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**Repeat Prescribing Policy**

**Rockwell & Wrose Surgery**

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Reviewed by: Dr A Gavin

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**Introduction**

This repeat prescribing protocol is based on the more detailed document produced Bradford Airedale PCT June 2010. It is intended to be a working document for general practice staff. All new staff should be given a copy of this policy as part of their induction programme and sign to indicate they have read and understood the policy

**Principles**

1. Patients who need long-term medication can obtain repeat prescriptions simply and within 3 working days ( 72 hours) of request.
2. Repeat prescriptions can only be authorised by a GP or approved clinical staff member or pharmacist
3. Repeat prescription status is not an automatic right for individual patients. The decision as to whether to make patients’ medicines repeat is based on clinical appropriateness and on the basis that the system will not be abused.
4. Medicines should only be made repeat when the treatment is stable, well tolerated, still needed.
5. All medication regimes are reviewed at appropriate intervals (usually yearly) by a responsible doctors or clinical member of staff.
6. Over use and under use of medication is easily recognised and managed.
7. SystmOne rights and authorisations are set correctly for all the practice team and for the repeat prescription system.

**1. Roles and responsibilities of staff**

**2.1 Authorisation**

Authorisation is the decision by a prescriber that a particular medication is suitable to be obtained on repeat prescription for a particular patient.

Only GPs, independent prescribers, nurse practitioners and practice pharmacists can authorise a medicine to be a repeat.

The prescriber must be satisfied that the patient requires long-term medicine and that the patient is stable on the medication and that the medicine is well tolerated and still needed.

Medicines that are subject to monitoring and dose titration (e.g. some new medicines following discharge from hospital) must not be added to the repeat until they are deemed to be safe and effective for the patient

**Medicines and other items not suitable for authorising as a repeat**

The following medicines are not usually suitable for authorising as a repeat because they require careful regular monitoring, are subject to abuse or not intended for long term use. There will be exceptions in specific circumstances when agreed by the GP.

* Dressings
* Methadone or other opiates prescribed to drug addicts
* Antibiotics, antifungals and antivirals
* Benzodiazepines

In some instances it is appropriate for these medicines to be authorised as a repeat. This is a clinical decision to be made by the prescriber. However consideration should be given to having a shorter review date to ensure they are flagged up for review early.

**Number of days supply**

Repeat prescriptions should be for 56 days.

Medicines should be prescribed in such a way that all medicines will run out at the same time.

Some products may not be possible to prescribe certain items for a common number of days – e.g. special containers, ‘when required’ items, the contraceptive pill and HRT.

Prescribing needs to be by number of drugs rather than pack for EPS e.g. “56 tablets” rather than “2x28”.

**Generic prescribing**

As a general rule prescribing will be by generic name rather than by brand.

In some circumstances a brand-name prescribing is preferred. These include:

* Where there is a difference in bioavailability between brands of the same medicine, particularly if the medicine has a narrow therapeutic index.
* Where modified release preparations are not interchangeable.
* Where there are important differences in formulation between brands of the same medicine.
* Where products contain multiple ingredients and brand name prescribing aids identification.
* Where administration devices (e.g. inhaler or self-injection) have different instructions for use and patient familiarity with the same product is important.
* Where different preparations of the same medicine have different licensed indications.
* Where the product is a biological rather than chemical entity.

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| **Medicine Category** | **Generic****name / group** | **Comments**  |
| **Drugs with a narrow therapeutic index**. | **Aminophylline** | Difference in bio-availability may affect plasma concentrations.  |
| **Ciclosporin** |
| **Carbamazepine** |
| **Lamotrigine** |
| **Lithium** |
| **Phenytoin** |
| **Sodium valproate** |
| **Tacrolimus** |
| **Theophylline** |
| **Certain****modified-release preparations**  | **Diltiazem** | Different formulations of these modified-release (m/r) preparations may have different clinical effects. |
| **Mesalazine** |
| **Nifedipine** |
| **Controlled Drugs including patches****(Schedule 2 and3)**  | **Morphine** | Caution - differing dosage regimes for SR and XL preparations.  |
| **Oxycodone** |
| **Fentanyl** |
| **Buprenorphine** |
| **Inhalers**  | **CFC Free Beclometasone** | Always state the type of device e.g.accuhaler, turbohaler.   |
| **Dry powder devices** |
| **Multi-ingredient products** | **HRT** | Generic prescribing may not be practical or may cause confusion due to multiple ingredients.   |
| **Oral contraceptives** |
| **Antacid preparations**  |
| **Multi-ingredient ENT preparations** |
| **Multi-ingredient laxatives** |
| **Bath oils, creams, liquids or gels** |
| **Antiseptics** |
| **Disinfectants** |
| **Miscellaneous**  | **Antipsychotic depot injections** | These should be prescribed using the brand name to avoid confusion.  Generic prescribing for these drugs may affect clinical response or contribute to dispensing or administration incidents. |
| **Stoma care products & appliances** |
| **Wound products** |
| **Insulin** |
| **Nutritional products** |
| **Vaccines** |
| **Nicotine Replacement Therapy** |

**2.2 Production of Prescription**

**Repeat requests**

Repeat requests must be submitted online, in writing or in person Telephone requests are only allowed in exceptional circumstances for patients approved by the practice manager or GP. This will be annotated on the front screen on the patient record.

Patients should be advised, at the time of request that the doctor/ANP may wish to speak to the before the item is issued.

This practice accepts requests electronically via SystmOne online and staff check electronically for repeat requests at regular intervals.  The repeat prescribing request should not be processed without all the relevant information highlighted below. When patients request to register for ordering prescriptions via SystmOne, a GP reviews to check all the data is correct e.g. issue length.

Repeat requests will be kept for a period of time 7 days as a reference source for both discrepancies and audit.

Requests for medicines that are not on repeat must be forwarded to the practice pharmacy system, or to a GP for review/authorisation.

Patient should be informed of the turnover time (72 hours) in order to leave adequate time to order a repeat prescription when their medication is running low.

This information is included on a repeat prescription patient information leaflet and available on the practice website

**Telephone Requests**

For those approved for telephone requests, the following must be asked for requests made over the phone

* Patient’s Full Name
* Date of Birth
* Address
* Telephone Number (on which to be contacted should the prescriber refuse to issue the request).
* Medication Requested:
	+ Name
	+ Strength
	+ Form
	+ Dosage Instructions

**A computer system must be used to issue all prescriptions**

All prescriptions must be generated by computer. **Exception:**

Acutes that are hand-written on home visits must be added to the patient’s record as soon as possible post-visit since this ensures an accurate record and allows for a double check on any contraindications or drug interactions.

Prescriptions that are issued by other prescribers e.g. hospitals may also be added to the patients drug list as ‘other medication’ (medication > ‘?’ record other medication)

Additions to the computer can only be made by a GP or approved clinical staff member.

**Amendments or additions to repeat prescriptions**

Where a clinical judgement needs to be made, (e.g. queries, amendment of review date, re-authorisation, review of hospital discharge), these can be performed only by;

* GPs
* Independent Prescribers working within their area of clinical competency
* Practice Pharmacists

Staff will only have functions on their smart cards which are appropriate to their specific role.

SystmOne functions have been set up to flag up e.g. when a prescription is requested early. All such queries should also only be assessed by the above authorised staff.

**Flagging up queries to GPs**

When reception receive a prescription query (e.g. a repeat reaching its authorisation date; a request for an item that is not a repeat etc) it needs flagging up to the practice pharmacy system This is done by:

Acute script requests are sent to the ‘Prescription Task List’. This will be sent to the hub pharmacists service, with any overflow sent to the GPs. Urgent requests are either taken personally to the doctor or a flagged task is sent

**Patient information leaflet**

The practice has a patient information leaflet which explains the repeat prescribing system and how medication reviews are carried out. This is on the Rockwell & Wrose website and access is highlighted to all new patients at registration and available for any existing patients on request. It can be printed of for any patients who wish it or who do not have access to the website.

**Processing a Request for a Repeat Prescription**

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| Patient communicates request to surgery |

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|   Check the patient’s name, address and date of birth against the computer screen record |

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| Check that the items requested are on the patients repeat list. |

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| If the patient requests any items not on the repeat list, refer to an appropriate clinician |

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| Place request in pile: ‘requests with queries’ and leave for appropriate clinician to deal with, indicating the nature of the problem  |
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| If there are discrepancies refer to an appropriately qualified person.If dosage instructions are missing they must be inserted by an appropriate clinician **only** |

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| If the item appears on the repeat list, check that name, form, strength and dosage instructions are identical to the request |

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| If past review date refer to an appropriate clinician to re-authorise |

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| Check medication review date has not been exceeded |

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| Check compliance to ensure patient is not under/over-using medication |

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| If patient is under/over-using medication refer to an appropriate clinician |

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| Issue item on request |

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| The name, address and date of birth must be checked with the person collecting the repeat prescription to confirm the identity of the patient. It is good practice to check the number of items the patient is expecting to receive, so any discrepancies can be dealt with immediately.   |

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| Place prescription into pile A: ‘requests with no queries’ and leave for prescriber to sign by hand or EPS. |

**2.3 Review**

**2.3.1 Review Dates**

Each medicine will have a review date rather than a maximum number of issues. The review date should be the same for all the medicines (except those where a particular medicine may need an earlier review).

The review date for stable medicines is set at 12 months but it should be set earlier for patients who should be seen more often (e.g. older people on polypharmacy set for 6 months). For patients on DMARDs there is a practice prescribing and monitoring policy.

The receptionist must check that the repeat item is within the authorised period.

*i.e.*             the review date has not been exceeded

                           OR   the number of authorised prescriptions has not been exceeded

The computer system has been set to prevent repeat medications that are past their review date being issued by staff who process the prescriptions.

If the review date is approaching, the item can be issued and the patient informed that a review appointment is due e.g. highlighter or stapled note attached to the prescription.

If the review date has been exceeded the prescription must NOT be issued by the receptionist,

**2.3.2 Informing the patient that they need to make a review appointment**

Patients must be informed when they need to make a review appointment. Where possible a SMS message should be sent to the patient , or a note should be added to the prescription indicating to the staff that the patient must make a review appointment before the prescription is handed to the patient.  (Where prescriptions go direct to the pharmacy the pharmacy staff should indicate to the patient that a review appointment must be made.) (Nb patients sign a consent form when signing up to SMS agreeing to ensure we have an up to date number, if they have consented it can be assumed they will get the message)

**2.3.3 Recall system**

A recall system is in place to ensure that patients who do not order their medication are also reviewed. This covers patients who should be on permanent therapy but do not order their medication and therefore ‘slip through the net’. These patients will be identified by a six monthly audit (appendix B

**2.3.4 The clinical review**

 Patients should ideally have their annual review within the month they were born.

The clinician will decide if a patient needs to be seen face to face for a review.

The review date must be updated each time a medicine is added or changed.

An entry must be made in the medical records at the time of medication review to indicate that it has occurred, noting any changes

The person reviewing the patient must be satisfied that the patient still requires long term medication and will check:

(i)                 which medicines are being taken

(ii)               whether the medication is at a stable dose

(ii)        whether the medication is achieving the desired effect

(iii)       whether the patient is experiencing any intolerable side effects

            (Side-effects/ ADR’s/ allergies should be recorded in the patient’s notes.)

(iv)       whether the medication is still appropriate and at an appropriate dose.

(There is no need for dosage increase or reduction)

(v)        whether the patient understands the purpose of the medication

(vi)       that the patient is able to take the medication and is concordant (cf Stage 4)

(vii)      that it is the most suitable medicine and there is no better alternative

(viii)     any medicines which are not being ordered and duplicate medicines, ensuring they are deleted from the patients’ medication record.  Searches should be run periodically to determine medications which are not being ordered.

(ix)       that the patient is not abusing their medication

(x)        that any necessary tests have been carried out at appropriate intervals ie LFTs, TFTs, FBCs, U&Es etc

(xi)       the dosage instructions are clearly written on the prescription. If the prescription states ‘when required’ then a maximum dose needs to be stated. MDU or ‘as directed’ are not acceptable.20, 21

(xii)      that all medication is prescribed in equivalent quantities. The quantities must be sufficient and not excessive.

(xiii)     that prescribing is generic where appropriate

(xiv)     all other medications prescribed (including those from other organisations) and over the counter medicines are identified.

(xv)      that the patient has been informed of the next review date

**2.4** **Systems for checking compliance**

The computer system provides a method of checking the patient’s compliance. Receptionists must be familiar with how the computer indicates compliance.

Under or overuse should be highlighted to the GP.

Early requests for items can be permitted in certain circumstances i.e. if a patient is due to go on holiday, even though the computer will identify this as overuse.

Medicines which can be taken on a ‘when required’ basis may be flagged by the computer as being underused e.g. pain-relief, indigestion remedies etc.

 **2.5 Signing repeat prescriptions**

The prescriber has an allocated and protected time set aside each day for signing/ reviewing repeat prescriptions. This need not necessarily be at the same time each day.

The prescriber must have access to the patients’ medical notes when signing/ reauthorising repeat prescriptions.

**2.6 Uncollected repeat prescriptions**

If a printed prescription is not collected after two months it is flagged up to Dr Gavin for a clinical decision on whether it needs follow up or whether to record and shred. The uncollected(physical) prescriptions are placed in her pigeon hole for assessment. Pharmacies are responsible should EPS prescriptions go uncollected.

**2.7 ‘lost’ prescriptions**

Any request for reprinting a lost prescription needs to be flagged up to a GP, independent prescriber or practice pharmacist

**3. Miscellaneous**

**3.1 Hospital discharge and home visits**

We are now routinely receiving tasks from hospital pharmacist on discharge which is aiding prescription accuracy. These are passed to the pharmacist as part of daily post and should be dealt with. For ‘Dosette’ box patients who have had medication changed GP must inform reception as per ‘Dosette’ protocol.

Hospital letters and discharge medication must be reviewed by an appropriate clinical member of staff for newly initiated medicines and alterations to previous therapy, and the repeat system updated.20

The discharge letter/ discharge advance note will be scanned into the patient’s record and read coded as appropriate.

The responsible GP, or pharmacist, will perform

* A medicines reconciliation (i.e. account for any difference in the medicine before admission and after discharge)
* A clinical medication review i.e. determine the ongoing need for the medicines
* Who is to undertake long-term prescribing and who is to review progress
* If a shared care protocol should be in place for the medicine (see below)
* Decide if the patient needs to be seen for review/monitoring
* Inform vulnerable patients of changes to their long term medicines

Before a medicine is made into a repeat the prescriber must be satisfied that the patient requires long-term medicine and that the patient is stable on the medication and that the medicine is well tolerated and still needed

**3.2 Shared care drugs**

For medicines of a more specialist nature, shared care arrangements must be provided by the specialists before the GP can prescribe e.g. DMARDs, transplant drugs

So called ‘red drugs’ or ‘hospital only’ drugs will not be prescribed by the practice.

**3.3 Care home and monitored-dosage system requests**

Monitored Dosage Systems (MDS e.g. Dosette boxes) are used as one method to help patients who have problems remembering to take their medicines. Before an MDS is decided upon alternative methods of helping the patient should be considered.

The GP should;

* perform a medication review to identify which medicines are no longer needed and if the regimen can be simplified e.g. to once daily doses.

MDS are intended for people on stable regimens of medicines but the reality is they are often used by patients having frequent hospital admissions and medicine changes. Communication about these changes to the community pharmacists and patient are important. To make the process of change to prescriptions for people on MDS safer this practice:

1. keeps a register of all patients on MDS and which pharmacy they use.
2. has one dedicated member of the reception staff at each site (with a back up for holidays/sickness) to act the point of communication with community pharmacists.
3. informs this member of staff when a change has occurred mid-month.
4. indicates if the change needs to occur immediately or if it can wait till the next box is filled.
5. If change occurs mid month, the receptionist or GP should inform the patient’s community pharmacist to recall any boxes that have gone out.

A dedicated member of the reception staff (with a back up for holidays/sickness) acts as the point of communication with community pharmacists. GPs must inform this member of staff when a change has occurred mid-month and indicate if the change needs to occur immediately or if it can wait till the next box is filled.(see appendix A). If change is to occur mid month the receptionist or GP should inform the patient’s community pharmacist to recall any boxes that have gone out using the form in appendix A. The form should be scanned into the patients record for future reference.

As a general rule patients on MDS should receive a 28 day script. If a 28 day script is provided the community pharmacist will dispense this all at once and any medication change mid month will require the recall of the MDS and a new prescription for ALL of the repeat medicines. For patients whose medication is liable to change, 7-day prescriptions may be appropriate for clinical (and cost-effectiveness) reasons. Only the 7 days rather than 28 days of medicine will be wasted if a change occurs.

Patients in care homes are often frail with multimorbidity and polypharmacy. As they are not in control of ordering their own medicines and because their medicines may change relatively frequently the practice has a system to ensure care home staff and community pharmacist are aware of changes that occur mid month. Like with Dosette boxes GPs must inform reception staff when a change to medicines has occurred mid-month and indicate if the change needs to occur immediately or if it can wait till the next box is filled.(see appendix A for form). If change is to occur mid month the receptionist, pharmacist or GP should inform the patient’s community pharmacist using the form in appendix A to recall any boxes that have gone out.

The form should be scanned into the patient’s record for future reference

**3.4 DMARD policy**

The Rockwell & Wrose Surgery has a DMARD prescribing and monitoring policy.



**3.5 Pharmacy repeat medication Services**

The Surgery will record on the patient’s record (and printed on the top corner of the prescription) if they have consented to a pharmacy prescription collection service and the name of the pharmacy the patient uses

The person collecting prescriptions on behalf of a pharmacy must show proof of identity, if unknown to the practice staff, before the scripts can be released.

If the surgery is concerned about ordering of unnecessary supplies the name of the pharmacy and affected patient should be highlighted to the practice manager who will, in first instance, speak to the pharmacy staff. If this does not resolve the issue the problem should be referred to the PCT Director of Medicines Management.

Details of community pharmacists responsibilities for ordering repeat medicines can be found in the PCT policy referred to at the beginning of this policy.

**3.6 Dossette box and repeat dispensing – changes to medication**

Any changes to medication must be detailed on the Rockwell & Wrose form (Appendix A). The completed form is returned to the receptionists to send to the relevant community pharmacy (and ensure the signed completed form is returned to the practice ensuring that the medication change has been actioned).

**4. Medication errors and significant event analysis**

The practice normal procedures should be used for reporting significant events (see practice standard operating procedure)

5 Requests for Medications where the patient is outside the UK

 Standard message response in all events

**"In line with GMC and international regulations we are unable to perform any medical consultations/prescriptions/advice for anyone currently outside the UK as we are not licensed to practice medicine overseas.**

**We advise that you consult medical services locally.”**

6 Short Term Benzodiazepines for Anxiety)

Will only prescribed for those patients awaiting essential clinical investigations such as MRI

DENTAL TREATMENT Patients requesting cover for forthcoming Dental surgery should approach their Dental practitioner for suitable medication

TRAVEL /TRANSPORT Nice guidance does not recommend short term benzodiazepines for travel and transport. Alternatives can be offered in their place

**Appendix A:**



THE ROCKWELL & WROSE PRACTICE CHANGE OF MEDICATION NOTIFICATION FORM

Patient Details

**Usual Pharmacy:**

Dosette Box Alteration Yes/No

Acute Prescription Yes/No

Repeat Prescription Yes/No

Describe Changes to be Made:

Does the Prescription require delivery Yes/No

If delivery is required -same day Yes/No

 -next day Yes/No

 -within 7 days Yes/No

GP Signature……………………………………………………………………………………Date……………………………………

TO BE COMPLETED BY PHARMACY

Received: Date:

Actioned: Date:

Signed:

Print: Date:

Number Prescriptions Required:

Batch (7days) X

PLEASE RETURN BY FAX TO WROSE HEALTH CENTRE 01274 772899

**Appendix B**

**Protocol for review of un-ordered repeat medicines**

**Background**

Repeat medicines are a convenient way for patients to order long term medicines. However not all repeat medicines are ordered. Some are not ordered because they are no longer required whilst others are intended to be prescribed by the GP but for various reasons the patient has stopped taking them.

The objectives of this audit are;

1. To identify all the patients who have not ordered a repeat medicine in a defined time period (normally > 1 year)
2. To identify those patients that need flagging up for a review with the GP or practice nurse as they ought to be talking the medicine.
3. To identify those repeats which can be removed from the system as no long required.

**Procedure**

In SystmOne go to “set up” and “bulk operations”. Choose “repeat template stopping “which looks like this:



If you find that you don’t have user rights to do this either get them or find somebody who does.

Specify the time period that you are interested in which is normally any repeat templates not ordered in the last 12 months.

Run the search to produce a list showing patients name, the repeat medicine and the date last ordered.

You will need to use for professional discretion to determine which medicines should and should not be removed, and the time scale to look over. Agree these with the GP prescribing lead. Review this list for

* Medicines that the patient really ought to be taking e.g. angina drugs, glaucoma eye drops, inhaled corticosteroids for asthma. Highlight these to the appropriate health care professional so they can be invited for review- do not remove these medicines.
* “When required medicines” that the patient may order in the future e.g. GTN spray.- do not remove these.
* Medicine only used seasonally e.g. antihistamines for hay fever.- do not remove these.

All other medicines can be removed.