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Medicines Management Policy for the Storage, Prescription and Administration of Medicines

Document Control

A. Confidentiality Notice

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B. Document Details

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Summary

Medicines are one of the most widely used interventions in healthcare. Data from the National Reporting and Learning System indicate that medication is amongst the top 3 incident types reported.

This policy and procedure sets out the company's commitment to and arrangements for safe storage, prescribing, medication review and administration of medicines. The purpose of this policy is to provide the overarching principles for good practice in relation to all aspects of medicines management, and to set out the way in which the Thanet Health CIC will monitor adherence to this overarching policy, related policies and procedures, and national guidelines (including national safety alerts and recommendations).

Introduction

The purpose of this document is to inform nursing, medical and other disciplines of the correct method of storage, control, prescriptions and administration or application of medicines and other pharmaceutical substances.

Additional Policies/Guidelines/ are available and where appropriate used in conjunction with this policy.

It is also the responsibility of staff prescribing and administering medicines to ensure that their knowledge and skills are up-to-date and satisfy the requirements of their professional bodies.

All National Patient Safety Alerts and other national guidance relating to medications will be managed via the clinical team disseminating the knowledge to the rest of the team during monthly clinical meetings.

The Medicine Management Lead is responsible for Safe Medicines Practice within the organisation supported by the Clinical and admin team.

It is the responsibility of all managers to ensure that this policy is understood and adhered to by all staff.

The Company recognises that it has a duty to have in place an appropriate policy which complies with relevant legislation* and guidelines on medicines management which will allow staff to fulfil their individual roles safely and effectively to ensure that the right patient gets the right medication by the right route at the right time.

The Company is fully committed to meeting the requirements of the Care Quality Commission, the General Medical Council, Nursing and Midwifery Council, Health and Care Professions Council and the General Pharmaceutical Council in respect of the different roles and responsibilities that are involved in the complex environment of medicines management.

*The manufacture, supply and use of medicines is governed by the Medicines Act 1968 and EC legislation (Directive 2001/83/EC)

Aims and Objectives

The principle **aims** of the policy are:

- that the right patients receives the right medicine in the right dose, by the right route at the right time;

- that the Company retains clear documentary records relating to medicine prescription, medication review and administration;

- that the Company is committed to reviewing and learning from incidents and near misses relating to the use of medicines in patient care.

The **objective** of this policy is to provide a clear framework for the delivery of an effective medicines management service across the company, and clear procedures for staff to follow to meet the objective of the policy.

Scope

This policy applies to all staff (including CCG, agency and locums) working in the Practice who are directly involved with medicines management, including staff who prescribe, administer, or store medicines in the Practice.

Policy Statements

A prescription is only valid if signed and dated by a recognised prescriber and be present for the prescription to be valid. A signed prescription is valid for 3 months after which it should be destroyed if not collected. The prescription box is checked first Wednesday of every month and the invalid prescriptions shredded and the information documented under patient's records.

Staff other than prescribers may have delegated rights within their competencies to write, transcribe or amend a portion of a prescription. Such an instruction does not become a valid prescription unless signed and dated by a Practice prescriber.

Monitoring Compliance with this Policy and Procedure

Compliance with the Medicines Management Policy in practice will be monitored by way of an annual monitoring and progress report, with recommendations and an associated action plan. Production of this report will be the responsibility of the Operational Manager to be discussed at Clinical Meetings and the meetings with CCG Medicine Management Team.

The monitoring report must evidence implementation of the processes documented in the policy in relation to:

- How the organisation makes sure that all prescription charts are accurate;
- How medicines are prescribed;
- How medication errors are reported;
- How the organisation learns from medication errors;
- How a patient's medicines are reviewed;
- How the organisation trains staff dealing with medicines.

Where the monitoring has identified shortfalls, evidence must be provided to demonstrate that changes have been made to address them.

How the Company Makes Sure That All Prescription Are Accurate Including the Prescribing and Administration of Medicines

- Prescription security protocol in place

- Extra precautions in place on the clinical system for high risk medicines
- All prescriptions signed by the GPs
- Nurses/ HCA administer medicines after PSDs are signed
- Regular searches on the clinical system to ensure safe prescribing done by the company in collaboration with the CCG medicine management team.

How Medication Errors and incidents are Reported, Managed and lessons learned

Medication related incidents will be monitored by the Operational Manager and Lead for Medicine Management. Staff involved should document what they remember about the incident as soon as possible. Complete significant incident report online and where the situation is deemed to be serious a Clinician must be informed. The patient and/or carer should be informed of the error and the action taken.
The Manager will monitor trends in incidents, ensure serious incidents are investigated appropriately, and that lessons are learned from individual incidents.

On-going investigations are reviewed on a monthly basis at Management meetings until the agreed outcomes are achieved and lessons learned.

Compliance with National Guidance and Recommendations in Relation to the Safety of Medication Use (Including NPSA)

This will be monitored via a regular audit program. Implementation of NICE technical appraisals will be monitored via the Clinicians getting email updates; this and other NHS guidance will be monitored and discussed in clinical meetings (every month).

Compliance with Prescribing in Accordance with the CCG Formulary

This will be monitored by the annual audit and the Medicine Management intervention audit with the help of the CCG medicine management team.

Compliance with Safe Storage and Security of Medicines

This will be monitored by the nursing team through regular audit on all medicines stored in the practice

PATIENT GROUP DIRECTIONS (PGDs) and PATIENT SPECIFIC DIRECTIONS (PSDs)

Patient Group Direction (PGD) – A PGD is a written direction to supply and/or administer a drug to a group of patients who fulfil the criteria on the written PGD proforma. Each PGD is signed by a Lead Clinician. Clinical Staff using PGD's should have a management folder with the relevant

information available to ensure that staff undertaking this skill are supported in practice. There must be an up to date signed copy of each PGD available for information within the folder. PGD's should only be used once the registrant has been assessed as competent and their name is identified within each document. The administration of drugs via a PGD must **not** be delegated.

Students cannot supply or administer under a PGD but would be expected to understand the principles and be involved in the process as a third party.

All health professionals using a PGD must ensure that they continue to update their knowledge and skills surrounding the use of PGD's.

All signed PGD's are kept by individual members of the Nursing team in their personal folders.

Patient Specific Direction (PSD) – PSD's are written instructions from a qualified and registered prescriber for the supply and/or administration of medication to a named patient who is individually identified and known before presentation for treatment. PSDs can be administered by any Company approved competent practitioner. The direction needs to be specific as do the drug, dose, route and frequency of administration.

Each individual patient must be identified on the PSD, an example of using a PSD is in the administration of routine vaccines where a list of patients due a vaccine may be identified beforehand. Note: Detailed instructions on a drug chart or other recognised document that forms part of the medical record are legally equivalent to a PSD. A formal approved PSD is needed when Company employees who are not registered health professionals administer or supply a medication unless an MHRA approved exemption applies.

Standards for Storage, Ordering, Security and Disposal of Medicines

For the purposes of storage in practice there are 4 classes of medicines and other pharmaceutical substances.

- **Controlled Drugs** – are those medicines which are regulated by the Misuse of Drugs Act. Some other drugs such as strong potassium chloride injections are also treated as controlled drugs following other national guidance.

- **Other medicines** – either internal or external regulated by the Medicines Act 1968.

- **Reagents** – agents used for the detection of substances by chemical or microbiologic means, e.g. urine testing sticks, pregnancy tests.

- **Disinfectants** – agents that reduce, remove or destroy bacteria and other organisms from skin, instruments and surfaces, e.g. alcohol, chlorhexidine, povidone-iodine. The appropriate disinfectant should be used for the appropriate item, at the correct dilution/ concentration to ensure maximum efficacy, taking into account health and safety/ COSHH regulations

    - Other products may be available to individual users where specific indications justify their usage.

- **'Other Medicines' (Internal, External and Dressings)**

Orders: The company keep an order book which is filled in by the relevant staff and the ordering is done by the Operational manager. The stocks are regularly checked by the nursing staff and kept to an appropriate level

Storage: All medicines must be stored in a locked medicine cupboard or locked fridge.

Reagents

Orders: Made by the nursing team

Security: Reagents should be kept in a separate locked cupboard. The key must be kept in a designated place which is not accessible to patients or visitors.

Use of Reagents – only approved reagents should be used within the building.

Disinfectants

Security: The cupboard must be locked and the key kept in a designated place, which is not accessible to patients or visitors.

Storage in a Refrigerator

Storage: All medicines labelled as requiring refrigeration must be kept in the drug refrigerators, which must be locked. No other items should be stored in the drug refrigerator and the key kept in the possession of the nurse in charge.

Precautions:

a) The lead nurse is responsible for the checking, monitoring and recording of information concerning the drugs refrigerator. A record must be kept.

b) The refrigerator must be checked daily to ensure that the temperature remains constant between 2 and 8 degrees Centigrade. Any readings outside this range must be reported to the Clinical lead at the earliest opportunity.

c) **The drug refrigerator must be reserved for the storage of medicines only.**

d) Regular checking of expiry dates must be undertaken by lead nurse on a 3 monthly basis.

Storage in Resuscitation Trolleys, Emergency Cardiac Drug Boxes and Trays

Emergency drugs stored in resuscitation trolleys if kept in an area where there is public e.g. in reception next to patient waiting area. It is the responsibility of the Lead Nurse to obtain a replacement and also to review the expiry dates, and rotate the emergency cardiac drug boxes. No other drugs may be stored on the resuscitation trolley.

The resuscitation trolley must be checked daily by nursing staff.

Disposal of Unused and Pharmaceutical Waste

NHS Properties is responsible for managing Pharmaceutical waste for the Practice through the lease agreement

All open/partially used vials/syringes/ containers – including residues are classified as Pharmaceutical waste, and must be disposed of in the appropriate waste bin.
Obtaining further supplies of waste bins (from the NHS supplies stores department) is the responsibility of the Operational Manager.

Separate bins are required for sharps, hazardous Pharmaceutical waste and non-hazardous Pharmaceutical waste. Lists of drugs which fall under the category of hazardous **must** be displayed on all clinical rooms.

A coloured poster of each waste bin **must** be displayed in all clinical rooms.

The bin for Non-hazardous Pharmaceutical Waste has a **Blue** Lid, and the bin for hazardous Pharmaceutical Waste has a **Purple** Lid.

Syringes and needles contaminated with non-hazardous Pharmaceuticals (e.g. plain IV fluids) are considered to be sharps and should be put in the yellow bin lid sharps container. Please note if the syringes or needles are contaminated with hazardous Pharmaceuticals, they are classified as hazardous waste and should be disposed of in the purple lidded bins.

Waste bins will be removed and destroyed in accordance with local policy.

Returned medicines: We do not encourage bringing back any unused medicines back and guide the patients to contact their pharmacies.

Standards for Prescribing Medicines

Prescribers

- All prescribers must have their professional registration status checked on appointment.

Process for Prescribing Medicines

Prescriptions are done mainly via the clinical system majority of them going electronically through EPS where available and the rest being printed on FP10.

Principles in relation to the prescription of medicines:

All professionals involved in the prescribing of medicines are accountable for their actions and omissions. Each discipline must adhere to the requirements of their own professional body and specific guidelines. They must exercise professional judgement and apply their knowledge and skills in the given situation. It is also important that the prescription should be based, whenever possible, on the patient's informed consent and awareness of the purpose of the treatment.

It is the responsibility of all staff concerned with prescription and administration of medicines to ensure that **any history of drug allergy is recorded on the clinical system**

Assessment of new drug allergy and communication of allergy must be consistent with NICE CG183 Drug allergy: diagnosis and management of drug allergy in adults, children and young people (http://www.nice.org.uk/guidance/cg183).
Patient Group Directions (PGD) can be used by a registered practitioner, who has the authority of their manager and following training, can provide evidence of competence. Policies and guidelines for the use of PGD's must be adhered to at all times. The use of a PGD should be documented appropriately in the once only part of the prescription chart; or the relevant patient documentation.

Gillick Competence/ Fraser Guidelines for Prescribing to People between 16 and 18

In general, in English Law a minor is a person less than 18 years old. However the Family Law Reform Act 1969 states:

"The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, should be as effective as it would be if they were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian".

It is probably the case that for a person between 16 and 18 years old consent may be obtained either from the parent or from the person themselves.

Adults, defined as people over the age of 18, are usually regarded as competent to decide their own treatment. The Family Law Reform Act 1969 also gives the right to consent to treatment to anyone aged 16 to 18.

Note though that consent to medical treatment can be given by a child under the age of 16 if s/he is 'Gillick competent'

Children under the age of 16 can consent to medical treatment if they have sufficient maturity and judgement to enable them fully to understand what is proposed. This was clarified in England and Wales by the House of Lords in the case of Gillick vs West Norfolk and Wisbech AHA & DHSS in 1985

In making his judgement the Law Lord, Lord Fraser, offered a set of criteria which must apply when medical practitioners are offering contraceptive services to under 16's without parental knowledge or permission. The so-called Fraser Guidelines (some people refer to assessing whether the young person is Gillick competent) state that all the following requirements should be fulfilled:

- the young person will understand the professional's advice
- the young person cannot be persuaded to inform their parents
- the young person is likely to begin, or to continue having, sexual intercourse with or without contraceptive treatment
- unless the young person receives contraceptive treatment, their physical or mental health, or both, are likely to suffer
- the young person's best interests require them to receive contraceptive advice or treatment with or without parental consent

Notes:
Although these criteria specifically refer to contraception, the principles are deemed to apply to other treatments, including abortion. The Fraser guidelines referred specifically to doctors but it is considered to apply to other health professionals, including nurses.

PRESCRIBING IN THE ELDERLY

Elderly patients often receive multiple drugs for co-morbidities. This greatly increases the risk of drug interactions as well as adverse reactions, and may affect compliance. The balance of benefit and harm of some medicines may be altered in the elderly e.g. increased falls risk. Therefore, elderly patients' medicines must be reviewed regularly

Guidelines for Good Prescribing in Primary Care

Medicines which are not of benefit should be stopped. Non-pharmacological measures, where they may be appropriate, should be considered. In some cases prophylactic drugs are inappropriate if they are likely to complicate existing treatment or introduce unnecessary side effects however elderly patients should not be denied medicines which may help them e.g. anticoagulants, statins, osteoporosis drugs

PRESCRIBING MEDICINES TO PEOPLE WHO LACK CAPACITY TO CONSENT

When patients lack the mental capacity to consent to treatment, medication may still be prescribed and administered to them, provided the principles of the Mental Capacity Act 2005 are followed.

Staff should also be guided by their local policy. For full details refer to the following source documents:-

- The Mental Capacity Act 2005 (40)
- The Mental Capacity Act: Code of Practice 2007(41): In summary:
- The person's capacity to consent to the treatment must be formally assessed according to the process prescribed in Section 2 and 3 of the Mental Capacity Act 2005, for which more detailed guidance is provided in Chapter 4 of the Mental Capacity Act Code of Practice (Department of Constitutional Affairs 2007).
- When an adult lacks the mental capacity to give or withhold consent to treatment, no one else can give consent on their behalf other than an attorney under the Lasting Power of Attorney (LPA) or a deputy appointed by the Court of Protection, where the decision is within the scope of their authority.
- If the person lacks capacity to consent, and in the absence of an attorney or deputy with relevant authority, the treatment can still be given, provided it is in the patient's "best interests". The process of determining best interests must be carried out in accordance with Section 4 of the Mental Capacity Act 2005, for which more detailed guidance is provided in Chapter 5 of the Mental Capacity Act Code of Practice (DCA 2007).

Guidelines for Good Prescribing in Primary Care

- The process of assessing capacity and determining best interests must be documented in the clinical records.
- Staff should be aware that the Mental Capacity Act 2005 includes provision for adults, who have the capacity to do so, to make advance decisions to refuse specified treatment for a time in the future when they lack capacity to consent to it. Provided it can be established that an advance decision is valid and applicable, it has the same effect as a decision made by a person with capacity, and healthcare professionals must respect this decision. The GMC consent guidance (43) summarises 'Making decisions when a patient lacks capacity' as follows: In making decisions about the treatment and care of patients who lack capacity, you must:

a. make the care of your patient your first concern
b. treat patients as individuals and respect their dignity
c. support and encourage patients to be involved, as far as they want to and are able, in decisions about their treatment and care
d. Treat patients with respect and not discriminate against them.

You must also consider:

a. whether the patient's lack of capacity is temporary or permanent

b. which options for treatment would provide overall clinical benefit for the patient

c. which option, including the option not to treat, would be least restrictive of the patient's future choices

d. any evidence of the patient's previously expressed preferences, such as an advance statement or decision.

e. the views of anyone the patient asks you to consult, or who has legal authority to make a decision on their behalf,(holders of lasting powers of attorney and court-appointed deputies) or has been appointed to represent them (Independent Mental Capacity Advocates)

f. the views of people close to the patient on the patient's preferences, feelings, beliefs and values, and whether they consider the proposed treatment to be in the patient's best interests

g. what you and the rest of the healthcare team know about the patient's wishes, feelings, beliefs and values.

Prescribing for Visitors from Overseas and Patients travelling abroad

Patients entitled to NHS treatment in primary care, including the provision of any necessary prescriptions are as follows:

- A person intending to be resident in this country for six months or more (registration with a practice is necessary)
- Patients from the European Economic Area in possession of a European Health Insurance Card (EHIC)
- Patients (from any country) who require immediate, essential treatment, which the treating doctor deems cannot reasonably be delayed until the patient returns home (EHIC not required).
- Patients from EEA member states holding an E112 (entitles the patient to seek treatment of a specific condition and prescriptions for this condition only). Patients from EEA member states holding an E128 (entitles the patient to seek NHS treatment for all conditions on same basis as UK residents)
- Patients allocated by NHS England.
- Refugees (those whose applications to reside in this country have been approved) and asylum seekers (those who have submitted an application and are awaiting a decision)

This list is not exhaustive. Please check an individual's situation before providing or declining NHS care as special conditions may apply. Further information is available from the Overseas Visitors section of the Department of Health website. (14)

- Patients who do not fall into these categories may be offered and charged for private care, including the provision of private prescriptions where necessary.
- Under NHS legislation, the NHS ceases to have responsibility for people when they leave the UK.
- For NHS patients travelling for three months or less, medication required for a pre-existing condition should be provided in sufficient quantity to cover the journey and to allow the patient to obtain medical attention abroad.
- For longer visits abroad (in excess of three months), the patient should be advised to register with a local doctor for continuing medication; this may need to be paid for by the patient.
- Anyone staying outside of their home country for longer than three months should register with a doctor in the country they are visiting for the purpose of receiving further prescriptions.
- Patients who are carrying certain controlled drugs abroad may require a personal export or import licence or a letter from the prescribing doctor.
- GPs are not required to provide prescriptions for medication which is requested solely in anticipation of the onset of an ailment whilst outside the UK, but for which treatment is not required at the time of prescribing.

The Repeat Prescribing Process

Requests for repeat prescriptions may be received from the patient, their carer, district nurse, pharmacist or care home staff. The practice should be confident that the person making the request has the patients' permission to do so. Children under 16 cannot request prescriptions or make online appointments unless deemed competent by the GPs. Parental access to children's accounts becomes disabled at 16.

Requests can be made by a variety of methods:

1. In writing
2. Via the internet through patient access

It is preferable that requests are made in writing as they are more likely to be accurate and there is a reduced opportunity for errors and misunderstandings.

Repeat prescriptions must normally be ready for the patient to collect within 3 working days of the request being made (excluding weekends and bank holidays)

Requests for "all repeats" or just involving a description of medication should not be accepted and the patient should be contacted to clarify what exactly they are requesting.

Issuing a Repeat Prescription

- Make sure that the items requested are on the patient's current repeat list. If not check the patients notes to see if there is an entry to say that the medication has been stopped, if not complete the request slip and pass it to the relevant GP
- If the item is on the list, verify that the name, form, strength and dosage instructions match the request. If there are any discrepancies, refer to the relevant doctor
- If the authorised number of issues has been met, follow the instructions below
- Investigate whether the request is being made earlier (or later) than expected as this may indicate over or under usage. If in doubt refer to the GP
- Cancel any repeat medication that has not been accessed for more than 12 months (except seasonal medications such as for hay fever)
- Always print a counterfoil with all repeats showing
- Prescriptions should be issued for 28 days
- Patients receiving their medications in Monitored Dosage Systems should receive a prescription for 28 days and not 4 x 7 days, unless clinically appropriate.
- GPs will consider issuing 2 months medication to patients going on holiday or who are on stable medication

Process to follow when the number of authorised repeats has been met

- Establish whether a medication review has been done recently. If so you may re-authorise the repeat items to end 12 months from the date of the review
- If the patient has not had a medication review check to see if they are due a chronic disease review, you may re-authorise the items, up to the date the review is due
- Re-authorise all items, not just those in italics, to keep the repeats in line

High Risk Medicines

- If the medication is a controlled drug e.g. "Morphine based drug" or Amiodarone, Methotrexate, Azathioprine. Lithium or Benzodiazepine are issued one month only and give a medication request slip to the prescribing doctor.
- Before issuing, check that up to date bloods (less than 2 months) are on the system
- For Warfarin, INR reading less than 6 weeks old on the system is a pre-requisite before issuing if requested. Warfarin is usually issued by the pharmacies.

PRESCRIBING OF HIGH RISK MEDICINES (WIP)

Prescribing of Insulin

Errors in the administration of insulin are common. To address this, the National Patient Safety Agency (NPSA) has produced two patient safety alerts:

1. NPSA/2010/RRR013(51) All regular and single insulin (bolus) doses should be measured and administered using an insulin syringe or commercial insulin pen device. Intravenous syringes must never be used for insulin administration. The term 'units' should used in all contexts. Abbreviations, such as 'U' or 'IU' must never be used.

2. NPSA/2011/PSA003(52) When prescribing insulin the NPSA recommends:

- Offering the use of an insulin passport to record information on the insulin products they use

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- Provide a patient information booklet which describes known error-prone situations and actions that may cause harm and enforce the benefits of using the insulin passport to minimise these risks
- Record the patient's decision of whether or not to use the passport offered to them (the patient's passport status) in medical notes.
- Assist patients in completion of therapy details in the insulin passport, specifically in how to describe their insulin products so that there is no ambiguity in what they are using
- Instruct patients to present their insulin passport when visiting all healthcare professionals.

Prescribing of Lithium

Some patients taking lithium have been harmed because they have not had their dosage adjusted based on recommended regular blood tests. If patients are not informed of the known side effects or symptoms of toxicity, they cannot manage their lithium therapy safely. Regular blood tests are important, linked to adjust of dose as necessary. Clinically significant alterations in lithium blood levels occur with commonly prescribed and over-the counter medicines. The blood level of lithium is dependent on kidney function and lithium has the potential to interfere with kidney (renal) and thyroid functions.

The NPSA (NPSA/2009/PSA005) (54) recommends:

1. Patients prescribed lithium are monitored in accordance with NICE guidance;

2. There are reliable systems to ensure blood test results are communicated between laboratories and primary care and specialist prescribers.

Guidelines for Good Prescribing in Primary Care

At the start of lithium therapy and throughout their treatment patients receive appropriate on-going verbal and written information and a record book to track lithium blood levels and relevant clinical tests*;

Prescribers and community pharmacists check that blood tests are monitored regularly and that it is safe to issue a repeat prescription and/or dispense the prescribed lithium; 5. Systems are in place to identify and deal with medicines that might adversely interact with lithium therapy. * The NPSA has

developed a patient information booklet, lithium alert card and record book for tracking blood tests. Resources are available from specialist services or Primary Care Support Services.

Prescribing of Methotrexate

Oral methotrexate is a safe and effective medication if taken at the right dose and with appropriate monitoring. However, very occasionally problems with taking the medication can cause serious harm and even death. Two thirds of all incidents result from the wrong dose being prescribed and a fifth are linked to poor monitoring. The NPSA produced advice in 2004 “Towards the safer use of oral methotrexate” and then a Patient Safety Alert in 2006:

1. Information on the risks and benefits of oral methotrexate should be given to the patient. Confirmation of the patient’s understanding and consent should be sought, baseline tests conducted, monitoring schedule explained, and patient-held monitoring booklet issued.

2. For NHS organisations with Shared Care Guidelines, the following issues should be addressed:

- clarity of prescribing and monitoring responsibilities;
- how often blood tests will be conducted and in which location;
- which clinician will be responsible for receipt and review of the results;
- who will communicate any necessary dosage changes to the patient and the GP;
- who will record test results on the patient-held monitoring booklet
- All prescribers must avoid the use of ‘as directed’ in prescribing – a specific dose must be applied to each prescription. Bear in mind that patients often understand their dose by the number of tablets they take rather than ‘mg’. The required quantity and frequency of dose should be regularly discussed with the patient.
- Repeat prescriptions should be retained separately for prescriber review prior to authorising. It may help to change the printer driver software so that it shades the prescription signature space on FP10/WP10 to alert the prescriber to this high-risk drug.
- Be aware of patients who attend with symptoms such as breathlessness, dry persistent cough, vomiting or diarrhoea, as these can be signs of oral methotrexate toxicity or intolerance.
- Handwritten prescriptions and discharge summary information must be complete, legible and include the form, strength, dose and directions in full.
- Consideration needs to be given to the duration of supply and frequency of issue of repeat prescriptions for methotrexate. Ideally patients should not be given more than a four week supply
- A check should be carried out to ensure necessary monitoring is conducted prior to issuing or reauthorising repeat prescriptions.

Prescribing of Warfarin

Anticoagulants are one of the classes of medicines most frequently identified as causing preventable harms and admissions to hospitals. Managing the risks associated with anticoagulants can reduce the chance of patients being harmed in the future. The NPSA issued a Safety Alert NPSA/2007/17(57) and gave the following advice to GPs.

1. Ensure that before issuing a repeat prescription for anticoagulant medication, check that the patient's INR is being monitored regularly and that it is at a safe level for the repeat prescription to be issued. The easiest way to do this is to ask to see the patient-held INR record, which may be in the form of a single printed sheet, a small booklet or contact the pharmacy providing the service.
2. Ensure that if a patient who is already on oral anticoagulants is co-prescribed one or more clinically significant interacting medicines, that arrangements are made for additional INR blood tests, and that the anticoagulant clinic is made aware that an interacting medicine has been prescribed. The patient may be empowered to ensure this happens in appropriate cases
3. Ensure that doses are expressed in mg and not in number of tablets.
4. Review and, where necessary, update any sections of clinical procedures and protocols that relate to parts of the anticoagulant care pathway for which they or their staff take responsibility.
5. Ensure that all dose changes, originated by the surgery, for patients in care homes are confirmed in writing.
6. Ensure that patients on anticoagulant therapy have received appropriate verbal and written information at the start of their therapy, and when necessary throughout their treatment. In practice, this means making sure that patients have received a 'yellow book' and ensuring that they (or their carers) fully understand its contents.
7. Participate in an annual audit of anticoagulant services.

Repeat Dispensing

Repeat dispensing is the process by which patients can obtain supplies of their repeat medicines over a defined period of time, without the need to contact their GP practice on each occasion a new supply is required. People with chronic conditions that are likely to remain stable for the duration of the repeatable prescription are most likely to benefit from repeat dispensing services. The decision whether to use a repeat dispensing service is a matter for the prescriber's clinical judgement and mutual agreement between the prescriber, the patient and, ideally, the pharmacist. Repeat dispensing will not be suitable for all patients, nor is it an overnight 'quick fix' for longstanding supply problems. It requires commitment and support from all those involved to realise all of the potential benefits.

The patient nominates the pharmacy to provide the service and presents the repeatable prescription at that pharmacy for dispensing in the usual way.

PRIVATE PRESCRIBING

After Private Referral

The responsibility for prescribing rests with the doctor who has clinical responsibility for a particular aspect of the patient's care. Where, for instance, an NHS doctor refers a patient (privately or otherwise) to a consultant for advice but, when appropriate, retains clinical responsibility, he/she should issue the necessary prescriptions and at NHS expense, provided it is considered normal clinical practice and within local guidelines and formularies.

People who opt to be referred privately (i.e. outside the NHS) are expected to pay the full cost of any treatment they receive in relation to the referral, including that of any drugs and appliances. Patients should be informed of this expectation prior to referral. Following a private consultation, there is no obligation for the GP to prescribe the recommended treatment if it is contrary to his/her normal clinical practice.

Patients have a right to revert to NHS funding at any point during their care. However, if they wish to exercise this right, their care will be transferred to local pathways

When a private referral is made, patients may be given the leaflet shown in Appendix 1, explaining the situation regarding NHS prescriptions following private consultations. Enclosing a copy with any referral letter may also be useful.

Private Prescriptions for NHS Patients

GPs should provide their NHS patients with any medication deemed clinically appropriate on an NHS prescription. A private prescription should only be provided in the circumstances listed below. Prescribers may provide private prescriptions for their NHS patients when the item is not prescribable on the NHS.

This includes:

- items on the DH "blacklist"
- drugs for the prevention of malaria
- drugs where the indication is outside those indicated on the selective list scheme (SLS)
- travel vaccines not included in current public policy
- travel packs or drugs prescribed solely in the anticipation of the onset of an ailment while outside the UK (e.g. antibiotics for travellers" diarrhoea, acetazolamide for altitude sickness).

NHS patients may be charged for the issue of a private prescription for malaria prophylaxis and travel related prescriptions, and will need to pay for the cost of the drugs, including travel vaccines where remuneration is NOT provided under the NHS.

NHS patients should not be charged for the issue of private prescriptions for drugs on the DH "blacklist" or SLS drugs prescribed outside the SLS criteria.

Patients have to pay the cost of all medicines that are prescribed on a private prescription.

NHS GPs providing private care e.g. private GP appointments or an occupational health service cannot issue an NHS prescription as this would constitute a breach of the GMS, PMS or APMS contract.

Prescribing by Community Nurses

- Where a non-medical prescriber, based in the community, issues a prescription for a patient they should fill in the recommended form and email it to the company as soon as possible.
- On receipt of the above form, the patient's doctor should be informed; they will authorise appropriate changes to the patient medical record e.g. the drug added as acute or repeat as appropriate and the form scanned into the patient's computer record

Process after Printing

Once printed, if the patient is tagged to a chemist, the prescription should be entered onto that chemist's collection sheet and tagged to the back of the sheet, in the order that they appear on the sheet. They should then be placed into the appropriate basket for signing.
Patients who are not tagged to a chemist – place the prescriptions into the appropriate basket for signing
After signing:

1. Check that all prescriptions have been signed
2. Check that all prescriptions listed on the chemist collection sheet are still attached
3. Prescriptions for collection by the patient should be filed in the collection box in surname then first name order

When a prescription is collected always check the patients name, date of birth and address.

Prescriptions should not be given out to children to collect

The prescription collection box should be checked on a monthly basis. Any prescription more than one month old should be destroyed and a note saying – prescription not collected should be added to the patient's notes, along with the date of the prescription and a note that it has been destroyed

Management control

Medications must only be added to a patients' repeat list by appropriately qualified staff.

When a repeat medication is added to the list a read coded reason must be added as to why the medication has been started

Staff who are involved in the preparation of repeat prescriptions must be appropriately trained

Lost Prescriptions

If a prescription is reported as lost check the date of issue and any places where it could possibly be – i.e. mis-filed, sent to the chemist or to the wrong chemist
If the prescription cannot be found **reprint** the prescription – **do not re-issue**
Make an entry in the patient's notes saying – lost prescription noting the date of the prescription and that it has been re-printed

Patients who report that their medication or prescription has been stolen should report the matter to the police and obtain a crime number
Patients who regularly "lose" their prescriptions should be seen by a doctor who will decide if it is appropriate to re-issue the prescription

Early requests for controlled or high risk medicines should always be approved by the clinician.

Under no circumstances must a Receptionist/ Admin re-print or re-issue a prescription for controlled drugs

Medicines Reconciliation

The aim of medicines reconciliation when patients change care settings is to ensure that medicines prescribed in the new setting (e.g. on admission to hospital) correspond to those that the patient was taking in the previous care setting (e.g. medicines prescribed by the patient's GP)

Medicines Reconciliation on Discharge from Hospital

- The following members of the staff should be responsible for medicines reconciliation (including the implementation of any drug changes in the patients' medical record)- a doctor or a competent nurse, pharmacist or pharmacy technician.
- Patients who are seen in an outpatient clinic or admitted often have their medication changed. It is important that these changes are made on the patients repeat medication list.
- Medication changes indicated on an outpatient letter may be amended by the admin staff once the GP has reviewed the letter and authorised the amendments
- Hospital discharge letters are distributed to the relevant doctor to amend the repeat screen as necessary to complete medication reconciliation.

- Any missing information on the discharge summary should be completed by contacting the ward, pharmacy department, the discharging practitioner or the patient
- Where missing information cannot be obtained the prescriber should undertake a full medication review with the patient.
- The discharge information should clearly state which medicines have been changed, those that have been stopped and those that have been started and the reason.
- The following data should be expected:
    - Complete and accurate patient details including full name, date of birth, weight if under 16 years, NHS/unit number, consultant, ward, date of admission, date of discharge
    - The diagnosis of the presenting condition plus co-morbidities
    - Procedures carried out
    - A list of all medicines prescribed for the patient on discharge form hospital (not just those dispensed at the time of discharge)
    - Dose, frequency, formulation and route of administration
    - Medicines stopped and started, with reasons and dates
    - Length of courses where appropriate (e.g. antibiotics)
    - Details of variable dosage regimens e.g. oral steroids, warfarin etc.
    - Known allergies, intolerance and hypersensitivities and previous drug interactions
    - Any additional patient information provided such as corticosteroid record cards, anticoagulant books etc.
    - Details of any follow up appointments

- Hospital only medicines should be recorded in the patient's records under the appropriate heading.
- Ongoing concerns about missing data should be fed back to the CCG and provider. All GP Practices should participate in local audits.
- Any future monitoring required after the patient has been discharged should be undertaken and facilitated by the use of screen messages and reminders in the patient's medical record
- The process should be double checked by another person from the list above
- The clinicians should be involved in medicines reconciliation, especially where the patients are at high risk of harm from either their prescribed medication e.g. patients discharged on controlled drugs, NSAIDs or warfarin or diuretics or on two anti-platelets or when they are in a vulnerable patient group e.g. the elderly, those with complex co-morbidities and/or patients receiving polypharmacy.
- Wherever possible assistive technologies should be used to reduce patient harm e.g. patient safety messages on ScriptSwitch.

Competencies for Practitioners undertaking Medicines Reconciliation

The following skills are required for practitioners undertaking medicines reconciliation:

Effective two way communication skills	• Verbal, • Non verbal • Written skills • Active listening • Questioning techniques • Giving and receiving feedback
Technical Knowledge	• Understanding of relevant policies and procedures e.g.: 1. Local medicines documentation 2. Discharge summaries 3. Patient own drugs policy 4. Repeat prescribing policy 5. GP practice system 6. MDS availability
Therapeutic Knowledge This level of therapeutic knowledge would normally be achieved by pharmacists, doctors, or suitably experienced pharmacy technicians or nurses.	• Up to date knowledge of brand and generic names of drugs • Forms in which drugs are available • Licensed indications • Common dosage directions • Ability to correctly interpret a prescription including dose and directions • Knowledge of the legal requirements for the prescribing, recording, administration and storage of medicines (including controlled drugs) • A basic understanding of what the medicine is intended to do and how it works

Home visits

Alterations to a patients medication made on a home visit must be amended on the patient's notes as soon as is practicably possible. Handwritten prescriptions must also be entered onto the patient's records.

Clinical Control

Medication review

The following protocol must be adhered to when reviewing patients' medication:

- Ask if experiencing any possible side effects or questions regarding the medication? Or direct to pharmacy for medicine use review (MUR).
- Is the patient still wishing to continue the medication, and what is their compliance like?
- Does the patient know what the drug is for and how to take it?
- Check if any blood or other tests are required for monitoring, if so arrange these.
- The fall back mechanism of regular searches by ***all GPs*** *should* pick up any of these defaulting.
- Is the drug being used for a recognised, and still valid, indication; and according to current guidelines?
- Are there any serious interactions or contraindications or particular advice. I.e. Missed COCP or how to take biphosphonates.
- Can any simplifications, switches or changes to generic medications be made?
- Is the patient on the Heart Failure or CKD register; if so are they also on an NSAID or COX2?
- If so make sure this medication is not interfering with their illness and discuss stopping if necessary.

The doctor then re-authorises all medications.

Doctor or pharmacist then enters the READ code **'Medication Review'** in the patients notes.
This is performed yearly for all patients on repeat medication and tailored to the individual patient's requirements.

Standards for Administration of Medicines

Process for the Administration of Medicines – Remember Your Accountability and Duty of Care

All health care professionals/practitioners undertaking the administration of medicines must have attended training and achieved competence at the required level. Staff need to show evidence of this training.
Non registered practitioners who have attended training and have been deemed competent to administer medicines are legally accountable for this delegated task. Registered professionals remain professionally accountable for the delegation of the task.

Student Nurses

All student nurses must adhere to the following guidelines:

- Students are allowed to prime an IV line under direct supervision but not attach it to the patient IV access.
- A student can, under direct supervision, prepare medication as part of a drug round e.g. nebulizers and insulin's. Under no circumstances should a student participate in any aspect of preparation or administration of intravenous drugs, this is an observation only task.
- A student can only act as a third person for any drug which requires checking

In exercising professional accountability in the best interests of patients, all professionals/practitioners administering a medicine must adhere to the following:

Know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications.

Be certain of the identity of the patient to whom the medicine is to be administered. Be aware of the patient's management plan.

Consider the dosage, method of administration, route and timing of the administration in the context of the condition of the patient and co-existing morbidity. Check whether any additional monitoring is required to support safe administration of the medicine, e.g. cardiac monitor, infusion pump, and pulse oximeter. Any staff using equipment to administer medications should be trained and competent in its use.

Check the expiry date of the medication to be administered. If a product has expired, seek replacement through normal procedures.

Check that the patient is not allergic to the medication before administering it.

High risk drugs listed below:

- Insulin preparations
- Warfarin
- *Opiates (e.g. morphine) administered by injection
- Therapeutic dose low molecular weight heparins e.g. enoxaparin

- Heparin
- DMARDs

Make a clear, accurate and immediate record of all medication administered, intentionally withheld or declined by the patient, ensuring that any written entries and the signature are clear and legible. Record the administration of unlicensed medicines dispensed for individual patients in the usual way.

Before issuing the DMARDs, the staff need to make sure the patient has had bloods done in the last 2 months. Patients on Warfarin need to have had their INR checked in the last 6 weeks for the admin staff to issue the medicine.

Management of Errors and Incidents Relating to Medicines Management

Regular alerts and updates will be discussed in the meetings to ensure and support learning from incidents and audit outcomes.

It is important that all disciplines understand their professional and legal accountability when prescribing or administering medicines. (Refer to own professional bodies/guidance.)

If an incident or near miss occurs it should be reported immediately to the Operational Manager. The medical staff must also be informed and agreed action to ensure patient safety must be carried out and recorded in the patient's notes.
Learning from errors or incidents is very important and therefore, a thorough and sensitive investigation should be undertaken. Staff involved should document what they remember about the incident as soon as possible. Complete significant incident report online and where the situation is deemed to be serious a Clinician must be informed. The patient and/or carer should be informed of the error and the action taken.

The management investigation report must be completed with the staff member and any learning needs identified and recorded with review dates.

In addition, it is the responsibility of medical staff to inform one of the Drs if they make a drug error.

All staff must adhere to the requirements of the Duty of Candour which apply to incidents that have caused prolonged psychological harm, moderate harm, severe harm or death.

Adverse Reactions to Medicines

Whenever there is a reason to suspect an adverse reaction from a medicine it must be reported to the doctor.

An adverse reaction is defined as a response to a medicinal product that is noxious and unintended effects resulting not only from the authorised use of a medicinal product at normal doses, but also from medication errors and uses outside the terms of the marketing authorisation, including the misuse, off-label use and abuse of the medicinal product EU Directive 2010/84/EU1

If the adverse reaction relates to a company instituted therapy and results in death it should always be notified as a clinical incident. Serious adverse reactions with respect to any medications should always be discussed at a senior level and should be notified as a clinical incident. Unexpected adverse reactions must be discussed with the Clinician and discussed in the clinical meetings

The Medicines and Healthcare Products Regulatory Agency (MHRA) uses the Yellow Card Scheme to receive confidential reports from all clinical staff, although usually prescribers are expected to take the lead in reporting. The Company expects its staff to make such reports on patients under their care. Healthcare professionals and doctors can complete the on-line reporting forms that can be accessed on www.yellowcard.gov.uk.

When the healthcare practitioner suspects that a patient is reacting adversely to an intravenous medication it must be stopped immediately, the patient treat appropriately, reported as above and documented in the nursing/medical notes. If an adverse reaction is confirmed, Drs must be immediately alerted so that they may withdraw the suspect batch if this is considered the cause.

Formulary

The BRITISH NATIONAL FORMULARY contains comprehensive information relating to medicines. A current copy should always be accessible in the clinic. It can also be accessed at http://www.evidence.nhs.uk/formulary/bnf/current. Paper copies of the BNF are only supplied free of charge to the company in September each year. The March version should be accessed on line.

Shared Care of Medicines (Working towards this)

Responsibilities for continuing care or treatment should be based on the patient's best interests. All parties including the patient should agree to this. Effective communication of all relevant information and continuing liaison are essential. Shared Care Agreements (sometimes called Shared Care Guidelines) are developed when sophisticated or complex treatments that were initiated in secondary care are then transferred for prescribing by a GP. Medicines initiated in hospital and prescribed for potentially serious conditions often have a relatively high adverse-effect profile and require specific monitoring and dose titration.

Staff to ensure there is a written agreement from the requesting consultant confirming how and by whom the patient will be monitored both for evaluating effectiveness of treatment, side effects and routine tests required. Shared care guidance should be used when required, however prescribers must feel confident to take on prescribing and be clear on their responsibilities within that guidance before agreeing to prescribe. Reference copies of agreed shared care guidance may be accessible via local medicines management websites. The following is taken from the Midlands Therapeutic and Review Advisory Committee policy on Effective Shared Care Agreements with emphasis added. Successful shared care arrangements enable the combination of the best of both primary and secondary care for the benefit of the patient. They allow the seamless transfer of patient treatment from the secondary care sector to general practice.

Effective shared care relies on Effective Shared Care Agreements including the following aspects.

- Individual, patient-by-patient arrangements - Effective Shared Care Agreements should be patient specific and encompass all aspects relevant to that particular patient.
- A reasonably predictable clinical situation - Clinical responsibility should be considered for transfer to primary care only where it is agreed that the patient's clinical condition is stable or predictable.
- Willing and informed consent of all parties - This includes patients, carers and doctors. Consenting parties must have sufficient, accurate and timely information in an understandable form. Consent must be given voluntarily.
- A clear definition of responsibility - The shared care arrangement should identify the areas of care for which each partner has responsibility and where, if appropriate, the specialist resources are available to the GP. This should be patient specific.
- A communication network - Agreed communication should include a telephone contact number for use when problems arise, and fax and email numbers if appropriate. Progress reports should be produced to an agreed time-scale with regular review.
- A clinical summary - This should include a brief overview of the disease and more detailed information on the treatment being transferred for which each partner has managerial and clinical responsibility. At a minimum, it should identify the product's licensed indications, therapeutic classification, dose, route of administration and duration of treatment, adverse effects (their identification, management, importance and incidence), monitoring requirements and responsibilities, clinically relevant drug interactions and their management, storage and reconstitution of product, peer reviewed references for product use, and contacts for more detailed information.
- Emergency support - Contact numbers should include those for out-of-hours queries.

- Training - Any training required by GPs and their staff should be identified and provided to a satisfactory standard by the specialist department seeking the shared care arrangement. The issue of patient safety is always paramount.

It is important that, when patients are transferred from hospital to general practice on a medicine that is not frequently prescribed in primary care, this should only take place with full local agreement and the dissemination of sufficient information to individual GPs. This could take the form of an agreed shared care management guideline. Clear processes and good communication are pivotal to effective shared care and GPs will need to be aware of their responsibilities when writing prescriptions for specialist medicines. Legal responsibility for prescribing lies with the doctor who signs the prescription. This is a particularly important consideration if a GP is intending, or has been asked to prescribe an unlicensed medicine or a licensed medicine either for an off-label indication or a dose outside that recommended in the Summary of Product Characteristics. (See advice from MHRA in section 8). Local commissioners could be asked to pursue any specific difficulties.

Appendices

Appendix 1 – Patient Synchronisation Form

Dear patient:

Synchronising your repeat medicines

We notice that on your last request for medication you only asked for some of your regular items. We would like to arrange that the renewal of all your medicines happens at the same time - this will have advantages for you, as you will be able to pick up all your medicines together, reducing the number of times you have to order / collect your medication.

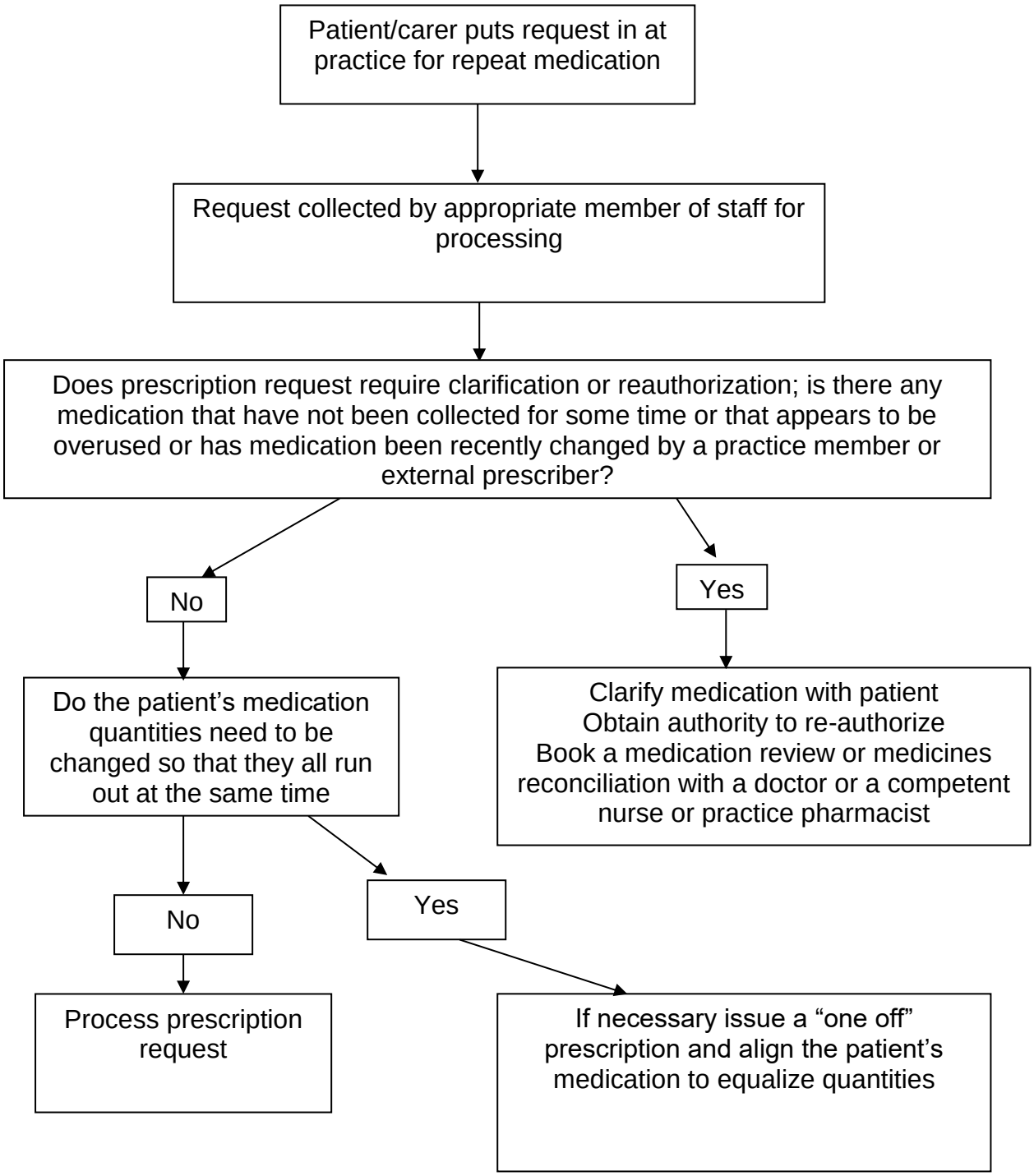
To achieve this we will issue a single synchronising prescription. To help us with this synchronisation please complete the form below and hand it in the next time you order your repeat prescription. When you next collect your medicines you will receive different quantities of each to bring them in line. In the future you should be able to order all your regular items together – there will be a couple of exceptions, where the dose of medication varies i.e., painkillers, anticoagulants, insulin.

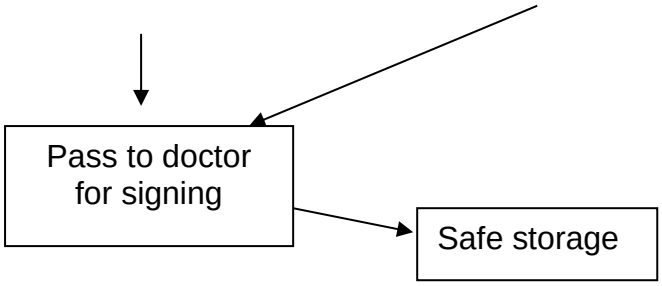
If you have any questions or queries then please speak to one of the reception staff.

Please complete the first three columns of the table, following the first example:

Name of medication	**How do you take the medication**	**How many tablets do you have left**	**PRACTICE USE ONLY** **1 MONTH SUPPLY =**	**Supply for synchronisation prescription**
EXAMPLE Aspirin 75mg	**One daily**	**7**		

Appendix 2- Repeat Prescribing Process





Appendix 3

Information for patients

What is a Medication Review?

- It is a talk you can have with a doctor, nurse or pharmacist to ensure that you are comfortable taking your medication.
- It is an opportunity to confirm that you are taking the right medicines in the right way; in the right amounts and that you are getting the right effects.
- It is also your opportunity to learn more about your medications and a chance to discuss any questions or concerns you might have

What are repeat prescriptions?

- They are prescriptions for your medication that you can order from the GP practice without having to see a prescriber each time.
- Repeat prescriptions regularly need to be checked by a prescriber to make sure that your medication is working correctly. Thus, you might only be able to order a certain number of repeat prescriptions before you have to see the prescriber
- On occasions the prescriber may request that you attend a medication review. It is important that you do attend.

How to order a repeat prescription

- Order you repeat prescription in plenty of time – allow at least 3 working days.
- If you use the repeat prescription form counterfoil please tick the items carefully**.** You will only be able to order items that are on your repeat slip; for anything else you may need to make an appointment with a prescriber

- If you order by e-mail, please order the items carefully and give the practice full details of the prescribed medicines.
- Order only those items that you need
- If you do not need a particular medication this time, please do not order it. You will still be able to order it at a later date when you do need it.
- When you collect your prescription from the surgery, please check that it is only for the medications that you have ordered. Please inform the receptionist if there are any errors.
- Repeat prescriptions should only be ordered in writing; however you may be able to order by e-mail.
- If you agree that a community pharmacy can collect and/or deliver your prescriptions then you must make it clear to your doctor which pharmacy you have chosen
- If you agree that a carer or community pharmacist can order your prescriptions on your behalf, please make sure you only allow them to order the items you need. If you receive any medicines that you did not request please inform your doctor
- When you receive or collect your medicines from the pharmacy please check that you only receive items that you requested. Inform the practice if there are any unexpected items.

Taking Care of Your Medication

- Know the names of all your medicines (these includes tablets, capsules, inhalers, liquid medicines, testing strips and so on) and what they are used for
- If you cannot remember what medicine is for then you can book a free medicines use review (MUR) with your regular dispensing pharmacist
- If you stop taking a prescribed medication for any reason, please make an appointment to discuss how you feel about the medicine with a with a doctor, nurse or practice pharmacist
- If you need to take more or less of a medication than the pharmacy label allows, please make an appointment to discuss how you feel about the medicine with a with a doctor, nurse or practice pharmacist
- Do not take non-prescribed medication (e.g. over the counter, health foods or herbal or Chinese medicines) without checking with your prescriber or pharmacist. It may interfere with your regular medication and may be harmful.

Medicines and Wastage

- A large amount of medication is wasted every year. Some of this is due to people ordering medication that they do not need or do not take.

- If you have decided not to take a medicine (you should take advice from a doctor, nurse or pharmacist before stopping any medication) please do not re-order it. Make an appointment with a doctor, nurse of pharmacist to discuss why you have made this decision.
- Medicines that have been ordered and returned to the pharmacy cannot be reused even if they are unopened and must be destroyed.
- You can help to reduce the amount of wastage by ordering only those items that you use and need.

Safe Disposal of Unwanted Medicines

- Do not throw away unwanted medication and **do not** flush any down the toilet
- Always return expired, unused and unwanted medication to your local pharmacy. They will dispose of it safely.

Repeat Dispensing Arrangements

- This is a system whereby your doctor or nurse can provide you with a series of repeat prescriptions which you can either keep or give to your dispensing pharmacist to keep for you. You can then have these dispensed at appropriate times without the need to see your doctor in between.
- You may be able to take part providing that you medication and health problems are unlikely to change in the near future.
- The system reduces the number of prescriptions your doctor or nurse needs to sign and involves your dispensing pharmacist more closely in your health care.
- The system can be arranged to allow you to control when you collect you repeat prescriptions, for example in advance of going on holiday.
- Each patient must give their consent before the arrangements can start.

Appendix 4

Authorised Members of Staff Responsibilities

Is the request for a patient at this surgery?

It is important that the prescriptions request form is one that was generated by your practice. Those that were generated by a new patients' previous surgery should be interpreted very carefully and reviewed by a doctor or competent nurse or pharmacist within your practice before being processed.

Is this a patient that the practice has particular concerns about?

There may be a handful of named patients who should not to have medications on repeat without direct contact with their prescriber.

Is it clear which medicines the patient requires?

If the patient has left the form blank and it is not obvious from their computer record which medication is needed then preferably the patient, or failing this, their authorised representative should be contacted.

Are the requested medicines allowable on repeat?

Confirm that items requested are allowed on repeat and are within their authorised period and that the prescriber specified that the item should be repeated and it was not a one-off supply.

The practice's repeat prescribing policy should list all of the items are not allowed on repeat prescription (WIP)

The following drugs or drug classes are generally less suitable for repeat prescribing (if you are unsure please contact the Medicines Management Team):

- Antibiotics-some exceptions
- The contraceptive pill
- HRT
- Benzodiazepines- some exceptions (Stable, elderly and in care homes- decided by individual GPs)
- Antidepressants- some exceptions (Stable, elderly and in care homes- decided by individual GPs)
- Schedule 2 and 3 controlled drugs with the exception of phenobarbital Drugs that require regular monitoring.
- Any drug that has an abuse potential-may be appropriate for certain patients only.
- Any new drugs, until effectiveness and tolerability have been established

Are there any repeats left for each requested item?

Check the number of repeats left before the patient's next review. If there are no repeats left for the item, the prescriber and patient should be notified and a review arranged.

Is the medicine being used too frequently?

Check the period since the last request. The computer should normally alert the user if the medication appears to be over used. If problems are suspected the prescriber should be alerted, preferably before the prescription is produced. Prescriptions should not be printed at less than the time intervals that have been authorized without agreeing the reason for this (e.g. holiday). The reason should be documented in the patient's notes

Is the medicine being used too infrequently?

Are there repeat items on the patient's computer record that have not been requested? Check the period since the last request. The computer should normally alert the user if the medication appears to be underused. If problems of non-compliance are suspected the prescriber should be alerted, preferably before the prescription is produced. Note some medicines may be seasonal e.g. antihistamines, or have a long shelf life but may be used infrequently e.g. GTN spray

Does the request form contain any notes or alterations from the prescriber?

The prescriber may have indicated on the previous occasion that the patient needs to be seen for a review, or may have requested a monitoring test/measurement (e.g. liver function test). The receptionist should confirm that the request has been fulfilled.

If the patient is overdue for review, this should be brought to the attention of the prescriber. A mechanism should be in place for dealing with patients who fail to make appointments when they are due for a review. This process should be explained in the practice repeat prescribing policy. If the prescriber has amended the dosage instructions on the repeat prescription, the patient's medical records should be amended accordingly once any change has been confirmed by the prescriber.

Does the request form contain any manual alterations from the patient?

Any manual alterations to the request form by the patient/or their authorised representative are to be brought to the attention of the prescriber (e.g. "I no longer take this medication"). Any manual additions by the patient should be referred to the prescriber before being added on to the list of repeatable medications.

Any request to alter the strength or dosage of a repeat item (other than in writing from an official source e.g. hospital doctor) MUST be referred to the patient's prescriber. Only when authorisation has been given by the prescriber, can the prescriptions details be changed.

Are full dosage instructions included?

Check that full instructions are provided for each requested item, e.g. name of drug, form of drug (e.g. tablets capsules), strength of the drug, the dosage, the frequency of dosage and the quantity to be supplied. Less information may be appropriate in the case of prescriptions for dressings, appliances (e.g. catheters) and chemical reagents (e.g. blood glucose testing strips). If in doubt, refer to the prescriber.

Is the quantity of each medicine being requested excessive?

Verify that quantity of each item equates to the maximum prescription length (*e.g. 28 days supply*) allowed by the practice as stated in the practice policy

Are there any discontinued therapies?

If the patient has not requested a particular item for a specified amount of time (*e.g. 3 months*) then this may indicate poor compliance. The prescriber should be alerted and the patient called in for a medication review. The items can be removed from the repeat request form <u>if the prescriber agrees that they are no longer needed</u>.

Note some medicines may be seasonal e.g. antihistamines, or have a long shelf life but may be used infrequently e.g. GTN spray

Are you in any way concerned or uncertain about the patient or the items being requested?

Any prescription requests about which staff are uncertain or concerned should be referred to the prescriber

Is the prescription legible?

The printed or handwritten prescription should be legible and contain the name and address of the patient, the patents date of birth, the full names of all the drugs prescribed and the detail as above.

Has a record of the prescription been made?

All repeat prescriptions issued are automatically recorded in the patient's computer medical records. There should be a process for adding the detail of handwritten prescriptions written by members of the practice, secondary care, Out of Hours or by community practitioners.

Can the prescription be altered?

Handwritten prescriptions should state the number of items on the prescriptions. Particular attention should be paid to certain drugs (e.g. where the quantity may be altered); if the prescriber has concerns then they can specify the quantity in words and figures.
To prevent the addition of further items, the spare space on the prescription should be crossed through by the prescriber. Where the computer has failed to cancel out unused space this should be done manually to prevent any unauthorised additions.

Is the patient suitable for the Repeat Dispensing Arrangements?

If the patient's medication requirements and disease(s) are stable they may be suitable for the repeat dispensing arrangements.

Appendix 4

Reviewing Medicines

Patients may use medicines long term. The initial decision to prescribe medicines, the patient's experience of using the medicines and the patient's needs for support to adhere to the prescribed medicine regimen may change over time and should be reviewed regularly.

- Offer repeat information and review, especially when treating long-term conditions with multiple medicines.

- Review at agreed intervals patients' knowledge, understanding and concerns about medicines and whether they think they still need the medicine.

- Ask about side effects and the patient's tolerance to these.

- Ask about adherence to the prescribed regimen when reviewing medicines. Clarify possible causes of non-adherence and agree any action with the patient (including a date for follow-up).

- Bear in mind that patients sometimes evaluate prescribed medicines in their own way (for example, by stopping and starting them and monitoring symptoms). Ask the patient if they have their own way of weighing up their medicine.

Medication Review

Types of Medication Review				
Review		**Access to patient notes**	**Patient /carer involvement**	**Description**
Type 1 (Medicines)	Prescription review	No*	Does not need patient/carer to be present	Assesses technical issues relating to the prescription e.g. anomalies, changed items and cost effective prescribing
Type 2 (Medicines use)	Concordance and compliance review	Not necessarily*	Usually requires patient and /or carer to be present	Addresses issues relating to patient's medicine taking behaviour
Type 3 (Medicines and condition)	Clinical Medication Review	Essential	Requires patient and /or carer to be present	Addresses issues relating to patient's use of medicines in the context of their condition

*Any changes to medication will have to be communicated to the patient/carer

- A full review of a patient's medical record is to be undertaken when the patient has had all the authorised repeats.
- Regular review should be included as part of the policy for patients with long term conditions e.g. asthma, COPD, diabetes, CVD, hypertension, heart failure etc. or high risk patients on key

drugs e.g. older patients taking NSAIDs, patients on warfarin, controlled drugs, diuretics or two anti-platelets.

- The practice should take note and act on any issues raised by Medicines Use Reviews, carried out by community pharmacists, and feedback where appropriate.
- Regular medication review should be a priority for patients that are housebound, in sheltered accommodation or in care homes. A six monthly review will be appropriate for most of these patients. Practices should have a system in place to remind practitioners when reviews are due and should allocate the required time for GP
- Depending on the results of the review, the prescriber will then either:
    - Authorise the prescription for further repeats and record in the patient's notes that a review has taken place and the prescription has been re-authorised, or
    - Request that the patient attend a consultation

Frequency of Review

- 12 month review for all patients who are on repeat medication.
- 6 month review for all patients over 75 years who are on four or more medications.
- Patients should be notified when they are required to attend for a review of their medication.
- The following are examples of what a patient's medication review may include:
    - Review of the patients medical condition(s)
    - Review of the effectiveness of the patients medication
    - Any monitoring and subsequent test results
    - Patient's understanding of the repeat prescribing system
    - Patient's understanding of what their medication is for and its effectiveness
    - Knowledge of dose, frequency and any other issues relating to administration
    - Any side effects or problems with taking the drug which might require review
    - A discussion around compliance and concordance
    - Other non-prescription drugs being taken e.g. over the counter or herbal/alternative products
    - Any general queries they may have about their medication
    - What quantity of each drug does the patient currently hold
    - Can they open the containers easily

- Following the review, the action taken is to be recorded in the patient's notes, preferably by read code.
- All changes to the prescription are to be recorded on the computer system by the reviewer.
- Sufficient time should be allocated for a face to face medication review.

If patients are having difficulty with complying with the prescriptions, they are referred to Medicine Concordance Team.

Competency Framework for Practitioners Undertaking Face –to-Face Medication Reviews

Competency Area	Competency	Overarching Statement
Building a partnership		
	Listening	Listen actively to the patient
	Communication	Helps the patient to interpret information in a way meaningful to them
Managing a Shared Consultation		
	Context	With the patient defines and agrees the purpose of the consultation
	Knowledge	Has up-to-date knowledge of area of practice and wider health services
Sharing a Decision		
	Understanding	Recognizes that the patient is an individual
	Exploring	Discusses illness and treatment options, including no treatment
	Deciding	Decides with the patient the best management strategy
	Monitoring	Agrees with the patient what happens next

Appendix 6

Operational Manager's Responsibilities

The Operational Manager needs to ensure that repeat prescribing process is practical, efficient and clearly understood by all involved including patients and community pharmacists.

Staff Training

Staff involved in the repeat prescription process should be appropriately trained on, the company protocols for repeat prescribing, the company protocols for the repeat dispensing arrangements, what their responsibilities are and the need for accuracy. This training should be ongoing and is particularly important for new staff members. Ensure that sufficient, adequately trained staff are available to cover sickness, holiday, sudden departures, etc

Monitoring

The repeat prescribing process should be monitored regularly, providing guidance when needed and regulated for signs of fraud.
There should also be a system of checking a patient's compliance with the prescribed treatment.

Auditing

Review and audits of the repeat prescribing process should be undertaken regularly. A built-in quality assurance mechanism should be incorporated into the repeat prescribing system to monitor: over-prescribing, under prescribing and review of prescribing.

Auditing the Repeat Prescribing System

The repeat prescribing system should be audited on a regular basis
Examples of how the repeat prescribing process can be audited are:

- The number of new repeat items that are linked to a diagnosis
- The number of patients who have had an annual medication review as a percentage of the total requiring review over the last 12 months (using a sample size of 100)
- The number of patients over 75 who are on four or more medications reviewed in the last 6 months as a percentage of those patients over 75 years who are on four of more medications
- The percentage of repeat prescriptions without specific dosage instructions
- Auditing the number of repeat prescriptions that have been synchronized
- Auditing how accurately patient's medical records are updated
- Surveying patients to ascertain how well they understand the repeat prescribing process e.g. A questionnaire given to patients when they collect their repeats.

Additionally, specific therapeutic areas can be audited. For example:

- Monitoring patients taking drugs that have a narrow therapeutic index e.g. lithium, Amiodarone, methotrexate or theophylline
- Auditing statin usage or the prescribing of two anti-platelets according to current clinical evidence
- Blood monitoring in patient on high risk medicines
- Any audit required after MHRA alerts

Appendix 7

PATIENT INFORMATION LEAFLET INFORMATION FOR PATIENTS CONSIDERING PRIVATE MEDICAL CONSULTATIONS

When you are see a private specialist you should be aware what may happen about medication you may need after the consultation

Guidance for NHS patients

In March 2009, the Department of Health (DH) published guidance (78) for NHS patients who wish to pay for additional private care. The guidance includes the key points below:

- your NHS care will continue to be free of charge
- you can't be asked to pay towards your NHS care, except where legislation allows charges, such as prescription charges
- the NHS cannot pay for or subsidise your privately funded care
- your privately funded care must be given separately, at a different time and place from your NHS care

Independent Private Referral:

- If you choose to refer yourself to a consultant independently of your GP for additional privately funded care (i.e. outside the NHS), whether in the UK or abroad, you are expected to pay the full cost of any treatment (including medication) you receive in relation to the package of care provided privately (including non-emergency complications). Private referral through your GP:
- After a private referral made by your GP, your private specialist may give you a prescription. You may only need one prescription. The prescription provided by your private specialist will be a private prescription and you must pay for the medication.

- If you need continued treatment you may initially be given just one private prescription (which you will need to pay for) and advised to return to your GP to see if further NHS prescriptions can be provided.

There is no obligation, however, for your GP to accept clinical responsibility to prescribe the treatment recommended by a private specialist. To judge your clinical need for the treatment including the reasons for the proposed medication, your GP must have received a full clinical report from the private specialist

If your GP does not feel able to accept clinical responsibility, then the GPs may consider:

- Offering a referral to an NHS consultant to consider whether the recommended medication should be prescribed as part of ongoing NHS funded treatment
- Asking the specialist to remain responsible for the treatment because of its specialist nature, and to provide further prescriptions, for which you will need to pay.

GPs have agreed to prescribe in line with local policies.

Only if your GP considers there is a clinical need and that an NHS patient would be treated in the same way would an NHS prescription to continue your treatment be considered If the recommendation from your private specialist is for treatment that is not in line with local policies, then your GP may change the medication in line with that used for NHS patients. For these reasons, you may not be able to have an NHS prescription immediately, if at all.