# Repeat Prescribing and Ordering Guidance

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<td>Lead Authors: Paula Wilson, MLCSU Head of Medicines Optimisation Cheshire and Janet Kenyon, Deputy Head of Prescribing and Medicines Optimisation, on behalf of Cheshire CCGs. Document supported by Cheshire, Warrington &amp; Wirral Local Pharmacy Network</td>
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<td>Intended Audience</td>
<td>GP Practices, Community Pharmacies, Care Homes</td>
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<td>Adapted from CMCSU Repeat Prescribing and Ordering Guidance July 2014. Lead Author Becky Birchall (CMCSU Medicines Management Team)</td>
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Repeat Prescribing and Ordering Guidance

This guidance provides good practice standards to facilitate GP practices, community pharmacies and care homes working in partnership to deliver safe and efficient management of repeat medication for patients.
Foreword

This document is a jointly produced document by the Medicines Optimisation Teams across Wirral and Cheshire CCGs to support development of best practice repeat prescribing systems in primary care. It is widely acknowledged that patients, carers, GP practices and pharmacies all have responsibilities within a repeat prescribing process that can help make the system safe, efficient and avoids waste. Section 1 details the patient and carer involvement in the repeat prescribing system. Section 2 focusses on GP practices and this document is intended to provide good practice guidance which GP practices can use to define their individual repeat prescribing and medication review policies. Section 3 provides detail on repeat ordering by pharmacies which has been agreed and supported by our community pharmacy colleagues. We would encourage practices to discuss the guidance with their local pharmacies to mutually agree the processes for pharmacy ordering. Section 4 relates specifically to Care Homes and provides useful guidance that can be used to facilitate discussions with our colleagues in the care setting. It is hoped this document will help support everyone involved in the repeat prescribing process to build a robust, safe system that minimises waste and maximises efficiency.
## Glossary of terms

The following terms are used in this document:

<table>
<thead>
<tr>
<th>Term</th>
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<tr>
<td>Automatic repeats</td>
<td>A facility within the practice clinical system to generate repeat prescriptions automatically on a set day / date.</td>
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<td>BNF</td>
<td>The British National Formulary is the key reference for prescribers, supplemented by local formulary recommendations</td>
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<tr>
<td>Care Quality Commission (CQC)</td>
<td>CQC is the regulator for all health and social care services in England.</td>
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<tr>
<td>Counterfoil</td>
<td>The right hand side of the prescription that should be used to re-order repeat medication at the appropriate time. These can also be called the ‘repeat slip’, ‘tick list’ and ‘b side’.</td>
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<tr>
<td>Datix</td>
<td>Reporting system used in some areas for reporting of adverse events</td>
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<tr>
<td>Electronic Prescription Service (EPS)</td>
<td>The Electronic Prescription Service (EPS) enables prescriptions to be sent electronically from the GP practice to the pharmacy and then on to the Pricing Authority for payment.</td>
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<tr>
<td>Electronic Repeat Dispensing (eRD)</td>
<td>Electronic repeat dispensing is a process that allows a patient to obtain repeated supplies of their medication or appliances without the need for the prescriber to hand sign authorised repeat prescriptions each time. This allows the prescriber to authorise and issue a batch of repeat prescriptions until the patient needs to be reviewed. The prescriptions are then available for dispensing at the specified interval by the patient’s nominated dispenser.</td>
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<tr>
<td>Medication</td>
<td>Indicates any medicines, dressings, appliances or equipment that can be prescribed on the NHS.</td>
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<tr>
<td>Medicine Managers/Medicines Co-ordinators</td>
<td>Member of the administration staff in a GP practice with responsibility for non- clinical medicine related issues.</td>
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<tr>
<td>Multi-compartment compliance aid (MCA) and Monitored Dosage Systems (MDS)</td>
<td>The Royal Pharmaceutical Society has defined a multi-compartment compliance aid as a repackaging system for solid dosage form medicines, such as tablets and capsules, where the medicines are removed from manufacturer’s original packaging and repackaged into the MCA</td>
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<td><strong>National Patient Safety Agency (NPSA)</strong></td>
<td>The National Patient Safety Agency was incorporated into the NHS Commissioning Board (NCB) from June 2012; the NCB intends to build on the expertise of the NPSA in learning from errors to improve patient safety.</td>
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<td><strong>Patient</strong></td>
<td>Throughout this document, wherever 'patient' is noted, this refers to the patient or their authorised representative.</td>
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<tr>
<td><strong>Patient Online</strong></td>
<td>Patient Online is a general term for online services that enable people to communicate with their practice to access services, such as ordering repeat medication and booking appointments. The service is called Patient Access in EMIS web, Waiting Room in Microtest and Systm Online in Systm One.</td>
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<td><strong>Prescription tokens</strong></td>
<td>Paper copies of electronic prescriptions are called ‘tokens’. They act as a hard copy of the details contained within the electronic prescription.</td>
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<tr>
<td><strong>Repeat collection services</strong></td>
<td>The patient orders a prescription directly from their general practitioner, which is collected from the surgery by the community pharmacy for dispensing.</td>
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<tr>
<td><strong>Repeat delivery services</strong></td>
<td>The community pharmacy dispenses the prescription and delivers the dispensed medication to the patient at home.</td>
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<tr>
<td><strong>Repeat Prescribing</strong></td>
<td>The traditional method of primary care prescribing. It involves prescribing regularly needed medicines to a patient that they have used before and can be renewed by the GP without the patient needing to be present. Standard practice allows patients to be able to collect their repeat prescriptions within 48-hours of taking their prescriptions to their GP.</td>
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<tr>
<td><strong>Repeat prescription B side or Right Hand Side (RHS)</strong></td>
<td>The current list of repeatable medicines that prints as a list for patients or their carers to use when ordering their next prescription</td>
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<tr>
<td><strong>Repeat Prescription</strong></td>
<td>Repeat prescriptions are defined as prescriptions issued without a consultation between the prescriber and patient.</td>
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INTRODUCTION

- The aim of this guidance is to provide practices, pharmacies and care homes with a description of best practice and to highlight areas of risk. This document can be used in local discussions and development of protocols, in order to gain tighter control of repeat prescribing and ordering systems.

- Repeat prescribing enables patients to obtain further supplies of medicines without routinely seeing the prescriber, thereby reducing unnecessary consultations. It is an essential part of busy general practice, and accounts for about 60-75% of all prescriptions written by GPs, and 80% of their cost¹.

- The Kings Fund highlighted concerns in 2011, regarding inappropriate and unnecessary prescribing and the potential hazards for patients and wasted NHS resources. Their indicators for improving prescribing are set out in the executive summary of ‘The Quality of GP Prescribing’ www.thekingsfund.org.²

- Evidence shows a prescribing error rate of 7.5%, with 1 in 5 hospital admissions being medicines related, with two thirds of these being preventable.³

- The Care Quality Commission (CQC) requires safe management of medicines (Outcome 9). Pharmacies are currently exempt from CQC registration, GP practices were registered from April 2013. A summary of the standards is available⁵.

This guidance is organised in four sections, from the perspectives of patients and carers, GP practices, pharmacies and care homes. Setting standards to improve repeat prescribing and ordering systems, and improving communication across these interfaces, will both improve patient care and maximise efficiencies.
WHY IMPROVE CURRENT SYSTEMS?

✓ Clear and efficient systems enable GP practices, pharmacies and care homes to work together to improve patient care

✓ Increased patient safety and high quality prescribing

✓ Improved risk management to learn from near misses and avoid errors

✓ Opportunities identified to improve patient/carer involvement and compliance with medication

✓ Patients better empowered to manage their own repeat prescription requests, and support appropriately to access the medicines that they need

✓ Defined standards, roles and responsibilities for everyone involved, saving time by reducing queries

✓ Appropriate use of skills for professionals and staff

✓ GPs save time via efficient systems and develop their staff to identify and manage concerns early

✓ Reduce wasted medication by controlling over-ordering and better use of NHS resources

✓ Mitigate risks from prescription fraud

✓ Compliance with standards, e.g., in contracts, from professional bodies and the Care Quality Commission
Section 1

Patients and Carers

Benefits for Patients and Carers
Above all else an efficient and effective repeat prescribing and ordering process is of major importance to patients and carers. They want a convenient and accessible service that they have confidence in, and that protects them from harm. A poorly designed system, or one that is not well managed, can cause frustration, waste precious time, as well as leading to an increase in the likelihood that mistakes can be made, thus putting patients’ health at risk.

Benefits to patients and carers include:

- Convenient and easy access to the medications they need.
- Clear understanding and appreciation of the process — knowing when and how to request the repeat, and knowing when, and from where, it can be collected. Reassurance that the system has a clear audit trail that can be tracked.
- Confidence that they are receiving the most appropriate medicines, tailored to their individual needs, provided through a system that conforms to good practice.
- Understanding of exactly how to take / administer medications as a result of receiving complete prescriptions with full instructions.
- An understanding of the importance and the process by which they have the opportunity to discuss their medication with a health care professional.
- Reduced potential for adverse incidents and adverse effects.
- Involvement in decisions about their health care, aiding self-management. This can improve concordance, resulting in improved outcomes of care, reduced hospital admissions, shorter hospital stays and fewer visits to the GP.

Patient/carer responsibilities

Patients and their carers are an important part of the repeat prescribing process and, within their level of competency, can take responsibility for:

- Making sure that they understand the repeat ordering system, and what help is available to enable them to obtain their medicines in a safe and timely way.
- Ensuring that they participate in medication reviews to discuss their medicines; including asking any questions that they have about how the repeat prescribing process works.
- Checking what is needed before placing an order for a repeat prescription, only ordering what will be needed before the next prescription is due, and then using it according the prescribers instructions.
- Placing the order for their repeat prescription using the most up to date counterfoil or the online ordering facility.
• Speaking to their doctor or pharmacist if any medicine is not suiting them, or they are not sure how and when to take the medicines.
• Checking that the medicines supplied are those that have been ordered, and that they are still needed, especially at times when things can change such as following a hospital admission.
• Letting their doctor and pharmacist know if they have a stock of medicines building up, and that they won’t need to order for a while.
• Planning ahead to allow sufficient time for the prescription to be checked, issued and dispensed, especially around holidays and Bank Holidays when there may be extra pressure on the system.
• Use of self-care services and over the counter medicines where appropriate.
Section 2

General Practices
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# Standards for Repeat Prescribing and Ordering

GP Practices

These standards reflect best practice and will be aspirational in some cases.

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<td>Only prescribers should authorise repeat status. If delegated to other members of staff this should be covered by a practice agreement and attached to the practice’s Repeat Prescribing Policy.</td>
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<td>2</td>
<td>All repeat items listed on the electronic medical records should be linked to an appropriate indication</td>
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<td>3</td>
<td>Written criteria exist in the practice for drugs that are unsuitable to be issued on repeat prescription or on an eRD (appendix 1)</td>
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<td>4</td>
<td>All drugs must have appropriate directions and be prescribed generically where appropriate.</td>
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<td>5</td>
<td>Most repeat prescriptions should be written for 28 days’ supply to minimise the potential for waste.</td>
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<td>6</td>
<td>Drugs for each patient should be synchronised i.e. they should all last the same length of time.</td>
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<td>7</td>
<td>Medication changes indicated on discharge and outpatient letters should only be entered onto the system by the prescriber or practice member with appropriate pharmaceutical knowledge and skills.</td>
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<td>8</td>
<td>The prescriber should update the patient’s electronic medical records with an account of any consultations outside of the practice e.g. home visits. Handwritten prescriptions should be added to the current medication screen</td>
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<td>9</td>
<td>Repeat prescription requests are usually taken using the computer-generated counterfoil or via the practice web site, patient access webpage or mobile App. Telephone requests should not generally be accepted.</td>
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<tr>
<td>10</td>
<td>Only individual items that are ticked on the counterfoil should be issued. It must not be assumed patient needs all the items.</td>
<td>20</td>
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<tr>
<td>11</td>
<td>Each practice should have a system to inform patients how to order repeat prescriptions, which should emphasise patients taking responsibility for ordering their own repeats whenever possible</td>
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<td>12</td>
<td>There should be a practice protocol for dealing with controlled drug requests.</td>
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<td>13</td>
<td>Practices should complete repeat prescription requests within 48 working hours.</td>
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<td>Practices should have a clear protocol for processing repeat prescriptions and audit this annually.</td>
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<td>15</td>
<td>Repeat prescriptions should be processed away from interruptions, by designated staff, who have received appropriate training.</td>
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<td>16</td>
<td>Each practice should have a procedure in place so that the prescriber is informed when the medication review or monitoring requirements are overdue and no further repeats authorised.</td>
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<td>17</td>
<td>Practices must have a procedure in place to ensure necessary monitoring has been done and assessed before a prescription is issued for high risk drugs.</td>
<td>25</td>
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<tr>
<td>18</td>
<td>All prescriptions that need re-authorising need to be passed to the prescriber. There should be a system in place to ensure this is done when the last available repeat is issued.</td>
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<tr>
<td>19</td>
<td>All people prescribed repeat medication should receive an annual medication review. Some people may require medication review more frequently based on clinical considerations.</td>
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<td>20</td>
<td>All patients receiving medication via electronic repeat dispensing should be reviewed before the time when their current set of prescriptions is due to run out. This is to ensure the patient is still suitable for system and that any amendments can be made if needed.</td>
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<td>21</td>
<td>A clear procedure should be in place to allow for the safe handing over of the correct prescription to the correct patient or representative and there should be a method of recording collection.</td>
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1. INITIATING REPEAT PRESCRIPTIONS

1.1 Authorisation of repeats

Repeat medications should only be set up once the patient is stable on a medication and efficacy and tolerability has been confirmed.

- Electronic Repeat Dispensing (eRD) should be considered.
- Only a prescriber can authorise repeat status. If setting up a repeat is delegated to other members of staff this should be covered by agreements specific to that practice and should be attached to the practice’s Repeat Prescribing Policy e.g. in some practices the medicine managers/coordinators may add repeats after obtaining authorisation from a prescriber.
- All items should be linked to an appropriate indication. If a medication is used in an unlicensed manner, this should be fully documented in patient’s notes and the patient informed that the medication is being used outside its license.
- Some medication is not suitable for repeat prescribing (see Appendix 1)

1.2 Recommended drug choices and generic prescribing

- In the majority of cases, prescribers should follow recommended drug choices agreed for the local health economy via local formularies and policies to improve prescribing quality and efficiency.
- If the drug dictionary allows, items prescribed should be written by generic name. Exceptions to this are:
  - Drugs specified in the BNF as unsuitable for generic prescribing, highlighted by clinical system or decision-support software. A list of medication to be considered for brand-name prescribing has been produced by UK Medicines Information
  - Where a patient has proven documented intolerance to a generic form of a drug, the brand may be prescribed and should not be switched.
  - Where branded prescribing has been recommended locally to optimise cost savings.
  - Where there is a high risk of introducing dispensing errors by prescribing by the generic name, the prescriber may use their judgement and/or advice from the Medicines Management/ Optimisation Team to prescribe by brand.
1.3 Number of days’ supply

Most repeat prescriptions should be written for 28 days’ supply because this repeat prescribing interval is recognised as being the best possible balance between patient convenience, good medical practice and minimal drug wastage. The number of units in total can be specified or the number of days’ supply.

- GP practices that decide against adopting the default 28 day recommendation should still reduce intervals for individual patients where risks are apparent, or treatment is frequently changing and medicines waste is more likely. 56 day intervals may be more suitable for patients expressing a preference for convenience or financial considerations if they pay for prescriptions, however this should only be agreed when the risks of medication changing are low.

- Situations where intervals of 28 days or fewer are more suitable:
  - Drugs liable to abuse
  - Situations where risks are perceived e.g., regarding storage in the home
  - Vulnerable patients prescribed complex regimens or with frequent hospital admissions and changeable therapy.
  - Terminally ill patients receiving palliative care support
  - Sip feeds
  - Dressings for short-term use or where likely to change
  - High cost medication
  - When necessary medication
  - All patients in nursing and residential care homes
  - Patients using monitored dosage systems
  - Patients on medication that requires monthly monitoring of either effectiveness or safety
  - Medications that are recommended for short term use only, e.g. hypnotics
  - Appliances
  - Newly prescribed medication when a shorter period is appropriate to assess response / titrate dosages etc.
  - An assessment of suicide risk in patients with a past medical history of overdosing should be undertaken and medication prescribed in a suitable quantity and with appropriate support. For example, medicines that are known to be associated with toxicity in overdose, such as tricyclic antidepressants and some analgesics, could be prescribed in smaller quantities (e.g. 7 days rather than 28 days).
  - Patients utilising electronic repeat dispensing.

- Situations where intervals of more than 28 days are suitable:
  - Oral contraceptives and HRT (supplied in 3 month packs)
  - Special packs
  - Where 28 days is not equivalent to the number of doses in a special pack i.e. a 200 doses inhaler as “1 OP” (original pack)

These patients’ other medication should be issued at more frequent intervals.
• Patients requesting medicines for longer periods than usual to take abroad should be advised that no more than 3 months is allowable, and that this may not be appropriate clinically in all cases. Further detail is provided in the CCG policy on prescribing for patients travelling abroad.

• Acute prescriptions should be used for the first prescription until treatment stabilised, particularly for drugs with a high incidence of adverse effects.

• On rare occasions, prescriptions for 7 days may be more suitable where risks are perceived or medication is frequently changing. Community pharmacies only require weekly prescriptions if the prescriber decides weekly dispensing is appropriate. Pharmacies must not issue more than one week at a time. Where the pharmacy is supplying medication in monitored dosage systems, 7 day prescriptions are not required unless the prescriber intends these to be dispensed and issued to the patient at 7 day intervals.

• The Misuse of Drugs Regulations 2001\textsuperscript{7}, updated in 2006, makes a strong recommendation that 30 day intervals should be implemented for all schedule 2, 3 and 4 controlled drugs. A shorter interval may also be appropriate.

• A one-off synchronisation prescription is recommended where regular, stable items run out at varying times during the month. The time invested to synchronise medication will reduce wasted medication and staff time in dealing with the same patient several times a month. Some practice clinical systems have facilities to allow one off issues to be prescribed.

• When changes to regular medication are made, or new medicines are added, ensure these medications are synchronised with existing medication.

• Where practice clinical systems have facilities for variable repeats, these should be used for items that are needed repeatedly but not regularly (e.g. salbutamol inhalers, analgesics for occasional painful conditions).

1.4 Dosage instructions

• All new drugs added to the computer system must include clear dosage instructions. This includes liquid feeds, creams, dressings, nasal sprays, drops and all other external products. An absence of dosage instructions or “as directed” is not sufficient information for patients to use items appropriately and leads to problems for carers.

• Exceptions to specific directions may include gluten free foods, and drugs requiring regular dose adjustments, particularly warfarin. For these the use of standard wording is advised.

1.5 The number of repeats to authorise
• The number of repeats authorised or the next regime review date set is a clinical decision and an important part of the repeat prescribing process. This should be low/short initially until the patient is stabilised, and compliance, monitoring requirements and chronic disease reviews should be taken into account.

• The number of days’ supply should be set on the clinical system where possible, as this enables monitoring of early requests and over-use.

• Items not suitable for long-term use (Appendix 1) should only be authorised on repeat for short periods e.g. steroid creams. Procedures must be in place to ensure that excessive prescribing does not occur.

1.6 Authorising repeats for new patients

• There should be a system to ensure that information on previous medication is obtained before the first prescription is issued e.g., asking the patient for a current counterfoil from their previous GP, contacting the previous practice for clarification, inviting the patient for a consultation. It is often more appropriate to initially issue an acute script.

1.7 Medication initiated by hospitals and other agencies

• There should be a system for dealing with requests to start medication from other agencies e.g. hospital discharge notifications, outpatient appointments.

• All such notifications should be reviewed by a prescriber who has access to the clinical record, before being added to the clinical system. Management systems should be in place to ensure these are dealt with efficiently and consistently and involve a prescriber. The prescriber should also ensure that any discontinued medication is removed from the screen and the reason documented in the patients notes. There is a significant risk of errors occurring if this guidance is not followed.

• Ensure new regular medication is synchronised with existing medication

• Responsibility for prescribing in some cases should remain with secondary care. Refer to the RAG list or other local formulary process to identify where prescribing should remain with secondary care or responsibility should be shared. Prescribing support tools e.g. Scriptswitch and Optimise RX can highlight local recommendations and should be taken note of.

• If prescribing is to remain with secondary care, details of these drugs should still be included on the practice system to enable prescriber awareness of any interactions with other drugs they may prescribe. See Appendix 2 for guidance on how this can be recorded in the clinical system. Patients should usually be discharged with at least 7 days’ supply of medication/products in line with local agreements to allow for necessary information to be received and processed by the GP practice.

1.8 Consultations outside the practice and handwritten scripts
• The prescriber should update the patient’s electronic medical records with an account of the home/care home visit in the same way as if the patient had been seen in a consultation at the practice. If available remote access should be used to ensure that the prescriber has full access to patient details and items can be added to the system.

• If a handwritten script is issued the medication should be added as an “acute” item and filed as a “hand written” prescription. Systems should be in place to ensure transfer to repeat if necessary. Any doses changed or medication discontinued should be added to the record.

1.9 Delegated authorisation

• Exceptions to prescriber authorisation must be by agreement with the practice and be supported by a written policy.

• With prior written agreement, Medicines Management/ Optimisation pharmacists and pharmacy technicians may add or discontinue medication; amend dosage instructions and quantities; re-authorise medication; and set review dates and monitoring requirements.

• Pharmacist or nurse supplementary prescribers may prescribe and authorise under an agreed clinical management plan.

• Non-medical independent prescribers may prescribe within their area of expertise and competence. Non-medical prescribers with expertise in specialist areas who are prescribing for patients who have other chronic disease states outside of their expertise are not authorised to prescribe for those conditions. Contra-indications, disease and drug interactions of all the diseases and medications need to be considered before prescribing in the specialist area. Non-medical prescribers should seek advice from the GP or pharmacist where they are unsure. Prescribers should be able to demonstrate competency as laid out in “A Competency Framework for all Prescribers” Royal Pharmaceutical Society: July 2016 (Review date: July 2020).

• To be able to prescribe in each practice all non-medical prescribers must be registered with the NHS Business Services Authority via a nominated person within the CCG. They must also deregister when they leave a practice.

2. ORDERING REPEAT PRESCRIPTIONS

2.1 Repeats ordered by the patient

• Patients should order medication via online methods e.g. Emis access, mobile App’s or using the counterfoil where individual items MUST be ticked. It must not
be assumed that the patient needs all items. Where ordering is unclear, the patient must be contacted and the request remains unprocessed until this is clarified.

- When counterfoils are handed over in person and there is an opportunity to discuss what medicines are required, this should be utilised to reduce waste and identify any patient concerns.

- Where requests are not handed over in person these should be collected in a locked box in reception, sent by post or ordered online. Fax should not be used for repeat prescriptions requests but only for urgent one off requests. Methods should be agreed by individual practices and included in their patient information. **Telephone requests should not be accepted.** The practice should ensure that any patient sensitive data is protected.

- Patients should be encouraged to order their own repeat prescriptions in line with local CCG guidance on patient-led repeat prescription ordering systems. However, practices should agree with pharmacies any support arrangements for patients who are unable to manage their own repeat prescriptions, which may include repeat dispensing and/or managed repeat systems.

- Practices are encouraged to regularly check with patients that items requested are still required and they are not building up stocks of these items at home. Challenge may be warranted when all items, including when required items, are being ordered every month.

- Each practice should have a system to inform patients how to order repeat prescriptions. This is usually done by issuing a practice information leaflet and via their website. Further information reminders may be given by use of posters in the waiting room, electronic message boards and recorded messages on the answer machine/telephone. Arrangements should be made for patients with additional needs to be supported to understand and use the system.

- Although this should not be publicised surgeries should have a policy in place for dealing with urgent requests. If a patient consistently requests medication late, it should be brought to the Practice Manager’s attention. The practice must not direct patients to the community pharmacy to obtain an emergency supply, as the pharmacist may legally refuse to supply.

- Practices should have systems in place to record supplies of repeat medication issued by community pharmacies providing the National Urgent Medication Supply Advanced Service (NUMSAS). The NUMSAS supply by the community pharmacy should include a discussion with the patient regarding how to avoid running out of their medication or appliance in the future. If there are any concerns (e.g. second or third requests for supply), the community pharmacy will raise this with the patient’s GP as part of the feedback process. In some cases, the GP may not wish a patient to be referred for NUMSAS and they can add a Special Patient Note (SPN) to the patient’s care record to flag this issue to NHS 111.

## 2.2 Pharmacy involvement in repeat ordering and collection
Where a patient is capable of ordering their own medication they should be encouraged to do so using the counterfoil or online ordering facility.

- Pharmacy services can be useful to some individuals who lack capacity to order their own medicines.

- This guidance includes a definition of the types of ordering by community pharmacies, it is recommended GP practices and pharmacies describe systems in this way to avoid confusion:
  - **Pharmacy accepting counterfoils** completed by patients
  - **Repeat ordering service** - where the pharmacy is involved in completing the counterfoil at the time the prescription needs to be ordered.
  - **Managed repeat ordering service** - where the patient completes their next order in advance via the pharmacy.
  - **Repeat collection service** - where the pharmacy submits the counterfoil and collects the prescription from the practice. This may or may not include delivery to the patient.
  - **Delivery services**

- GPs and practices may not direct patients to a particular pharmacy.

- It is best practice to obtain written permission from patients to allow a pharmacy to collect prescriptions on patients’ behalf or manage their ordering if they are incapable of doing so themselves.

- GP practices should keep records of prescriptions handed to third parties.

- Pharmacies are guided to alert the practice to any feedback from the patient about discontinued items or items not regularly needed that remain on the counterfoil. Practices should operate a system to ensure this feedback is actioned, any compliance concerns addressed and the repeat medication list updated.

- **GP practices should become familiar with the section on pharmacy ordering guidance**, as further detail is included that underpins how these systems should operate to maximise safety and reduce wasted medication.

### 2.3 Third Party request

- For the purpose of this guidance a Third Party is defined as a supplier other than a pharmacy. This is often either a Dispensing Appliance Contractor (DAC) or Appliance Manufacturer or a manufacturer of supplementary feeds.
• The patient should order the items they require in the same way as medicines, but it is advisable to allow more than 48 hours as the prescription usually needs to be posted to the contractor.

• Prescriptions for appliances or enteral feeds should always be on a separate prescription.

• Retrospective prescriptions should only be issued in exceptional circumstances. Requests for new items from suppliers should be referred to the GP for a decision and confirmed by the specialist clinician involved in the patient’s care.

2.4 Requests for controlled drugs

• There should be a practice protocol for dealing with controlled drug requests. Careful consideration should be given to deciding if the controlled drug should be available as a repeat

• Currently requests for controlled drugs cannot be sent via EPS system and separate printed FP10 will be available

• Prescribers can issue computer generated prescriptions for all controlled drugs. All details except the signature can be computer generated.

• Prescriptions for schedule 2, 3 and 4 controlled drugs are only valid for 28 days. Quantities should not exceed 30 days’ supply and a shorter interval may be more appropriate. It is recommended that quantities are kept to 28 rather than 30 for regular items to help keep in line with other items on repeat

• All CD prescriptions should be signed for when collected from the GP practice, whether this is a healthcare professional, community pharmacy staff, the patient or their representative. A bound book or electronic record should be kept to include the patient’s name, controlled drug, name of person collecting the drug, their signature and date of collection. Note: CD prescriptions should not be posted.

2.5 Requests from nursing and residential homes

• Nursing and Residential Homes should request their medication on a monthly basis using the counterfoil, by agreement between the GP practice, care home and pharmacy.

• Medication should be ordered by the care home and not via the pharmacy.

• Twenty-eight days’ supply ONLY should be given. Any requests for increased quantities should be referred to the prescriber.

• Items required that month should be clearly indicated, and only those should be processed. If over-ordering is suspected, the prescriber should be alerted.

• Requests for dressings should be for current wound care that has been authorised by the prescriber and documented on the patient’s records. These do not usually
require repeat prescriptions and should only be issued as an acute prescription. Practices should encourage care homes to order dressings on the local dedicated form, as this requires a reason for non-formulary choices and highlights this to the prescriber to check.

3. GENERATING A REPEAT PRESCRIPTION

3.1 Period of notice

- Practices should complete repeat prescription requests within 48 working hours. In a normal week, a prescription ordered on a Friday will be ready on a Tuesday.

- Patients and community pharmacists should be informed of the notice needed when ordering prescriptions and when the prescription will be ready for collection. This can be via the practice information leaflet, information on the website or via a reminder notice close to the prescription request box.

3.2 Processing repeat requests

- All repeat prescriptions must be computer generated by designated staff, who have received training on the processes and have appropriate access on the system.

- Practices should have a clear protocol for processing repeat prescriptions and review this annually as minimum, to ensure there are no gaps between protocol and operating practice. It is good practice to encourage that:
  - Repeat prescriptions are processed away from interruptions; no other duties should be performed whilst repeat prescriptions are processed.
  - Request slips should be marked with the date processing started
  - The drug name, form, strength and dosage instructions should be checked, in order to highlight any discrepancies between the request and the repeat medication list to the prescriber.
  - Good practice is to ensure staff members know how to handle queries and documenting the query. There should be an audit trail of any communications regarding the request and therefore the clinical system functionality should be utilised to do this electronically.
  - When the medication review or monitoring requirements are overdue or there are no further repeats authorised, the prescriber should always be informed.
  - Early or late requests may indicate over or under use of medication and this should be highlighted to the prescriber. Under use needs to be assessed with regard to risk of endangering the patient or others e.g., antipsychotics, asthma preventer inhalers. Over use is just as important clinically, e.g., for medication with addictive potential, or from a wasted
medicines perspective. If early requests are processed, the reason should be documented in the notes.

- Checks should be made routinely to ensure all items requested are required

- Items are discontinued when they have not been ordered during a specific time period (e.g. 6-12 months). Exceptions are medication required infrequently, such as GTN spray, glucose oral gel. These items may be added to the variable repeats section in the practice clinical system, where the facility is present.

- There is a clear policy for dealing with repeat private prescriptions to ensure these are not issued as an NHS item.

- There is a clear system for forwarding to the prescriber for signing. When the original prescriber is away there should be a system to identify who is responsible for signing and access to the clinical record is essential.

- Prescriptions awaiting collection are stored in a safe place away from reach of patients at reception desk

3.3 Requests for “High Risk” Drugs.

- “High risks drugs” include those that are toxic and require unusual dosing and those that require monitoring under a shared care agreement. Practices must have a procedure in place to ensure necessary monitoring has been done before a prescription is issued. Examples of high risk drugs are: Methotrexate, Warfarin, Lithium, DMARDs, insulin.

4. RE-AUTHORISATION OF REPEATS AND MEDICATION REVIEW

4.1 Clinical responsibility for re-authorisation

- Only the prescriber can re-authorise repeats when the number of authorised issues has been reached or the regime review date is due. When a repeat is re-authorised it is the prescriber’s responsibility to ensure ongoing need, repeat prescribing remains appropriate and necessary monitoring and medication review have been carried out. This is an essential part of the repeat prescribing system.

- All scripts that need re-authorising need to be passed to the prescriber. There should be a system in place to ensure this is done when the last available repeat is issued.

- Post-dating prescriptions is not recommended, as on some systems this will cancel reauthorisations.
• Re-authorisation is a good opportunity to align quantities so they all run out at the same time. This will avoid medicines waste and wasted staff time if multiple scripts are ordered each month for different items.

• Re-authorisation is a good opportunity to assess if the patient may benefit from repeat dispensing.

• Practices are encouraged to have the prescribing decision support software installed on all PCs where prescribers are adding new medication

4.2 Medication review

• Patients with repeat medication should be regularly reviewed according to clinical need. The review date must be apparent on the counterfoil.

• The benefits of medication review are well documented and contribute to improving health outcomes, reducing medicines-related admissions and reducing waste.

• Medication review is an integral clinical component of the repeat prescribing system. One of the functions of medication review is to confirm that it is appropriate to continue to issue repeat prescriptions as written without further clinical intervention.

• Medication Review is integral to the care of the patient and therefore a professional responsibility. The term ‘medication review done’ should be used at the point where a review of the entire patient’s medication has been undertaken by a prescriber. The medication review date should only be moved forward when the entire patient’s medication has been reviewed.

• A suitably trained and competent professional should conduct medication reviews. Nurses conducting disease specific medication reviews should only do so within their area of clinical training and sphere of competence. Healthcare professionals review different aspects of the medication review and referral to a general practitioner may be necessary for aspects of care appropriate to clinical need or from a GP to a nurse or pharmacist.

• All people prescribed repeat medication should receive an annual medication review. Some people may require medication review more frequently based on clinical considerations. Some individuals are at greater risk than others from either medicines related problems or not achieving intended benefits from prescribed medicines and these patients may require more frequent review. Such patients include:

  - Patients over 65 years
  - Patients of any age prescribed 4 or more regular repeat medicines
  - Patients living in care homes – both residential and nursing care
  - Older patients who have fallen
  - Patients recently discharged from hospital
- Patients whose request for a prescription does not conform with their authorised repeat
- Patients on particular drugs known to have a low therapeutic/toxic ratio and which need particular monitoring for example, those on warfarin, digoxin, theophylline, lithium, methotrexate, DMARDs.
- Patients with long-term conditions such as COPD, diabetes, coronary heart disease, heart failure.
- Patients whose medication regimen is being altered for any reason including a new condition, problems with existing medication, new national or local guidance and identification of modifiable risk factors.

It is important that practice staff members dealing with repeat prescriptions know when and how to refer patients to GPs for medication review.

Recording Medication Reviews

It is recommended to Read code appropriately following a review of all medicines as follows;

- **Level 3 Review** - Medication review with patient; this is a full clinical medication review with the patient present. The objective is to reach a concordant agreement about treatment thereby optimising the positive impact of, and minimising the problems associated with, their medicines. Review of notes, clinical records and laboratory results is required. The communication needs of the patient are taken into account, and an interpreter or BSL (British Sign Language) signer will be booked as appropriate. (Suggested Read codes include 8B3V Medication Review Done and 8B3x Medication Review with Patient)

- **Level 2 Review** - Medication review of medical notes; the patient is not present and so a full review of concordance is not possible. An in-depth review of the current treatment with reference to notes, clinical records and laboratory results. (Suggested Read codes include 8B3y Medication Review of Medical Notes or 8B3h Medication Review without Patient).

Disease specific medication reviews should be Read coded as such and not as a full medication review. Examples include:

**EMIS**
- 8B3k CHD medication review
- 8B3j Asthma medication review
- 8B3l Diabetes medication review
- 8BIF Epilepsy medication review

**System One**
- XalfK Asthma medication review
- XalfM Diabetes medication review
- XalyV Epilepsy medication review
• Practices will receive reports of Medicine Use Reviews (MUR) conducted by Community Pharmacists. This involves a concordance review with the patient and the clinical record is not reviewed. This is not a full medication review. Read code: 8BMF MUR

• Documentation of the most important aspects of a medication review needs to be clear within the clinical record for all healthcare professionals involved in the care of the patient to see. This should include, where appropriate, discussions with the patient, considerations relating to compliance, investigations needed and any changes to the medication and arrangements for follow-up. It is recommended that practices have a system in place to provide patients with a written record of their review. This should include any advice provided and outcomes agreed.

• Examples of best practice to include in the medication review summary are as follows:
  - Reasons for changes to medication
  - Compliance and concordance issues
  - OTC medicines recorded
  - Issues discussed with the patient, side effects, and risks
  - Investigations required monitoring the condition or medication
  - Practical problems with medicines taking
  - Ongoing care plans / follow-up.

• As well as recording the current review, a date should be set for the next planned review. The review date should not be set for longer than 1 year. The review date may be moved forward for less than a year depending on clinical circumstances (e.g. if regular chronic disease monitoring or medication monitoring is needed more frequently than annually or the patient’s condition is not stable).

Recall Systems

• A system should be in place to recall patients for medication review and monitoring. Often this will be linked with the repeat prescribing system, so that patients requesting repeats whose review dates are approaching can be considered and the GP can decide whether to conduct a face to face (level 3), telephone or notes-based review (level 2) depending on circumstances.

• There should also be processes in place to recall patients who are prescribed regular medicines but who do not come to the attention of practice staff because they are not requesting their medicines regularly.

• Practices will need to ensure that they can recall patients for medication review in particular circumstances, such as when a medicine is withdrawn or when national or local prescribing / management guidance changes.
5. COLLECTION AND MANAGEMENT OF PRESCRIPTIONS

5.1 Issue of prescriptions

- The issue of completed prescriptions to either the patient or the patient’s representative can be by collection at reception, by post, via community pharmacist or via electronic transfer through the NHS spine (EPS).

5.2 Collection

- A clear timetable of when prescriptions will be ready for collection should be on display to the patients.

- A clear procedure should be in place to allow for the safe handing over of the correct prescription to the correct patient. Reception staff should check the identity and address of the patient collecting the prescription. If a patient’s relative or friend can demonstrate proof they are collecting a prescription and the person is unknown to the reception staff, they should be required to sign for the prescription.

- Measures to determine the identity of a representative collecting a prescription are particularly important in the case of controlled drug prescriptions, and these must be signed for.

- Collection of prescriptions by children will be at the discretion of the Practice Manager or prescriber, and will need the permission of the parent or guardian or the person for whom the prescription is being collected.

- The EPS tracker is a tool that enables prescription status and should be checked regularly to determine if a prescription has been dispensed or not.

- There are a small number of patients who must collect their own prescriptions personally. These patients must have a screen message displayed on their computer record. This message should be clearly marked on the request form and transferred to the issued script. Staff should ensure that these prescriptions are given to no one other than the patient.

5.3 Faxing Prescriptions

- Prescriptions may be faxed to community pharmacies but ONLY in exceptional circumstances. A log should always be maintained of when and where the fax was sent and when the prescription was collected.

- Prescriptions faxed at the request of the prescriber must be given to the community pharmacy within a reasonable time, and it is the responsibility of the practice to get the original prescription to the community pharmacy. It is the responsibility of the GP practice to phone the pharmacy to let them know a prescription is being faxed.
• If a request for a prescription to be faxed is made by the community pharmacy it is their responsibility to collect the original prescription later.

5.4 Prescriptions to be posted

• The name and address of the patient should be checked against the addressed envelope in which it will be posted to ensure it is going to the correct person/agency.

• Name, address and number of items on the prescription should be logged in the prescription log book, including the date of sending and the name of the person who prepared the post.

5.5 Uncollected/returned prescriptions

• Any prescriptions not collected after one month from date of issue must be reviewed by the prescriber. Where the issue is deleted from the computer, the prescription should be shredded and disposed of in the confidential waste, in the presence of a witness. A record should be made of the serial number within the practice records.

• If it was not possible to cancel the last issue, the serial numbers should be recorded on the patient records, and a comment to the effect that the prescription was not collected. Then the prescription should be shredded.

• Practices should have a procedure in place to deal with notifications from a community pharmacist that a prescription hasn’t been collected.

5.6 Prescription Charges

• Practices should have systems in place to advise patients regarding prescription charges. The charges are set nationally, and there are a variety of schemes in place to help patients with health costs. The prepayment scheme is an effective way for patients to reduce any potential increase in cost through transition to 28 day prescribing and so the Practice is encouraged to promote the scheme for those patients affected.

• Information on exemptions and prepayment certificates should be readily available in pharmacies and practices. Further information is available from the Prescription Pricing Division. http://www.nhsbsa.nhs.uk/healthcosts

6. QUALITY ASSURANCE

6.1 Repeat prescribing and ordering protocol

• Practices must have a clear, written protocol, describing the roles of each person involved in the production of prescriptions.

• This should be written by the practice and reviewed every two years.
There should be a named person who is responsible for the policy and ensuring that all staff are adequately trained.

All members of staff, including locum prescribers, need to be trained and fully aware of how the practice repeat prescribing system works, and are aware of their individual responsibilities.

A system should be in place to ensure that all staff have read the procedure and it is included in the induction programme for new staff.

### 6.2 Improving the repeat prescribing and ordering system

The Medicines Management and Optimisation Team are well placed to offer advice and spread best practice from other GP practices they work in, for example, how to maximise clinical system functionality or innovative improvement strategies.

### 6.3 Dealing with errors

There should be a system in place to investigate and learn from any errors. The prescriber who signs the prescription takes ultimate responsibility for the prescribing of that medication and therefore needs assurance that the system is robust. Errors should be reported e.g. via the DATIX system or Professional Concerns Template. Errors should be discussed at practice meetings.

In the event that unexpected or avoidable death or severe harm of one or more patient occurs, as a result of a prescribing error, this is classed as a serious incident. All serious incidents MUST be reported on the Strategic Executive Information System (StEIS) which the CCG can access and report on. All such incidents must be reported to the relevant CCG and an investigation conducted into the circumstances of the incident.

### 6.4 Audit

The repeat prescribing system is required to be audited annually in order to ensure that patients and staff are kept safe by having systems to ensure that medicines are handled safely and securely.

The practice manager will be responsible for ensuring the audit is carried out and learning and updates to the practice’s protocol or additional training are followed through.

The medicines optimisation team can support with development of audit tools to assess practice systems.

### 6.5 Security of Prescriptions

All blank and completed prescriptions must be stored in a safe and secure manner. There are a wide range of aspects the practice must consider in line
with national guidance and it is recommended that the practice have a Standard Operating Procedure (SOP) and all staff are trained.

- See Appendix 3 for more information on prescription security
- All staff must be aware of the process for dealing with missing/stolen prescriptions; this should also be detailed within the SOP.
- Risk assessment of prescription security should be carried out on a regular basis to ensure appropriate systems are in place.
- Safe storage away from reception desk to reduce risk being of stolen

6.6 Contingency plan for hardware failure

- The practice should have a contingency plan for power failure or system failure with degrees of time built in. They should ensure that prescriptions printed or handwritten are legible.
- This process should include provision to record information on the clinical system once the problem is resolved.
- Record telephone numbers of local pharmacies and trusts as part of business continuity plans.

7. ELECTRONIC PRESCRIPTION SERVICE (EPS)

- The Electronic Prescription Service (EPS) allows prescribers to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff.
- EPS will bring gains in both efficiency and safety for both patients and health professionals:
  - Improve patient safety by reducing the likelihood of dispensing errors due to unclear or illegible prescriptions.
  - Allow the timely cancellation of prescriptions thought no longer clinically appropriate.
  - Prevent the loss of prescription forms.
  - Reduce the number of fraudulent prescriptions.
  - Allows preparation of prescriptions in advance of collection, saving patient time at the dispensary, and making workflow and stock control easier for pharmacists to manage
  - Relieve patients of the need to collect prescriptions from the prescriber.
  - Eliminate the need for pharmacists to re-enter prescription information, thereby saving time and increasing dispensing accuracy.
  - For electronic repeat dispensing, as the repeat dispensing regime is stored electronically this reduces the risk of a batch of prescriptions getting lost and improves accountability for prescriptions issued and
dispensed. Pharmacies will no longer need to retain and store repeatable prescriptions and batch issues therefore decreasing workload and storage requirements.

- When electronic transfer of prescriptions is used it is important to remember that:
  - Prescriptions electronically sent to the NHS spine for access by the dispensing pharmacy, must be authorised by the prescriber and this is represented by the electronic signature
  - The signature must not be used by any other person than the authoriser.
  - The practice must have a robust protocol for electronic issue of prescriptions which meets clinical governance and risk management issues. This protocol must comply with the latest NHS IT standards.
  - The EPS system does not currently allow urgent prescriptions to be highlighted to the receiving pharmacy when sent from a GP system. For urgent prescriptions, a phone call is required to alert the pharmacy team to the patient need.
  - EPS prescriptions should not be post dated as post dated EPS prescriptions will be held locally within the clinical system and automatically be sent to the pharmacy system on the specified date. Additionally, the prescription will not necessarily become available first thing on the specified date, and in fact may only become visible to the dispensing site later in the day. Post dating EPS prescriptions could lead to increased prescription queries being received by the practice and delays for patients in receiving their medication.

**EPS Prescription Queries**

- If a patient has a query in regards to whether or not their electronic prescription is with their Community Pharmacy, both GP practices should utilise the NHS Prescription Tracker to check this information before contacting the Community Pharmacy. This can be accessed via the following web link: https://portal2.national.ncrs.nhs.uk/prescriptionsadmin/. Please note a smartcard will be required in order to access this information, smart card queries should be directed to the users local Registration Agent.

**Cancellation of an Electronic Prescription**

- The Electronic Prescription Service allows for the cancellation of prescriptions. Whole prescriptions all individual items may be cancelled
by the prescriber and new prescriptions generated if required. It is good practice to inform Community Pharmacies and or Direct Appliance Contractors (DAC) of any changes made to a patients’ prescription.

- Once a cancellation request has been made the prescriber will receive one of the following three messages:
  
  - **Prescription cancelled successfully** – in this case a new electronic prescription can be generated and sent to the patient nominated pharmacy if required.
  
  - **Cancellation unsuccessful with dispenser** – this means the patients nominated pharmacy has already downloaded the prescription from the NHS spine. Therefore the prescriber should contact the patients nominated pharmacy which will be displayed on their screen and request that the prescription is returned to the spine. There it will be automatically cancelled or the dispenser can mark as ‘Not dispensed’ A new prescription can then be generated if required.
  
  - **Cancellation unsuccessful dispensed.** In this case the item prescribed has been dispensed and has been given to the patient. Prescribers should contact the patient to discuss further.

### 8. ELECTRONIC REPEAT DISPENSING (ERD)

- eRD offers an alternative way for patients with stable long-term conditions to access their medicines via the pharmacy without the need to contact the GP practice every time a new prescription is needed.

- Patients must have a ‘nominated pharmacy’ and be using the Electronic Prescription Service to receive prescriptions in this manner.

- Well managed eRD systems can reduce the time spent by GPs, and practice staff processing prescriptions, improve services to patients, reduce medicines waste and enhance the role of community pharmacies.

- Designating staff members as eRD champions is recommended to help manage the scheme.

- eRD is not suitable for all patients. It is suited to patients with chronic conditions who are likely to remain stable on their medicines for the duration of the batch of repeat prescriptions. Patients prescribed significant numbers of items or who are likely to be hospitalised are less suited to inclusion in the repeat dispensing scheme.
• Best practice housekeeping principles should be applied before starting a patient on eRD. See Standard Operating Procedure Repeat Prescription Housekeeping.

• Patients’ medication should be suitable for issuing via eRD. Items to be issued via eRD must be in the dictionary of medicines and devices (dm+d). A list of medication that is suggested to be unsuitable is listed in Appendix 1.

• Where patients are prescribed a mixture of both medications that are suitable for issuing via eRD and those which are not, a patient should be excluded from the scheme to avoid any confusion surrounding split prescriptions.

• Patients should be fully informed of the eRD process and consent obtained and documented in patients’ records before eRD is commenced. The following read codes should be added.

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<tr>
<th>Activity</th>
<th>Emis System Read Code</th>
<th>Systm One Read Code</th>
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</thead>
<tbody>
<tr>
<td>Patient Consent given for repeat dispensing information transfer</td>
<td>9Nd3</td>
<td>XaKRX</td>
</tr>
<tr>
<td>Repeat dispensing service declined</td>
<td>8IEF</td>
<td>XaXoR</td>
</tr>
<tr>
<td>Withdrawn from repeat dispensing system</td>
<td>8BMD</td>
<td>XaKuV</td>
</tr>
</tbody>
</table>

• Patients receiving medication via eRD should be clearly identified.

• Only staff members trained in processing eRD prescriptions should cancel / add new eRD prescriptions.

• eRD prescriptions MUST NOT be amended, all items within the batch should be stopped, and a new batch prescribed which coincides with the date previous eRD prescriptions were due to end

• eRD prescriptions should not be post-dated.

• eRD batch durations should not exceed 12 months.

• Once a patient is nearing the end of an eRD batch their Community Pharmacy should advise them to contact their GP Practice for a review.

• Patients should be reviewed before their current set of eRD prescriptions finishes, to ensure patient is still suitable to use the scheme and thus obtain further supplies.
• Clear communication channels should be established between GP practices and Community Pharmacies, with GP practices regularly updating Community Pharmacies regarding new patients being added onto the scheme.

Repeat Ordering Guidance

Section 3

Pharmacies
## Index - Repeat Prescribing Guidance for Pharmacies

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Standards for Repeat Prescribing and Ordering Pharmacies

All pharmacies should have Standard Operating Procedures (SOPs) that detail their repeat prescribing and repeat dispensing services; ideally the following recommendations should be covered by these SOPs.

These standards reflect best practice and will be aspirational in some cases:

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<td>The patient should initiate involvement in any repeat prescribing services provided by the pharmacy.</td>
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<td>An agreement should be signed by the patient; details of this agreement must be retained and also shared with the GP practice.</td>
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<td>Patients should be asked and reminded wherever possible to inform pharmacy if any medicines are changed or stopped, for example after hospital admission.</td>
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<td>Procedures should be in place so that messages from practices via counterfoils are passed on to patients as intended.</td>
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<td>9</td>
<td>Return any ‘not dispensed’ prescriptions to the practice with a brief explanation of reason.</td>
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<td>10</td>
<td>Alert the practice if the patient provides feedback that they no longer require an item, this should be communicated back to the surgery for the attention of the prescriber.</td>
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<td>11</td>
<td>Pharmacies should have an audit trail that identifies each request and supply of repeat prescriptions.</td>
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<tr>
<td>12</td>
<td>Any incidents, near misses or errors that occur as part of providing these services should be recorded and reported as per clinical governance requirements. The patient’s GP practice should also be informed where appropriate.</td>
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<tr>
<td>13</td>
<td>When prescriptions are collected from the practice these should be checked against pharmacy records of items ordered. Any missing or excess items appearing on the prescription should be resolved with the practice.</td>
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INTRODUCTION

Pharmacies provide a range of services that offer benefits by increasing access for patients in need of support and also convenience regarding longer opening hours. These services offer an opportunity for pharmacies to manage the dispensing workload and therefore reduce risks, but they should only ever be initiated in the patient’s best interest.

There are examples of tightly managed pharmacy repeat ordering systems and they always result from a good relationship and on-going communication between the pharmacy and the practice to ensure systems are mutually acceptable to both parties.

Increasingly practices are requiring that most patients order repeat prescriptions directly from their GP practice. This empowers patients to take control of their own medication ordering with the aim of increased safety and decreased waste. Where this system is in place there are exceptions to this from vulnerable patients.

1. Pharmacy services

Community pharmacists can be involved in the repeat prescribing process in various ways. Confusion about level of involvement can lead to misconceptions. Therefore these services should be described in the following way to facilitate understanding and they should not be confused with repeat dispensing.

- **Pharmacy accepting counterfoils** completed by patients

- **Repeat ordering service**- where the pharmacy is involved in completing the counterfoil at the time the prescription needs to be ordered.

  Some patients are not capable of ordering their medication without support. Community pharmacies can order on their behalf following agreement with all parties i.e. patient, GP practice and pharmacy.

  There needs to be a clear system in place for agreeing patients requiring support, updating list and continually reviewing individual’s needs

- **Managed repeat ordering service**- where the patient completes their next order in advance via the pharmacy.

- **Repeat collection service**- where the pharmacy submits the counterfoil and collects the prescription from the practice. This may or may not include delivery to the patient.

  Obtain and record the patient’s consent to receive prescriptions during the Repeat Collection Service provision.
Explain fully to the patient what the service involves including timescales to allow for collection / receipt of the prescription and dispensing of the medication.

Counterfoils delivered to the practice from the pharmacy should show the pharmacy stamp as a guide to show practice staff that the pharmacy will be collecting the prescription.

- For patients who drop off counterfoils to the practice, the pharmacy should compile a list of patients they collect for that is taken to the practice when they collect prescriptions.

- On receipt of prescriptions a check should be made that the pharmacy has authority to receive and dispense the prescriptions for each individual patient. Any prescriptions received for which this authority is not in place should be returned to the surgery or directed to the pharmacy authorised to receive it.

**Delivery services**

Pharmacies should ensure that there are safe systems for deliveries and that delivery drivers operate to same standard as medicines counter assistants. They have a responsibility to ensure any concerns are fed back and an audit trail ensures these are followed up.

If pharmacies order medication on behalf of patients they must ensure all items are required prior to dispensing and delivering as items will not be able to be returned to stock once the driver has left the pharmacy.

**Electronic Repeat dispensing** – see section 6

**2. PATIENT COMMUNICATIONS**

- It should be the patient that initiates involvement in some or all of the services provided by the pharmacy. It is best practice to obtain written permission from patients to allow the pharmacy to collect prescriptions on patients’ behalf or manage their ordering if they are incapable of doing so themselves. Details of this agreement should be retained. Arrangements can be changed by the patient at any time

- The patient/carer should be given information about their responsibilities. The risks from medication changing are a particular concern and therefore patients should be asked at the outset and reminded wherever possible to highlight if any medicines stopped or changed, for example after hospital admissions.

- Pharmacies will need to ascertain the identification of the person making the request and, if this is not the patient; that the person has authority to order on behalf of the patient. These aspects are particularly important for telephone communications.
Where paper counterfoils are stored in the pharmacy due regard should be given to secure storage and patient confidentiality. Ensure the patient has an up to date copy of their counterfoil if they routinely leave these with the pharmacy. A copy should be provided if the patient does not already have a copy. Counterfoil information may be needed by the patient for interaction with health professionals e.g. subsequent hospital admission, dental treatment etc. Important messages from the practice e.g. reminders of tests required, booking flu injections etc. must be passed on by the pharmacy as intended.

Verbal communications present additional risks that need to be managed e.g. where different strengths or forms of the same medication are on the counterfoil.

i. The staff member should have access to the electronic Patient Medication Record or the counterfoil during these conversations.

ii. It is recommended that a record of the conversation should be made and kept for internal audit processes. For example who requested the order (patient / carers name), who from the pharmacy discussed the order with the patient/carer, the date and exact items ordered.

iii. Phone calls should be taken in a manner with regard to patient confidentiality i.e., without the risk of patient details being overheard.

iv. SOPs in the pharmacy should detail who can deal with verbal requests, the training needed etc. e.g., be able to show that there are enough staff suitably qualified and skilled, for the safe and effective provision of this service.

v. Include in what situations telephone requests will be taken e.g., managed prescription service where there has been prior discussion with the patient.

For MDS patients it would be recommended that medications not in blister packs (e.g., creams and inhalers) receive special attention with regard to suitability of reorder on each occasion to prevent stockpiling or waste.

Ensure that patients are asked on handout if they still require all the items they ordered and pay particular attention to PRN items.

3. GP PRACTICE COMMUNICATIONS

Pharmacies are encouraged to use the publication of this document as an opportunity to arrange a meeting to discuss processes with local GP practices and agree mutually beneficial systems that are safe, efficient, reduce waste.
and are flexible to patient choice. Ideally GP practices should participate in these meetings to ensure processes run efficiently and smoothly.

- Particularly in the case of repeat ordering and managed repeat ordering services, there should be co-operation with local prescribers. Before the pharmacy offers such services to their patients, they should agree the arrangements for the service they plan to offer with participating practices. GP practice guidance also encourages active communication of their views with pharmacies to avoid misunderstandings.

- Any concerns over the patient’s competency to reorder their medication should be discussed with the relevant GP and an appropriate strategy for reordering agreed in conjunction with the GP and the patient. This may be the case for patients with learning difficulties, dementia, confusion, as well as for patients whose medication is provided in Monitored Dosage System (MDS) or blister packs where they no longer know which medications are in their MDS packs. Details of such arrangements, the date the arrangement was agreed, details of the pharmacist and GP involved and appropriate review date should be recorded with the patient’s agreement to these arrangements.

- Return any 'not dispensed' prescriptions to the practice with a brief statement (e.g. duplicate, not required by patient, discontinued medicines, not ordered by the patient etc.). This allows the practice records to be amended to reflect prescribed medicines that the patient did not receive.

- The practice needs to be alerted if the patient provides feedback when the medication is dispensed that they no longer require an item. This should be communicated back to the surgery by either the pharmacy or the patient so that any non-compliance concerns can be addressed and repeat records updated. Any particular concerns regarding over or under ordering should be discussed with the patient and if appropriate the GP. This could involve a Medicines Use Review if appropriate. Appropriate records of such interventions should be recorded and entered on the patient’s PMR. Note: See also the section on EPS.

4. PHARMACY PROCESSES

- This guidance constitutes good practice and compromise to facilitate close working relationships with GP practices. GPhC Standards of Conduct, Ethics and Performance underpin a range of these aspects. Pharmacies must have standard operating procedures that detail these services. These must be in accordance with GPhC standards and it is strongly recommended they support the aims of this local guidance.

- Ensure that an audit trail exists to identify each request and supply. Record all interventions on the PMR, in order to be able to deal with any queries that may arise.
Any incidents, near misses or errors that occur as part of providing these services should be recorded and reported as per clinical governance requirements from the NHS contract. The patient’s GP practice should also be informed where appropriate.

5. ELECTRONIC PRESCRIPTION SERVICE (EPS)

The Electronic Prescription Service (EPS) allows prescribers to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. NB The ordering of prescriptions would still be carried out in line with local agreements between GP surgeries, Pharmacies and Patients.

- EPS will bring gains in both efficiency and safety for both patients and health professionals:
  - Improve patient safety by reducing the likelihood of dispensing errors due to unclear or illegible prescriptions.
  - Allows the pharmacy to mark prescriptions as not dispensed if no longer clinically appropriate.
  - Prevent the loss of prescription forms reducing the risk of duplicate prescriptions being generated.
  - Reduce the number of fraudulent prescriptions.
  - Allows preparation of prescriptions in advance of collection, saving patient time at the dispensary, and making workflow and stock control easier for pharmacists to manage
  - Relieve patients of the need to collect prescriptions from the prescriber.
  - Eliminate the need for pharmacists to re-enter prescription information, thereby saving time and increasing dispensing accuracy.

EPS Nomination

- Patient may choose where they wish to collect their prescribed medication from, this is referred to as their 'Nomination'.

- The four principles of nomination: these are based on the legislation and are endorsed by professional bodies. These include.
  - Patients must be provided with sufficient information about EPS before a nomination is captured.
  - Patients must not be influenced or persuaded to nominate a specific dispensing contractor and inducements cannot be offered.
  - Prescribers and dispensing contractors will need to capture, set, change, cancel and reconfirm a patient’s nomination in a timely manner.
  - Prescribers and dispensing contractors must establish clear processes for nomination.
Community Pharmacies may wish to nominate a patient for EPS and the relevant documentation should be completed. Community Pharmacies may have their own form designed for this purpose, however a copy of the PSNC form can be found in Appendix Four

- When electronic transfer of prescriptions is used it is important to remember that:
  - Prescriptions electronically sent to the NHS spine for access by the dispensing pharmacy, must be authorised by the prescriber and this is represented by the electronic signature
  - The signature must not be used by any other person than the authoriser.
  - The practice must have a robust protocol for electronic issue of prescriptions which meets clinical governance and risk management issues. This protocol must comply with the latest NHS IT standards.

**EPS Prescription Queries.**

- If a patient has a query in regards to whether or not their electronic prescription is still at the GP practice, Community Pharmacies should utilise the NHS Prescription Tracker to check this information, before contacting the GP practice. This can be accessed via the following web link: https://portal2.national.ncrs.nhs.uk/prescriptionsadmin/. Please note a smartcard will be required in order to access this information, smart card queries should be directed to the users local Registration Agent.

It is good practice for Community Pharmacies to regularly download prescriptions from the Spine.

Non collection of prescriptions: GP practices should be informed of any medication that has not been collected by patients in a timely manner.

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**6. ELECTRONIC REPEAT DISPENSING**

This offers an alternative way for patients with stable long-term conditions to access their medicines via the pharmacy without the need to contact the GP practice every time a new prescription is needed.
• GP practices will identify and sign patients up for eRD based on a review of the patient with their clinical notes.

• Community Pharmacies can help identify patients who they think may be suitable, and can suggest them to the GP practice.

• Best practice is that Community Pharmacies work together with GP practices to identify patients suitable for eRD. Community Pharmacies should not offer eRD directly to patients without discussion with the practice as they do not have access to the patient clinical record. GP practices may deem a patient unsuitable which may result in both parties not managing patient expectations.

• Community Pharmacies should be asking the four contractual questions as per NHS Community Pharmacy Contractual Framework – Essential Service Repeat Dispensing before preparing patients medication.

• These being:

  • Have you seen any health professional (GP, nurse or hospital doctor) since your last repeat was supplied?
  • Have you recently started taking any new medicines either on prescription or that you have bought over the counter?
  • Have you been having any problems with your medication or experiencing any side effects?
  • Are there any items on your repeat prescription that you don’t need this month?

If issues are highlighted from the patient that the Community Pharmacist cannot rectify the patient should be re-directed back to their GP. After each electronic prescription has been dispensed, the Community Pharmacy must send a notification up to the Spine to state this activity has taken place.

Patients should be re-directed back to the GP once they receive their final supply of medication from the eRD batch.

Community pharmacies may wish to provide patients with Patient Reminder Cards to prompt patients on when they need to collect further supplies of medication.

Further information regarding eRD for Community Pharmacies is available at: https://digital.nhs.uk/Electronic-Prescription-Service/Electronic-repeat-dispensing-for-dispensers
Repeat Prescribing Guidance

Section 4

Care Homes
This section of the policy gives guidance to care homes on ordering repeat medication. Community pharmacies and GP surgeries will have policies for handling the repeat prescriptions and care home policies must be written in conjunction with the community pharmacy and the GP surgeries. Good communication between GP, Pharmacist and Home is essential.
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Standards for Repeat Prescribing and Ordering
Care Homes

These standards reflect best practice and will be aspirational in some cases:

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<td>For the efficient ordering and supply of medication ideally a care home should deal with one pharmacy.</td>
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<td>A suitably trained member of staff in a care home should be responsible for all aspects of the repeat ordering process.</td>
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<td>If possible the home should identify a named person in the pharmacy and surgery they can deal with, with regards to any queries.</td>
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<td>Medication administered in an unlicensed manner e.g., crushed must be authorised by the prescriber and detailed on the MAR chart.</td>
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<td>The prescription ordering system should highlight any changes made to the medication in the last month to the pharmacy.</td>
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<td>Creams, ointments and oral liquids must be marked with the date of opening and can usually be used up to 6 months once opened unless otherwise stated on the label/information sheet.</td>
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<td>7</td>
<td>Prescriber should be consulted about reducing quantities of creams, ointments and liquids that last for more than 3 months after opening.</td>
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<td>Unused PRN medication that is in date should be carried over for the next month rather than being removed to reduce waste. It is good practice to keep a running total of boxed prn medication. PRN medication should not be put into blister packs</td>
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<td>Dosage instructions for ‘when required’ medication should include an indication for use, dose, frequency and if appropriate, a maximum daily dose. Any medicines received with instructions such as ‘as directed’ or ‘when required’ should be referred back to the GP for clarification.</td>
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<td>Medicines should be ordered on a 28 day cycle</td>
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<td>The care home should allow adequate time to for the surgery and pharmacy to process prescriptions and supply medicines. A minimum of two weeks is recommended.</td>
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<td>13</td>
<td>The pharmacy cannot organise ordering of medication on behalf of the home.</td>
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<td>New medication needed part way through a 28 day cycle should be requested by the care home for a quantity that will ensure that this medication will then fit in with future 28 days cycles of prescribing and be recorded on a MAR chart.</td>
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<td>It is good practice for care home staff to keep written records of all queries so there is a clear audit trail.</td>
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<td>Care staff must not transfer medication to other containers; this is called secondary dispensing and is illegal.</td>
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<td>If medication hasn’t been ordered for 6 months or more the GP should be notified to see if this item can be discontinued</td>
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<td>A trained member of staff should check the prescriptions received from practice for each resident against MAR chart and list of requested medicine, before sending it to the pharmacy. They will check they have all medication ordered, any anomalies and for any items which are not required, these should be clearly marked 'not required'. If prescriptions are sent via EPS this step is not possible. Care staff should work with the pharmacy and GP practices to ensure robust systems are in place for communicating medication changes after ordering but prior to dispensing to avoid waste.</td>
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<td>The community pharmacy should deliver all medications and MAR charts for the next 28 day cycle at least two days before the start of the cycle.</td>
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<td>21</td>
<td>Trained care home staff need to check the medicines against their records of what they ordered, identify any problems and discuss any discrepancies with the pharmacist/GP surgery as appropriate.</td>
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<td>The home should have product information leaflets available for all medications received. If missing follow up with pharmacy.</td>
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<td>The MAR chart is a legal document and should be kept by the home for a period of at least 3 years from the last date of entry.</td>
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LEGAL ISSUES AND NATIONAL GUIDELINES

Management of medicines in care homes is identified as a regulated activity in The “Health and Social Care Act 2008 (Regulated activities) Regulations 2014 – Regulation 12\(^9\).

“Regulation 12: Safe care and treatment 12

a. Care and treatment must be provided in a safe way for service users.

b. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—

i. assessing the risks to the health and safety of service users of receiving the care or treatment;

ii. doing all that is reasonably practicable to mitigate any such risks;

iii. ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;

iv. ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;

v. ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;

vi. where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs;

vii. the proper and safe management of medicines;

viii. assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;

ix. where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.”

“The act also states that the Care Quality Commission is the responsible regulatory body. The care qualities document “Guidance about compliance; Essential standards of quality and safety”\(^5\) gives guidance to care homes on how to comply with this act.

Outcome 9 applies to management of medicines.

Outcome 9b states that the home should have:

“Systems in place to ensure they comply with the requirements of the Medicines Act 1968 and the Misuse of Drugs Act 1971, and their associated regulations, the Safer Management of Controlled Drugs Regulations 2006, relevant health technical memoranda and professional guidance from the Royal Pharmaceutical Society of Great Britain and other relevant professional bodies and agencies.”

Therefore any guidelines for care homes must be mindful of these constraints and we advise that not only care home staff but community pharmacists and any GP practice staff who deal with care homes have a basic knowledge of the guidelines from the Royal Pharmaceutical Society. Pharmaceutical Society guidance on pharmaceutical
services to social care settings\textsuperscript{10} and ‘The Handling of Medicines in Social Care’ is available on its website\textsuperscript{11}.

NICE Guidelines, Managing medicines in care homes, March 2014

(nice.org.uk/guidance/sc1).\textsuperscript{12}

“The purpose of this guideline is to provide recommendations for good practice on the systems and processes for managing medicines in care homes”, and “The scope of this guideline is for all people who have a collective responsibility for residents’ care, ensuring safe and effective use of medicines in care homes”.

“This guideline considers prescribing, handling and administering medicines to residents living in care homes and the provision of care or services relating to medicines in care homes.”

In essence, this guideline covers good practice for managing medicines in care homes. It aims to promote the safe and effective use of medicines in care homes by advising on processes for prescribing, handling and administering medicines. It also recommends how care and services relating to medicines should be provided to people living in care homes.

It is aimed at people who provide care in care homes, including care home staff, GPs, community nursing teams and specialist nurses. It is also aimed at people who provide services to care homes, for example supplying pharmacies, GPs, dispensing doctors and appliance contractors. People who commission or monitor how care is provided in care homes, for example, local authorities, the Care Quality Commission (CQC) and the Office for Standards in Education, Children's Services and Skills (Ofsted) are also targeted and people who live in care homes and their families and carers.
Guidance

1. SELF ADMINISTRATION OF MEDICATION

Residents in care homes should be actively encouraged to self-administer their own medicines, where possible. In some situations this means they will be responsible for obtaining their own medication. In the majority of situations the care home will order supplies. The following policy applies to residents where the home has taken over responsibility for ordering medication for the resident.

2. RELATIONSHIPS WITH GPS AND COMMUNITY PHARMACIES

The emphasis in the CQC (Care Quality Commission) standards is to ensure person centred care and that the resident is consulted on all aspects of care and their views are taken into account when decisions about their treatment are made. These views have to be taken into account with all aspects of the medication cycle.

Care homes often have a number of different GP practices to deal with e.g., a 40 bed home may deal with 10-12 GP practices. In this situation the resident will decide which GP practice to register with (if the GP is in agreement). In some areas Clinical Commissioning Groups have developed locally enhanced services for care homes. In this situation one GP surgery will take over the care for the entire home and most residents will be registered with that practice. Residents still have the right to be registered with another surgery if they wish.

For the efficient ordering and supply of medication it is recognised that a care home should deal with one pharmacy.

Therefore care home staff may deal with a number of GP practices but routinely only with one community pharmacist. Wherever possible the same community pharmacy should be used for both acute and repeat scripts.

It would be good practice for any GP who has a financial interest in the care home where they also prescribe for residents; or for any community pharmacist who has a financial interest in a care home where they supply medicines for residents, to declare that interest through the normal route, it is also good practice to inform the Medicines Management Team.

3. ADMINISTRATION SYSTEMS

The system of administration used in most homes is a monitored dosage system (MDS). There are a number of different MDSs in use, Nomad (which is a 7 day system in a plastic tray) and the Venalink and Manrex systems which are often referred to as blister packs. They are perceived by some care homes as a ‘safer’ means of medicines administration than traditional containers. However in practice all homes have to also administer from bottles and cartons, as liquid medication, and some solid dose medications are not suitable for a blister pack.
The CQC Inspection **does not require** that medicines for Care Homes are dispensed in a monitored dosage system.

The use and funding of MDS in care homes is an arrangement between the care home and the pharmacy. When this decision is made both parties should consider the following points:

- There is no legal requirement to use MDS.
- Only certain medication can be put in an MDS so some medication will still need to be dispensed in other containers.
- Homes will need to have procedures in place to deal with changes in dose, because the use of MDS can lead to delays in doses being changed and extra waste. In certain situations e.g., end of life medication MDS may not be appropriate.
- Only regular medication should be dispensed in a MDS. As required medication should be dispensed separately to give flexibility of dosing and reduce waste.
- If a MDS is used the person administering the medication is still responsible for ensuring that the right medication is given to the right patient and that they are aware of side effects, special dosing requirements such as before food etc.
- Patient information leaflets should be available.

Community pharmacists should comply with professional guidance on MDS.

### 4. TRAINING AND EDUCATION

For the repeat ordering system to run smoothly it is essential for staff to be trained and competent in all aspects of the process. Suitably trained members of staff in a care home should be responsible for all aspects of the repeat ordering process. This should be a nurse (in a nursing home) or a senior carer (in a residential home).

The manager should keep a list of suitably trained staff and ensure that training is up to date. It helps with the smooth running of the process for the pharmacy and surgery to have a named person within the home they can contact with queries relating to prescriptions. However the manager should ensure that there is adequate cover for holidays etc. and that the system isn’t reliant on one member of staff. If possible the home should identify a named person in the pharmacy and surgery they can deal with, with regards to any queries etc.

### 5. PATIENTS WITH SWALLOWING DIFFICULTIES

If a patient is unable to take their medication in the prescribed form the prescriber should be notified, so that a medication review can be carried out. This may involve simplifying the regime, prescribing an alternative medication or prescribing an alternative preparation. Although it is good practice to only use medication that is licensed it is sometimes necessary to use it in an unlicensed way (e.g., crush, open
Medication may need to be crushed or dissolved in water before administration, if the patient is unable to swallow tablets/capsules and there is no licensed liquid preparation available. This can only be done if authorised by the prescriber. If a medication is to be given in this way the MAR chart should be annotated appropriately.

6. ORDERING REPEAT PRESCRIPTIONS

Community pharmacies and care homes need to develop a robust system for ordering medication to ensure the following points are taken into account:

- Checks are made to highlight any changes made to the residents’ medication in the previous month.
- Creams, ointments and oral liquids can usually be used up to 6 months once opened unless otherwise stated on the label/information sheet.
- They should be marked with the date of opening. If the product is lasting more than 3 months consult with the prescriber about reducing quantity.

When necessary (PRN) medication, creams and ointments etc. should be retained and used for the next month if still in date. There is no need to discard as this is a waste.

- Any instructions which state “when required” should be clarified with the GP surgery. The instructions for when required must include an indication for use, dose, frequency and if appropriate a maximum daily dose. The use of ‘as directed’ should be avoided.

- The home and GP surgery should agree whether the counterfoil should be used or whether the carbon medication request form which is part of the MAR chart may be used. Whichever system is used the home should ensure that the community pharmacy is aware of any discontinued medication and that the GP is aware of any discrepancies between the MAR and the counterfoil.

If discontinued medication has been left on repeat notify the surgery that this medication has been discontinued so it can be taken off repeat.

- Medicines should be ordered on a 28 day cycle (see exceptions below).
- Allow adequate time for the surgery and pharmacy to process prescriptions and supply medicines, a minimum of two weeks is usually needed.
• The pharmacy cannot organise ordering of medication on behalf of the home as this is unethical and carries a higher risk of error because the pharmacy may not be aware of changes that have occurred during a previous month.
• Records of the medication requested should be kept by the home.
• New medication needed part way through a 28 day cycle should be requested in a quantity that will ensure that this medication will then fit in with future 28 days cycles of prescribing.

It is good practice for care home staff to keep written records of all queries e.g., telephone conversations and action taken in the course of managing medication for care home residents. There should be a clear audit trail.

7. EXCEPTIONS TO 28 DAY’S SUPPLY

Supply of medication in care homes should be for 28 days, however some exceptions apply:

• If an item is started mid-cycle it is good practice for a prescriber to issue a prescription for amount needed until the start of the next cycle, to avoid waste.
• Patients who require palliative care or who are terminally ill, often have frequent changes of medicines, especially those to relieve pain and nausea. During this phase of a patient’s care, the home should arrange with the GP and community pharmacist that medicines are prescribed in 7 day amounts (taking into account supply over a weekend) and dispensed by the community pharmacy in bottles or cartons to allow for greater flexibility when frequent changes are made.
• At other times the home may request unusual quantities of medication to cover residents going on holiday. The home should try to make such requests to the surgery in writing with an explanation for such a request. If a resident regularly goes out for a day the home should discuss the options with the prescriber. It may be possible to change the timing of medication or to issue a separate prescription.

Care staff must not transfer medication to other containers; this is called secondary dispensing and is illegal.

8. CHECKING EXISTING STOCKS

• Before starting the ordering process it is important to establish the quantity of medication left from the previous cycle.

If you don’t need it, don’t order it.

• Particular attention must be made to quantities of dressings, topical products (creams, ointments, and scalp applications bath/shower products), stoma and
continence products. If available use dressings order form. As some PRN medication can be kept for several months, care should be taken with storage especially with items like dressings that may be supplied individually.

**Creams, ointments and oral liquids must be marked with the date of opening and can usually be used up to 6 months once opened unless otherwise stated on the label/information sheet.**

- Checks should be made to see if required medication is needed. If this hasn’t been ordered for 6 months or more the GP should be notified to see if this item can be discontinued.

**Always inform the GP if a resident is regularly refusing medication**

- Any recent deliveries should be taken into account when ordering medication.

### 9. PRESCRIPTIONS

- All drugs issued on a prescription must include clear dosage instructions. This includes liquid feeds, creams, dressings, nasal sprays, drops and all other external products. “As directed” is not sufficient information for patients to use items appropriately and leads to problems for carers.
- Once issued the prescription should be sent to the care home. A trained member of staff should check the prescription for each resident against MAR chart and list of requested medicine, before sending it to the pharmacy. They should have a process in place to ensure they have a prescription for all the items they ordered. Any anomalies or omissions should be rectified with the surgery at this stage.
- Systems should be in place to ensure that any changes to medication made in the previous month are highlighted to the community pharmacist.
- Any items which have been printed on the prescription which are not in fact required should be clearly marked ‘NOT REQUIRED’.
- The GP must also be notified of any items not required so they can amend their systems accordingly. If a prescribed item has previously been discontinued this should be highlighted to the GP so it can be removed from the repeat screen to save confusion in the future.

**Time spent sorting out discrepancies at this stage will enable the repeat process to run smoothly and save time in the future**

- All prescriptions should be issued for the quantity required for 28 days. Issuing of larger quantities can cause practical and safety issues for care homes. Contact the GP surgery and ask them to reduce quantities on repeat if necessary.
10. DELIVERY AND CHECKING MEDICATION

- The community pharmacy should deliver all medications and MAR charts for the next 28 day cycle at least two days before the start of the cycle.
- Trained care home staff need to check the medicines against their records of what they ordered, identify any problems and discuss any discrepancies with the pharmacist/GP surgery as appropriate.
- This includes checking the amount received the accuracy of the labels and the accuracy of the information recorded on the MAR charts. Any medicines received with instructions such as ‘as directed’ or ‘when required’ should be referred back to the GP for clarification.
- The home should have written information available for all medications received. Check all new medications to ensure product information leaflets are available. If not follow up with the pharmacist.

   It is good practice for care home staff to keep written records of all queries e.g., telephone conversations and action taken in the course of managing medication for care home residents. There should be a clear audit trail.

11. RECORDING SYSTEMS

The community pharmacist will usually supply printed Medicine Administration Record (MAR) charts as part of the service to the home. This is an additional service not remunerated by the NHS. Production of an accurate up to date chart is only possible if there is adequate communication between the prescriber, care home and pharmacist.

   It is essential to inform the pharmacist of any medication that is discontinued so it can be deleted from the MAR.

Community pharmacists who provide MAR charts should comply with the practice guidance for ‘Provision of printed medicine administration record charts (MAR) by community pharmacists for use in health and social care settings.’ from the RPharmS13

The MAR chart is a legal document. The Care Quality Commission document, “Guidance About Compliance: essential standards of quality and safety” states that people should be confident that records are kept for a period of at least 3 years from the last date of entry.

If a new medication is prescribed part way through the cycle the community pharmacist should provide a new MAR chart. However, if this is not possible, it may be necessary for care staff to hand write the new medication on the MAR chart. They should have a supply of blank MAR charts from the community pharmacist for those occasions when there is not sufficient room on the chart of an existing resident, or to hand write medication for a new resident.
Any additions/amendments to the MAR chart should be signed, dated and the reason for the change clearly stated. It is good practice for the member of staff who adds information to the MAR chart to sign and date it and for a second member of staff to check, countersign and date it too. NB GPs/prescribers do not need to sign documents relating to medicines administration e.g. MAR charts. It is also good practice to attach a photocopy of the original prescription to the MAR chart, to evidence the details of the handwritten record.

| There should be a clear audit trail for any changes made to a MAR sheet, it is a legal document. |
APPENDIX 1
Medications Generally Not Suitable For Repeat prescribing and Electronic Repeat Dispensing (eRD)?

Medications Generally Not Suitable For Repeat prescribing

<table>
<thead>
<tr>
<th>Drug group</th>
<th>Examples of medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antibacterials / antifungals short term courses</td>
<td>Amoxicillin, Azithromycin, Ciprofloxacin, Cefalexin, Clarithromycin, Clindamycin, Co-amoxiclav, Co-trimoxazole, Doxycycline, Erythromycin, Flucloxacinil, Lymecycline, Metronidazole, Nitrofurantoin, Ofloxacin, Oxytetracycline, Phenoxyethylpenicillin (Penicillin), Trimethoprim.</td>
</tr>
<tr>
<td>Antibiotic eye/ear drops/ ointment</td>
<td>Chloramphenicol, Fusidic acid, Ciprofloxacin, Otomize, Aciclovir, Fluconazole, Terbinaine</td>
</tr>
<tr>
<td>Antivirals</td>
<td>Aciclovir, Fluconazole, Terbinaine</td>
</tr>
<tr>
<td>Controlled Drugs</td>
<td>Temazepam, Buprenorphine, Fentanyl, Methadone, Morphine, Oxycodone (Longtec®, Pethidine, Tramadol.</td>
</tr>
<tr>
<td>Dressings</td>
<td>Allevyn adhesive etc.</td>
</tr>
<tr>
<td>Hypnotics and Anxiolytics</td>
<td>Nitrizepam, Temazepam, Zopiclone, Zolpidem. Buspirone, Diazepam, Lorazepam, Loprazolam, Lormetazepam. Oxazepam</td>
</tr>
<tr>
<td>Oral Nutritional Supplements</td>
<td>Aymes Shakes, Complan, Ensure Shake, Fortisip, Fortijuice, Forticreme all varieties.</td>
</tr>
<tr>
<td>Potent Topical Corticosteroids</td>
<td>Clobetasol propionate 500 micrograms/ 1 gram,(Clarelux®, Dermovate®)</td>
</tr>
<tr>
<td></td>
<td>Clobetasol with neomycin and nystatin Diflucortolone valerate 3 mg per 1 gram (Nerisone Forte®, Nerisone Forte®)</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>Varenicline (Champix®) and Nicotine Replacement Products.</td>
</tr>
<tr>
<td>Topical preparations containing antimicrobials</td>
<td>Clotrimazole, Miconazole, Fusidic Acid, Nystatin, Timodine, Bactroban, Naseptin, Metronidazole preparations</td>
</tr>
<tr>
<td>Weight Loss treatment</td>
<td>Orlistat.</td>
</tr>
<tr>
<td>Additional Practice Specific Drugs</td>
<td></td>
</tr>
</tbody>
</table>

Additional medication not suitable for prescribing on eRD but may be prescribed as repeat medication.
Drugs requiring intensive monitoring:

<table>
<thead>
<tr>
<th>Drug group</th>
<th>Examples of medication – further information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antibacterials</strong></td>
<td>Amoxicillin/Doxycycline for acute COPD exacerbation with explicit instructions, to be issued once only within a 3 issue batch of repeats.</td>
</tr>
<tr>
<td><strong>Oral Corticosteroids</strong></td>
<td>Budesonide, Fludrocortisone, Hydrocortisone, Prednisolone, only when patient stable on therapy. (have been taking same dose for 6 months) Prednisolone as part of a COPD rescue pack maximum of 2 issues in any 12 month period</td>
</tr>
<tr>
<td><strong>Antidepressants</strong></td>
<td>Only when patient’s dose is stable and patient has a clear review date annotated in notes.</td>
</tr>
<tr>
<td><strong>Additional Practice Specific Drugs</strong></td>
<td></td>
</tr>
</tbody>
</table>
Within the local health economy formulary some medicines are designated ‘specialist only’ status as they require intensive monitoring or close specialist supervision. Whilst provision of these prescriptions is the responsibility of secondary care, it is important that there is an accurate record within general practice to ensure safe co-prescribing of other medications.

Adding these medications to the patient’s record enables prescribers and repeat prescribing clerks to view all current medication and should prompt a clinical safety alert if prescribing an interacting medication or if the patient’s condition alters e.g. a reduction in renal function.

The purpose of this guide is to identify an appropriate method to record hospital prescribed medications in the patient notes. However, this is only a suggested guide and it is the responsibility of individual practices to record medicines prescribed by secondary/tertiary care in the most appropriate way agreed by the practice.

**To add a hospital only medication to Emis Web**

**Please note:**
Some hospital only medicines can be added by repeat prescribing clerks. Others, such as, immunosuppressants may be restricted to clinicians only. In EMIS Web restricted medicines appear in **RED** and can only be added by an authorised prescriber.

Add the medication (or edit the medicine if it is already on the record) and allocate a hospital only status by doing the following:

1. Select the medicine
2. In the quantity box add 0. In the latest EMIS update a new message is displayed stating ‘**Medication with a quantity of zero can only be issued as record for notes. Either enter a quantity or issue as record for notes**’.
3. Click on ‘optional prescribing information’ on the right hand side of the screen, the pharmacy information box will appear. In this box write ‘**DO NOT DISPENSE, TO BE ISSUED AND DISPENSED BY THE HOSPITAL**’.
4. Click on ‘update’.
5. Once the medication has been added, select the product and ‘issue’

6. At the top of the issue box which appears, click on the downward arrow next to ‘change all’ and select ‘Hospital (no print)’
7. A text box will then appear saying ‘Authoriser’. It is helpful to type the name of the consultant providing the treatment in this box as this information will be retained within the electronic audit trail.

8. Click ‘approve and complete’

9. The medication will then appear listed under the hospital as below:

If a member of the practice should attempt to issue a hospital medication then a warning is displayed stating that the last issue was ‘hospital’ and the ‘approve and
complete’ button is greyed out. This can only be over-ridden if the item is then restarted and issued as an acute or repeat.

Please note:
Items marked ‘hospital’ on EMIS Web are not displayed on the right hand side of repeat prescriptions that the patient uses to request prescriptions.

They are therefore not visible to the dispensing pharmacy or to any healthcare professional who may request a copy of the current repeat prescription e.g. on hospital admission.

To add a hospital only medication to Microtest Evolution
Add the medication in the usual way. Or you can edit an existing medication by right clicking on the drug and go ‘change details of drug selected.’

1. Select ‘Patient Dosage’ on the bottom right hand side. In the patient dosage instructions add ‘DO NOT DISPENSE, TO BE ISSUED AND DISPENSED BY THE HOSPITAL’.
2. Change the qty to 1 (0 cannot be entered in Microtest) click ok and ok again.

1. With the drug highlighted, select the icon with the white bag and red cross (circled below). The 'add script as prescribed elsewhere' box pops up. In the ‘where’ section type ‘Hospital only issue’ click ok. The icon will now appear next to the drug.
2. You can then right click on the medication and select ‘pin drug’ from the drop down list. This will stop the medication falling into past when it has not been issued.

3. You can also right click again on the medication and select the free text note, add the message ‘do not issue’

4. You can have the medication listed in the acute or repeat list, whichever is the practice preference, although leaving in acute would stop the medication from being issued or requested in error.
Adding ‘other’ medication to a patient’s record on Systm One

- Go into patient record
- Right click on Medication in the clinical tree
- Click red question mark icon Record Other Medication.
- Enter drug name, strength, dose and quantity with administration notes as to where it is supplied from
- Select correct source i.e. Hospital Medication
- Enter note in Administration notes regarding source of medication i.e. “Supplied from Hollins Park, GP not to prescribe.”
- Document action in patients notes.
- Save entry once checked.
- To view ‘other medication’ from the repeat screen, click on relevant information on the bottom of the repeat screen and enlarge if required. (see screenshot below)
- Reminders can also be added to patients home screen or patient plans regarding this.

Once entered this information will appear on a patient’s Summary Care Record (SCR).
Please note:
Items marked ‘as Other’ on Systm One are not displayed on the right hand side of repeat prescriptions that the patient uses to request prescriptions.

They are therefore not visible to the dispensing pharmacy or to any healthcare professional who may request a copy of the current repeat prescription e.g. on hospital admission.

Appendix 3
Security of prescription forms

Aide-mémoire for prescribers

- Be aware that blank prescription forms in the wrong hands are like a blank cheque with an extremely high street value.
- Prescription form stock in possession of prescribers should always be stored securely when not in use.
- Prescribers should keep a record of the serial numbers of prescription forms issued to them. The first and last serial numbers of pads should be recorded.
- Prescribers should be encouraged to use prescription forms in number sequence order to aid tracking of usage, should a potential loss occur.
- To reduce the risk of misuse, blank prescriptions should never be pre-signed.
- Patients, temporary staff and visitors should never be left alone with prescription forms or allowed into secure areas where forms are stored.
- Prescribers on home visits should, before leaving the practice premises, record the serial numbers of any prescription forms/pads they are carrying. Only a small number of prescription forms should be taken on home visits – ideally between 6 and 10 – to minimise the potential loss.
- Prescribers on home visits/working in the community should take suitable precautions to prevent the loss or theft of prescription forms. Keep them out of sight when not in use and do not leave any prescription forms in vehicles overnight.
- Prescribers using the FP10PCD forms should exercise extra caution as there is greater potential for misuse of these forms.
- Blank or signed prescription forms should never be left at patients’ homes, care homes or community pharmacies for GP or locum visits.
- Personalised forms which are no longer in use should be securely destroyed (e.g. by shredding) before being put into confidential waste, with appropriate records kept.
- Spoiled or cancelled prescription forms should be retained for audit purposes.
- In the event of a loss or theft of prescription form stock, local procedures should be followed and the practice manager, area team, Controlled Drugs Accountable Officer and the police should be notified as required. The incident should also be recorded on the organisation’s incident reporting system. NHS Protect should also be notified at prescription@nhsprotect.gsi.gov.uk using the form at annex B of the Security of prescription forms guidance document.
Security of prescription forms

Aide-mémoire for practice managers

- Develop a prescription security awareness culture amongst practice staff and prescribers.
- Ensure that robust policies and procedures are in place to manage the effective security of prescription forms in the practice.
- Designate a member of staff to accept overall responsibility for overseeing the whole process involved – from the ordering, receipt, storage and transfer of prescription forms to their overall security (including access to them).
- Maintain an up-to-date list of all prescribers within the practice to account for those who have left, moved employment/CCG area or been suspended from prescribing duties.
- Check deliveries of prescription form stock from the area team/supplier whilst the delivery driver is present, to check order and amount are correct and packaging is sealed and unbroken.
- Report and investigate irregularities at delivery stage immediately with the area team/supplier.
- Transfer prescription form stock to secure storage immediately.
- Ensure access to secure storage is restricted and all staff access is recorded.
- Maintain clear and unambiguous records on prescription form stock received and distributed.
- Patients, temporary staff and visitors should never be left alone with prescription form stock or allowed into secure areas where forms are stored.
- Prescribers conducting home visits should be alerted to and be mindful of the potential dangers associated with carrying around prescription forms or leaving them unattended.
- Personalised prescription forms which are no longer in use should be securely destroyed, e.g. by shredding, before putting into confidential waste.
- Spoiled or cancelled prescription forms should be retained for audit purposes.
- In the event of a loss or theft of prescription form stock, local procedures should be followed and the area team, Controlled Drugs Accountable Officer and the police should be notified as required. It should also be recorded on the organisation’s incident reporting system. NHS Protect should also be notified at prescription@nhsprotect.gsi.gov.uk using the form at annex B of the Security of prescription forms guidance document.
Security of prescription forms

Aide-mémoire for NHS England area teams

- Develop a prescription security awareness culture amongst area team staff, all prescribers and GP practice staff. Reports of lost, or potentially lost prescriptions require immediate action.
- Ensure that robust policies and procedures are in place to manage the security of prescription forms effectively.
- Designate a member of staff to accept overall responsibility for overseeing the whole process involved – from the ordering, receipt, storage and transfer of prescription forms to their overall security (including access to them).
- Maintain an up-to-date list of prescribers and GP practices to account for those who have left, moved employment/CCG area or been suspended from prescribing duties.
- Check orders received from prescribers and GP practices against current details and status before issuing prescription form stock.
- Check deliveries of prescription form stock from the secure printer/supplier whilst the delivery driver is present, to check order and amount are correct and packaging is sealed and unbroken.
- Report and investigate irregularities at delivery stage immediately with the secure printer/supplier.
- Transfer prescription form stock to secure storage immediately.
- Maintain clear and unambiguous records on prescription form stock received and distributed.
- Patients, temporary staff and visitors should never be left alone with prescription form stock or allowed into secure areas where forms are stored.
- For onward delivery within NHS England and to other organisations (e.g. to GP practices, nurse/pharmacist prescribers), prescription form stock should be sealed to prevent access whilst in transit.
- Onward deliveries should be by internal/approved courier and only handed over when signed for.
- In the event of a loss or theft of prescription form stock, local procedures should be followed and the Controlled Drugs Accountable Officer and the police should be notified as required. It should also be recorded on the organisation’s incident reporting system. NHS Protect should also be notified at prescription@nhsprotect.gsi.gov.uk using the form at annex B of the Security of prescription forms guidance document.
### NHS Electronic Prescription Service

#### Patient Nomination Form

<table>
<thead>
<tr>
<th>Patient name and address</th>
<th>Bag label</th>
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</thead>
<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone number</th>
</tr>
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<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>NHS number</th>
</tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>I am the patient named above/carer of the patient named above. Nomination has been explained to me and I have also been offered a leaflet that explains nomination. I would like to nominate Pharmacy name as my nominated pharmacy for dispensing prescriptions issued by the NHS Electronic Prescription Service.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature</th>
</tr>
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<table>
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<tr>
<th>Date</th>
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<tbody>
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</tbody>
</table>
References


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12. NICE Guidelines, Managing medicines in care homes, March 2014 (nice.org.uk/guidance/sc1).