How to Write a Good Prescription

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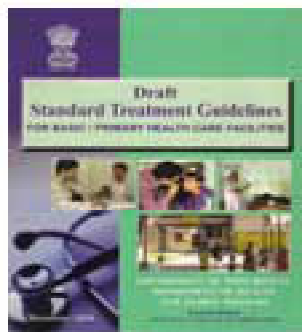
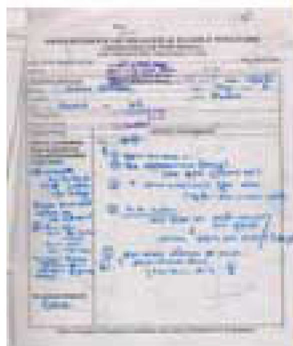
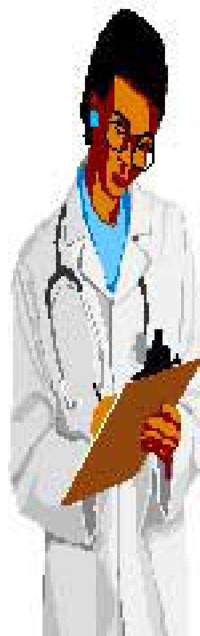






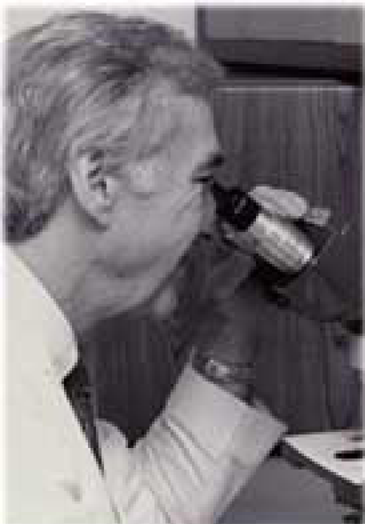
DEPARTMENT OF HEALTH & FAMILY WELFARE

GOVERNMENT OF WEST BENGAL

OPD / EMERGENCY TREATMENT CARD

History

- Prescriptions have been in use since ancient times
  - Latin adopted as standard language
  - "Rx" = prescription
  - "Sig." = directions
- Federal Food, Drug, and Cosmetic Act (1938)
  - Non – prescription
  - Prescription
    - Legend drugs
    - Controlled drugs



532

Mangala Basu

25 y

BP — 120/80 mm/Hg

Wt — 31 kg

(1)

Tab F S-10-D

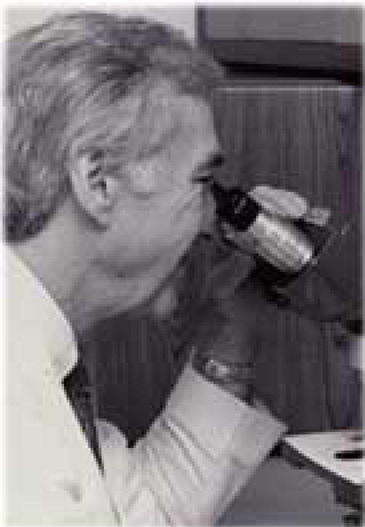
5 FITT B D AC

(10)

Tab Calonate - D

10 - D

USG of Abdomen



- Once a patient with clinical problems has been evaluated and a diagnosis is reached, the physician can select any one of the variety of therapeutic approaches.
- Medication, surgery, radiation, physical therapy, health education, counseling, further consultation and no therapy are some of the options available.

- Of these options, drug therapy is by far the one most commonly chosen. Usually prescriptions of medications are the results of 67% cases of physician patient contact.

- Definition and Format

A prescription is a written, verbal, or electronic order from a practitioner or designated agent to a pharmacist for a particular medication for a specific patient.

Prescription

- **Prescription** is the physician's written order to pharmacist for preparing and dispensing medicines and also direction to the patient for the proper use of medicines.

- Writing a good prescription is not only a good scientific practice but also involves arts of medical science.

- Good prescription is the first step for **rational drug use**.

- Rational drug use indicates right drug for the right patient in right dose at right time and at right cost.

- Good prescription or rational prescription or right prescription is one of the preconditions for use of right medicines by the society.

- Prescription is an outcome of the interaction between the doctor and the patient.
- Writing a prescription rationally & correctly is the prime responsibility of any physician.
- It carries more importance in countries like ours where superstition and ignorance is still persisting in the society.

- **Good prescription plays crucial role in dissemination of rational and scientific knowledge throughout in the society.**

- A prescription should cover all the relevant information about patient, disease & medicine advised.

- In recent times, the trend has been to prescribe the medicines that are produced in mass and packaged in convenient formulations under brand names.
- Now the practice of writing complex prescription orders containing many active ingredients, adjutants, correctives and vehicle has been abandoned in favour of single drug compounded by pharmaceutical companies.

- The prescription in this case refers to the physician's written order to the pharmacist or chemist for dispensing a medicine.

The followings important points should be remembered during prescription writing

- A prescription is an important medico-legal document.
- A prescription should be clear, legibly written in ink in English with good handwriting or computer printed.

The followings important points should be remembered during prescription writing

Local vernaculars can also be used for better understanding of the patients.

- Abbreviations of all type should be avoided as much as possible.

The followings important points should be remembered during prescription writing

- A prescription must have a **date**. Date serves multiple purposes like legal aspect, maximum number & time of refilling, patient compliance etc.

The followings important points should be remembered during prescription writing

- A prescription should contain **prescriber details** including the name, address and contact phone number. It serves proper identification of the physician and the doctor can be contacted if any clarification is needed, for unavailability of the prescribed branded drugs, for adverse drug reaction and emergency.

The followings important points should be remembered during prescription writing

- Information regarding the patient should be complete. It should contain name, age, sex, address, body weight and body surface area if needed.

The followings important points should be remembered during prescription writing

- Name of the drugs should be written correctly and clearly & in capital letter if possible. Use of Generic names should be preferred.
- Use leading zeros (0.125mg not .125mg) are always preferred, but never use trailing zeros (5mg not 5.0 mg).

The followings important points should be remembered during prescription writing

- Dosage form, Strength, Units, Dose, Duration and Route, Timing of drugs with meals should be clearly mentioned. The dose and duration of the therapy should be specified. This information must be ventilated to the patient or the relatives.

The followings important points should be remembered during prescription writing

- If there is more than one dosage form by different routes in a prescription, the order should be as follows –
  - ► Injections, followed by
  - ► Oral preparations in this order –

    Capsules
    Tablets
    Liquids & finally
  - ► Topical preparations

The followings important points should be remembered during prescription writing

- If there is any special instruction for the pharmacist or chemist, it should be written clearly.
- The prescription should be explained to the patient or the relatives.

The followings important points should be remembered during prescription writing

- All prescriptions **must be signed** by the competent authority, i.e., physician or registered medical practitioner. Registration number if required must be written.

- Poor prescribing habits can lead to ineffective and unsafe treatment, exacerbation or prolongation of illness, distress and harm to the patient and higher costs of therapy.

- It may be a source of medication error.

- In this modern era of scientific explosion, it is the right of common people to get right and appropriate information about health. It will be very difficult if the doctors are not able to prescribe good, rational, scientific, cost effective prescription, if the pharmacists & chemists are not able to follow the prescription and to ventilate the necessary information to the users and if the patients are not realizing the importance of rational use of medicines.

Guidelines for writing good prescription in Standard Treatment Guidelines (STG)

- Doctors are requested to follow the following guidelines suggested by STG.

There must be a **standard format or proforma** for both Out Patient Door (OPD) and Indoor/Emergency.

STG developed a format for OPD/Emergency. This standard format is already used by different health facilities of North & South 24 parganas district. The physicians are requested to use this format while prescribing in OPD/Emergency. A copy of this format is shown here.

OPD Ticket

DEPARTMENT OF HEALTH & FAMILY WELFARE
GOVERNMENT OF WEST BENGAL
OPD / EMERGENCY TREATMENT CARD

Name of the Health Facility .... PHC/BPHC/RH
Address .... Tel. No. ....

PATIENT DETAILS Registration Number Date
Name ....
Age .... Sex .... Religion .... Caste ....
Address .... Vill ....
P.O. .... PS ....
Doctor's Name ....

Clinical notes	ADVICE / Investigations
History/Complaints Signs & Symptoms Clinical Examinations Provisional Diagnosis Injury Notes	Date ....

Follow Standard Treatment Guidelines and Ensure Rational Use of Medicines

- Importance of standard OPD/Emergency format

Afija Khatu

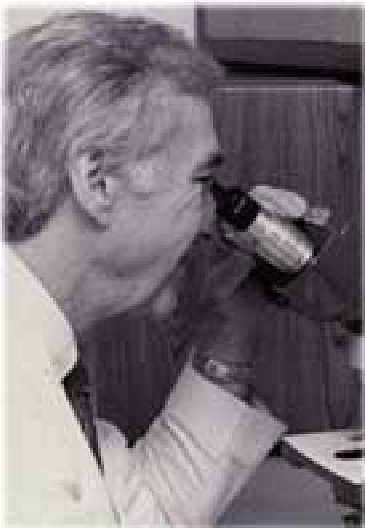
19 F

19/8/09

Allergy

Avoid pond bathing

Albenda-



12326

9/3/05

(3)

(7)

[illegible]

[illegible]

[illegible]

[illegible]

OPD Ticket

DEPARTMENT OF HEALTH & FAMILY WELFARE
GOVERNMENT OF WEST BENGAL
OPD / EMERGENCY TREATMENT CARD

Name of the Health Facility ....
Address .... Tel. No. ....

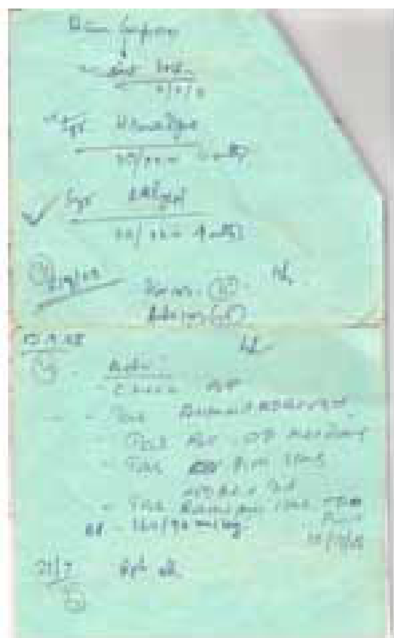
PATIENT DETAILS Registration Number Date
Name ....
Age .... Sex .... Religion .... Caste ....
Address .... Vill ....
P.O. .... PS ....
Doctor's Name

Clinical notes	ADVICE / Investigation
History/Complaints Signs & Symptoms Clinical Examination Provisional Diagnosis Injury Notes	Date ....

Follow Standard Treatment Guidelines and Ensure Rational Use of Medicines

It is essential that the prescription is legible

It must be legible, if hand written.



তারিখ	চিকিৎসার বিবরণ
19/7/07	23/07/03
BP 160/90	C/c: [illegible] Cough [illegible] mild [illegible]
19/7/07	[illegible]
[illegible]	BP: 150/80
BP 150/80	
24/7/07	
BP 150/80	
24/7/07	
BP 130/80	
C/c [illegible]	

তারিখ	চিকিৎসার বিবরণ
21/7/07	BP 150/80
	[illegible] = 12
	[illegible] = 10
	Blood for [illegible]
22/7/07	
25/7/07	[illegible]
	[illegible]

T-1

Chandpur PHC

(3)

26/03/09

West Bengal Form No. – 769

TICKET FOR OUT-DOOR PATIENTS

Chandpur P.H.C. Rajarhat Block

North - 24 Parganas

Date of First Visit 16/8 No. in O.P. Register 507

Name [illegible]

Age 11 yrs Caste [illegible] Sex F.

Disease

Date	Treatment
	[illegible]
14/8	[illegible]

It must be clear.

Identity of the health facility

- DEPARTMENT OF HEALTH & FAMILY WELFARE
- **GOVERNMENT OF WEST BENGAL**
- OPD / EMERGENCY TREATMENT CARD

- Name of the Health Facility...PHC/BPHC/RH

- Address...............................Tel. No..

Identity of the patient

- **PATIENT DETAILS**
- **Registration Number- Date-**

- Name…………………………
- Age……………………….Sex………………Religion……………Caste……………………….
- Address……………………………….Vill……………….
- P.O.-……………………………PS……………………..

Identity of the prescriber/doctor

- Doctor's Name……………………………

Identity of the patient

- **PATIENT DETAILS**
- **Registration Number- Date-**

- Name…………………………
- Age………………………Sex………………Religion………….Caste………………………..
- Address……………………………Vill……………….
- P.O.-……………………………PS…………………….

- Name of the medicines should be in capital letter. But small letter legible name can also serve the purpose, if writing in capital letter is laborious due to patient overload.

- **Provisional diagnosis** and **important findings** supporting the **provisional diagnosis (PD)** should be written.

- Relevant information related to provisional diagnosis (PD) or differential diagnosis (DD) should be written.

- Chronology of prescribing drugs/medicines-
- **Core Drug**
- **Complimentary Drug**
- **Supportive or Symptomatic Drugs.**

- Each prescribed drug/medicine must be provided with—
- **Dosage form**
- **Strength**
- **Dose**
- **Frequency**
- **Duration**

- Supportive advice following the provisional diagnosis or the drugs/medicines should be written. Important advice in the prescription indicates quality prescription.

- Advice of supportive investigation will strengthen the purpose of prescription.

- Try to **avoid abbreviation** as much as possible.
- Registration number should be written whenever necessary as per prescription.

- How to Evaluate a Prescription

Prescription Audit in STG

- Drug or medicine is any substance or product that is used or is intended to be used to explore the physiological system or to modify pathological states for the benefit of recipients (World Health Organization).

- **Drugs or medicines can do good, can do harm & whenever a drug is taken a risk is taken. So doctors should be aware of its importance.**

- **Medication error** is defined as "any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer...related to professional practice, health care products, procedures and systems including prescribing; order communication; product labeling, packaging, & nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use."

- Statistics shows that 44,000 to 98,000 Americans die each year as a result of medical errors.

- This is associated with a cost of USD 17 to USD 29 billion and ranks medical error the eighth-leading cause of death in the US.

- Though in India, a proper reporting of medication errors in the hospital is not available still now, but survey shows that out of all visits to the medical emergency department- six per cent are drug-related.

- Of all ADE-related visits, 52 per cent and of all ADE-related admissions, 55 per cent were considered preventable.

- Several survey confirmed irrational drug use in India.

- **Recent initiatives of regulatory authorities (MCI) warned that doctors found to be unethical and irrational prescribing would be punished.**

- The fast growing rates of medication errors all over the world indicates the need for starting a routine prescription auditing in all health setup, this is more important in respect to India, where resources are limited.

- **Standard Treatment Guideline (STG) prepared and implemented by Institute of Health & Family Welfare, Department of Health & Family Welfare, Govt. of West Bengal, Swasthya Bhavan,(29 GN Block, Sector-V, Bidhan Nagar, Kolkata-700091) is a justified and timely approach.**

Prescription auditing

This is a process of auditing prescription in a particular health care system with the purpose of identifying the medication errors, finding out the way to prevent such errors and thus improving the overall health care system.

- The process of prescription auditing in its broader sense include **prescription monitoring**, **drug utilization studies**, **prescription pattern studies**, **study of prescription habits of doctors**, **adverse drug reaction monitoring**, **drug interaction monitoring**, **criteria based prescription auditing** and many other activities.

- But the most important and basic activities include **checking the prescription for drug name (brand name or generic), strength, formulation, dose, route of administration, frequency, duration of treatment and drug allergies.**

- The process of prescription auditing is a type of vigilance activity, which is very beneficial for the health system in terms of reducing the financial burden because of medication errors and increasing the rate of patient recovery and discharge from the hospital. Not only that, prescription audit ensures quality health service which is very much essential.

- There is no routine auditing system of prescription audit in India. The method used for prescription auditing depends upon purpose for which it is carried out. Different studies audited prescription in different ways. Though there is **no standard methodology**, these studies are very helpful in collecting data regarding prescription habits of doctors, the comparison of efficacies of different drugs.

- **Standard treatment guidelines** and its implementation in the primary health care evaluated and monitored the prescription habit of doctors. A standard method is developed for routine screening of some sample prescription (usually ten) and all the prescription drugs along with the prescribed information regarding the drug name (brand names), strength, formulation, doses, route of administration, frequency and duration of treatment. We also evaluate some other important aspects of prescriptions.

Standard procedure for collection of prescription

- 1. Doctor should prescribe medicines on the standardized OPD/Emergency tickets (STG). These prescriptions contain PD, symptoms, signs, drug name, strength, formulation, doses, route of administration, frequency & duration of treatment, necessary advices and investigations.

- 2. STG monitors/assessors will collect sample prescription randomly, carefully during the visit of health facilities for audit. **Prescription containing more that one encounter should reflect better prescribing trends.**

- Collect only OPD/Emergency prescriptions. Try to avoid Eye, ENT, Dental, RNTCP, Antenatal Check up, Discharge Tickets.

DEPARTMENT OF HEALTH & FAMILY WELFARE

GOVERNMENT OF WEST BENGAL

OPD / EMERGENCY TREATMENT CARD

Name of the Health Facility: [illegible] PHC / BPHC / RH

Address: [illegible] Tel. No.

PATIENT DETAILS — Registration Number: [illegible] Date: [illegible]

Name: [illegible] Age: [illegible] Sex: [illegible]

Address: [illegible]

Visiting Date: [illegible]

Doctor's Name:

Clinical Notes	ADVICE / Investigation
History / Complaints Signs & Symptoms Clinical Examination Inform Note	Date: [illegible handwritten notes]
Provisional Diagnosis	

Follow Standard Treatment Guidelines and ensure Rational Use of Medicine

আপৎকালীন বিভাগ

আপৎকালীন বিভাগ

PATIENT DETAILS **Registration Number:** 226/[illegible] **Date:** [illegible]

Name: [illegible] KANTABAD PHC Age: [illegible] Sex: [illegible]

Address: [illegible] Vill: [illegible]

P.O.: [illegible]

Visiting Date: [illegible]

Doctor's Name: [illegible]

Clinical Notes	ADVICE / Investigations
History / Complaints **Signs & Symptoms** **Clinical Examination** **Injury Notes** [illegible]	Date: [illegible] [illegible] daily after food x ___ days [illegible] x 5 days [illegible] ___ days [illegible] 5 days CAP [illegible] ___ days [illegible] ___ days TAB CIPROFLOXACIN [illegible] [illegible] twice daily [illegible] food x ___ days TAB NORFLOXACIN [illegible] [illegible] daily before food x 5 days TAB METRONIDAZOLE [illegible] [illegible] three times [illegible] x 5 days ORS [illegible] TAB [illegible] [illegible] ___ days CAP [illegible] [illegible] before food [illegible] daily x ___ days
Provisional diagnosis [illegible]	[illegible]

বাকুলতেড়িয়া চড়িয়াল ব্লক প্রাথমিক স্বাস্থ্য কেন্দ্র

বজবজ - ১নং ব্লক, পোঃ বুইতা, দক্ষিণ ২৪ পরগনা

- If possible xerox or scan the prescriptions, if no such copying system available nearby then the monitors can use carbon copy of the prescriptions or copy the prescription by handwriting.
- Properly preserve the prescription and hand over it to the respective authority for audit.

Prescription auditing methodology

- Following the guidelines of World Health Organization (WHO) and under the guidance of our respected teachers we **developed a methodology for prescription auditing**.

- Some modification of WHO formula was done to make it simple and practical and compliant to our primary health care setup.
- This methodology was already tested and proved effective during the audit of prescription in piloting of STG (Number of prescription/encounters audited - 4867, North 24 pgs-2373 & South 24 pgs-2658).

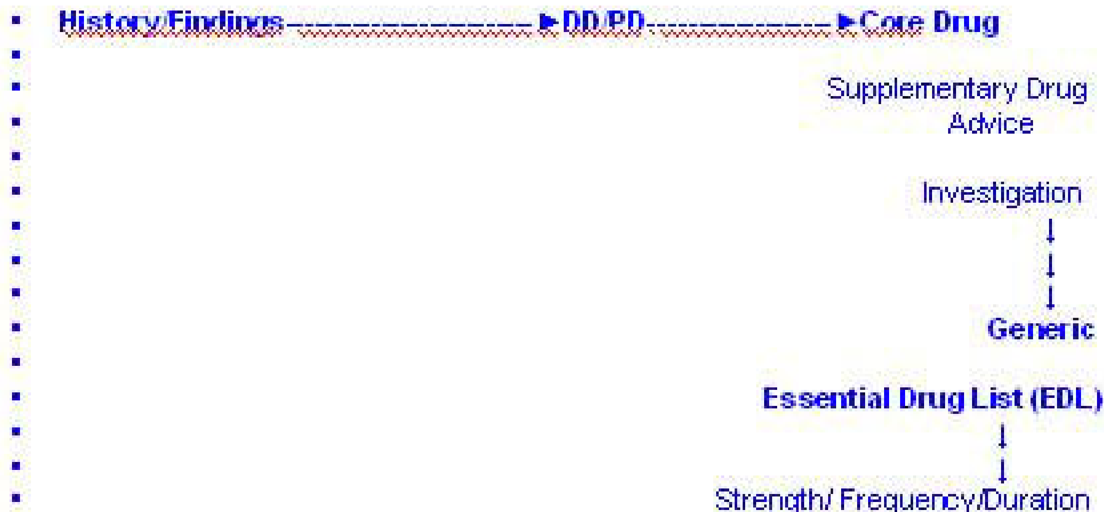
Steps to be followed in prescription audit of STG-

- 1. All prescriptions collected should be numbered as ----------
- Number the Prescription as 1,2,3……….etc.
- &…………..→ Then
- Number of Encounters as 1,2,3,4………
- 2. **In audit we will evaluate the encounters.**
- 3. Encounters without date will be cancelled and not evaluated.

- 4. If the prescription is **ILLEGIBLE** at any item then that item should not be considered and **0 (ZERO)** points will be given.

- 5. The main **Objectives** for evaluation --- ►Prescription should be understandable.

Scheme & Flow Chart of Evaluation process of Prescription Audit-



- 6. **Evaluation scoring system-** Each encounter/prescription will be assessed on the following four facets,
- **Completeness of Prescription** (Diagnosis, Findings, Signature),
- **Whether Prescription corroborates with Symptoms/Diagnosis** (Selection of core drugs, Selection of subsidiary/symptomatic drug, Relevant advices/instructions for patients),
- **Prescribing Behavior** (Generic Prescription, Essential drugs Prescription, Judicious Investigations)
- **Dosage Schedule** (Dose, Frequency of administration, Duration of therapy).
- All the points/question/item scores 2 (two) marks.

- **Negative marking** will be there depending on prescribing of vitamin / tonics / enzymes / poly pharmacy (antimicrobials) / parenterals for unnecessary indicators.

PRESCRIBING INDICATORS

- Category: 4 (Each category comprises of three questions / items)

- Questions 12 (Each question / item carries 2 marks)
  Total marks: 24
  Marks obtained:

  Rational 24 - to >18:

  Semi Rational 18 - to >12:

  Un acceptable = or >12:

DEPARTMENT OF HEALTH & FAMILY WELFARE
GOVERNMENT OF WEST BENGAL
OPD / EMERGENCY TREATMENT CARD

Name of the Health Facility ______

Address ______

Tel. No. ______

PATIENT DETAILS — Registration Number — Date

Name — Age — Sex

Address

Visiting Date ______

Doctor's Name ______

Clinical Notes	ADVICE / Investigation
History / Complaints **Signs & Symptoms** **Clinical Examination** **Injury Notes** Flatulence Dyspepsia Acidity **Provisional Diagnosis**	Date ______ Albendazole 400mg 1 tab - to be chewed Tab Antacid Tab Domperidone

Follow Standard Treatment Guidelines and ensure Rational Use of Medicine

Masbat PHC

DEPARTMENT OF HEALTH & FAMILY WELFARE

GOVERNMENT OF WEST BENGAL

OPD / EMERGENCY TREATMENT CARD

Name of the Health Facility

Address

Tel. No.

PATIENT DETAILS Registration Number: Date:

Name: Sanjay Das Age: Sex:

Address: Vill: Gadakhali

P.O. P.S.

Visiting Date

Doctor's Name

Clinical Notes Investigations

History / Complaints

Signs & Symptoms

Clinical Examination

Injury Notes

Date:

Rx

→ Rest

→ Tab Paracetamol (500 mg)

→ Tab Cetrizine (10 mg)

Provisional diagnosis

Viral fever

Follow Standard Treatment Guidelines and ensure Rational Use of Medicine.

- **I. Completeness of Prescription**
  - ► Diagnosis
  - ► Findings
  - ► Signature

- **II. Whether Prescription corroborates with Symptoms/Diagnosis**

- ► Selection of core drugs
  ► Selection of subsidiary/symptomatic drug
  ► Relevant advices/instructions for patients

-

- **III. Prescribing Behavior**

-
  - ► Generic Prescription
  - ► Essential drugs Prescription
  - ► Judicious Investigations

- **IV. Dosage Schedule**

- ► Dose
  ► Frequency of administration (Interval)
  ► Duration of therapy

- There are **twelve items** to be evaluated in each encounter / prescription. Each item scores 2 (two) marks. So, **total points are 24**. Negative markings (2 marks for each item) will be given for tonics/enzymes/poly pharmacy (antimicrobials)/parenterals for unnecessary indicators. Now the total marks scored by each encounter will be converted into percentage and then graded into Rational (R), Semi Rational (SR), and Un Acceptable (UA).

DEPARTMENT OF HEALTH & FAMILY WELFARE

GOVERNMENT OF WEST BENGAL

OPD / EMERGENCY TREATMENT CARD

Name of the Health Facility ____________

Address ____________

PATIENT DETAILS	Registration Number:	Date:
Name:	Age:	Sex:
Address:		
P.O.	P.S.	

Visiting Date ____________

Doctor's Name: DR. B. BISWAS

Clinical Notes	ADVICE / Investigation
History / Complaints Signs & Symptoms Clinical Examination Injury Notes	Date ____________
Provisional Diagnosis	

Follow Standard Treatment Guidelines and ensure Rational Use of Medicine

DEPARTMENT OF HEALTH & FAMILY WELFARE
GOVERNMENT OF WEST BENGAL
OPD / EMERGENCY TREATMENT CARD

Name of the Health Facility: [illegible] PHC / BPHC / RH
Address: [illegible] Tel. No.:

PATIENT DETAILS — Registration Number: [illegible] — Date: [illegible]
Name: [illegible] — Age: [illegible] — Sex: [illegible]
Address: [illegible]
P.O.: [illegible] — PS: [illegible]

Visiting Date: [illegible]
Doctor's Name: [illegible]

Clinical Notes	ADVICE / Investigations
History / Complaints Signs & Symptoms Clinical Examination Injury Notes	Date: 27/3/09
Anasarca hook worm weakness x 7 days. Eye discharge x 7 days	Capsule B complex 1 capsule twice daily after meal x 5 days Tablet Albendazole 400 single dose after meal. Ciplox eye drop 2 drops x 3 times x 5 days
Provisional Diagnosis Hook worm c anaemia c conjunctivitis	[illegible signature] 27/3/09

Follow Standard Treatment Guidelines and ensure Rational Use of Medicine

- **Evaluation Scheme**

- Total Points = 24 = 100%

  R = Rational = Points - >18- to 24:
  Rational = >75% to 100%

  SR = Semi Rational = Points - >12- to 18
  Semi Rational = > 51% or = or < 75%

  UA =Un Acceptable=Points - < or = 12:
  Un Acceptable = = or < 50%

PATIENT DETAILS Registration Number - 1157? Date : [illegible]

Name [illegible] Age 55 Sex

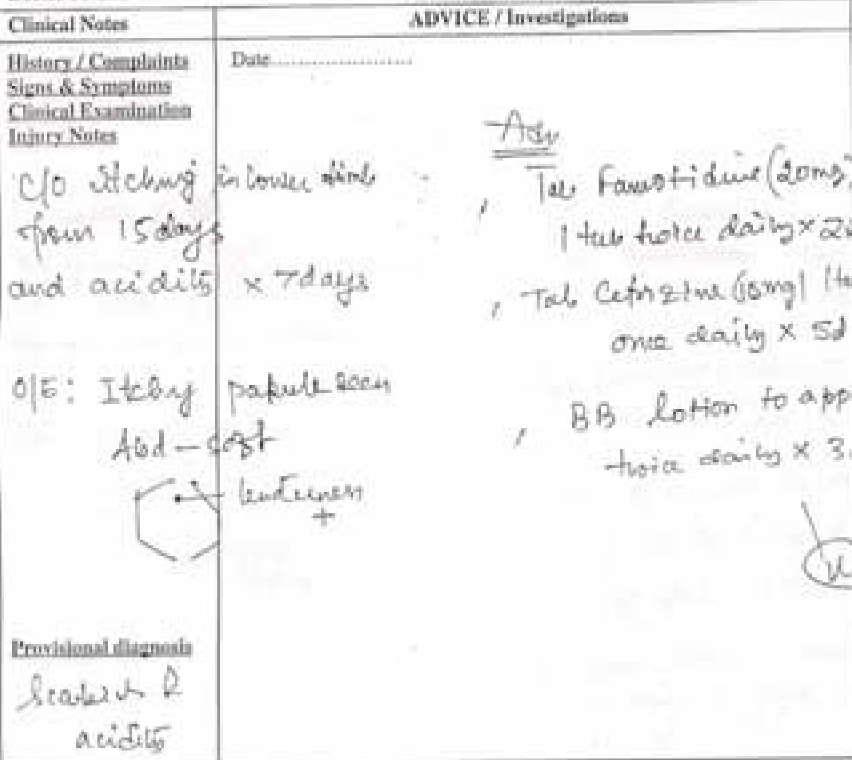
Address [illegible] Vill [illegible]

P.O. [illegible] P.S. [illegible]

Visiting Date [illegible]

Doctor's Name Dr. [illegible]

Clinical Notes	ADVICE / Investigations
History / Complaints Signs & Symptoms Clinical Examination Injury Notes P.V. white discharge x 3 yrs.	Date 8/7/09 Candid vaginal gel TD x 7 days. Tab FCZ (150) once wk x 6 wks.
Provisional Diagnosis Leucorrhea.	Arnab Ghosh 8/7/09



F.U. [illegible]

Visiting Date 08/07/09

Doctor's Name Dr Parul Ghosh

Clinical Notes	ADVICE / Investigations
History / Complaints **Signs & Symptoms** **Clinical Examination** **Injury Notes** C/O Itching in lower limb from 15 days and acidity x 7 days O/E: Itchy papule seen Abd – soft tenderness + **Provisional diagnosis** Scabies & acidity	Date …………… Adv Tab Famotidine (20mg) 1 tab twice daily x 2[illegible] Tab Cetirizine (10mg) 1 tab once daily x 5d BB lotion to app[illegible] twice daily x 3[illegible]

Prescription audit of STG also evaluated following points

- •**Prescription with identification-**
- **a). Identification of the health facility**
- **b). Prescribers identification**
- **c). Patient identification**
- **d). Stamp of the prescribers**
- **e). Signature of the prescriber**

- **Other points-**
- Prescription with provisional diagnosis/findings written
- Illegible prescription
- Percentage of prescription without abbreviation
- Prescription with medicine written in capital
- Prescription with drugs from Generic / EDL
- Number of drugs prescribed per prescription
- Percentage of prescription with an antibiotic
- Percentage of prescription with an injection
- Number of prescription without drugs (only advice)
- Prescription written in local language

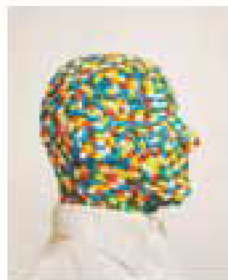
- A zero medication error is an impossible thing to achieve because we are humans and not machine. So, the only way to get rid of irrational, unscientific prescription is a thorough screening all components of a prescription. That is why to ensure rational prescription auditing must be an integral component of the health system.

- This unique approach of prescription audit in Standard Treatment Guidelines at primary health care is a definite step for right medicine for right person at right time in right dose and at a right cost.

CONCLUSION: -

- The process of prescription auditing is a kind of vigilance activity
- The objective of prescription auditing is to detect medication errors preferably before they are dispensed
- Prescription auditing reduces medication errors and increases the rate of patient recovery and discharge from the hospital

Right Drug for Right Person at Right Time in Right Dose……….



Thank you