Health and Social Care Board

DEVELOPING A PRESCRIBING PROTOCOL
GUIDANCE FOR GP PRACTICES

Version: 2.0
Date: May 2016
Review: December 2019

Background

The majority of prescribing incidents reported to the HSCB have been the result of poor prescribing systems for example:

- patients receiving medication for long periods of time without having a medication review by a prescriber or pharmacist
- administration staff adding or deleting medication from patient records

The Medical Defence Union (MDU) and the General Medical Council (GMC) consider that a practice prescribing protocol is a vitally important policy to have in general practice.[1,2] Therefore, all practices should have a written Acute and Repeat Prescribing Policy in place to ensure that there is a robust prescribing system operating in the practice and **every** member of the practice team has an understanding of their roles and responsibilities within the system.

Efficient prescribing systems have an important role in enhancing medicines optimisation principles; ensuring cost effective and clinically appropriate medicines are prescribed and medicines waste is minimised. In Northern Ireland approximately £18 million per year is wasted on unused medicines. A large proportion of this is attributed to repeat medicines that have been ordered, are prescribed, dispensed and collected by the patient/carer but are never used and subsequently wasted.[3]

Not only can an efficient prescribing system minimise waste, it can also increase productivity with less staff time spent on generating prescriptions that may not be needed. It has the potential to improve medication safety by ensuring safe systems for prescribing and to identify and manage patients who require a medication review; **this is a key component of the practice prescribing protocol**.[4,5] Other benefits are: reducing the number of future appointments required, admissions to hospital and disease progression in some cases.

In addition to professional, the contractual obligations are outlined in The Health and Personal Social Services (General Medical Services Contracts) Regulations (Northern Ireland) 2004, which provides the legislative arrangements for the GMS contract and there are pertinent elements with respect to prescribing in particular the regulations have a specific reference to “excessive prescribing”:

Excessive prescribing

43.—(1) The contractor shall not prescribe drugs, medicines or appliances whose cost or quantity, in relation to any patient, is, by reason of the character of the drug, medicine or appliance in question in excess of that which was reasonably necessary for the proper treatment of that patient.

(2) In considering whether a contractor has breached his obligations under sub-paragraph (1), the Board shall seek the views of the Local Medical Committee (if any) for its area.[5,6]

In summary, a poorly run prescribing system may:

- lead to errors that potentially expose patients to harm
- be frustrating to patients and practice staff
- waste resources, patient and practice time
- cause an increase in patient complaints

Implementing and regularly reviewing a robust prescribing system within a practice will:

- promote high quality, safe prescribing
- reduce potential for ‘near misses’ and adverse incidents and reduce the risk of patient harm
- allow earlier recognition of problems, identify any risks associated with the process
- improve patient access to their medication
- reduce medicine waste and improve efficiency and allow a more manageable workload
- ensure appropriate and efficient use of professional and practice staff time and skills
- ensure greater understanding of the process by everyone involved, including roles responsibilities and timelines
- minimise patient complaints and potential litigation

The following sections must be considered in the development of your protocol:

- **Ordering Prescriptions**
- **Prescription Generation, Recording and Computer Security**
- **Prescription Collection**
- **Managing Patients Using Multiple Dispensing Systems**
- **Duplicates**
- **Care Homes**
- **Hospital and Other Correspondence Letters Issued By Health Care Professionals**
- **Communication**
- **Specialist Drugs**
- **Drug Monitoring**
- **Medication Review**
- **Prescription Security**
- **Learning from Adverse Incidents**
- **Audit and Updating The Prescribing Protocol**
- **Staff signature list**

1. Ordering Prescriptions

Patients should take responsibility for ordering their own prescriptions unless there are **exceptional** circumstances. These must be agreed in advance between the patient, prescriber and community pharmacist or appliance contractor, and a note made in the patients clinical record.[4,5]

This section in your protocol should include details of:

- How prescriptions can be ordered from the practice for example; in person, by telephone, online, right hand side of the prescription or by post
- The practice policy on posting prescriptions for example, patient consent, use of special delivery[7]
- Who can order a prescription for example, patient, relative or carer
- When 3rd party requests are acceptable, for example, by a community pharmacy, and how consent from the patient is obtained and recorded
- Minimum information required to confirm patient ID; name, address and date of birth
- When prescriptions issued will be ready for collection, e.g. 24 or 48 hours
- Confirmation of the transfer arrangements with the patient when the prescription is ordered, for example: patient may request collection by a specific community pharmacy, or be posted to an appliance supply company.

- How temporary residents may request medication-e.g. reason for request, what info required to confirm identify, Electronic Care Record (ECR) check, proof of address, issue quantities of medications in line with potential risk and record onto clinical record
- Lost medication- reason for request, police number if appropriate, has this happened before?
- Practice staff training on the prescription process mechanism (Appendix 1).

Acute prescriptions

An acute prescription is one that is usually issued by the prescriber during a consultation where there is a defined number of days a medication is to be taken. This may be for example, a trial of a new medication for a chronic condition, or treatment for an acute condition, an antibiotic or short course of pain relief.
Acute items must not be generated by administration staff, even if it is currently listed on the acute screen.[8]

This section in your protocol should include details of:

- How requests are recorded, for example, acute screen
- Questions to ask patient when a telephone request is received by reception, for example,
  - Who is the patient?
  - What are the symptoms?
  - How long have they had them?
  - Any allergies?
  - Medicines already tried (for example, over the counter)
  - Is patient pregnant or breastfeeding? (if applicable)
  - Are symptoms getting worse?
- Managing patient expectation at the time of ordering
- Training and awareness around requests where the patient must speak to doctor, for example, antibiotics, analgesics
- At the time of order if appropriate, referral to minor ailments scheme
- Managing situations where no prescription is required (eg advice only)
- Managing requests for special groups for example, vulnerable, nursing home or very ill patients.

Repeat prescriptions

Repeat prescribing can be described as a partnership between a patient and prescriber that allows the prescriber to authorise medication at agreed intervals without the need to see the patient each time by the prescriber.
This section in your protocol should include details of:

- Managing early or late requests or medication not being ordered– using compliance checkers if available on the IT system, reasons when an early request maybe acceptable, (for example holidays) and actions to be taken when a request is received. Refer to prescriber with following information documented on the patient notes:
    - READ code – early request
    - Reason and quantity needed for example, Length of holiday
    - Has early issue been requested before
    - List of medications required
- Drugs unsuitable for repeat prescribing
- Patients who may be unsuitable for repeat prescribing, for example, registered drug addict, patients detained in prison[4,9]

2. Prescription Generation, Recording & Computer Security

This section should include details of:

- When prescriptions are routinely printed and signed

- Who can generate, re-issue (re-authorise) and print acute and repeat prescriptions
  NOTE:
  - Acute items must not be generated by administration staff, even if it is currently listed on the acute screen.[8]
  - It is recommended that only prescribers may review and re-authorise repeat medication for up to a maximum 12 months' supply allowing for at least annual review of medications
  - The transfer of acute to repeats must only be undertaken by a prescriber, administration staff should not change patient medication records[9]
- For practice support pharmacists, any changes that may only be made on the authorisation of a prescriber
- Prescribers - should not issue an acute from past medication list as this increases the risk of an error and possible adverse incident occurring
- Who can add new repeats to patient's medication list, note this must be a prescriber,
- Administrative staff security settings should be set so that they cannot:
    - issue acute prescriptions
    - add drugs to either the repeat or acute screen
    - re-issue a script from past drugs[8]
    - issue duplicate prescriptions[10]
- How to manage requests for regular acute prescriptions, for example, those unsuitable for repeat for example, methotrexate, hypnotics

- Non-medical prescribers (pharmacist, nurse) who may prescribe based on their competencies
- Use of full directions on all prescriptions
- Generic prescribing- exemptions list [11]
- Prescribing- compliance with the NI formulary[12]
- Quantity routinely issued on prescription 28 days or 56 days
- Recording prescriptions issued out of hours or on home visits (section 8)
- Recording allergies (prescribers only)
- Linking medicines to a clinical indication (prescribers only)
- Restrictions, set on the clinical system so that only a prescriber may delete a script from patient medication record, a note should be added detailing the need for each deletion.

Computer security

There have been several incidents of prescription fraud involving personnel working in GP practices. The circumstances were similar; scripts were issued, printed, passed off as genuine scripts for signing by GPs in the practice and then deleted from the patient record by the person in an attempt to conceal their actions.[8]

So that actions taken are identifiable to a specific staff member, this section should include details of:

- The importance of the use of personal computer logins, password protection and logging off a terminal when tasks completed
- When the clinical system's screen will automatically lock if not used after a short period of time
- Who can delete prescriptions from patient's records.

3. Prescription Collection

This section should include details of:

- Who can collect prescriptions, for example, what is the practice policy on children under 16 not being allowed to collect prescriptions? Are there exceptions to this for example, for family planning prescriptions or for treatment for STIs?
- How identity is checked, for example, pharmacy collection drivers
- Precautions for certain groups of medicines for example, controlled drugs, drugs liable to abuse
- Precautions for high risk patients eg: patients susceptible to overuse or misuse of medicines
- Recording of a collection of prescriptions a group of prescriptions by a community pharmacy noting in particular controlled drugs
- Use of collection record book including signature of person collecting prescriptions for a patient and use of a private area for signing.

- Collection by 3rd party for example, pharmacy or appliance delivery company and patient consent for this
- Posting prescriptions in **exceptional** cases. Note the practice should obtain and document informed consent from each patient prior to transferring prescriptions by this method. Records should be kept of all prescriptions posted and postage should be by special delivery.[7, 13]
- Telephoning in exceptional cases only and prescriptions should only be telephoned from healthcare professional to healthcare professional for example, prescriber to community pharmacist [14]
- Faxing urgent prescriptions to pharmacy[15]
- Uncollected prescriptions- documenting when these will be reviewed by a prescriber, recording of this in the patient notes and destruction.

4. Multiple Dispensing, Repeat Dispensing and Mid-cycle changes

Multiple dispensing

The definition of multiple dispensing is set out in the NI Drug Tariff:
'20a. Multiple Dispensing is the supply, by a pharmacist, of part of the total quantity of a prescription-only-medicine, at set intervals (e.g. weekly or daily) as requested in writing by the GP or other authorised prescriber.

*Multiple Dispensing is an "**exception**" facility for use where the prescriber considers that it is **essential** to protect the well-being of the patient (to prevent abuse, misuse or life-threatening non-compliance) that installments of the drug prescribed should be supplied to the patient at stated intervals. The prescriber may endorse the prescription to that effect in those circumstances and READ code and document the reason for the patient requiring multiple dispensing in their notes. It must be clearly indicated on the prescription which item(s) require multiple dispensing and which are for normal dispensing'.*[16]

Monitored Dosage Systems (MDS)

As above, the Drug Tariff specifically **excludes** multiple dispensing as a means to provide MDS (weekly trays of dispensed medicines). The purpose of **multiple dispensing is as an exception facility** in specific circumstances, it is also **not appropriate for patients in care homes or other settings where staff administer medications to patients.**

*Endorsement of a prescription with **'weekly dispensing' should NOT be applied in respect of**:-*
(i) prescriptions for patients registered for review of medication under the Managing your Medicines scheme (for which separate payments apply); or (ii) presentation of medication(s) in compartmentalised MDS weekly trays (Managing your Medicines scheme payments may apply).[16,17]

"Managing Your Medicines" is a service commissioned by the HSCB. It is a pharmacy based medication review service provided for patients who are vulnerable or at risk. Some of the aims of this service for patients, who meet the eligibility criteria, are to educate the patient to improve understanding of their medication and address any compliance issues identified which may be a barrier to patients taking their medicines as prescribed.
ECR records show practices which patients are currently in hospital (excluding psychiatry). Practices may wish to regularly review this list and identify those patients who are on interval dispensing. The patient's pharmacy can then be contacted to inform them that the interval dispensing is on hold and will be reviewed on discharge.[18]

Repeat Dispensing Scheme (RD) is where the practice issues a batch of prescriptions that may last up to a year. These are held and dispensed at intervals agreed by the prescriber and patient (usually every 28 days) by the community pharmacy.[19,21]

Mid-cycle changes to either MDS or RD

This is an area of risk and there have been a number of errors involving prescriptions dispensed into MDS or issued against an out of date RD prescription, which have resulted in serious adverse reactions for patients. The main learning point from these incidents is that:

- Communication on changes in medication must be directly between the prescriber and the pharmacist not via third parties. Any changes given verbally from the prescriber to the pharmacist should be followed in writing to confirm and a note recorded in the patient record.

This section should include details of:

- Which patients may be suitable for MDS or RD and who may approve patients to use these aids[18,19]
- Use of correct READ codes:
  -**'Repeat Dispensing' 8BM1** for EMIS, Vision (INPS) and **XaJus** for Healthy (Crosscare).
  -**'Uses Monitored dosage system' 8BIA** and **XaIoB** for Healthy.
- Arrangements for ordering prescriptions for MDS and collection of these prescriptions by community pharmacies with the agreement of prescriber and patient
- Managing under or over ordering of MDS or RD prescriptions
- Medicines that require risk assessment for example, warfarin
- Medication suitability for example, medication stability outside original packaging which are not suitable for MDS and Schedule 1, 2 & 3 Controlled Drugs cannot be prescribed on or dispensed against a RD prescription. This includes tramadol, temazepam and phenobarbital[18,20]

- If withdrawing a patient from MDS or RD, this should be recorded in the patient notes[21]
- A record of which community pharmacy the prescription is held in, is clearly visible in patient notes[18]
- Procedure for medication review
- **How to manage mid-script changes**, the prescriber must contact the community pharmacist directly[18,20] and **written** documentation of this communication should follow, this must be recorded in the patient notes.
  A practice template may be incorporated into the GP clinical system as an easy way to document mid-script changes into the patients notes this can be printed and shared with the community pharmacy for their records.

5. Duplicates

A duplicate prescription is an identical prescription reprinted as a replacement for a lost, defaced or damaged prescription. The issuing of a duplicate prescription should only occur in exceptional circumstances.
The patient's clinical record will show one prescription and audit trail will show the reason for this and that a second copy was printed.[22]

This section should include details of:

- Practice system for dealing with missing prescriptions
- Management of requests for example, when, how and who can reprint prescriptions
- GP clinical system restriction on which staff members can issue duplicates.
- Recording reasons for printing a duplicate prescription in the patient's medical record

It is considered good clinical governance that regular audit should be undertaken to ensure compliance with this section of the protocol.

6. Care Homes

The ordering of prescriptions and supply of medicines to nursing homes are important processes (Appendix 2). There are particular risks associated with these processes for patients resident in care homes and is an area which requires clear and robust systems.[23] There should be a clear understanding and appreciation of everyone's role in the process: care homes, the surgery and community pharmacy who should meet together as required, to agree the process and ensure efficient running of the system.[3]

This section should include details of:

- Who can order prescriptions

- How prescription orders are taken for example, written lists of medications for patients or orders on MAR sheets
- Timescales when prescriptions are planned to be ready and returned to home as per RQIA guidelines
- Who can collect prescriptions and if a record of the collection is to be kept
- Managing acute requests for homes, please note, the GP is responsible for ensuring homes are alerted to new medication or changes to directions for existing medications
- Managing mid-cycle changes.[23] The GP or other prescriber is responsible for ensuring homes are alerted to changes to patient's medication (see also section 4)
- Quantities of medications issued (28 days is the norm) and working with the home to synchronise and bring repeat medications into line
- Processes are in place for medication review for this group of patients to assess on-going patient need for repeat medication to ensure waste is minimised.[24]

To reduce potential wastage, care should be taken when processing orders for "when required" or "prn" medications, such as analgesics, laxatives, nutritional supplements, appliances and dressings. Ensure that the person generating the prescriptions for care homes is clear when a medication is not being requested on the ordering sheet.
Do not generate prescriptions for any medicines that are not required.

7. Hospital and other Correspondence Letters Issued by Health Care Professional

This section should include details of:

- What happens from receipt of the letter. What are the roles for all persons involved in the process:
    - How all types of correspondence are scanned into the patient record
    - Timescales for issue of new prescriptions and communicating especially with vulnerable patients about the start of new medications or changes to directions for existing medications
    - Who is responsible for actioning monitoring requests and advising patient of any follow up tests required
- Role of a prescriber and other qualified clinical staff -who can review correspondence letters and amend patient records[25]
- GP review of uncollected prescriptions on a frequent basis and the process for deleting the prescription and the recording this in the patient clinical notes
- Processes for written communication of any medication changes to community pharmacy for patients on MDS (see section 4 and 8) [26,27]
- Supply arrangements for patients on stoma care products.[28]

8. Communication

Serious adverse incidents can occur where incorrect or inappropriate prescriptions are dispensed by community pharmacies. If there is a concern that a prescription may not be appropriate, or for example if there is a query about the directions on a prescription, the pharmacist (not other dispensary staff) must speak **directly** to the prescriber (not reception staff) about this. Involvement of third parties such as dispensary/reception staff can lead to confusion or a missed opportunity to discuss clinical concerns with potentially serious consequences.[26, 27]

This section should include details of:

- How telephone queries or interventions from other health care professionals for example; pharmacist, hospital doctor, community nurse, stoma or continence nurse, palliative team or dieticians are managed
- What type of communication the practice will accept for example, by secure email or in writing
- Recording interventions advised or made by other health care professionals into the patients notes.

  Examples of queries:

  - Changes in medication doses
  - Changes to medicines
  - Drug interactions
  - Concerns about adherence to medication
  - Arrangements for medicines in MDS (see section 4)

- If a printed prescription needs altered, the amendment should be made on the clinical system and a new prescription generated. Prescribers are asked **not** to make hand written amendments to prescriptions as it makes it more difficult for community pharmacists to recognise fraudulently altered prescriptions.[29]

- If it is necessary to write a prescription by hand for example, on a home visit, the prescriber should draw a diagonal line across the blank part of the form under the prescription to prevent further items being added fraudulently. It is important that the patient's record is updated to reflect that a hand written prescription has been issued.[1,29,30,31]

9. Specialist Drugs

The Red Amber List of specialist medicines is a guide for practitioners in both Primary and Secondary care. It provides professional guidance on where prescribing responsibilities should lie for these specialist medicines along with shared care guidance if appropriate.

When a GP receives a request to prescribe an unfamiliar medicine, the Red/Amber list should be checked at the Interface Pharmacist Network (IPNSM) website (http://www.ipnsm.hscni.net) and appropriate action taken.[32]

All specialist medicines prescribed and supplied by hospitals should be recorded onto the GP repeat prescribing screen, stating in the dose/directions 'hospital issue only'. The prescription should be issued but not printed or the drug source entered as being issued outside the practice once every six months. This will help ensure that ECR medication list will be accurate.[31,32]

For Amber drugs, for example Methotrexate, there are shared care arrangements that are agreed on initiation of treatment from secondary care. These should be scanned onto the patient's journal to document patient specific arrangements or can be accessed via the IPNSM website.[32]

Medicines prescribed for substitute prescribing for example, Subtex®, and are prescribed by another GP practice that provide this service to patients, must also be recorded on the patient medication record and therefore will be noted on ECR.[30]

This section should include details of:

- Managing requests for red list drugs
- Managing requests for amber list drugs
- Use of interface pharmacist network website (IPNSM) website
- Systems for dealing with red list drugs inadvertently prescribed by practice
- Contact details for local interface pharmacist
- Recording of red list drugs 'not to be issued'
- Recording of substitute prescribing drugs 'not to be issued'

10. Drug Monitoring

Therapeutic drug monitoring is used to optimise individual dosage regimens. It is unnecessary for the majority of medications and is used mainly for monitoring drugs with narrow therapeutic ranges, drugs with marked pharmacokinetic variability, medications for which target concentrations are difficult to monitor and drugs known to cause therapeutic and adverse effects.[33]

This section should include details of:

- The systems that are in place to ensure necessary monitoring is carried out before a prescription is issued for relevant medication[33]
- Patients notes are READ coded (High Risk Drug Monitoring 66P..00) if on a high-risk medicine for example, methotrexate, lithium and warfarin. [34, 35, 36]

11. Medication Review

Regular medication review is important and should be part of the normal everyday clinical management of patients on repeat medications. A medication review has been defined as 'A structured critical examination of a patient's 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'. The initial decision to prescribe medicines, the patient's experience of using the medicines and the patient's needs may change over time. [4,17,24]

Who should be prioritised for a medication review?
Suggestions include those who are higher risk of side effects of medications: elderly or 'frail', patients on polypharmacy, residents in care homes, those on weekly dispensing and patients recently discharged from hospital.

This section should include details of:

- Who can undertake medication reviews
- How a medication review date is recorded on the computer for all patients receiving repeat medicines
- Processes in place on the GP clinical system to ensure medication reviews are carried out in a timely manner and all staff including locums, are trained on how the system in the practice works
- Action required and by whom if the review date is due/overdue
- When a face-to-face medication review is required
- Points to be addressed during a medication review
- Systems are in place to highlight medication over or under use
- Review arrangements for patients receiving private prescriptions
- Those undertaking medication review documenting
- Only prescribers or practice support pharmacists can undertake medication review and remove unused medications from current list.[4,5,24]

GP practices must ensure the time interval for review of medication is based on both safety and the health and care needs of the patient. The interval between reviews should be no more than one year. More frequent review may be needed for those at most risk for example, patients recently discharged from hospital or those receiving weekly dispensed prescriptions.

Patients Failing to Attend for Review of Repeat Medication
The GMC in its publication 'Good Medical Practice' states that a clinician must only prescribe drugs or treatment including repeat prescriptions when 'you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patients' needs'. Without having contact with the patient the clinician cannot be assured of this and therefore attempts should be made to contact the patient or carer.[1]

1. For patients who fail to attend, a number of different means of contacting the patient should be tried. It is not possible to suggest one strategy as this will vary depending on the patient but possible ideas include:

- Letter explaining the GPs obligation to ensure the welfare of the patient.
- Phone call
- Visit to home
- Reducing the quantity of repeat medication issued *
- Text message
- Using practice extended hours to offer appointments
- Email alerts
- Notifying the community pharmacist

*It would be difficult to stop a patients' medication altogether because this would effectively be withholding medication knowing that the patient may suffer harm as a result.

2. Check whether the patient has recently been reviewed by another health professional/organisation e.g. secondary care / mental health team etc.

3. Check that it is appropriate to contact the patient using one of the methods above. It may be that the patient's carer should be contacted.

4. Check that the patient is still resident at the registered address; it may be that the patient has moved and the practice has not been notified, for example, students and patients living abroad for the winter months.

5. For patients that have co-morbidities, try to co-ordinate medication reviews with chronic disease review so that the attendances at the practice are reduced.

6. All attempts to contact the patient or carer must be documented in the notes.

12. Prescription Security

The effective management of prescription forms e.g. how they are stored and accessed by authorized prescribing and non-prescribing staff is very important and there should be appropriate security policies, procedures and systems in place in each practice.[35]

Guidance and audits to review your Prescription Security protocol are available on the primary care intranet.[37,38]

This section should include details of:

- Reference to the practice Prescription Security Protocol
- Ensuring that all staff have appropriate security settings for their role including who can add medication or delete prescriptions.

- Regular audit should be undertaken to ensure compliance with protocols.

13. Learning From Adverse Incidents

Good communication between all practice members of staff is essential in building and maintaining a strong safety culture based on an open, blame-free working environment.[39]

This section should include details of:

- How adverse events are notified within the practice
- Who co-ordinates review of incidents
- How learning is shared
- How incidents are reported to HSCB
- Who is responsible for sharing HSCB learning letters and medicine safety newsletters within the practice.[39]

14. Audit and Updating The Prescribing protocol

Audit of prescribing systems may be considered under the practices clinical governance plan. It is recommended that this is undertaken at least every 3 years and sooner if new local or national guidance is issued or a significant event has occurred.[40]

This section should include details of:

- Who is responsible for and co-ordinates audit of prescribing systems
- Who is responsible for updating protocols in response to National and Regional safety alerts and warnings
- How often audits are performed-audit plans
- How outcomes are actioned
- How staff are trained on practice protocols including update training.

15. <u>It is recommended that practice staff read the practice prescribing protocol and sign in agreement with the procedure (sample form)</u>

I have read, understood and agree to follow the above protocols

NAME	SIGNATURE	DATE

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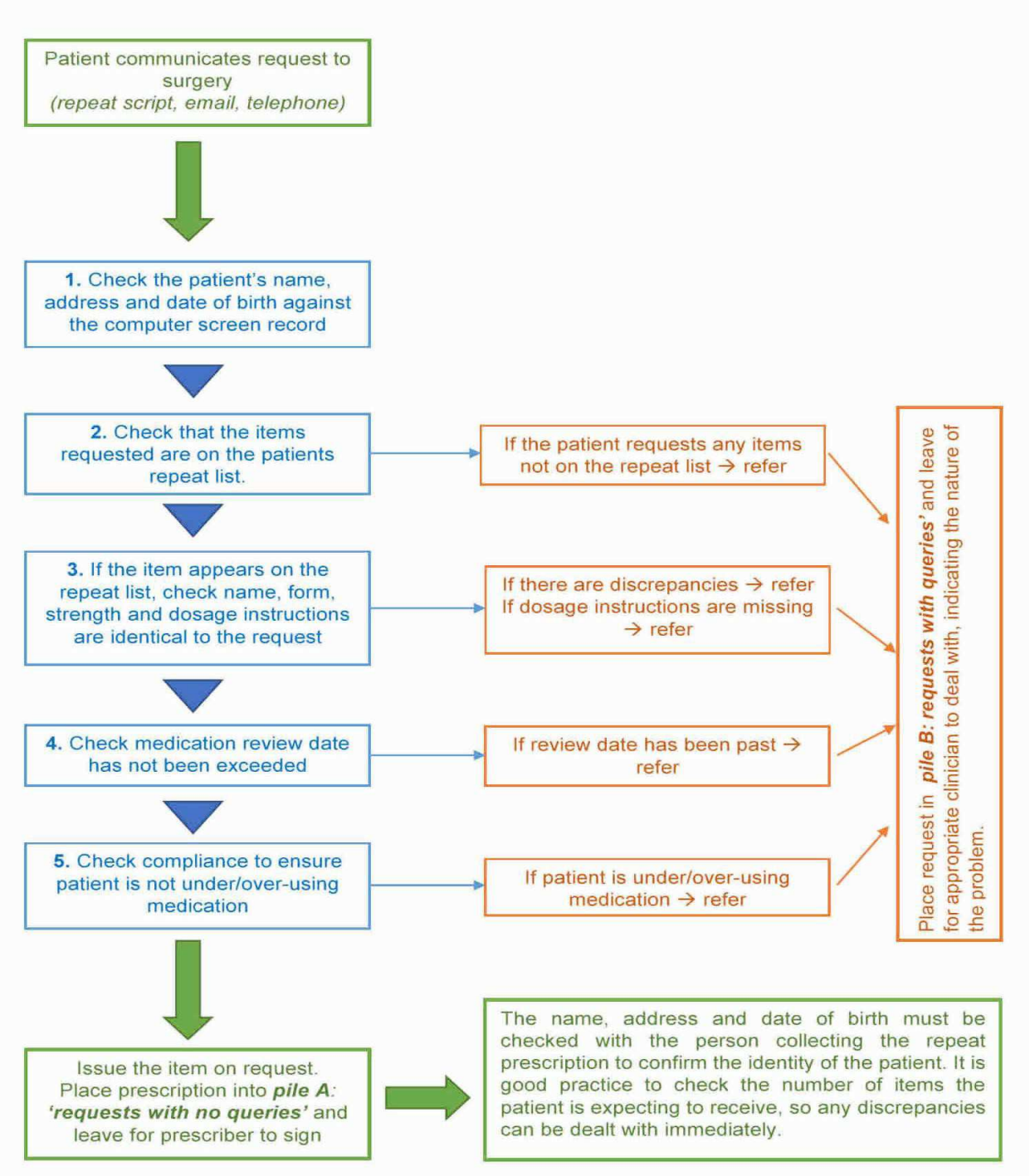
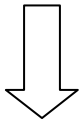
Appendix 1. Processing a request for a prescription. Flow diagram summary. (Presqipp 2015).



Appendix 2. Summary of the key stages for managing REPEAT medication requests for patients in care homes

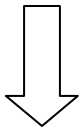
Care Home

- Current stock levels checked
- Medication required identified
- Request submitted to GP practice



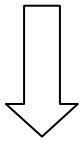
Surgery

- Repeat Prescriptions generated, taking into account information supplied by care staff and collected by the home or their representative



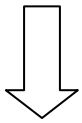
Care Home

- Repeat Prescriptions checked before submission to pharmacy for dispensing



Pharmacy

- Repeat Prescriptions checked and dispensed **against prescription**
- Medication supplied to home



Care Home

- Repeat Medication checked against order and Patient Medication Records. Accurate record of medication received.

A 28-day supply of regular repeat medication should normally be issued to care home patients.