MHS MRG 09

Instructions for the use of the NHS GG&C Mental Health Prescription Sheet

Entries should be written in BLOCK CAPITALS in black or blue indelible ink

1. Patient Details

Complete all patient details. Use alert sections where appropriate e.g. High dose antipsychotic therapy, T2/T3, risk of infection and allergies/adverse drug reactions. Document the details of any allergy or adverse drug reaction.
Additional info can be used for patient photographs in areas that use the photo ID policy or for documenting any additional prescribing charts e.g. warfarin, IV fluids, etc.

2. Start Date Column

Enter the date the medicine was commenced. If rewriting a sheet use the original date on which the prescription was written, not the date of rewriting. If re-writing a sheet the date of discontinuation should be written on the old sheet and date re-written stated on the new sheet.

3. Medicine Column

Print in full the approved name of the medicine. Approved name is usually the generic name. However, there are some exceptions:
Lithium, theophylline, some anticonvulsants, most sustained or modified release preparations should be prescribed by their brand name.
The medicine administered will be in standard oral dosage form (e.g. tablet/capsule) unless otherwise specified e.g. liquid, suspension, orodispersible tablet

4. Dose Column

Medicine dose must be written in metric units. The following abbreviations may be used.

g= gram mg= milligram ml=millilitre

All other dose units must be written in full e.g. ‘micrograms’ and ‘units’ for insulin international units.
Where compound preparations are prescribed e.g. co-codamol 30/500, the dose should be stated as the number of dosage units, i.e. 2 tablets.
The use of a decimal point must be avoided where possible e.g. 0.1mg should be written as 100 micrograms. If the use of a decimal point in unavoidable, a zero must be written in front of the decimal point, i.e. 0.5ml, not .5ml.

5. Route Column

The route of administration should be documented using the approved abbreviations.

PO = oral	IV = intravenous	SC = subcutaneous
IM = intramuscular	SL = sublingual	NG = nasogastric
PR = rectally	PV = vaginally	TOP = topical
INHAL = inhaled	NEB = nebulised	

6. Times

The times of administration should be indicated by marking a tick in the appropriate time interval column or by writing the time (using 24 hour clock)in the ‘other times’ column and marking a tick accordingly.
Particular attention must be paid when prescribing once weekly medicine e.g. bisphosphonates for osteoporosis or methotrexate.

7. Signature

A full signature of the prescriber is required for each item. It is not acceptable to use initials or to bracket items together with one signature.

8. As Required Medication

As required medication must be written with all the following information

- Indication e.g. pain, shortness of breath, agitation, etc
- Dose interval e.g. 2 hourly, 4-6 hourly, etc
- Maximum dose in 24 hours e.g. 4mg in 24 hours

9. Depot Injections/ Long-Acting Injections

Daily or as required injections should be written in the respective ‘ regular’ or ‘as required’ sections. Depot antipsychotics or long-acting injections e.g. hydroxocobalamin every 3 months should be written in the depot section of the prescription sheet with appropriate frequency.

10. Once Only

For medication required on a once only basis, the date and time for the medication to be given must be written and signed.

11. Discontinuing Medicines

To discontinue a medicine, draw a straight line through the complete entry, mark the date of discontinuation and initial.
If a medicine is discontinued because of a suspected adverse drug reaction, a note must be made in the adverse drug reaction section of the prescription sheet.

12. Alterations to Prescription Sheet

Individual entries on the prescription sheet must not be altered or amended. If a change is required, the entry must be cancelled and a new entry must be written.

13. Needing Additional Lines for Prescribing.

When all available lines on the prescription sheet are filled, all medicines still being used should be re-prescribed on a new prescription sheet using the original date of prescribing and recording the date of rewriting. The original prescription sheet should be cancelled by drawing two parallel diagonal lines across it and writing ‘cancelled’ with the prescriber’s signature and date of cancellation.
If a patient requires more medicines than can be accommodated on a single prescription sheet, then two sheets can be used simultaneously. Each sheet must contain all the relevant patient details and be numbered ‘1 of 2’ and ‘2 of 2.’

14. Recording Sheet

When administering medication, each medication given should be recorded by writing the appropriate letter in individual boxes in the appropriate time column. Each time of administration should be accompanied by clear and legible signatures/ initials.
A record must also be made if medication is intentionally withheld or refused by the patient as described on the recording sheet. Document any discrepancy e.g. patient absent, medication refused, out of stock, intentionally withheld, etc.
A new recording sheet must be taken each time a prescription sheet is rewritten.
The original prescription sheet and recording sheet should be stapled together and filed in the patient’s medical notes.
If two prescription sheets are required, then 2 recording sheets must also be used, marked ‘1 of 2’ and ‘2 of 2.’

References :

1. Nursing and Midwifery Council. Standards for Medicines Management.
2. NHSGG&C Safe and Secure Handling of Medicines in Hospital Wards, Theatres and Departments. Version 1 Apr 08.

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