ESIC' S Standard Operating Procedure for Prescription

Background: The Employee State Insurance Corporation (ESIC) places a paramount emphasis on healthcare quality and patient safety The Standard Operating Procedure (SOP) for prescription writing serves as a guiding framework for ESIC doctors utilizing the comprehensive Dhanwantri module, ensuring standardized, clear, and patient-specific prescriptions.

Objectives:

- Improved quality of care
- Efficient use of therapeutic agents
- Encouragement of using generic names
- Reduction in polypharmacy
- Prevention of irrational prescribing

In ESI Dhanwantri module has been adopted for prescription writing wherein the demographic details of the patient are recorded by default at registration.

The treating doctor must examine the patient and fill in his/her findings and prescribe accordingly.

A standard prescription should have the following details:

1. **Details of the Health Facility**: Name, Address, Logo,

2. **Details of the Doctor:**
   a. Every prescription in the OPD should have a personal stamp of the prescribing doctor which would have his/her name and registration number.
   b. The Doctor's name is mentioned on prescription for record and that patient can contact the doctor if need be case of adverse effect, any emergency, or non-availability.

3. **Details of the patient**: Name, Age, Sex, Weight, Address,

a. OPD Registration Number should be mentioned.

b. A Unique Health Identification Number (UHID) should be generated for each patient.

c. Complete Name of the patient is written: It should have first, middle (if have) and last name

d. Age: It should be written in years.

e. Occupation of the IP/IW must be recorded and updated as and when required

f. Weight is recorded in Kg,

g. Weight of pediatric patients need to be recorded up to two points after the decimal. Weight of low birth weight neonates needs to be recorded in grams.

h. Date of consultation: In the format(day/month/year).

i. Gender of the patient: Male/Women/Others.

4. Clinical Details:

- Brief past medical history to be recorded.
- Allergy status- Enquire and mention about a drug that has caused allergy/side effects/unexpected and record any drug allergies
- History of pain must be elicited.
- Elicit and record relevant family history
- Present medical history and clinical Examination
- Vitals and general Physical examination: Chest, CVS, Per abdomen, CNS findings in brief

5. Diagnosis:

Record provisional /differential/final diagnosis as per your judgement

Recording diagnosis is mandatory

6. Investigations:

Briefly report significant previous investigations.

Clearly list newly advised investigations if required.

7. Prescription of medicines: Important where prescriptions are being hand written in case of server issues and other exigencies.

a. Legible: As per 'Indian Medical Council, (Professional Conduct, Etiquette and Ethics) Regulations published in Part-III, Section 4 of the Gazette of India, dated 6th April 2002, it is notified by the Medical Council of India that "Every Physician should prescribe medicines with generic names legibly and preferably in capital letters and he/ she shall ensure that there is a rational prescription and use of medicine.

b. Abbreviations: Latin abbreviations/directions for use are avoided. Instead, local vernaculars are used for understanding by the patients.

c. Avoid error-prone symbols and Abbreviations to the extent possible:

Do not use symbols like '>' and '<'

Do not abbreviate 'microgram' and 'nanogram' since the abbreviated form 'µg' is very easily misread as 'mg', a 1000-fold overdose.

The strength of the medicine should be stated in Standard units using abbreviations that are consistent with SI (system international) units.

"Micrograms" and "Nanograms" should not be abbreviated since abbreviation form "g" is very easily misread as "mg", a 1000-fold overdose.

Do not abbreviate 'units' as U since handwritten abbreviated form ('U') can be misread as '0 or 4'.

Don't use abbreviations such as 'D/C' for discontinue, 'TCA' for 'to come again', 'CST' for continue same treatment, or discontinue 1,2, 5, rest to continue, etc.

Errors due to mix-ups between numbers and alphabets: 'l' & '1'; 'O' & '0,'; 'Z' & '2,' '1' & '7.'

Q1d can easily be mistaken for QID leading to four times the dose.

Abbreviations/acronyms for medicine name should not be used example PCM (paracetamol), CPM (chlorpheniramine), CPZ (chlorpromazine), carbamazepine (CBZ), chlor promazine (CPZ), Trihexyphenidyl (TFT) and TFP (Trifluoperazine).

d. Medicine Details: Name of the medicines, dosage, form (injections, tablets, syrup, etc.), strength, frequency, and timings of medicines with meals, duration, route of administration are specified and informed.For frequency OD/,BD/TDS are not to be written.Instead once/twice/thrice to be clearly written as per GoI guidelines

e. Medicines Prescribed should be as per DG ESIC RC list

f. Generic Names: medicines prescribed must be by generic names only.

g. Spacing between medicine and its strength: Give space between medicine and strength as no space may be misread (e.g. Amlodepine 10 mg can be misread as Amlodepine110 mg).

h. Use of '0' zero: Leading zeroes should be preferred (e.g. 0.25 mg). Trailing zeros should not be used e.g. 5.0 mg)

i. Chronology: Chronology to be followed while prescribing medicines e.g. Core Medicine, Supplementary Medicine, Symptomatic medicine or Injections, Oral medicines (Tablets, Capsules, Syrups) Tropical medicines (Ointments, Drops, Creams)

j. Avoid stemmed medicine names. "Nitro' drip for nitroglycerine can be mistaken as sodium nitroprusside infusion. "Norflox" for norfloxacin can be mistaken as Norflex (Orphenadrine).

k. Medicines should be prescribed in line with Standard Treatment Workflow(STW) of ICMR

I. Clearly write the exact quantity of a drug to be dispensed.

8. Rational prescription:

a. Antibiotics should be prescribed rationally. Follow the WHO's 2021 guidelines on antibiotics usage as per **AWaRe** List-Access, Watch and Restrict

b. Vitamins, Tonics or Enzymes prescribed: Must be in line with the standard treatment guidelines.

c. Investigations advised: Must be in line with the standard treatment workflow, ICMR.

d. Number of medicines prescribed: To avoid poly pharmacy, as per WHO average no of drugs prescribed is expected to vary from 2 to 2.9 in a general OPD. However, number of drugs per prescription would increase at health facilities, taking care of senior citizens.

9. Advice &Any special instruction like methods of administration (before/after food), unpleasant taste or drug interactions/side effects must be written on the prescription. Patients must be informed of any changes in their medication.

Chronic Conditions-Ensure an adequate supply of medicines for chronic patients to avoid frequent visits, balancing medication safety and regulations.

Any supportive advice regarding diet/exercise

10. Follow-up

Clearly state follow-up advice and the next visit date.

11. Referral

In case of referral, the relevant clinical details and reason for referral should be given. It should include the name of the referral health facility, department referred to, name of the specialty to be visited, along with the detailed reason for referral.

This SOP serves as a guide and may not cover all situations. Doctors should consult additional resources and refer to their professional judgment when necessary.

Conclusion: ESIC's SOP for prescriptions embodies a commitment to excellence, patient safety, and adherence to best practices, thereby ensuring that ESIC beneficiaries receive healthcare of the highest standard through the Dhanwantri module.