Six important things to consider when prescribing on drug charts

This briefing highlights six issues often identified as problems when doctors write on drug charts, which addressed will increase patient safety.

1. **Whose signature is it?** If your signature is not absolutely clear, then write your name beside the signature in block letters. Juniors have raised concerns that on-call doctors have written on drug charts with no one being able to identify who did the prescribing when a query arises.

2. **Why is this medicine being prescribed?** The drug chart now has a box called ‘Indication’ in both the ‘Regular’ and ‘As required’ sections. This was added a couple of years ago to inform everyone why a medicine is being administered. This is required as medications may be used for several different clinical indications. Please always complete this box so it is clear why each medication is being prescribed.

3. **How can I reconcile the patient’s medication on admission?** A minimum of two information sources (e.g. patient, carer, GP record) should be used to confirm a patient’s medication on admission. Pharmacy will double check when the team is next on duty, but serious errors and omissions can occur if medicines are not reconciled at the point of admission. A patient’s Summary Care Record (SCR) held by their GP can be accessed on the ward either directly by medical staff, or by the senior nurse on duty if approved to access the records. Don’t forget to ask patients and carers about ‘over the counter’ medicines, illicit substances and herbal remedies to obtain a full picture. Information on SCRs can be found at: [www.sussexpartnership.nhs.uk/node/4786/attachment](http://www.sussexpartnership.nhs.uk/node/4786/attachment)

4. **Am I prescribing legally under the Mental Health Act (MHA)?** If a patient is detained under the MHA there are legal obligations linked to prescribing, including ensuring the correct paperwork is in place and up to date. Further guidance can be found at the link: [www.sussexpartnership.nhs.uk/node/3822/attachment](http://www.sussexpartnership.nhs.uk/node/3822/attachment)

5. **Have I transcribed everything to the new chart?** A lot of important additional clinical information is added to the drug chart (often by the pharmacy team) after medication is initially prescribed – e.g. when to administer in relation to meals, or information about interactions or blood results. If rewriting a drug chart, make sure you transfer this information to the new chart, not just the medicines.

6. **Have I made my intentions clear?** When you stop a medicine, make sure you put lines through future administration boxes as well as the prescription information. Also, if a drug is not administered every day, put ‘X’s in the appropriate administration boxes to identify ‘Prescribed omissions’.

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