed as a STAT dose at the front of the chart with subsequent doses prescribed on the Antibiotics Only page of the drug chart. Refer to the Antibiotic Policies on the intranet for appropriate antibiotic therapy and duration. Before prescribing an antibiotic the allergy status of the patient should be checked and the red Allergies Checked box ticked and the prescribers initials added.

2.18.2 Indications for antibiotics should always be documented on the drug chart, (unless the information is confidential, in which case only document indication in the patient's notes). A review date or duration should always be documented.

2.18.3 For patients requiring gentamicin or vancomycin there are specific protocols and prescription sheets at the back of the prescription. The antibiotic should still be prescribed on the Antibiotics Only page however for dose apc (as per chart) should be endorsed. This is to alert all staff to check and administer the drug using the correct protocol and prescription.

2.18.4 All antibiotic prescriptions should be reviewed at 48-72 hours by the clinical team to ensure the most appropriate therapy (including route). Clinical response, sensitivities, infection markers, other lab results, and any adverse effects should be reviewed. Options include:

1. Stopping antibiotics, if no signs of infections
2. Switching from IV to PO, when appropriate
3. Changing antibiotics to suit sensitivities or the patient's clinical response
4. Continuing the current antibiotics and updating the stop or review date
5. Considering Outpatient Parenteral Antibiotic Therapy or Home IV Therapy Service, if available.

The yellow highlighted 72 hour review section should be completed, signed and dated, including a new review date where appropriate.
Appendix one

Equality Analysis (Impact assessment)

1. What is being assessed?

The Trust policy for the prescribing of Medicines

Details of person responsible for completing the assessment:
- Name: Kashif Haque
- Position: Chief Pharmacist
- Team/service: Pharmacy

State main purpose or aim of the policy, procedure, proposal, strategy or service:
This policy provides guidance relating to the prescribing of medicines for all staff in East Cheshire NHS Trust (ECT).

2. Consideration of Data and Research

To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it.

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

Cheshire East (CE) covers Eastern Cheshire CCG and South Cheshire CCG. Cheshire West & Chester (CWAC) covers Vale Royal CCG and Cheshire West CCG. In 2011, 370,100 people resided in CE and 329,608 people resided in CWAC.

Age: East Cheshire and South Cheshire CCG’s serve a predominantly older population than the national average, with 19.3% aged over 65 (71,400 people) and 2.6% aged over 85 (9,700 people).

Vale Royal CCGs registered population in general has a younger age profile compared to the CWAC average, with 14% aged over 65 (14,561 people) and 2% aged over 85 (2,111 people).

Since the 2001 census the number of over 65s has increased by 26% compared with 20% nationally. The number of over 85s has increased by 35% compared with 24% nationally.

Race:
- In 2011, 93.6% of CE residents, and 94.7% of CWAC residents were White British
5.1% of CE residents, and 4.9% of CWAC residents were born outside the UK – Poland and India being the most common

3% of CE households have members for whom English is not the main language (11,103 people) and 1.2% of CWAC households have no people for whom English is their main language.


**Gender:** In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.

**Disability:**
- In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability
- In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia
- Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
- C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
- In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
- Mental health – 1 in 4 will have mental health problems at some time in their lives.

**Sexual Orientation:**
- CE - In 2011, the lesbian, gay, bisexual and transgender (LGBT) population in CE was estimated at18,700, based on assumptions that 5-7% of the population are likely to be lesbian, gay or bisexual and 20 per 100,000 are likely to be transgender *(The Lesbian & Gay Foundation).*
- CWAC - In 2011, the LGBT population in CWAC is unknown, but in 2010 there were c. 20,000 LGB people in the area and as many as 1,500 transgender people residing in CWAC.

**Religion/Belief:**
The proportion of CE people classing themselves as Christian has fallen from 80.3% in 2001 to 68.9% In 2011 and in CWAC a similar picture from 80.7% to 70.1%, the proportion saying they had no religion doubled in both areas from around 11%-22%.

- **Christian:** 68.9% of Cheshire East and 70.1% of Cheshire West & Chester
- **Sikh:** 0.07% of Cheshire East and 0.1% of Cheshire West & Chester
- **Buddhist:** 0.24% of Cheshire East and 0.2% of Cheshire West & Chester
- **Hindu:** 0.36% of Cheshire East and 0.2% of Cheshire West & Chester
- **Jewish:** 0.16% of Cheshire East and 0.1% of Cheshire West & Chester
- **Muslim:** 0.66% of Cheshire East and 0.5% of Cheshire West & Chester
- **Other:** 0.29% of Cheshire East and 0.3% of Cheshire West & Chester
- **None:** 22.69%of Cheshire East and 22.0% of Cheshire West & Chester
• **Not stated:** 6.66% of Cheshire East and 6.5% of Cheshire West & Chester

**Carers:** In 2011, nearly 11% (40,000) of the population in CE are unpaid carers and just over 11% (37,000) of the population in CWAC.

**2.2 Evidence of complaints on grounds of discrimination:** (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)

| No- none aware of |

No- none aware of

**2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?**

| No |

2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?

| No |

3. **Assessment of Impact**

Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

**RACE:**

From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently?

| No |

No

**Explain your response:** Applies equally to all staff employed by the organisation.

**GENDER (INCLUDING TRANSGENDER):**

From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently?

| No |

No

**Explain your response:** Applies equally to all staff employed by the organisation. The Trust has a transgender policy and staff will be mindful of this.

**DISABILITY:**

From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, disabled people differently?

| No |

No

**Explain your response:** Applies equally to all staff employed by the organisation. Prescribers are able to prescribe via different routes if patients are unable to swallow due to disability.

**AGE:**
From the evidence available does the **policy, procedure, proposal, strategy or service**, affect, or have the potential to affect, age groups differently?  

**Explain your response:** Applies equally to all staff employed by the organisation. Staff will ensure that age appropriate doses are prescribed.

**LESBIAN, GAY, BISEXUAL:**  
From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, lesbian, gay or bisexual groups differently?  

**Explain your response:** Applies equally to all staff employed by the organisation.

**RELIGION/BELIEF:**  
From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, religious belief groups differently?  

**Explain your response:** Applies equally to all staff employed by the organisation. Staff will be mindful of the content of medication and how there is a potential conflict with religious belief.

**CARERS:**  
From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, carers differently?  

**Explain your response:** Applies equally to all staff employed by the organisation.

**OTHER:** EG Pregnant women, people in civil partnerships, human rights issues.  
From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect any other groups differently?  

**Explain your response:** Applies equally to all staff employed by the organisation. Staff will be mindful of prescribing for pregnant patients.

4. **Safeguarding Assessment - CHILDREN**

| a. Is there a direct or indirect impact upon children? | No |

| b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people): |

| c. If no please describe why there is considered to be no impact / significant impact on children. |

This policy only relates to staff in relation to the process of prescribing of medicines

5. **Relevant consultation**  

*Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?*

Policy applies to all patient groups equally.

6. **Date completed:** 28/12/16  
**Review Date:** January 2019
7. **Any actions identified:** Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

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<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
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8. **Approval** – At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net

Approved by Trust Equality and Diversity Lead:

[Signature]

Date: 28.12.16