

## REPEAT PRESCRIBING POLICY

### THERE ARE FOUR STAGES:

1. **Initiation/ Request**
2. Production/ **Authorisation**
3. **Clinical control/ Review**
4. Management control

The GP should retain an active involvement throughout the repeat prescribing process and should not delegate any entire part of the process to ancillary staff. Those stages in **bold** above are entirely the responsibility of the GP.

#### 1. Initiation/ Request

##### Initiation

- The decision to transfer a drug from an acute prescription to a repeat prescription must always be made by the **doctor** after careful consideration of whether the drug has been effective, well-tolerated and is required long-term. (The patient should be seen, or at least spoken to, at this stage to ascertain the above and to check compliance). It is the duty of the doctor at this stage to ensure that the patient understands the repeat prescribing process and what is required of them.
- Care should be taken to ensure the repeat record is accurate, quantities for each drug are synchronised where possible and review dates are entered.
- Drugs should be **linked to medical conditions** within the clinical system as appropriate.
- Consideration should be given to alternative drugs and / or **generic prescribing** where appropriate.

##### Request

- This will largely be the responsibility of the patient.
- The patient should be given a list of drugs they are currently taking on repeat prescription, preferably as a computer-generated list (usually forming the right hand side of the prescription slip).
- The patient or his /her representative must have an active role in requesting a repeat prescription.
- Patients should allow 24 hours for repeat requests to be dealt with. This allows adequate time for a good quality repeat prescribing system to operate.
- Patients should be encouraged to tell their GP's if they are no longer taking a repeat medication. The appropriateness of this can then be assessed and the computer updated to reflect the change.
- We allow chemists to order drugs on behalf of patients if they have signed a consent form.

#### 2. Production/ Authorisation

##### Production

- This will usually be the responsibility of the repeat prescribing lead
- A compliance check is preferable 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 problems are suspected the doctor should be alerted, preferably before the prescription is produced.
- Staff should not supply further repeat prescriptions at shorter time intervals than have been authorised without agreeing the reason for the early request, e.g. holiday.
- Provided there appears to be no problem, a prescription can be generated and left for the doctor to authorise and sign, with the notes to hand (computerised or manual) as far as practically possible, to cross check the validity and appropriateness of the request. Situations where notes should always be available include:

1. Where the request slip indicates that a review is necessary

2. Where any drug requested by the patient is not on their repeat record

3. Where any of the following drugs are requested:

- Temazepam
- Diazepam (Valium )
- Dihydrocodeine
- Paracetamol and codeine 500/30 preparations, e.g. Solpadol, Tylex
- PPI
- All controlled drugs

4. Where the item requested has been issued less than one month previously.

5. Any request about which the practice staff are concerned or uncertain.

- Where additions or corrections are made the doctor signing the prescription should initial or countersign against them. A record should be made of any subsequent handwritten alterations to computer-generated prescriptions.
- Blank prescriptions should never be signed by a doctor for later completion by him/herself or a delegate. **To do so is in breach of terms of service.**
- Unused space should be cancelled out under the last drug by a computerised mechanism or by the doctor deleting the space manually.
- All repeat prescriptions issued should be recorded on the computer.
- Practices should store prescriptions awaiting collection in a secure way and have a standard time limit for collection of repeat medication (e.g. 4 weeks) after which those not collected should be investigated, e.g. no longer required or medication underused etc. A receptionist should check the box on a monthly basis and destroy uncollected prescriptions and make a consultation note about it as well as informing the doctor.

### 3. Clinical Control/ Review

- This is solely the **responsibility of the doctor**, although the nurse can review certain patients on behalf of the doctor, e.g.: contraception and asthma although patients may not necessarily have to be seen by the doctor. The review date is set on the computer for every 12 months.

- A 28-day supply of 28 days will be given. A few patients being given three months supply, e.g. Oral contraceptives, HRT, hypertension, cholesterol drugs.
- When patients are on several regular long-term medications, quantities should be prescribed to synchronise repeat intervals. In the UK patient packs are moving towards multiples of 28 days (rather than 30)
- 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 **doctor** should amend the repeat record **personally**. A check of prescriptions not yet collected should also be made to ensure that it contains the correct medication.

The following considerations should be kept in mind by the doctor when carrying out medication review consultations:

1. **Control** of the condition - is this optimal?
2. **Unnecessary medication** - can anything be stopped?
3. **Compliance**-
  - Is the patient taking the medication properly?
  - Could the regimen be simplified?
  - Is there a problem with unwanted adverse effects?
  - Check understanding of medication?
4. **Monitoring** - is this required, e.g. phenytoin levels, INR, TFTs, LFTs, U&Es
5. **Cost considerations** - change to generics if appropriate, or consider change to a more cost-effective treatment (consider PCT formulary)

#### 4. Management control

This would largely be the responsibility of the practice manager.

Practice staff that write, or are involved in the preparation of, repeat prescriptions should be appropriately trained in the practice protocols for repeat prescribing, what their responsibilities are, and the need for accuracy. This should be on going, but is particularly important for new staff.

Liaison with local community pharmacists is essential if procedures are changed that may ultimately impact on them.

**An adequate system for the secure storage and use of FP10's should be in place.**

The practice computer system holding the prescribing records must be backed-up regularly.

#### Setting up a repeat prescription.

- The medication to be included on a repeat prescription should be agreed between GP and patient.
- The importance of the need for regular review of repeat medication should be stressed to the patient.

- It is the responsibility of the patient's GP to ensure that an accurate up-to-date record of a patient's repeat medication is held in their computer records and that all prescriptions are indicated / linked to a condition.
- Repeat medication prescriptions should last for an agreed length of time, usually 6-12 months, before medication should be reviewed (although this period can be extended if felt appropriate at the discretion of the prescribing GP).
- Provide patients with details of the system operation at an appropriate time (on registration with the practice, on commencing a repeat prescription). Posters detailing the operation of the system should be displayed around the practice.

### **Operation of the system**

The prescription lead is responsible for the day to day running of the system. This should include:

- An appointed member of staff being given responsibility for the daily collection and processing of all repeat prescription requests.
- Routine reauthorisation of repeat prescriptions is the responsibility of the Doctor. If items requested have expired and need reauthorisation the patient is required to attend a medication review, unless housebound. If housebound, the GP is then responsible for deciding whether to automatically re-authorise the repeat prescription or to provide a home visit.

### **When to refer the prescription back to the doctor**

- If anything is unclear with a repeat prescription request refer back to the prescribing GP.
- If a patient requests an item which is not included or differs from the details recorded in their records, they should be referred to the GP.
- If a patient under or over orders items on their repeat prescription indicating poor compliance, this should be highlighted with the GP.

### **Monitoring of repeat prescribing**

Ideally a GP should carry out a medication review when:

- A block of repeat medication comes to an end.
- Patients attend for monitoring of the condition requiring repeat treatment.
- Opportunistically should a patient attend with another complaint.

### Repeat Prescribing Flowchart

Following agreement between patient and doctor to commence medication on a repeat prescription:

