

# PRESCRIPTION WRITING

## QUICK REFERENCE GUIDE

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## Preface

The purpose of this guide is to give you some rules of thumb to support you as you begin to practise prescribing. In clinical practice you will see variation in the way prescribing is carried out. This may be related to the systems being used (paper drug charts, electronic prescribing – of which there are multiple brands and versions) and/or the individual prescriber's preferences and (good/bad) habits.

As with other aspects of medicine that you will encounter in your training this can appear confusing or contradictory (e.g. although you are taught one way to examine the respiratory examination, in practice different people may approach the respiratory exam in different ways but achieve the same result). However, there are often multiple ways to tackle the same task, some of which are the preferred way to do things, some which are acceptable but not necessarily preferred, and some which should be avoided. We have tried to grade our prescribing advice in this way.

Remember, the key thing about a prescription is that it is a form of communication to ensure the right patient gets the right medicine, at the right dose, by the right route, at the right time. Try to imagine you are the pharmacist or nurse having to dispense or administer the medicine – from what you have written, would you know which drug to pick of the shelf and how and when to give it?

Making your written prescriptions clear is a key part of this process, so this guide is all about making things as clear as possible, without being unduly laborious.

## Abbreviations – dosage

Only milligrams, grams, millilitres, litres, millimoles and moles are acceptable dosing units to abbreviate.

Preferrable	Acceptable	Avoid
nanograms		ng
micrograms		m <sub>cg</sub> , μg, ug
mg		
grams, g		
mL	ml (capital L preferable)	
L	l (capital L preferable)	
mmol		
mol		
tablet(s), tab(s)		T
units		U, IU
puffs		

Drug: <i>Digoxin</i>				Date
Dose: <i>125 micrograms</i>	Route: <i>Oral</i>	Frequency: <i>Daily</i>	Time	1/9
Signature: <i>A Doctor</i>	Bleep: <i>1234</i>		<i>0800</i>	
Additional information:				



Drug: <i>Digoxin</i>				Date
Dose: <i>125 mcg</i>	Route: <i>Oral</i>	Frequency: <i>Daily</i>	Time	1/9
Signature: <i>A Doctor</i>	Bleep: <i>1234</i>		<i>0800</i>	
Additional information:				



Drug: <i>Digoxin</i>				Date
Dose: <i>125 μg</i>	Route: <i>Oral</i>	Frequency: <i>Daily</i>	Time	1/9
Signature: <i>A Doctor</i>	Bleep: <i>1234</i>		<i>0800</i>	
Additional information:				



## Abbreviations – routes

Avoid Latin abbreviations where possible, although some are commonly understood and acceptable.

Preferrable	Acceptable	Avoid
IM (intramuscular)		
INH (inhaled)		
IV (intravenous)		
NEB (nebulised)		
Oral	PO (per os)	O
PEG, NG (by enteral tube)		
PR (rectal)		
SC (subcutaneous)		
SL (sublingual)		
PV (vaginal)		

<b>Drug:</b> Paracetamol				<b>Date</b>
<b>Dose:</b> 1 gram	<b>Route:</b> Oral	<b>Frequency:</b> 6-hrly	<b>Time</b>	1/9
<b>Signature:</b> A Doctor	<b>Bleep:</b> 1234		0600	
<b>Additional information:</b>			1200	
			1800	
			2200	



<b>Drug:</b> Paracetamol				<b>Date</b>
<b>Dose:</b> 1 gram	<b>Route:</b> PO	<b>Frequency:</b> 6-hrly	<b>Time</b>	1/9
<b>Signature:</b> A Doctor	<b>Bleep:</b> 1234		0600	
<b>Additional information:</b>			1200	
			1800	
			2200	



<b>Drug:</b> Paracetamol				<b>Date</b>
<b>Dose:</b> 1 gram	<b>Route:</b> O	<b>Frequency:</b> 6-hrly	<b>Time</b>	1/9
<b>Signature:</b> A Doctor	<b>Bleep:</b> 1234		0600	
<b>Additional information:</b>			1200	
			1800	
			2200	



## Abbreviations – frequency

Avoid Latin abbreviations where possible, although some are commonly understood and acceptable. When the dosing interval is particularly important (e.g. antibiotic dosing to ensure consistent blood concentration over 24 hours) we prefer using hourly intervals (e.g. 8-hrly, so dosing at 6am, 2pm and 10pm) rather than number of times per day (e.g. three times daily, which can lead to asymmetric intervals, such as 8am, 2pm and 10 pm i.e. a 6 hour dosing interval in the morning and a 10 hour dosing interval overnight)

Preferrable	Acceptable	Avoid
Daily	OD (omni die)	QD (quaque die, every day)
Morning	OM (omni mane), mane	
Nightly	ON (omni nocte), nocte	
Twice daily, 12-hrly	BD (bis die)	BID (bis in die)
Three times daily, 8-hrly	TDS (ter die sumendum)	TID (ter in die)
Four times daily, 6-hrly	QDS (quater die sumendum)	QID (quater in die)
Six times daily, 4-hrly		QQH (quater quaque hora)
As required	PRN (pro re nata)	
With/after food		PC (post cibum, after meals)
Before food		AC (ante cibum, before meals)

<b>Drug:</b> <i>Co-amoxiclav</i>			
<b>Dose:</b> <i>1.2 g</i>	<b>Route:</b> <i>IV</i>	<b>Frequency:</b> <i>8-hrly</i>	<b>Time</b>
<b>Signature:</b> <i>A Doctor</i>	<b>Bleep:</b> <i>1234</i>		<i>0600</i>
<b>Additional information:</b>			<i>1400</i>
			<i>2200</i>



<b>Drug:</b> <i>Co-amoxiclav</i>			
<b>Dose:</b> <i>1.2 g</i>	<b>Route:</b> <i>IV</i>	<b>Frequency:</b> <i>TDS</i>	<b>Time</b>
<b>Signature:</b> <i>A Doctor</i>	<b>Bleep:</b> <i>1234</i>		<i>0600</i>
<b>Additional information:</b>			<i>1400</i>
			<i>2200</i>



<b>Drug:</b> <i>Co-amoxiclav</i>			
<b>Dose:</b> <i>1.2 g</i>	<b>Route:</b> <i>IV</i>	<b>Frequency:</b> <i>TID</i>	<b>Time</b>
<b>Signature:</b> <i>A Doctor</i>	<b>Bleep:</b> <i>1234</i>		<i>0600</i>
<b>Additional information:</b>			<i>1400</i>
			<i>2200</i>



Avoid 'stat' (meaning immediately); instead give clear instruction on when or how quickly you wish the drug to be administered (i.e. hh:mm, over 2 minutes). When administering a medicine in an emergency, you may give a verbal instruction and write the prescription retrospectively, but aim to do this only when writing the prescription would lead to an inappropriate delay (e.g. during a cardiac arrest, or treatment of status epilepticus).

Preferable	Acceptable	Avoid
At HH:MM, over X mins e.g. at 18:05 over 15-mins	STAT	

Once only prescriptions					
Date	Time	Drug	Dose	Route	Signature
1/9	18:05	Lorazepam	4 mg over 2 mins	IV	A Doctor



Once only prescriptions					
Date	Time	Drug	Dose	Route	Signature
1/9	STAT	Lorazepam	4 mg	IV	A Doctor



## Brand names

Generally we encourage prescribing by **generic name** (e.g. paracetamol rather than Pandadol®), but you may prescribe by brand name when:

- ***no approved non-proprietary name exists***—this applies to many compound preparations (e.g. where two drugs are combined into one tablet, such as colecalciferol with calcium carbonate, available as Adcal-D3®, Calcichew-D3® and others), but not all (e.g. co-amoxiclav and co-codamol are approved non-proprietary compound names). You should know how to recognise the difference in the BNF—proprietary names are denoted by an initial capital and a ‘registered’ (®) symbol. Don’t ‘make-up’ compound names (e.g. write ‘Tazocin®’ or ‘piperacillin with tazobactam’ rather than ‘pip-tazo’).
- ***there are significant differences between brands***, e.g. in relation to dosage interval or absorption characteristics—often the case for modified-release preparations, e.g. oral morphine (‘Oramorph’ vs ‘MST Continus’), diltiazem m/r (‘Adizem-SR’, ‘Tildiem LA’)
- ***drugs have a narrow therapeutic index and bioavailability differs between brands*** (e.g. phenytoin, carbamazepine, theophylline)
- ***drugs have a specific administration device*** which most commonly applies to inhalers (e.g. ‘Seretide 250 Evohaler’, ‘Spiriva HandiHaler’) and insulin pens (e.g. ‘Novomix 30 FlexPen’).

## Fluids

When prescribing fluids, use the name specified in the BNF or on the product label. Synthetic colloids (which are rarely indicated) can be prescribed by brand name (e.g. Gelofusin®, Volplex®) as they do not have approved non-proprietary (generic) names.

Preferrable	Acceptable	Avoid
0.9% sodium chloride	0.9% NaCl, 0.9% saline	Normal saline, N. saline
5% glucose	5% Dextrose®	
Compound sodium lactate, Hartmann's solution		CSL
Potassium chloride	KCl	

Infusions									
Date	Fluid				Drug added (If any)		Signature	Bleep	Given
	Type	Volume	Duration	Route	Name	Dose			
1/9	0.9% sodium chloride	1 L	6-hrly	IV	Potassium chloride	20 mmol	A Doctor	1234	A Nurse



Infusions									
Date	Fluid				Drug added (If any)		Signature	Bleep	Given
	Type	Volume	Duration	Route	Name	Dose			
1/9	0.9% NaCl	1 L	6-hrly	IV	KCl	20 mmol	A Doctor	1234	A Nurse



Infusions									
Date	Fluid				Drug added (If any)		Signature	Bleep	Given
	Type	Volume	Duration	Route	Name	Dose			
1/9	N Saline	1 L	6-hrly	IV	KCl	20 mmol	A Doctor	1234	A Nurse



## Stopping / changing prescriptions

To stop or change a prescription on a paper chart, cross through the prescription and administration section, but ensure the underlying record can still be read. Initial and date the change. Most electronic prescribing systems have their own specific way of indicating whether a drug has been suspended (temporary) or discontinued (permanent); and a way to view these non-active prescriptions.

When changing a dose or frequency, we generally recommend re-prescribing the whole drug for clarity and crossing through the previous prescription to make it clear when the change was made and what the change was. You may wish to use a horizontal T-bar or 'X' to indicate clearly on which day the new prescription starts.

Drug: <i>Ramipril</i>				Date →			
Dose: <i>2.5 mg</i>	Route: <i>Oral</i>	Frequency:	Time	1/9	2/9		
Signature: <i>A Doctor</i>	Bleep: <i>1234</i>	<i>Daily</i>	<i>0800</i>	<i>AM</i>	<i>AM</i>		
Additional information:							
Drug: <i>Ramipril</i>				Date →			
Dose: <i>5 mg</i>	Route: <i>Oral</i>	Frequency:	Time	1/9	2/9	3/9	
Signature: <i>A Doctor</i>	Bleep: <i>1234</i>	<i>Daily</i>	<i>0800</i>				
Additional information:							

*Stopped 2/9*  
*A Doctor*  
*Bleep 1234*

Drug: <i>Ramipril</i>				Date →			
Dose: <i>2.5 mg 5 mg</i>	Route: <i>Oral</i>	Frequency:	Time	1/9	2/9		
Signature: <i>A Doctor</i>	Bleep: <i>1234</i>	<i>Daily</i>	<i>0800</i>	<i>AM</i>	<i>AM</i>		
Additional information:							

Drug: <i>mm</i>				Date →			
Dose: <i>mm</i>	Route: <i>mm</i>	Frequency:	Time	1/9	2/9		
Signature: <i>mm</i>	Bleep: <i>mm</i>	<i>mm</i>	<i>mm</i>	<i>mm</i>	<i>mm</i>		
Additional information:							

## **Which sections to use in the Good Hospital Drug Chart**

The Good Hospital Drug Chart is a UCL study resource which mimics the type of paper drugs chart you may see in practice. We recognise that many hospitals you train in now use electronic systems, but the principles of prescribing remain similar, whether paper or electronic.

### ***Patient details***

This section is self-explanatory, but extremely important to ensure the right patient gets the right medicines. An up-to-date weight can be important for medicines dosed according to body weight.

### ***Allergies and intolerances***

This section is also self-explanatory. It may include allergies (true allergic reactions) or intolerances (side effects) which the patient has experienced in the past. Try to document the exact reaction as this can help determine whether the drug can be trialled again, or whether a drug closely related to the medicine can be used.

For example, many patients say they have a penicillin 'allergy'. If the reaction is severe (e.g. anaphylaxis, bronchospasm, urticaria) then a patient with penicillin allergy should not be treated with cephalosporins due to the risk of allergy crossover with this class of drugs. If the reaction is non-severe (e.g. delayed rash) then a cephalosporin could be trialled in place of a penicillin.

### ***Once only***

This section should be used for medicines which need to be administered immediately and/or in a timely fashion (first dose of an antibiotic in a patient with sepsis, anti-epileptic for status epilepticus, first dose of diuretic for acute pulmonary oedema). Once the patient is stabilised, if the medicine needs to be continued, it can be prescribed in the regular section of the drug chart.

### ***Oral anticoagulation***

This section should be used for oral anticoagulants that require INR monitoring (i.e. warfarin). For patients receiving direct oral anticoagulants (DOACs, e.g. rivaroxaban) the

regular prescriptions section of the drug chart is acceptable to use, given that therapeutic drug monitoring with INR is not required.

### ***Thromboprophylaxis***

This section should be used to prescribe venous thromboembolism (VTE) prophylaxis. All patients should have an assessment of their VTE and bleeding risk on admission, at 24 hours and if their condition changes (e.g. they develop renal failure). Appropriate treatment should be prescribed if the risk of VTE outweighs the risk of bleeding (usually a low molecular heparin e.g. dalteparin, enoxaparin, tinzaparin; or in renal failure unfractionated heparin).

### ***Oxygen***

Oxygen is a medical gas and as such requires a prescription. We recommend prescribing oxygen for ALL patients at admission to make it clear what their target saturation range is and what the initial device would be should they fall outside the range (for most patients this will usually be nasal cannula at a low flow e.g. 1-2 L/min).

The most important caveat to this is patients at risk of type 2 respiratory failure (carbon dioxide retention), commonly those with chronic obstructive pulmonary disease. For such patients, controlled oxygen with devices that can achieve more precise inspired oxygen concentrations may be preferred (e.g. Venturi device with percentage FiO<sub>2</sub> specified i.e. Venturi 35%).

### ***Regular prescriptions***

This section should include the patient's regular medicines, and any medicines which are being given regularly, including intravenous medicines being given at regular intervals (as 'bolus' doses, rather than continuous infusions). For injectable medicines prescribed in this section, you only need to state the drug name (the details of the solution in which the drug is being reconstituted for injection does not need to be prescribed; those administering the medicine can find this information in their local infusion guide). Prescribe "**co-amoxiclav 1.2 grams IV 8hrly**", rather than "**co-amoxiclav 1.2 grams in 20mL water Iv 8hrly**".

### ***As required prescriptions***

This sections should include any medicines the patient might require intermittently for symptom control. Typical examples include painkillers, anti-sickness, as required inhalers or nebulisers.

### ***Infusions***

This section is reserved for fluids and medicines that are being administered as an infusion i.e. over several minutes to hours. Typical examples would include fluids for resuscitation or maintenance, aminophylline infusion for acute asthma, glyceryl trinitrate or furosemide infusion for heart failure, and continuous subcutaneous infusions ('syringe drivers') for the administration of palliative care medicines. Infusions being given regularly but at intervals (e.g. antibiotics) should be prescribed in the regular section of the drug chart.

### ***Anti-infectives***

This section is reserved for antimicrobial medicines like antibiotics or antiviral medicines. In many hospitals, which may not have a specific anti-infective section to the chart, anti-infectives are commonly prescribed in the regular prescriptions section of the chart, with an indication and duration clearly stated in the 'additional information' section.