

Common Errors while Prescribing



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Prescriptions Vs. Medical Records



- UK – NHS requires to maintain records until 10 yrs of death of patient.
- In Georgia, the record should be maintained for 10 yrs from the date it created.
- The AMA guideline advises these to be kept up to the length of time of the statute limitation for malpractice claim. (usually 3-5 yrs)
- But no clear guideline in India.

MCI on medical records



1.3 Maintenance of medical records:

1.3.1 Every physician shall maintain the medical records pertaining to his / her indoor patients for a period of 3 years from the date of commencement of the treatment in a standard proforma laid down by the Medical Council of India and attached as **Appendix 3**.

1.3.2. If any request is made for medical records either by the patients / authorised attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours.

MCI format for Medical records

FORMAT FOR MEDICAL RECORD

(see regulation 3.1)

Name of the patient :

Age :

Sex :

Address :

Occupation :

Date of 1st visit :

Clinical note (summary) of the case:

Prov. : Diagnosis :

Investigations advised with reports:

Diagnosis after investigation:

Advice :

Follow up

Date:

Observations:

Signature in full

Name of Treating Physician

Suggested format of Prescription

Doctor's Name
Qualification (eg.MBBS, MD)
Regn. No.: (ALLOPATHY)
Full Address, Contacts: (telephone No. E-mail etc.)
Date:
Name of the Patient
Address*
Age& Sex weight**
Rx
1) Name of Medicine***
Strength, dosage instruction, duration & total quantity ***
2) - do -
3) - do-
Doctor's signature
Stamp
DISPENSED
Date: Pharmacist:
Name of Pharmacy:
City

*Postal address/E-mail/Mobile
***for Paediatric Patients ***

What is Prescription



- A prescription is a health care program implemented by a qualified practitioner in the form of instructions that govern the plan of care for a patient.
- As medical practice has become complex, the term prescription also include clinical assessment and investigation reports.

Contents in a Prescription



- **Doctor's**

- Name, Address, Phone Number, (email, website – optional)
- Qualifications (only approved), Registration Number
- May add membership of professional associations

- **Patient's**

- Name, age, sex, address. Weight (Children), Gravida (female)
- Provisional Diagnosis
- Investigation
- Instructions for patient, pharmacy and other paramedics.

Legibility of Prescription



- We are famous for our handwriting.
- A report says in US quite many Pt die indirectly due to illegible handwriting.
- MCI suggest we write in capital esp. Drug names.
- Computer printed prescription is need of hour.

²[(9) (a) Substances specified in Schedule H or Schedule X shall not be sold by retail except on and in accordance with the prescription of a Registered Medical Practitioner and in the case of substances specified in schedule X, the prescriptions shall be in duplicate, one copy of which shall be retained by the licensee for a period of two years.

(b) The supply of drugs specified in Schedule H or Schedule X to Registered Medical Practitioners, Hospitals, Dispensaries and Nursing Homes shall be made only against the signed order in writing which shall be preserved by the licensee for a period of two years;]

(10) For the purposes of clause (9) a prescription shall—

(a) be in writing and be signed by the person giving it with his usual signature and be dated by him;

¹(b) specify the name and address of the person for whose treatment it is given, or the name and address of the owner of the animal if the drug is meant for veterinary use;

Instructions



- For the patients – should be written in native language.
- Careful use of decimal points to avoid ambiguity:
 - Avoiding unnecessary decimal points: e.g write 5 ml instead of 5.0 ml
 - Use zero where required e.g. 0.5 instead of .5 or .50
- “ML” is used instead of “cc” even though they are technically equivalent
- Where the directions are "as needed", the quantity should always be specified.
- Where possible, directions should specify times (7 am, 11 pm) rather than simply frequency (T.D.S or B.D.) and relationship to meals.
- Avoiding units such as "teaspoons" or "tablespoons."
- The use of permanent ink.

Drugs



- MCI suggest we should PREFERABLY write GENERIC drugs.
- Prescription may also be required for non-prescription drugs or medical devices etc.
- Prescription is valid only for the period it mentions.
- Plain paper prescription can only be used in case of emergency.
- **REPLACEMENT OF PRESCRIPTION DRUGS BY PHARMACY?**

Prescription as a notepad



- **Disclosures**
 - About Treatment plan and it's possible outcome and complications
 - Alternative treatments, their advantages and disadvantages.
- **Noncompliance**
 - Refusal to follow advice like surgery, investigation etc.
 - Improper follow up in appointments
 - Non-adherence to instructions given.
- **Progress notes**
 - Response to treatment.

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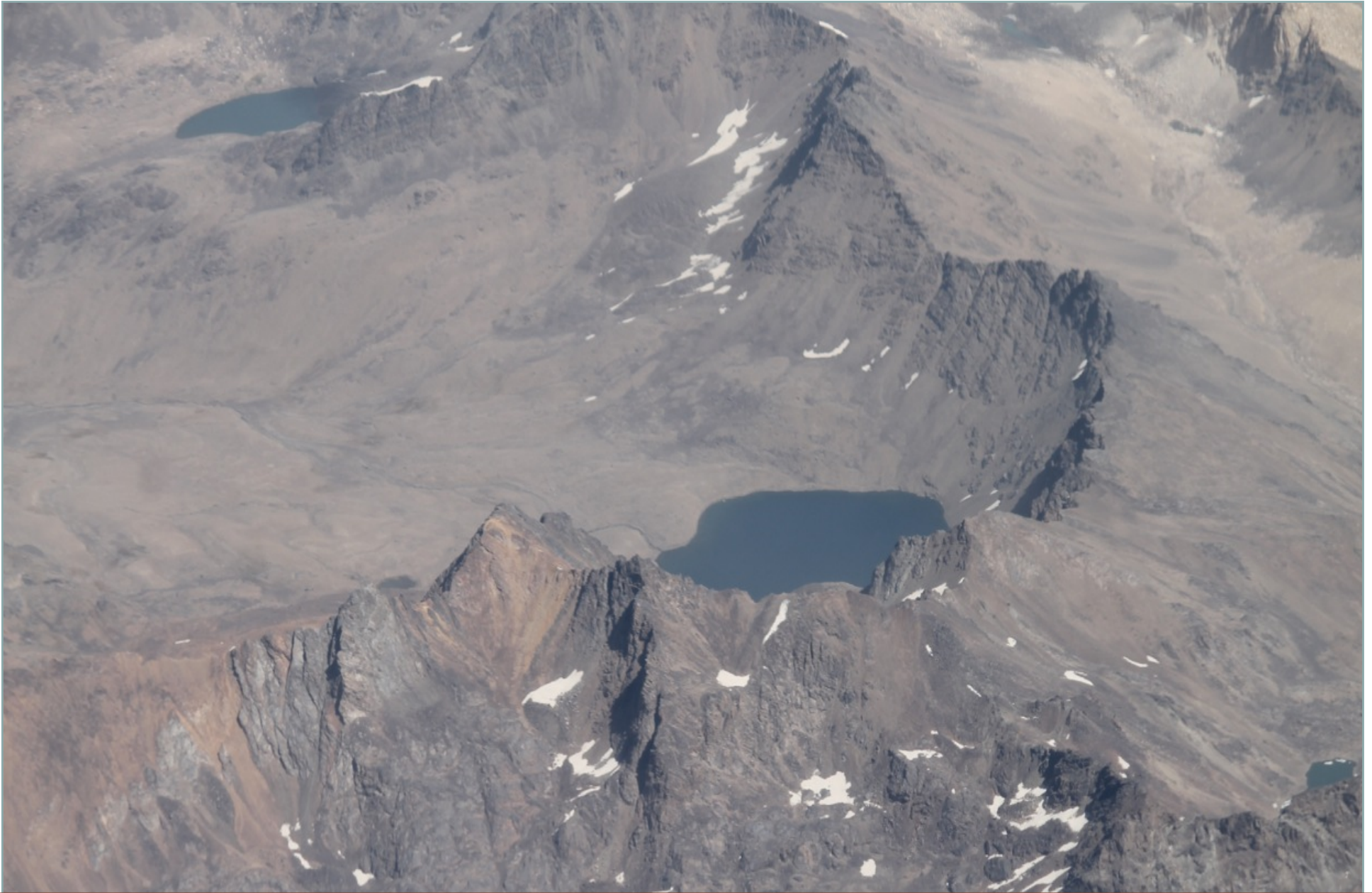
Min

1. समझें कि गंभीर मानसिक रोग नहीं है
2. जीवन की समस्याओं और आवेगों से दवा से हल और प्राप्त नहीं किया जा सकता है
3. नियमित दिनचर्या, परीक्षण
4. जो है उस से संलग्न करें
5. जो नहीं है उस का पुनर्गठन करें

Prabhat Sith

The joy of medicine is in doing good , which is why patients still confer a special status on us – we need to prove ourselves worthy of it.

Give a minute or two in writing the prescription, our patient deserve that.



THANK YOU