Health and Social Care Board

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11th January 2013

To: All GPs and Community Pharmacists Nursing and Residential Homes

Dear Colleague

Medication Requests for Patients in Care Homes

1 Introduction

The ordering of prescriptions and supply of medicines are important processes and are areas which require clear and robust systems. There are particular risks associated with these processes for patients resident in care homes, and the purpose of this letter is to highlight the need to have procedures in place for managing medication requests for patients in the care home setting.

2 Adverse Incidents

A range of incidents have occurred that are linked to the prescription ordering and supply processes for patients resident in care homes, including:

- Prescription supplied to a pharmacy for a patient with the same name as a care home patient but a different address
- Red listed medicine prescribed and dispensed when the full supply of medicine had already been provided to the patient by the hospital
- Over-ordering of medicines which were not required
- Delay in the supply of clinically urgent items
- Medicines allegedly ordered by a third party for patients who had not previously been prescribed these. The medicines were subject to abuse and were allegedly then stolen by the third party.

3 Summary of Roles in Prescription management process

In summary, the following roles and responsibilities should be adhered to:

3.1 Care Home

Care homes must retain responsibility for ordering prescriptions for their patients. This is in line with RQIA recommendations. Prescription requests should be managed appropriately and efficiently to ensure:

- Sufficient notice is given to the GP practice for the prescription to be generated and authorised;
- Management of prescription requests is co-ordinated to avoid unnecessary duplication.

3.2 GP Practice

To facilitate governance requirements for Care Home and Pharmacy staff, as well as the timely supply of medicines to patients, GP practices should have in place repeat prescription systems for care home patients that allow sufficient time for the care home to review the prescriptions issued and for the community pharmacy to dispense them.

It is recommended that practices should ensure that repeat prescriptions are made available for care home patients within the same timescale as for community patients e.g. if repeat prescriptions for community patients are available from the practice in 24 (or 48 hours), then care home prescriptions should be available within the same time period.

3.3 Community Pharmacy

The Board acknowledges the valuable role that community pharmacy can play in advising care homes on medication related issues and ensuring the continuity of ongoing medication supply for patients. Whilst it is also acknowledged that in **exceptional** circumstances, it may be beneficial for the community pharmacist to order medication on behalf of some patients, this responsibility should not be passed to the community pharmacy for care home patients.

When carrying out these roles and responsibilities, the following points should be noted for repeat medicines (section 4) and acute medicines (section 5):

4 REPEAT MEDICINES

Care home staff should note the following points when ordering repeat prescriptions:

i. Check current stock levels and identify medication required for each patient, taking into account any recent medication changes and appropriate quantities. As a rule, sufficient medication should be ordered and supplied to cover a 28 day supply. Occasionally, however, it may be necessary to request quantities of greater or less than 28 days' supply to allow medication to be synchronised into the home's 28 day cycle, e.g. if there has been a dose or drug change mid-prescription cycle. This may mean that the next prescription is ordered from the practice sooner or later than would be expected, based on the patient records.

   To reduce potential wastage, care should be taken when ordering "when required" or "prn" medications and attention paid to the appropriate quantity required for the forthcoming prescription time period, taking into account existing stocks.

   Medication requests should be submitted by the home in writing directly to the surgery and the prescriptions generated should be sent directly to the care home from the surgery.

ii. Liaise with the surgery to ensure procedures for prescription requests allow sufficient time to ensure continuity of medication supply.

iii. The home should check all repeat prescription forms before they are submitted to the community pharmacy for dispensing. This enables the home to check what has been prescribed against their records and allows correction of any queries or omissions. The care home should also advise the community pharmacy if there is any prescribed medication that is no longer required, to minimise waste.

iv. Confirm that all dispensed medication received from the community pharmacy corresponds with the medication

requested and the patient's medication record. A record should be made confirming the medication received is accurate.

Appendix 1 summarises the key stages in the procedure for managing medication requests for patients in care homes.

GP practices are reminded of the need to ensure that they have processes in place to assess on-going patient need for repeat medication. In line with Medicines 11&12 in QoF, a medication review should be recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines.

Community pharmacies should ensure that they have processes in place to manage repeat prescriptions for care home patients. If a repeat dispensing (RD) service is being provided for care home patients, the pharmacist is required to carry out an assessment prior to dispensing each batch issue of the RD prescription, to ensure the on-going appropriateness of the patient's medication. This assessment should include:

- Does the patient require all the prescribed item(s)?

- Is the patient taking or using the medication as directed?

The pharmacist should communicate any clinical/ compliance concerns or supply queries to the prescriber.

5 ACUTE MEDICINES

Care Home Staff must advise the GP practice and the pharmacy of the degree of urgency for obtaining acute prescriptions and medicines, e.g. same day, next day, not urgent.

Where the **community pharmacy** collects ACUTE prescriptions from the GP surgery, it is considered good practice that a photocopy of the prescription form(s) should be provided to the care home with the medicines. This should also be the case if a prescription is faxed through to a community pharmacy for dispensing.

GP practices should have processes in place to ensure that there is a clinical need for any acute medications requested by the home on behalf of the patient.

6 Action by GP Practices, Community Pharmacies and Care Homes

1. Ensure a policy is in place for managing both acute and repeat medication requests for care home patients. Current procedures should be updated to reflect the guidance in this letter.

2. A process should be in place to ensure that any medication changes, including those made mid-cycle, are communicated to all relevant parties.

3. GP practices and community pharmacies should ensure the guidance highlighted in the HSCB Medicines Safety Alert on Risks if monitored dosage systems are used for patients (see Appendix 2) is implemented.

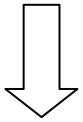
If you have any concerns or questions regarding these issues, please contact your Medicines Management Adviser. Care home staff may also contact RQIA to discuss further.

Yours Sincerely

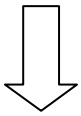
Mr Joe Brogan
Assistant Director, Directorate of Integrated Care
Head of Pharmacy and Medicines Management

Appendix 1: Summary of the key stages for managing REPEAT medication requests for patients in care homes

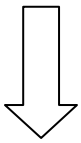
Care Home
Current stock levels checked
Medication required identified
Request submitted to surgery



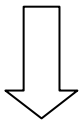
Surgery
Repeat Prescriptions generated and returned to the home



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 PMRs
Receipt of accurate medication recorded

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

Appendix 2

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BT47 6FN

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To: All GPs

July 2010

Dear Colleague

RE: Risks when dispensing medicines into monitored dosage systems (MDS)

I am writing to alert you to the risks of errors that can arise when prescribing medicines to be supplied to patients in compliance aids or monitored dosage systems (MDS).

There have been a number of recent errors involving prescriptions dispensed into compliance aids which have resulted in serious adverse reactions for patients.

Community pharmacists have already received a Medicines Safety Alert (March 2010) highlighting dispensing issues in relation to MDS. This letter to GPs focuses on prescribing issues, some of which will require communication with local community pharmacies.

The main learning points which have resulted from recent incidents are:

- Both the GP practice and the pharmacy should hold a record of patients who are receiving medications in a compliance aid and this information should be clearly visible on the patient record when prescriptions are being prepared by the practice.

- The practice must take steps to ensure communication with the community pharmacist if there are any changes to the patient's medication regimen, including any changes following discharge from hospital. This communication should take place as soon as possible after the change has been made to ensure that further compliance aids issued to the patient contain the correct medication.

- Any communication about changes in medication must be directly between the prescriber and the pharmacist, not via third parties. A written record of changes made by verbal communication between the prescriber and the pharmacist should be made in the patient's notes in the surgery.

- When medication is required to be taken at a specific time of day, this should be stated on the prescription eg metformin - taken at meal times; simvastatin – taken in the evening; bisphosphonates taken after rising, half an hour before breakfast. This will assist in the correct labelling and preparation of compliance aids.

- A review of the procedures in place in your practice around the management of patients receiving compliance aids should be carried out to ensure that your arrangements are as robust and safe as possible.

Please be vigilant when prescribing medicines that are supplied to patients in a compliance aid and ensure that protocols and procedures are in place to make the supply of medicines as safe as possible.

Yours sincerely

J Brogan

Mr Joe Brogan
Asst Director Integrated Care
Pharmacy and Medicines Management

Pharmacy Safety Alert No. 4

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To: All Community Pharmacists

March 2010

Dear Colleague

RE: Risks when dispensing medicines into monitored dosage systems (MDS)

I am writing to alert you to the risks of dispensing errors with medicines supplied in compliance aids or monitored dosage systems (MDS).

There have been a number of recent dispensing errors involving prescriptions dispensed into MDS which have resulted in serious adverse reactions for patients. The main learning points which have resulted from these incidents are:

- That the dispensing into a MDS is undertaken directly from the current prescription. Labels produced from the PMR must be cross referenced with the current prescription.

- If there appears to be a change in the medication i.e. a medicine formerly on repeat is not on the new prescription, the medication must not be dispensed until the reason for the absence or change is clarified with the prescriber.

- Communication on changes in medication must be directly between the prescriber and the pharmacist not via third parties. A written record of changes made by verbal communication between the prescriber and the pharmacist should made and kept in the pharmacy and surgery.

- The GP practice and the pharmacy should hold a record of patients who are receiving medications dispensed into MDS and local arrangements between the pharmacy and the practice must encourage communication between both when the medication regimen is changed.

- Good practice dictates that the pharmacy must have a written SOP in place for supplying medicines to patients via a MDS.

- A regular audit should be carried out to ensure that the established process for assembling, dispensing and supply of medication in a MDS is as robust and safe

as possible. To aid this audit procedure see www.rpsgb.org/pdfs/mds.pdf

Please be vigilant when dispensing medicines via MDS and ensure that protocols and procedures are in place to make the supply of medicines in this way as safe as possible.

Yours sincerely

Mr Joe Brogan
Asst Director Integrated Care
Pharmacy and Medicines Management