NHS
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Clinical Commissioning Group

Repeat Prescribing Guidelines

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REPEAT PRESCRIBING GUIDE

Executive Summary

Repeat prescribing is a system which enables patients to obtain further prescriptions for medicines without necessarily seeing a prescriber. Repeat prescriptions account for about 70% of all prescriptions issued by GP practices.

A well-managed repeat prescribing system is essential in all practices to ensure on-going good quality, safe and cost effective prescribing and to minimise medicines waste.

A good repeat prescribing process will begin with the clinicians' decision to initiate a repeat prescription and end at the point that the patient receives the prescription.

Key points to consider when developing a practice process for repeat prescribing:

- Where possible requests for repeat medication should be in writing (electronic methods e.g. email, internet ordering system are acceptable). Verbal requests should be kept to a minimum.

- Medicines should be linked to their condition and a repeat authorisation period stated by the prescriber at the time of their initiation.

- Repeat clerks can be authorised to make simple amendments such as quantities for synchronisation, but should make no clinical amendments and should never restart or reauthorize a medication on the clinical system. Prescriptions should always be started by a clinician.

- Prior to issuing a prescription, staff should check for compliance – under or over prescribing should be brought to the prescribers attention. Particular attention should be paid to items such as inhalers, topical preparations or 'prn' medicine to ensure they are only ordered as needed rather than every month (particularly if someone orders on behalf of the patient e.g. carer, residential care setting or community pharmacy).

- Signing the prescription is not a mechanical process – the person who signs take full clinical responsibility. Prescribers should assure themselves that the medication is appropriate and all relevant monitoring and safety tests are up to date.

- Non-medical prescribers must only sign prescriptions within their areas of evidenced competence and must never sign a prescription printed in another prescriber's name.

- Linking of repeat process with a high quality medication review process is essential to ensure good clinical care of the patient.

- Records should be kept of any incidents such as requests not being completed within 48 hours, mislaid prescriptions and prescribing errors. Practices should have a process for learning from these and should audit their repeat prescribing process at least bi-annually.

- All staff involved in the repeat prescribing process should be suitably trained and understand their roles and responsibilities and the processes to be followed**.**

1.0 Introduction

A repeat prescribing system enables a patient to obtain further prescriptions without necessarily having to see the GP or nurse, thereby reducing unnecessary clinical consultations. Repeat prescriptions represent about 80% of the cost and about 70% of all items prescribed in general practice.

This guidance should be read in conjunction with the CCG's "A guide to medication review" and the CCG's Non-medical Prescribing Policy.

All practices should have in place a repeat prescribing policy which reflects the guidance in this document.

2.0 Scope

The repeat prescription process applies to all members of staff working at GP Practices within Shropshire CCG and includes stages in the electronic prescription service (EPS). The procedure should be applied at all times including normal working hours, on-call and weekend working, where applicable.

3.0 Education and Training

Practice staff involved in the preparation of repeat prescriptions will need to be appropriately trained in the practice protocols for repeat prescribing. They will need to understand their responsibilities and the need for accuracy and the limitations of their role. As part of the induction process this procedure will be fully explained to new members of staff (where relevant). The Practice Manager will circulate the most current SOP to all current staff who are involved in the process. Training records should be maintained.

The CCG's medicines management team can provide practice staff a training session on managing repeat prescriptions, which aims to improve procedures and cut down on the considerable waste generated in repeat prescribing.

4.0 Aims

- Increased patient safety and more effective risk management of therapeutic misadventure
- Monitored patient compliance (under and over usage)
- An efficient system benefiting both practice staff and patients
- Any changes to patient's medication are promptly reviewed and incorporated into patient's records
- Less wastage of medication
- Savings within the practice prescribing budget
- Reduced opportunity for prescription fraud

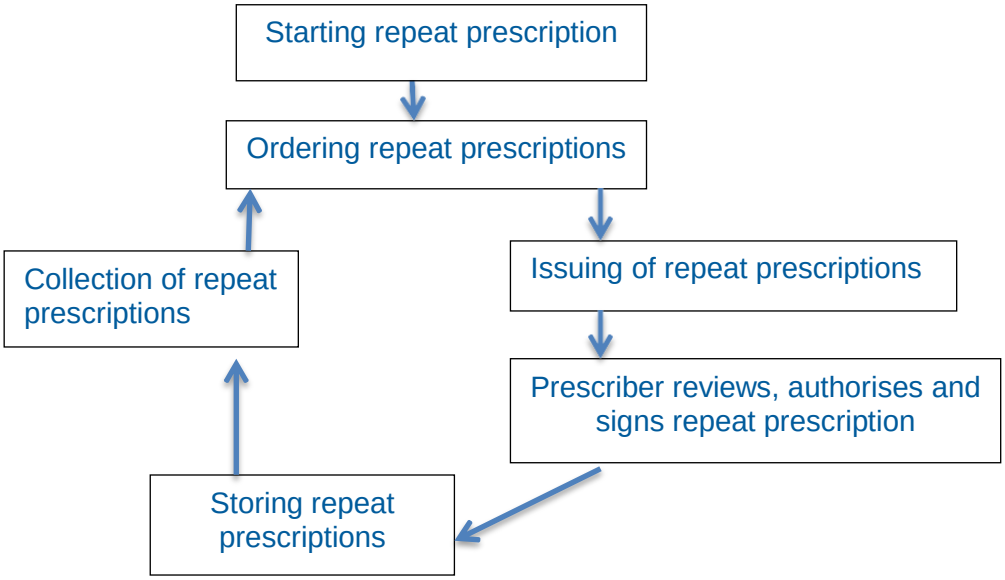
5.0 Definitions

CCG	Clinical Commissioning Group
Prescriber	Registered heath care professional with authorisation to prescribe encompasses medical prescribers (doctors and dentists) and non-medical prescribers (nurses, pharmacists, physiotherapists, optometrists, radiographers, occupational therapists)

Repeat prescribing is collaboration between prescriber and patient that permits the patient to obtain further prescriptions for medicines at agreed intervals without seeing the prescriber at each issue.

6.0 Repeat Prescribing Process

In this guidance, the repeat prescribing process has been divided into the stages depicted in the flow diagram below:



See Appendix A for a flowchart detailing pertinent steps at each stage.

6.1 Starting Repeat Prescription

6.1.1 Acute versus Repeat Prescribing

An acute prescription is one that is issued on a “one-off” basis, as the result of a consultation. A repeat prescription is a continuation of a previously prescribed medication that is issued without the need for a consultation.

The decision to transfer a drug from an acute prescription to a repeat prescription must always be made by the **prescriber** after careful consideration of whether the drug has been taken by the patient (compliance check), has been effective and well-tolerated, and is required long-term. It is the duty of the prescriber at this stage to ensure the patient understands the repeat prescribing process and what is required of them.

For newly registered patients, who were previously on repeat prescriptions, a current reorder prescription slip(s) from the previous surgery could be used for entering data on computer systems whilst waiting for records from the previous practice.

For electronic prescription service (EPS), the patient should have nominated a pharmacy to which the repeat prescription will be transmitted to.

Care should be taken to ensure the repeat record is accurate, quantities for each drug are synchronised where possible and review dates are entered.

All prescriptions (acute and repeat) should be computer generated. Hand-written scripts may be generated during domiciliary visits; however this information will be added to the patient’s clinical record at the earliest possible opportunity.

As a general rule, the following medicines will **NOT** be added to repeat prescription screens:	
Antibiotics, antivirals and antifungals for acute infections	Glyceryl Trinitrate pump spray
Colecalciferol (Vitamin D)	Hypnotics
Benzodiazepines	Nicotine replacement therapy and varenicline
Cough remedies and decongestants	NSAIDs
Dressings, dietary supplements or district nurse requested items	Oral contraceptives and hormone replacement therapy
Drugs that require specific repeated monitoring e.g. rheumatology drugs	Schedule 2 and 3 controlled drugs
Very potent steroid creams/ointment e.g. clobetasol propionate	Weight loss drugs e.g. orlistat

6.1.2 Hospital Discharges, Out-patient Appointments and Home visits

When patients are discharged from hospital, their regular medication may have changed. This is a particularly vulnerable time for errors to occur and ideally the **prescriber** will amend the repeat record **personally** or at least check it at the time it is amended as therapeutic decision-making will be required and re-authorisation is essential. A discharge letter should be made available to the prescriber when checking and updating records. The following checks should be made:

- Duplication of drug or drug class
- Brand-generic name duplication
- Correct dose, dosage form and quantity
- Deletion of discontinued medication
- The new medicines are appropriate for prescribing in primary care and suitable to be put on repeat prescriptions.
  If the medicine is supplied by the hospital, the medication needs to be added to the patients' medication list (with annotation that it is supplied by the hospital)to allow interactions to be identified.

The prescriber should sign and date discharge/out-patient's letter once the information has been correctly entered onto computer system. A copy of the letter should be uploaded onto computer system and the patient's medical record updated to explain changes in medication.
Medication prescribed during home visits should be entered onto the computer system by the clinician who carried out the visit within 72 hours of the visit.

6.1.3 Dosage Instructions

All repeat prescriptions should include dosage instructions to facilitate compliance checks. Compliance is the extent to which a patient takes or uses a medicine as intended by the prescriber.

The instruction "when required/ prn" should be only used in conjunction with a regular or maximum daily dosage instruction.

When prescribing methotrexate, the practice will follow best practice advice to prescribe only 2.5mg tablets and express the dosage in terms of tablets and milligrams e.g. four tablets (10mg) to be prescribed weekly; when the dosage is variable the instructions will include as a minimum “to be taken weekly as directed”. The instructions “as before” and “as directed/ mdu” should be avoided.

6.1.4 Generic Prescribing

Drugs will generally be prescribed by their generic (active drug) name, unless there is a good reason not to e.g. to avoid confusion between different formulations and to ensure that there is no resulting loss of control in the patient’s condition. The British National Formulary recommends a limited number of drugs that must be **prescribed by their brand name** as the different formulations are not equivalent.

Occasionally brand prescribing will be recommended for cost efficiency reasons. Prescribers should follow recommendations made by Scriptswitch.

6.1.5 Products to be prescribed by brand name

Medicine Category	Generic Name/ Group	Examples	Comments
Drugs with narrow therapeutic index	Aminophylline	Phyllocontin Continus™	There may be differences in the bioavailability of the preparations and /or the difference between therapeutic and toxic plasma concentrations. Therefore the brand name should be prescribed. However, where bioequivalence is not so significant e.g. pain control, brand prescribing is not necessary.
	Ciclosporin	Neoral™, Sandimmum™	
	Carbamazepine	Tegretol™, Carbagen™, Epimaz™	
	Lithium	Priadel™, Camcolit 400 mg™, Liskonum™ Lithium Carbonate Essential Pharma 250 mg	
	Sodium Valproate	Epilim™, Epilim Chrono™	
	Theophylline	Nuelin SA™, Slo-Phyllin™, Uniphyllin Continus™	
Certain modified-release preparations	Diltiazem	Slozem™, Adizem XL™, Tildiem LA	The BNF states that the brand names should be specified as different versions of these modified-release (m/r) preparations may not have the same clinical effect.
	Nifedipine	Coracten SR or XL™, Adalat™, Adalat Retard™, Tensipine™	
Controlled Drugs including patches (Schedule 2 and 3)	Morphine	Zomorph™, MST™, MXL™, MorphgesicSR™ and Sevredol™	Caution due to differing dosage regimes for SR and XL preparations. The BNF states that dosage should be reviewed if brand altered.
	Oxycodone	OxycontinTM, Oxynorn™, Longtec™ and Shortec™	
	Fentanyl	Fencino™ Matrifen™, Durogesic DTrans™, Fentalis™, and Mezolar™,	
	Buprenorphine	BuTrans™, Butec ™ and Transtec™	
	Methylphenidate	Ritalin	
Certain inhaler devices	CFC Free Beclometasone	Qvar™, Clenil™	Always check the type of device e.g. accuhaler, turbohaler. Caution should be exercised when changing from CFC-containing aerosol to Qvar (dose adjustment required) – MHRA/BNF recommends prescribing beclometasone CFC free by brand name. This also applies to combination products. Licences and instructions for use vary between different preparations.
	All combination MDI and dry powder devices where more than one device exists	Seretide™, Symbicort™, Sereflo™, Spiriva™	

Medicine Category	Generic Name/ Group	Examples	Comments
Multi-ingredient products	See examples →	Calcium salts Hormone replacement therapy Oral contraceptives Antacid preparations e.g. Peptac™ Multi-ingredient ENT preparations Multi-ingredient laxatives Multi-ingredient haemorrhoidal preparations Bath oils, creams, liquids or gels Antiseptics Pancreatin preparations Disinfectants Sando K™ Bowel cleaning solutions	Generic prescribing may not be practical or may cause confusion due to multiple ingredients. Some combination products are appropriate for generic prescribing using 'co- 'prefix e.g. co-amoxiclav, co-codamol, co-amilofruse.
Specific brands for Specific indications	Liraglutide	Victoza™ or Saxenda™	
Miscellaneous		Wound products Insulin Nutritional products Vaccines NRT	

6.1.6 Quantities

Initial prescriptions for a new medication should be minimal (usually 28-day pack) to avoid wastage should the patient experience side effects or the drug prove to be ineffective for the individual patient.

As per the General Practitioners committee of the BMA, prescribing intervals should factor in possible reactions, possible need of a change in the prescription and so drug wastage, patient compliance (and also patient convenience) and any necessary monitoring.

In practice this means that patients could have up to a 56 day repeat interval.

It is good practice to prescribe 28-days' supply for patients in nursing/ care homes. Two weeks' supply of dressings should be appropriate in most circumstances.

Ensuring routine medication is provided for the same time period (**synchronisation**) as existing medication reduces the workload for patients and the practice by ensuring each patient can order all of their routine medicines on a single occasion rather than on a number of times throughout the month. Once synchronisation is achieved, the prescription should still be monitored to ensure it does not go out of sync. This could happen if the patient does not take medication according to the instructions, if new items are added or if as required medicines are used quickly or not at all.
Prescriptions for contraception and HRT may be given for up to 6 months.

The maximum duration recommended by NHS choices for supplies for an extended holiday is 3 months. See "Can my GP prescribe extra medication for my extended holiday"
http://www.nhs.uk/chq/Pages/1755.aspx

Any decision to prescribe 7 day prescriptions should be for those at risk of suicide and also for unstable patients where therapy needs to be amended frequently. The reason for 7 day prescribing should be documented. 7 day prescriptions should not be issued for meeting the costs of supplying a monitored dosage system.

6.1.7 Linking medicines and indications

When a medication is first added to a repeat prescription it should be clearly noted why the medication was started; this is good clinical practice and will assist with future medication reviews. It is also important to include the number of repeats or the time period allowed before the next review together with details of any monitoring (specific tests & frequency) required ensuring patient safety. Medicines will only be added to a patient's repeat medication list on the authorisation of an appropriately qualified clinician/ prescriber.

6.1.8 Review period

The review period for each drug is solely the responsibility of the prescriber. Guideline for review intervals in chronic conditions is tabulated on the next page**:**

Chronic conditions (patient stable and reviewed only by GP practice)	Recommended minimum review
Asthma	12 months
CHD – secondary prevention	12 months
Diabetes	12 months
Epilepsy	12 months
Hypertension (stable)	6 months
Menopausal symptoms/ HRT	12 months
Older People (over 75 years)	12 months
Older People (over 75 years taking 4 or more medicines)	6 months
Oral contraception	6 months
Schizophrenia	12 months
Thyroid disease (hyper + hypo)	12 months

If patients fail to attend for a review (read code 9N4), they should receive a maximum of one month's supply of medication and be advised of the need to attend for review within that 28-day period before further supplies can be issued.

6.1.9 Repeat Dispensing

Repeat dispensing allows a single master prescription to be issued for a patient with a stable long-term condition that can be dispensed in instalments by the community pharmacist of their choice. This process makes it easier for patients to obtain their medicines and reduces workload in the practice.

Patients with stable long-term conditions could be identified and provided with information about repeat dispensing and offered the option to move to this system.

The prescriber can issue a master repeat prescription followed by a series of batch prescriptions (up to 12). Only the master prescription requires a signature and the batch issues will be stored at the community pharmacist.

If a change in medication is required, the patient must be issued with another prescription. If this is the case, or if the prescriber feels that a repeatable prescription they have issued is no longer appropriate, they should inform the patient and make every effort to contact the pharmacy. For this reason the practice must document which pharmacy the patient is using.

6.1.10 Electronic Prescription Service

The Electronic Prescription Service (EPS) will allow a patient's prescription to be sent electronically from their GP to a pharmacy. Patient may nominate a preferred pharmacy or dispensary (for dispensing practices) to which their prescriptions can be sent automatically. GP practice staff should have their relevant roles in the prescription process assigned on the smartcard. With EPS the prescriber can cancel prescriptions any time before the prescription is dispensed and record reason for cancellation.

6.2 Ordering/requesting of repeat prescription

6.2.1 Receiving requests

The patient should be given a list of drugs they are currently taking on repeat prescription as a computer-generated list (the right hand side of the prescription slip).

The patient or their representative must have an active role in requesting a repeat prescription. The community pharmacist should not initiate a repeat prescription, except by prior written arrangement with the patient/carer. Community pharmacists are expected to confirm with the patient that items are required before requesting a prescription from the practice.

The patient should be encouraged to indicate on the repeat request slip which drugs they require when a request is made. If they have left the form blank and it is not obvious which medication is needed, the patient should be contacted, rather than all the medication given. It is important for patients to understand that medications will not be removed from their repeat list because they are not ordered on every occasion. If patients do not have the repeat request slip, or the slip does not list the required item, then the patient should fill out a prescription request form.

The completed request form can be handed in directly to the practice or posted in the practice's prescription request box or faxed or sent by post.

Patients may also order medication by email or online or through the Prescription Order Direct (POD) service if in place.

Patients should give 2-3 working days' notice when ordering repeat prescriptions.

Repeat prescriptions are not issued at weekends or on bank holidays under normal circumstances.

The practice will ensure patients are not left without important medication – even if it is they who have forgotten to order it. Reception staff are reminded to check with the prescriber if unsure if a medicine is urgent.

6.2.2 Patient representatives

The practice must have a system to satisfy itself that patient representatives are authorised to act on the patient's behalf, i.e. checking the patient's and representative's name and address.

6.2.3 Community Pharmacies ordering on behalf of patients

The community pharmacist should not initiate a repeat prescription, except by prior written arrangement with the patient/carer. The pharmacy must gain written consent from the patient to participate in pharmacy repeat ordering services. The GP practice must be given a copy of this patient consent before any prescriptions are issued and this consent form should be scanned into the patient's records. Prescription requests from the patient's pharmacy should have the pharmacy's name stamped/written on and signed by community pharmacist. Practice staff should in turn write the pharmacy's name on the prescription to ensure a robust collection process.

The patient or their representative must have an active role in requesting a repeat prescription. Community pharmacists are expected to confirm with the patient that items are required before requesting a prescription from the practice. However in practice this often occurs at the point of the last dispensing several weeks before the request is made, which may lead to over ordering of 'as required' medications such as inhalers, creams etc., or even ordering of medication which has been stopped since the previous issue. Staff producing repeat prescriptions should be aware of these risks and check with the patient or prescriber when in

doubt.

6.2.4 Nursing/ Residential/ Care Homes

It is important that nursing/ residential/ care homes designate one member of staff to have overall responsibility for ordering medicines for their patients. This will ensure continuity in the ordering process and will avoid under ordering or stockpiling of medicines. It is not appropriate that community pharmacists be given the responsibility for ordering medicines for residents.

The practice should only accept requests for medication marked on the right-hand-side prescription slip. Medication should not be issued against MAR charts.

Nursing homes are another source of potential over-ordering of dressings, sip feeds, stoma appliances, continence products, insulin and 'as required' medicines(e.g. paracetamol, senna, lactulose etc.) if good stock control and re-ordering systems are not in place and all repeat medicines are automatically ordered each month.

Systems should be in place to ensure practice computers, nursing home kardexes and MAR charts hold identical records. Some ways of achieving this include:

- Designated receptionist or doctor for each home and a designated contact in the home to ensure communication is consistent.
- Work with the home to ensure ordering is synchronised.
- Ensure the GP/clinician has a list of medicines the patient is on when visiting.
- The home and pharmacy should be notified of any changes in medication following a visit, review or hospital discharge.

6.2.5 Appliance contractor

Appliance contractors are expected to contact the patient before ordering the appliance(s). However in practice, some contractors may contact 'stable' patients up to 3 months beforehand. Thus if items are requested from an appliance contractor (e.g. stoma appliances or continence products), it is advisable to contact the patient to check whether they need the supplies as patients are not always aware when the contractor requests a prescription.

6.2.6 Items often over-ordered

6.2.6.1 Inhalers

Inhalers may be ordered at shorter intervals than expected. Care should be exercised to ensure inhalers are not being over-ordered as:

- If a patient is using excessive amounts, it could be that their condition is not controlled and they may need a change in inhaler.

- Over-ordering causes waste.

The length of time an inhaler should last depends on the dose the patient is taking and the number of doses in the inhaler. See table overleaf for guidance on quantity of inhalers to issue.

- It may be difficult to judge quantities of combination inhalers (e.g. Fostair) for MART regimes- tailor quantity to individual needs.

- It may be prudent to restrict 1 "reliever" (e.g. salbutamol) inhaler for to a maximum of every 100 days in asthmatics to alert prescribers to higher users. Some asthmatic patients may request 2 inhalers at a time; for use at home and work/school- ensure that appropriate

quantities are issued at subsequent visits.

Inhaler quantity guide		
Number of doses per day	Number of doses in inhaler	Time the inhaler should last
1 puff BD	200	100 days
2 puffs BD	200	50 days
2 puffs QDS	200	25 days
1 puff BD	120	60 days
2 puffs BD	120	30 days
1 puff BD	100	50 days
2 puffs BD	100	25 days
1 puff BD	60	30 days
2 puffs BD	60	15 days

6.2.6.2 Glyceryl trinitrate (GTN) spray

GTN sprays should ideally be prescribed as acute prescriptions. Where it has been prescribed on repeats, a patient usually does not need to order a spray every month. If the patient appears to be over-ordering GTN spray, it could mean that their angina is not well controlled.

6.2.6.3 Blood Glucose test strips

- Some diabetic patients monitor their glucose levels with test strips. The number of test strips needed varies depending on the type of diabetes, medication, inter- current illness, amongst other things. Monitor for over-ordering using the CCG's self-monitoring of blood glucose (SMBG) guidance accessible on the formulary.
- Ordering of lancets should match the ordering of test strips.
- If a patient is ordering two different types of blood glucose test strips, alert the prescriber.

6.2.6.4 Insulin

- The quantity of insulin pens/vials depends on the patient's dose of insulin. In order to ensure appropriate quantities are issued, a record of current insulin doses is crucial.

The table below gives a rough guide as to how much insulin to prescribe. Please note that for most insulin pens, a pen lasts for 28 days when stored at room temperature. Insulin calculations will be needed for each type of insulin being used. At times of sickness, infection, pregnancy or steroid treatment, more insulin will be required for that period. People who vary insulin dose with meals will need enough to cover the average amount taken each month.

Daily dose	With a 2-4 units air shot every injection Daily units	No. of units used per 31 days with air shots for pen and cartridges	No. of 3 ml cartridges or pens 100 unit/ml needed per monthly prescription	Frequency and No. of prescriptions for boxes of 5 pens or cartridges	No. of 10 ml vials (100 units/ml) needed per monthly prescriptions. No air shot required
10 units	14	434	2	1 box 3 monthly	1
20 units	24	744	3	1 box 2 monthly	1
30 units	34	1054	4	1 box monthly	1
40 units	44	1364	5	1 box monthly	2
50 units	54	1674	6	2 boxes monthly	2
60 units	64	1984	7	2 boxes monthly	2
70 units	74	2294	8	2 boxes monthly	3
80 units	84	2604	9	2 boxes monthly	3
90 units	94	2914	10	2 boxes monthly	3
100 units	104	3224	11	3 boxes monthly	4

6.3 Issuing the prescription

Issuing prescription from computer

This will usually be the responsibility of the receptionist/prescription clerk. All reception staff should receive basic level training in the issue of prescriptions.

Prescriptions (computer paper & FP10s) are controlled stationery – the legal requirements for the safe storage and handling of prescriptions must be followed.

Patient records on computer screens should not be visible to unauthorised personnel, patients or representatives.

A compliance check should occur at this stage and the computer should normally alert the user if medication appears to be over or under used. Particular attention should be paid to 'as required' drugs and if any compliance problems are suspected the prescriber should be alerted before the prescription is produced. Under usage is as important as over usage (e.g. asthma inhalers, blood pressure tablets) and can lead to poor disease control. Vigilance should be exercised to check for overuse before issuing prescriptions for medication with potential for misuse or dependence e.g. gabapentin, pregabalin, codeine, dihydrocodeine, diazepam etc.

A repeat prescription would normally be issued up to seven days prior to its due date (to avoid periods without medication e.g. manufacturer's supply difficulties). Practices will not supply further repeat prescriptions at shorter time intervals without agreeing the reason for the early request e.g. bank holidays, holidays etc. Early requests because of holidays should be documented in patient's records.
At this stage the receptionist/prescription clerk should also check that quantities are synchronised allowing the patient to order all their medication in one go. Where quantities are

not synchronised, reception staff may be authorised to amend **quantities** to allow future supplies to be synchronised before generating a prescription. Prescription clerks should not make any other alterations.

Provided there appears to be no problem, a prescription can be generated and left for the **prescriber to authorise and sign**.

Prescriptions **should not be generated before** consulting the prescriber in the following instances:

- The request slip indicates that a review is necessary (prompting a consultation for a medication review). Prescription clerks must **never** reauthorise medication. Reauthorisation may only be done by a prescriber.
- Any drug requested by the patient that is not on their current repeat record
- Patients are requesting a drug that they have previously received to be restarted
- Directions are unclear. 'As directed' is not recommended.
- Where authorisations have reached the maximum number of issues.
- Patient may be suitable for repeat dispensing scheme.
- Patient appears to be under or over ordering medication.
- Any request which the practice staff are concerned or uncertain about.
- Any 'high risk' medicine should be flagged up to the prescriber before a prescription is issued. Each practice should agree a list of medicines that will be treated in this way and suggested groups include medicines which require monitoring e.g. Lithium, Warfarin, Methotrexate etc.
- Where a 3 monthly MUST score has not been done for a sipfeed (e.g. Ensure shakes, Aymes, Complan, Fortisips, Fortijuice etc.) request.

Where additions or corrections are made the prescriber signing the prescription should initial or countersign against them. The prescriber should ensure that a member of staff makes a record in the patient's computer record of any hand-written alterations to a prescription.

6.4 Reviewing, authorising and signing the prescription

Practices should have a designated time and procedure for prescribers to sign repeat prescriptions. This results in less disruption to surgeries/consultations and more timely service for patients. Prescribers must have access to full medication records. Ideally the prescription should be signed by a prescriber who knows the patient. The production and signing of prescriptions should be systematised and monitored to reduce the risk of mislaid prescriptions, consequent errors and possible theft. Electronic signatures must be applied for electronic prescriptions.

Signing of repeat prescriptions should never be considered a mechanical process. The person signing the prescription is legally responsible for that prescription regardless of who initiated the medication. Each prescription should be reviewed to check that the medication being issued is still appropriate and that any safety checks e.g. blood tests have been carried out at appropriate intervals e.g. lithium, warfarin, DMARDs. Any repeats that have not been ordered for over 1 year should be archived.

The prescription, once signed, should be returned to the receptionist for storage.

Non-medical prescribers signing repeat prescriptions
Non-medical prescribers may only sign prescriptions within their designated area of **competency**. For a full explanation of the requirements for demonstrating prescribing competency see the CCG's 'A guide to non-medical prescribing'. As a general rule, non-medical prescribers should not routinely sign repeat prescriptions for medication they have not either initiated or personally reviewed that patient.

In addition non-medical prescribers may only sign prescriptions which clearly indicate their name and prescriber number and that their prescriber type. It is **illegal** for a non-medical prescriber to sign a script printed in someone else's name.

Medication Review
Prescriber's attention should be drawn to any due medication review. Medication review should be carried out at least annually (six monthly if complex medicines regimes) in accordance with the CCG's 'A guide to medication review'. See section 6.1 above.

A medication review is a structured, critical examination of a patient's medicines (prescribed, over-the-counter, complementary and herbal medicines) with the objective of reaching an agreement with the patient about treatment, optimising the impact of medicines, minimising the number of medication-related problems and reducing waste.

A recall system should also be in place to ensure that patients who do not order their medication are also reviewed.

If a review date is required or overdue, the patient should be informed of this via a note attached to the prescription to request them to make an appointment. Computer records should be updated to reflect that the need for review has been communicated.

6.5 Storage of prescriptions

Practices should store prescriptions awaiting collection in a collection box, away from patient contact areas (reception desk). All signed prescriptions and prescription pads/stationery will be locked away when the surgery is closed.

Prescriptions identified as "to be posted" must not be put into the box awaiting collection and these should be recorded into a log book/computer records before posting. Care should be taken to ensure correct prescription is enclosed in the envelope with the correct name and address label before posting.

Prescription to be collected by community pharmacies must be stored separately.

6.6 Collection of prescriptions

The name, address and date of birth of the patient collecting the prescription should be checked when handing out the prescription to avoid the prescription being given to a patient with the same or similar name.

Increasingly prescriptions are collected by community pharmacy representatives/drivers as part of a prescription collection service offered to patients. Practices should ensure they have documented evidence of patient consent to this service, and should only hand over prescriptions specifically requested by the pharmacy representative. Pharmacies must never be allowed to look through prescription boxes to select prescriptions themselves. It is good practice to record patient details of all prescriptions handed directly to a community pharmacy and obtain a signature of the personnel collecting, especially where large volumes of prescriptions are collected this way, in case of later queries and 'missing prescriptions'.

Prescriptions should not be collected by children under the age of 16 years. Under exceptional circumstances, prior written arrangements by the parents with the practice manager or prescriber should be made.

6.6.1 Non-collection of prescriptions

Prescriptions waiting for collection should be checked monthly to identify scripts that have not been collected within four weeks of their issue date. An investigation should be made into every script to determine a reason for non-collection e.g. discontinued item. The record of

issue will then be removed from the computer and an entry made detailing the reason for the removal. Where the reason is suspected non-compliance, the prescriber should be informed. The prescription should be destroyed (shredded).

6.6.2 Missing prescriptions

A repeat prescription that has “gone missing” should be thoroughly investigated. If not located, the script should be re-printed rather than re-issued after obtaining prescriber agreement and a note with the reason for the reprint should be included in the patient record. Prescription should be marked as ‘duplicate’. Care should be made to ensure patients do not run out of medication.

Local procedures for reporting lost prescriptions should be followed. Lost prescriptions for controlled drugs and drugs with potential for misuse should be reported on datix.

Where it is suspected that claims that prescriptions have gone missing are being made in an attempt to gain excessive quantities of medicines the practice will need to put in place procedures to prevent this e.g. record when the patient collects each prescription.

If prescriptions regularly go missing either at the practice or at a community pharmacy, the CCG medicines quality team should be contacted for advice on reviewing the repeat prescribing procedures.

7.0 Risk management

There are considerable risks associated with the repeat prescribing process. Remember to always check:

- Correct patient – watch out for patients with the same or similar names. Check date of birth.
- Correct drug name and strength – watch out for similar sounding names, brand and generic name.

It is important to record all critical incidents and “near misses” in order to ensure safer future practice. The practice should have received the necessary report forms from the Risk Management department. The aim of the anonymous reporting system is to reduce problems not to assign blame. The practice will follow the process detailed in practice policy – Significant Events.

8.0 Audit

There should be a clear audit trail for all medicines added to or removed from a patient’s repeat prescription list.

Audit trails for prescription reprints, deletions, and where prescriptions have been printed and then deleted should be produced regularly.

The practice computer system allows the practice to identify patients who have received repeat medication for a long time without review.

Periodic audit of repeat prescribing should be undertaken in all practices. Audits are important for identifying standards of good practice and identifying areas that fall short of this. Audits may include:

- Registered nursing care home patients with no documented review of their medicines in the last 12 months.
- Alignment of repeat medication – do patients collect all repeats at the same time.
- Items on the repeat list not collected for 12/18/24 months.

The repeat risk scoring tool (Appendix B) helps practice staff to identify areas of improvement in their repeat prescribing system. Red, amber, green (RAG) score has been used. Action following risk assessment needs to be implemented within 1 month for red areas and within 3 months for amber areas.

Please see Appendix C for an example of practice based audit tool.

Refer to appendix D for a template of an action plan template for actioning issues identified in audits/risk assessments.

9.0 References

- Adapted from Repeat Prescribing policy template November 2011 Wolverhampton Primary Care Trust Prescribing Support team
- Repeat Prescribing risk assessment & Repeat prescribing audit 2010-2011 Halton and St Helen's Primary Care Trust
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- Significant event auditing. Guidance for primary care teams. Bowie P, Pringle M. NPSA 2008
- A Guide to Medication Review. Clyne W et al. NPC 2008
- Improving the repeat prescribing process in a busy general practice. A study using continuous quality improvement methodology. Cox et al. Quality in Health Care 1999; 8: 119- 125
- Saving time, helping patients – A good practice guide to quality repeat prescribing. NPC 2004
- Managing Medicines. A resource Centre for Medicines Management and Pharmaceutical Care @www.managingmedicines.com
- Modernising Medicines Management. A guide to achieving benefits for patients, professionals and the NHS. April 2002.
- Improving compliance with oral methotrexate guidelines NPSA Safety Alert NPSA/2006/1
- Prescribing in General Practice available at http://bma.org.uk/-/media/files/word%20files/practical%20advice%20at%20work/managing%20your%20staff%2 0practice%20services/prescribingingeneralpractice.docx accessed 05/04/14
- Pitstop-Insulin calculator
- CEPP national audit: Repeat Prescribing All Wales Medicines Strategy Group

Appendix A: Repeat Prescription Process

Starting repeat prescription

- Prescriber to decide if suitable for patient - based on drug efficacy & tolerability and patient compliance. Check table 1 for drugs not suitable for repeat prescribing. Link drug with condition
- Inform patient how the process works, including 48 hours repeat prescription process time lines. 48 hours
- Care- Check repeat record accurate
  - Quantities synchronised
  - Review dates where applicable
  - Hospital discharges/out-patients- prescriber to add on drugs ideally

Requesting of repeat prescription

- Written requests-right hand side of repeat slip
- Telephone requests for house-bound patients only
- Community pharmacists must check what patient needs) Care-over ordering
- Nursing/residential home –designated staff – not via MAR chart) potential
- Appliance contractor- NO Retrospective prescription allowed

Issuing repeat prescription

- Legal requirements for safe storage and handling of prescriptions
- Can issue up to 7 days prior to due date: early requests reasons (e.g. due to holiday) must be documented
- Medication reviews due- issue 28 days and invite patient for review, advising no further supplies will be issued before review
- **Prescription should NOT be generated before consulting with prescriber if review is needed, for drugs not on repeat, past drugs, over or under - ordering of drugs suspected, or if in doubt**

Reviewing, authorising & signing repeat prescription

- Designated time and process for this- prescriber should not be disturbed during that period
- Each prescription must be reviewed (appropriate & safety checks) before signing
- Queries? Prescriber should contact patient and invite them for a review
- Signed prescriptions should be returned to prescription clerk
- Systematic process to prevent lost/stolen prescriptions and errors

Storage of prescriptions

- Locked collection box- accessed by practice staff only
- Prescriptions to be posted kept separate. Records maintained when posted
- Prescriptions to be collected by community pharmacy kept separate

Collection of prescriptions

- Check name, address and DOB of patient
- Generally prescriptions Not to handed to children < 16 years
- Consent from patient for community pharmacy to collect prescriptions on practice computer

Appendix B

Risk scoring table

Red	Action within 1 month
Amber	Action within 3 months

Question	Answer	Tick	Colour Code
Is there a written policy for repeat prescribing?	Yes		Green
	No		Red
	Do Not Know		Amber
Has this policy been reviewed in the last three years?	Yes		Green
	No		Amber
Have all staff signed to say they are aware of and understand the practice's repeat prescribing protocol?	Yes		Green
	No		Amber
	Do Not Know		Amber
Request			
Are all other requests taken by post / fax / email or written?	Yes		Green
	No		Amber
	Do Not Know		Amber
If the request is written is it presented on a repeat request slip?	Yes		Green
	No		Amber
	Do Not Know		Amber
Are the required items marked?	Yes		Green
	No		Amber
If the request is taken verbally which of the following is carried out?	Handwritten as request is taken then generated from computer		Amber
	If telephone request, prescription is generated from the computer as the request is taken		Green
	If face to face repeat request slip generated for patient to fill in		Green
	Do Not Know		Amber

If the request is taken verbally does the same person generate the script?	Yes		Green
	No		Amber
	Do Not Know		Amber
Does the policy specify what to do if the patient requests a repeat which needs to be re- authorised?	Yes		Green
	No		Red
Production			
Is the member of staff designated and trained?	Yes		Green
	No		Amber
	Do Not Know		Amber
Are the scripts computer generated?	Yes		Green
	No		Amber
	Do Not Know		Amber
What is the turnaround time for a repeat request?	<48 hours		Green
	>48 hours		Amber
	Do Not Know		Amber
Is there a designated time set aside for doing the repeats?	Yes		Green
	No		Amber
	Do Not Know		Amber
Is there a designated time set aside for signing?	Yes		Green
	No		Amber
	Do Not Know		Amber
Are the appropriate resources available (e.g. computer) when signing?	Yes		Green
	No		Amber
	Do Not Know		Amber
Miscellaneous			
Does the policy have specific details relating to repeat requests for high risk drugs e.g. warfarin, lithium, DMARDs?	Yes		Green
	No		Amber

Are uncollected prescriptions recorded before destruction?	Yes		Green
	No		Amber
	Do Not Know		Amber
If a prescription is reprinted, is the reason documented?	Yes		Green
	No		Amber
	Do Not Know		Amber
Authorisation			
Who authorises the repeats?	Receptionist		Red
	Nurse		Amber
	Doctor		Green
	Nurse Clinician		Green
	Pharmacist Prescriber		Green
	Do Not Know		Amber
What is the process for reauthorisation?	GP notified		Green
	GP not notified		Red
	Do Not Know		Amber
What is the process for reauthorisation?	GP notified		Green
	GP not notified		Red
	Do Not Know		Amber
How many issues are made?	0-6		Green
	6-12 (stable patients)		Green
	6-12 (unstable patients)		Amber
	More than 12		Red
	Do Not Know		Amber
Compliance			
Is compliance (days since last issue) checked before prescription issued?	Yes		Green
	No		Amber
	Do Not Know		Amber

Is there a standard written procedure for over compliance (ordering too frequently)?	Yes		Green
	No		Amber
	Do Not Know		Amber
Is there a standard written procedure for under compliance (not ordering at regular intervals)?	Yes		Green
	No		Amber
	Do Not Know		Amber
Acute Requests			
Who issues acute requests?	Receptionist		Red
	Receptionist from written protocol		Amber
	Doctor		Green
	Do Not Know		Amber
Discharges/Outpatients/Home Visits			
Who makes the decision to add/delete medication from the repeats?	Doctor		Green
	Nurse Clinician		Green
	Pharmacist prescriber		Green
	Nurse		Amber
	Receptionist		Red
	Do Not Know		Amber
Who updates the patients repeats after hospital discharge/outpatient's appointment/home visits?	Doctor		Green
	Receptionist not checked by doctor after update		Red
	Receptionist but doctor checks after update		Amber
	Do Not Know		Amber
Medication Review			
Who carries out the medication review?	Nurse		Green
	Doctor		Green
	Pharmacist		Green
	Has not been reviewed at appropriate intervals		Amber

Is there a procedure for highlighting when a medication review is due?	Yes		Green
	No		Amber
Are the notes/computer records clearly marked with date if present/future repeat medication reviews?	Yes		Green
	No		Amber
Prescription Collection			
Is there a record of prescriptions collected by pharmacies?	Yes		Green
	No		Red
Are uncollected prescriptions removed from patient's records and paper copies destroyed?	Yes		Green
	No		Red
Does the practice have a policy regarding missing scripts? Do they check with chemist, reprint?	Yes		Green
	No		Red
Prescription security			
Is there a procedure for recording serial number of prescriptions?	Yes		Green
	No		Amber
Are there appropriate storage facilities for signed prescriptions awaiting collection?	Yes		Green
	No		Red

Appendix C

Audit Instructions:

Audit 10 patients per GP or 20 per practice, whichever is greater. Complete the repeat prescription (Rx) audit on page 24 for randomly selected patients.

Part 1

- Enter number of items on repeats for each patient in the relevant column (patient 1 to 10).
- Repeat the above process for each of the criteria listed under part 1.
- Add up the total of each criteria and enter number in the last column- this yields the total for each criteria **(A)**

Part 2

- Enter Yes (Y) or No (N) under each criterion.
- For each criteria add up the number of yes answers and enter the total number in the last column {which reads "No. of 'Yes' **(B)**}
- For 7 day prescriptions (if any selected in the random sample) – ensure you count and enter the number of 7 day script items where indicated on the table.

Transcribe the results **A and B** of repeat Rx audit onto the 1st column of Part 1 and Part 2 respectively of the 'Summary of results from the repeat Rx' audit form.

Part 1

- The sum of all items on repeat is referred to as **D** for calculation purposes on part 1 of the 'Summary of repeat Rx audit' form (see page 25).
- Calculate the percentage (%) by dividing A by D and multiplying by 100.
- Compare your practices' percentage with the suggested standard listed in the table. This will help you identify areas for improvement.

Part 2

- Divide the number of Yes **(B)** on repeat Rx audit by the total no. of patients audited(**C**) and multiply by 100 to give the practice percentage. Compare your practice's percentage with the standard listed to help you identify areas of improvement.
- For the '7 day prescription' criteria, divide 'No of 7 days scripts items issued properly **(E)'**
- by Total no. of 7 days script items**(F)** and multiplying by 100 gives the practice %.

Appendix C
Repeat prescription (Rx) audit

Practice: _____ **Date of audit:** _____

Audit 10 patients per GP or 20 per practice, whichever is greater

Criteria \ Patient	1	2	3	4	5	6	7	8	9	10	Total no. of Items **(A)**
Part 1 Enter number(no.) of items with reference to computer screens of randomly selected patients											
No. of items on repeat											**(D)**
Number of items linked to indications											
Number of drugs prescribed that should not be on repeat											
Number of items with appropriate directions (dose and frequency). Instructions PRN or MDU alone are not acceptable											
No. of items not ordered in the last 6 months (excluding seasonal medication e.g. hay fever)											
No. of PRN oral or topical analgesics including NSAIDs											
Part 2 Answer Yes(Y) or No(N)											No. of 'Yes' **(B)**
Are quantities prescribed appropriate to dose?											
Are all quantities synchronised (so they all last the same time)?											
Are all repeats authorised for a maximum of 12 months?											
Are all regular repeats (excluding PRN items) being ordered regularly?											
Are repeats being issued after the authorisation period has expired?											
Have drugs not ordered in the last year been removed from the repeat prescribing screen?											
Is there a record of a medication review in the past 12 months?											
Are there any items that are prescribed as generic that should be prescribed by brand?											
Are there any items for which dose could be optimised? (e.g. 2x 5 mg switched to 10 mg?											
Are there any duplicate items on repeat?											
Checked with patient-all items required?											
Are 7 days scripts items being issued for valid reasons?											Total no. of 7 day script items……

Summary of the results from the repeat prescription (Rx) audit

Practice: _____

Total no. of items on repeat sampled (**D**): _____

Part 1	Total no. of items **(A)** on repeat Rx audit	Practice % **A/D** x 100	Suggested standard
Total no. of items linked to indications			90%
No. of drugs(items) prescribed that should not be on repeat			<5%
No. of items with appropriate directions (dose and frequency). Instructions PRN or MDU alone are not acceptable			90%
No. of items not ordered in the last 6 months (excluding seasonal medication e.g. hay fever)			<10%
No. of PRN oral or topical analgesics including NSAIDs			No suggested standard-could be a practice discussion point
Part 2	No. of Yes **(B)** on repeat Rx audit	Practice % **B/C** x 100 **C**=total no. of patients audited	Suggested standard
Are quantities prescribed appropriate to dose?			90%
Are all quantities synchronised (so they all last the same time)?			100%
Are all repeats authorised for a maximum of 12 months?			90%
Are all regular repeats (excluding PRN items) being ordered regularly?			90%
Are repeats being issued after the authorisation period has expired?			10%
Have drugs not ordered in the last year been removed from the repeat prescribing screen?			90%
Is there a record of a medication review in the past 12 months?			90%
Are there any items that are prescribed as generic that should be prescribed by brand?			0%
Are there any items for which dose could be optimised? (e.g. 2x 5 mg switched to 10 mg?			10%
Are there any duplicate items on repeat?			0%
Checked with patient-all items required?			90%
	No of 7 days scripts items issued properly **(E)**	Total no. of 7 days script items **(F)**	% **E/F** x 100	Suggested standard
Are 7 days scripts being issued for valid reasons?				100%

Appendix D: Action Plan Template

Area	Issues Identified	Action	Estimated completion date	Details of Implementation For Example: • Date protocol changed • Date all staff signed updated protocol • Date audited	Date Completed