Health and Social Care Board

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To all GPs and Community Pharmacists

12th March 2012

Dear Colleague,

Prescribing, Generating and Dispensing Repeat Medications

1 Introduction

Repeat prescribing and dispensing was highlighted by the DHSSPS Permanent Secretary, Chief Medical Officer and Chief Pharmaceutical Officer in their letter of 7th July 2011. Following this letter, the Board is now expected to provide an assurance regarding the systems in place for these services. We are therefore writing to outline the Board's position and to remind GPs and pharmacists of the Board's expectations with regard to repeat prescribing systems.

2 Context

Some 35 million prescription items were prescribed and dispensed in NI in 2010/11. It is estimated that at least 60% of these items were prescribed and dispensed by way of a repeat prescribing system. It is recognised that repeat prescribing systems are necessary to maintain safe, timely, appropriate and accurate therapy with medicines to patients.

However, a number of adverse incidents have come to light recently concerning the issuing of repeat prescriptions for patients where:

1. It is evident there has been no review of patients' ongoing requirements for repeat medicines by their GP for some years
2. Requests for repeats have routinely been made by the pharmacist on behalf of patients, where no clinical need for the pharmacist to act on behalf of the patients has been established

3. Repeat medication has been issued by pharmacists prior to issue of the prescription
4. There was no evidence of a clinical assessment of the prescription, or subsequent appropriate intervention, by the GP or pharmacist at the time of prescribing or dispensing.

The incidents that we refer to are varied and have occurred infrequently but they have led to serious repercussions such as:

- Patient harm, including death
- Legal challenge
- Professional sanction, including removal from the professional register

At the heart of these incidents, there have been deficiencies in repeat prescribing and dispensing systems within GP and community pharmacy provision, including occasions where the GP or pharmacist did not intervene or the GP did not act upon pharmacist interventions.

Recently, the issues of repeat prescribing, dispensing and patient review were highlighted by Professor Jack Crane, the State Pathologist, in a communication to the Coroner's Service. This was as a result of concerns about the amount of paracetamol and tramadol that had been prescribed for a deceased patient. Professor Crane expressed the following concerns:

"As you know, we deal with cases where the general practitioner has not seen the deceased within the preceding 28 days…In many such cases these patients have been receiving regularly and routinely, drugs on repeat prescriptions without having been reviewed, sometimes for periods of up to several years by their General Practitioner…"

"It seems that in some instances the pharmacy rather than the patient, ***instigates*** *the request for the repeat prescription from the GP surgery, collects the prescription, dispenses the medication and delivers it to the patient….."*

In the DHSSPS letter to the HSC on 7th July 2011, it states:

"It is essential that the management of repeat prescribing (and the dispensing arrangements that flow from it) include mechanisms that ensure the ongoing need for the medication, its continued effectiveness and the patient's compliance with any prescription."

3 Prescribing Repeat Medications

It is normal and accepted practice for GP surgeries to operate a repeat prescribing system for some of their patients with chronic or long-term

conditions. The GMC has issued guidance to doctors on the appropriate use and application of repeat prescribing.
http://www.gmcuk.org/static/documents/content/Good_Practice_in_Prescribing_Medicines_0911.pdf
HSCB has also developed a number of resources to assist practices to audit, review and revise their systems (see appendix for details of these).

One of the most important aspects of any repeat prescribing system is a clear process for review of **all** patients receiving their prescriptions in this way. The need for patient review is reinforced in the GMS contract by Medicines 11 and 12 of the QoF framework, which state that a medication review should be recorded in the notes in the previous 15 months for all patients being prescribed repeat medicines. In Professor Crane's letter, he recommends that more frequent review should be undertaken and suggests six monthly intervals as appropriate.

Other factors that should be considered when prescribing repeat medications include:

- The ordering of a repeat prescription should provide an opportunity for surgery staff to discuss and highlight any medication issues such as compliance, medication changes or monitoring requirements directly with the patient
- A reasonable time period should be allowed between a repeat prescription being ordered and it being available for the patient / care home. For most practices, this will be between 24-48 hours.
- GP practice staff should not issue details of prescriptions before they are signed and ready for collection
- For some patients with chronic illness who are considered to be stable, it may be appropriate for them to receive their regular medication via the repeat dispensing service.

4 Generating Repeat Prescriptions

The Board recommends that, in the majority of cases, patients should contact their surgery directly to order their medicines. This approach is considered best practice for the following reasons:

- Direct communication between the surgery and the patient reduces the potential for misunderstanding and the risk of error in transferring information. For example:
    - medication requirements could have changed between the time of initial ordering and supply of medication leading to wastage, confusion and the potential for adverse incidents

- repeat items may be ordered from the patient's own medication list which may be incomplete or not up to date.

- As outlined above, this also provides an opportunity for surgery staff to discuss and highlight any medication issues with the patient. By encouraging patient ownership of the management of their medicines, there is an opportunity for self management.

The majority of patients should therefore take responsibility for ordering their own medicines.

Strategically, the HSCB wishes to develop the role of community pharmacists in providing medicines management services for patients. It is recognised that some patients e.g. very elderly, mentally ill or infirm patients, or those with learning disabilities, may require additional support when ordering their repeat medications and the role of the community pharmacist in providing this support is well recognised. The Board therefore acknowledges that in certain circumstances, it may be beneficial for the Community Pharmacist to order medication on behalf of some patients. Where this is deemed necessary, pharmacists must adhere to the Pharmaceutical Society of NI Professional Standards. Fundamentally, this type of arrangement requires co-operation with local prescribers, whereby pharmacists will provide professional support to assist in the rational, safe, effective and economic use of medicines.

The pharmacist must therefore:
- Ensure consent is obtained from the patient before requesting a repeat prescription from a surgery
- Establish, at the time of each request by a patient for the repeat prescription, which items are required
- Ensure that unnecessary supplies are not made
- Professionally assess for concordance or other problems encountered by the patient which may require early reference to the prescriber

The Board is aware that a number of GP and community pharmacy systems now provide on-line repeat prescription facilities and practitioners are advised that the above principles apply equally to any on-line service being offered. GPs and community pharmacists should be aware of the risks associated with online ordering systems and take action as appropriate.

5 Dispensing Repeat Prescriptions

Community Pharmacists are expected to comply with all relevant legislation when dispensing prescriptions, as outlined in the HSCB letters from January and July 2011 (see appendix). They are also required to have standard

operating procedures in place for the dispensing services they provide, and to adhere to professional standards outlined by the Pharmaceutical Society of Northern Ireland. These standards include:

- Clinical assessment of every prescription is undertaken, by a pharmacist, to determine the suitability of the medication, the appropriateness of the quantity and its dose frequency for the patient. If there is a concern that the prescription may not be wholly appropriate for the patient, the pharmacist must speak directly to the prescriber about this and should only dispense the medication if they are satisfied that it is appropriate to do so
- Appropriate records of clinical interventions are maintained
- Procedures are in place to minimise the risk of dispensing errors.

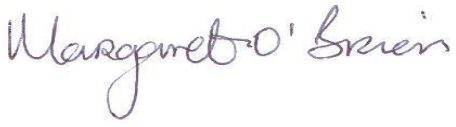
Prescribers should pay due regard to pharmacists' interventions. The local office of the Board should be contacted if there appear to be difficulties in clinically justified interventions being acted upon, as patient safety must be the paramount concern.

6 Action Required by GPs and Community Pharmacies

1. This guidance should be communicated to all relevant practice and pharmacy staff, including locums.
2. GP Practices should review and update:
    a. Acute prescribing protocols
    b. Repeat prescribing protocols
    c. Patient review processes
3. Community Pharmacies should review and update:
    a. Standard Operating Procedures
    b. Repeat Prescription Schemes

If you require further information or would like to discuss this further, please contact a member of the Medicines Management Team in your local office.

Yours Sincerely



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Appendix - Further Information/Support Materials

- HSCB Managing Risk with Repeat Prescribing Audit Tool
  - http://primarycare.hscni.net/PharmMM_Resources_Non%20Clinical%20Resources.htm

- HSCB Medicines Safety Alert: Clinical Risk Assessment When Issuing Repeat and Acute Prescriptions No.1 March 2010
  - http://www.hscboard.hscni.net/medicinesmanagement/Medicines%20Safety%20Alerts/index.html#P-1_0

- HSCB letters to GPs and Community Pharmacists:
  1. Dispensing Medicines without a Prescription, 1st July 2011
  2. Supplying Medication without a Prescription, 7th January 2011
  - http://primarycare.hscni.net/PharmMM_Correspondence.htm
  - http://www.hscboard.hscni.net/medicinesmanagement/Correspondence/index.html#P-1_0

- PSNI Professional Standards and Guidance for the Sale and Supply of Medicines (June 2009)
  - http://www.psni.org.uk/professionals/code-of-ethics.php

- GMC Guidance: Good Practice in Prescribing Medicines (September 2008)
  - http://www.gmc-uk.org/guidance/ethical_guidance/prescriptions_faqs.asp

- Quality and Outcome Framework guidance for GMS contract 2011/12
  - http://primarycare.hscni.net/QOF.htm