LONGTON HEALTH CENTRE
MEDICINES
POLICY

APPROVAL HISTORY	
Date agreed and issued	5.2.2024
Review Date	5.2.2025
Target Audience	**All staff**

Introduction

This Policy provides General Practice staff with guidance on the general principles required to ensure good prescribing practice and medicines management.

It includes information related to the prescribing of medicines, including high-risk drugs and controlled drugs, via acute (short-term) prescribing, repeat prescribing (authorising future prescriptions without having to have a review with a prescriber) and repeat (batch) dispensing.

Repeat Prescribing Process

	Repeat Prescribing	**Key Personnel**	**Process**
1	**Production**	Practice Reception Staff	Requests for prescriptions will be accepted via the electronic prescription service (EPS) or by the practice in writing (preferably using the right-hand side of the repeat prescription) or via AccuRx triage form. Telephone requests will only be accepted for housebound patients in an emergency or for those patients with specific access or communication needs. The following information must be obtained before a request is processed: • Patient's full name; • Patient's address or date of birth; • Name/strength/ form and dosage of medication(s). Any queries arising from the request should be clarified at this stage. **Production of Repeat Prescriptions** • The Practice clinical computer system must be used for generating all repeat prescriptions. • A medication list must be generated with every prescription. • Practice staff must not recommend or direct to a particular pharmacy. **Processing a Request for a Repeat Prescription** • Check that the items requested are on the patients' current repeat list. If the patient requests any items not on the list, refer to the prescriber.

			• Check that the name, form, strength and dosage instructions are identical to the request. If there are any discrepancies, refer to the prescriber. • Verify that the medication review date has not been exceeded (annual review or more frequently, if required). If there is no review date set, forward to prescriber to set a review date. • Check the last date issued. Where the prescription requests are more than 20% earlier or later than expected, (this may indicate over or under use of that item), refer to the prescriber. • Cancel repeat prescriptions that have not been ordered for one year or more, (exceptions to this rule would be seasonal medications e.g. hay fever). • Patients receiving their medications in monitored dosage systems from the pharmacy, known as 'blister packs', should receive a prescription for 28 days' supply and not (4x7) days' supply, unless clinically appropriate and there is a need for weekly delivery/collections from the community pharmacy—this will be at the clinician's discretion. • Practices should not request that the pharmacy dispense a 'blister pack' or create an expectation with patients or their carers that a 'blister pack' will be issued. This is for the supplying pharmacy to assess and make appropriate adjustments, based on their assessment. If support is deemed appropriate, there are a range of possible options available. **Processing a Repeat Prescription** • Once the prescription has been ordered via EPS or printed, arrange for signing by the prescriber. • The signed prescription should be stored in a secure, supervised place, out of reach of the public. • The name, address and date of birth should be checked with the person collecting the repeat prescription to confirm the identity of the patient. • Any prescriptions being collected by an outside agency (e.g. community pharmacy), will have been agreed and a signed consent or EPS nomination will be in the patient's notes. This should be checked and verified if the receptionist is not aware of such an arrangement. • Prescriptions should not be collected by anybody under 16 years of age. • Any prescription that has not been collected after 1 month should be highlighted to the prescriber. If it is determined that the prescription should be destroyed, the issue should be deleted from the issue record.

			• If a review date is required or overdue, the patient should be advised of this, and an appointment made.
2	**Management Control**	Practice Pharmacy Clinical Lead	**Authorisation** • Within the practice, it should be clearly stated who can add authorised medications to a patient's repeat medication list (only an appropriately qualified prescriber can authorise repeats, e.g. GP, non-medical prescriber). • When a medication is first added to a repeat prescription, the indication and rationale should be documented in the patient's medical record and the medicine linked to a problem. • The number of repeats, or the period of time allowed before the next review should be defined. • In the event that a request is placed for a drug that is not authorised as a repeat item, a prescription **MUST NOT** be generated: ➢ An explanatory note should be attached to the patient' record or EPS request; and ➢ The prescriber informed. If the prescriber decides to authorise the prescription, ensure any message from the prescriber to the patient is communicated to the patient. **Compliance check** **If a patient is over/under-ordering medication**, **a**n explanatory note should be added to the patient record and attached to prescription request to inform the prescriber. If the prescriber decides to authorise the prescription, any message from the prescriber to the patient should be communicated to the patient via EPS "Note to Patient" or handwritten by the prescriber on the right-hand side of the prescription. **Flagging of problems** If there is a query, a prescription **MUST NOT** be generated: ➢ An explanatory note should be attached to the patient record or EPS request; and ➢ The prescriber informed. If the prescriber decides to authorise the prescription, ensure any message from the prescriber to the patient is communicated to the patient as above.

			Handwritten prescriptions should be used rarely. Mobile technology allows electronic prescribing, even during home visits. When necessary handwritten prescriptions must be entered onto the computer system at the earliest opportunity. This will: • Reduce inadvertent duplication of prescribing. • Reduce the possibility of unintentional drug interactions; and • Provide an audit trail. **Patient information** • This policy will be included on the GP practice website. **Quality Assurance** An audit of the repeat prescribing system should be conducted annually and cover. **Prescription Security** • Blue FP10MDA prescriptions are rare. These are for installation prescribing of controlled drugs for addiction. Patients requiring maintenance on a controlled drug should be supervised by a specialist service. A separate register is required for any FP10MDA (blue prescriptions). • All prescriptions must be stored in a safe and secure manner at all times. • Blank prescriptions not in use must be kept in a locked cupboard. • There should be no more than ten FP10's in doctor's drawers or bags at any one time. • Stock levels must be kept at an acceptable level in line with safe storage facilities. • Forms should not be left unattended at any time in practice or in a vehicle. • All rooms containing printers with prescription pads in them must be locked when unoccupied. If this is not possible, prescriptions should not be left in printers. • A limited number of forms should be taken for home visits/use outside the practice. • Under no circumstances should multiple signed prescriptions be handed to any person who is not a member of the practice staff to find a prescription. • The practice must maintain clear and unambiguous records of all prescription stationery stock received. • An audit template including the date of delivery, serial numbers and the signature of the staff member receiving these should be maintained.

			• The prescription form stock must be checked on delivery and then securely stored as soon as possible. As a minimum this should be in a locked cabinet within a lockable room or area. Access to forms should be restricted to authorised individuals. • The prescription security audit template should then be used to record the distribution of pre-printed prescription form stock within the practice (i.e. into printers) including the serial numbers, where, when (date/time) and to whom the prescriptions have been distributed. • This audit template should also be used to maintain the security of forms used in printers when the printer is left unattended, such as overnight or when the surgery/consulting room is not in use. • Regular stock checks on prescription forms should be undertaken on a monthly basis by a named staff member and this will be recorded in the prescription security audit template. • If a member of staff suspects that prescription forms/paper has gone missing then they need to notify the Practice Director / Practice Pharmacy Clinical Lead at the earliest opportunity, who will then notify NHSE of the missing prescriptions following a thorough check to confirm they are missing. **Uncollected prescriptions** • The prescriptions in the reception area must be stored safely at the end of each day. • The patient identifiable box must be reviewed each day by reception staff to highlight any uncollected prescriptions. • Where there is an uncollected prescription, the reception staff will telephone the patient in the first instance and establish the reason for non-collection, they will be given 48 hours to collect. • Any uncollected prescriptions will be flagged to a clinician—GP, practice-based pharmacist or other non-medical prescriber—and the patient will be followed up with a medication review, with appropriate documentation, and the prescription will be destroyed. • Ensure the practice has an appropriate process in place within the practice to alert prescribers to missed collections of prescriptions for high-risk drugs, for example, lithium.

3	**Clinical Control**	General Practitioner /Pharmacist	**General** • A "medication review" is the periodic review of the patient at which the continuing need for the acceptability and safety of medication on the repeat prescription are considered. • A recall system should be in place to ensure that patients who do not order their medication are also reviewed. **Initiation of medication** • The prescriber must be satisfied that drug treatment is appropriate and necessary. • Consideration should be given to non-drug treatments and lifestyle interventions. • The patient must be reviewed at least once before granting a prescription repeat status. • Medication should be prescribed to only cover the period until assessment of suitability. • Patient sensitivities and significant interactions should be considered. • Prescribing should be generic, unless there is good reason not to do so. This reason should be documented. • The dose and frequency must be specified: ➢ The instruction "as directed" should not be used. ➢ The instruction "when required" should not be used alone. • The patient should be given an explanation of what is being prescribed and why. • The patient should understand if the drug is an addition or a replacement for a current medication. • The patient should understand if a new medicine is for a limited time, or for ongoing treatment. Special care is needed around acute prescribing of chronic medication; since these do not appear on the right-hand side of the prescription ordering slip or online, a patient could easily assume they are not to continue taking the new medication. • Common adverse effects should be discussed; consider if the patient might be concerned by the manufacturer's patient information leaflet. • An explanation as to how the drug(s) is administered (and demonstrated, if appropriate) should be provided. **Authorisation** • The prescriber must have an allocated time set aside each day for signing/reviewing repeat prescriptions. • The prescriber should be satisfied:

			➢ The drug is effective (look for objective evidence). ➢ Long-term treatment is needed. ➢ The patient is concordant. • No important adverse effects are experienced. • It is the practice's aim that only prescriptions for patients with stable, chronic conditions should enter the repeat system. • The prescriber should check the following: ➢ Drug name, strength, form and dose. ➢ Indication for each drug. ➢ Monitoring plan, ➢ Date of next review. • Repeat prescriptions should be reviewed and signed by the prescriber who knows the patient in conjunction with accessing the patient's medical notes. All drugs requested within the system should be regularly reviewed. **Hospital Discharge Medication/Outpatient Attendance/Home Visits** Patients who have been discharged from hospital or seen in outpatients often have their medication changed. • The discharge medication/hospital letter must be reviewed by the prescriber in conjunction with details of the patient's current medication. • The medicines are reconciled so that the patient's medical record is updated containing the most accurate list of medicines to be prescribed, stating that a medication review has been conducted. • Delete medication that has been discontinued. • Synchronise repeat medication quantities. • If a patient requests a supply of medication before the hospital communication has been received, an email copy must be requested from the hospital.

Duration of prescription	Prescribe 56 days' supply where appropriate – state why.
Controlled drugs (CDs)	Ensure schedule 2, 3 & 4 controlled drugs are prescribed for a maximum quantity of 30 days—if longer is clinically indicated and does not pose unacceptable risk to the patient, the reason must be documented each time. Benzodiazepines and Z drugs should only be prescribed on an acute rather than repeat prescription. The prescription is legally valid for 28 days. **Schedule 2 and 3 controlled drugs (including tramadol), with the exception of temazepam, must fulfil the following criteria:** • Be written in indelible ink. • State the patient's full name, address and, where appropriate, age. • State the name and form of the drug, even if only one form exists. • State the strength of the preparation. • State the dose to be taken. • State the total quantity of the preparation, or the number of dose units to be supplied in both words and figures (for liquids, total volume in ml). • Be signed by the prescriber with their usual signature (handwritten or via the electronic prescription service) and dated by them. The date can be either the date of signing OR the date the prescriber wishes the prescription to start. • Include the practice address on the prescription. **Temazepam and Schedule 4 and 5 controlled drugs** • These are exempt from the specific prescription writing requirements of the Misuse of Drugs Regulations 2001. • However, they must still comply with the general prescription requirements under the Medicines Act.
Synchronising quantities	Where possible ensure all medication will run out together by synchronizing quantities. This reduces waste and helps to identify compliance issues.
Directions	Do not put "as directed". Ensure correct full instructions (no abbreviations) are included for all medication and devices to ensure the patient uses them correctly.
Problem linking	Ensure all medication is linked to a problem on the patient's electronic medical record.

Medicines reconciliation	When a patient transfers between healthcare settings, whether it be as an inpatient or an outpatient, all medicines must be reconciled, and changes updated on the patient medication record in a timely manner.
Repeat dispensing	The aim of this service provided by community pharmacies is to allow patients to request and collect their medication at the community pharmacy. The prescriber can issue a master repeat prescription, followed by a series of batch prescriptions (up to 12), with only the master prescription requiring a signature. The batch prescriptions are then stored at the community pharmacy. Consider for all stable patients, particularly those with: • 7-day prescriptions • Hypertension that is well-controlled with medication • Patients stable on levothyroxine. NB: Do not prescribe schedule 2 & 3 CDs using repeat dispensing.
Electronic prescription service (EPS)	EPS means that prescriptions will be transferred electronically to the community pharmacy and/or an appliance contractor nominated by the patient. The prescriptions will also be sent automatically to the Prescription Pricing Authority.
Non-medical prescribers (NMPs)	These are independent or supplementary prescribers (e.g., nurse or pharmacist). **GPs should not sign prescriptions generated by a non-medical prescriber.** Only the NMP can sign these.
Medicines and devices alerts	All healthcare professionals are obliged to show they follow advice from NHS England, alerts from the National Patient Safety (NPSA), and information provided by the Central Alerting System (CAS): https://www.cas.mhra.gov.uk/Home.aspx
Unlicensed medicines/'specials'	Prescribers are reminded to avoid prescribing unlicensed medication unless a specific clinical need exists. Please discuss with the practice-based pharmacist to see if suitable a licensed alternative exists.
High-risk medicines	Prescribed in line with an effective shared care agreement (ESCA). Ensure appropriate monitoring is up to date before prescribing. Methotrexate to be prescribed in multiples of 2.5mg tablets and at weekly dosing.

Adapted from the Dudley GP Practice Prescribing Policy, https://www.dudleyformulary.nhs.uk/download/404/sample-gp-practice-prescribing-policy Accessed 28/03/2023.

Supporting resources:

- General Medical Council (GMC). Good practice in prescribing and managing medicines and devices. April 2021. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices
- NHS England. Medicines optimisation resources. https://www.england.nhs.uk/medicines-2/medicines-optimisation/ Accessed 17/05/2023.
- National Institute for Health and Care Excellence (NICE). NICE Guideline [NG5]. Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. March 2015. https://www.nice.org.uk/guidance/ng5