# Guidelines for Repeat Prescribing by General Practitioners

<table>
<thead>
<tr>
<th>Version:</th>
<th>Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratified by:</td>
<td>PCT Professional Executive Committee</td>
</tr>
<tr>
<td>Date ratified:</td>
<td>7th April 2009</td>
</tr>
<tr>
<td>Lead Executive/Director:</td>
<td>Richard Harling</td>
</tr>
<tr>
<td>Name of originator/author:</td>
<td>Mary Shaw</td>
</tr>
<tr>
<td>Name of responsible committee:</td>
<td>Professional Executive Committee</td>
</tr>
<tr>
<td>Date issued:</td>
<td>April 2009</td>
</tr>
<tr>
<td>Review date:</td>
<td>April 2012 or sooner if necessary</td>
</tr>
<tr>
<td>Target audience:</td>
<td>Prescribers in general practice</td>
</tr>
</tbody>
</table>
### Key individuals involved in developing the document

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary Shaw</td>
<td>Pharmaceutical Adviser</td>
</tr>
<tr>
<td>Anne Kingham</td>
<td>Senior Pharmaceutical Adviser</td>
</tr>
</tbody>
</table>

### Circulated to the following individuals for comments

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Paul Stewart</td>
<td>GP &amp; Member of Worcestershire Area Prescribing Committee</td>
</tr>
<tr>
<td>Sue Lunec</td>
<td>Senior Pharmaceutical Adviser</td>
</tr>
<tr>
<td>Jane Freeguard</td>
<td>Head of Medicines Management &amp; Pharmacy</td>
</tr>
</tbody>
</table>
Guidelines for Repeat Prescribing by General Practitioners

1.0 INTRODUCTION

Repeat prescriptions are convenient for both patients and prescribers but in order to minimise risks the process needs to be tightly controlled. Some important risks include the inability to promptly detect changes in a patient’s medical condition and side-effects, continued treatment beyond the period necessary, continued use of ineffective treatments, polypharmacy and potential drug wastage.

2.0 AIMS OF GUIDANCE

These guidelines have been written to encourage all practices operating a repeat prescribing system to undertake a regular review and that careful monitoring of the systems is carried out by practice staff. The National Audit Office, the Medical Advisers’ Support Centre, the NSF for older people and research by the Academic Unit of General Practice, Leeds University, have all made very similar recommendations about controlling repeat prescribing and these can be used as a basis for a review.

3.0 DEFINITIONS

Repeat prescribing involves the setting up of prescriptions, ordering and producing the prescriptions and the review of medication - medication review is only briefly covered in this guideline.

4.0 SCOPE OF THE GUIDELINES

Anyone involved in the prescribing system in general practice including GPs, practice nurses, district nurses, receptionists and practice managers and other non medical prescribers such as pharmacists. Prescribers should also refer to:

- The Policy for Managing Inappropriate or Excessive Prescribing
- The Guidance on Prescribing in Situations not covered by the NHS.

5.0 PRACTICE PROCEDURES

Practices should have clear, written procedures for the repeat prescribing process, describing the roles of each person involved in the production of prescriptions. They should be written by the practice and reviewed every 2 years. A system should be in place to record that all staff have read the procedures and that it is included in the induction programme for new staff. Patients should have access to written instructions on how to order repeat prescriptions. Accessibility issues must be considered. An equality impact assessment must be undertaken on all procedures.
6.0 SETTING UP THE PRESCRIPTIONS

It is strongly recommended that the person who sets up the prescription i.e. keys in the details, should be a doctor, nurse, PCT pharmacy technician or practice pharmacist. This ensures that the correct item is chosen from the database and that there is clinical input to the process. Deviation from this recommendation is at the practice's risk and should be by strict written procedure only.

6.1 It is recommended that most prescriptions are computer generated to avoid misinterpretation of handwritten items and directions and to ensure the medication record is complete. Items that are prescribed on a home visit should be transferred to the practice computer or notes as soon as possible.

6.2 Repeat prescriptions should be set up on a computer, preferably one where the PCT/practice formulary is highlighted.

6.3 It is strongly advised that only clinical team members add items to the repeat prescribing system.

6.4 Drugs should be prescribed by generic name with the following exceptions:
- Slow release theophylline
- Slow release calcium channel blockers e.g. nifedipine MR as Coracten XL
- Slow release morphine sulphate (use MST twice daily)
- Carbamazepine
- Lithium (use Priadel)
- Oral contraceptives
- Hormone replacement therapy
- Mixed preparations e.g. alginates and antacids, some emollients – please follow formulary recommendations.
- Wound management products - please follow County guidance
- Combination products where there is no internationally recognised non-proprietary name including Insulin preparations
- Combined Parkinson's disease medication
- Enteric coated mesalazine e.g. Asacol

Prescribing the above treatments by generic name can introduce significant risk of misinterpretation of the prescription. Additionally, community pharmacists may spend a considerable amount of time trying to identify the intended treatment.

6.5 Practices should agree and adhere to written guidelines on the length of repeats (28 days, 56 days etc) and which drugs should not be on repeat. The PCT and SHA currently strongly recommend 28-day prescriptions for most patients with a maximum of 56 days in exceptional cases in order to ensure equity across the PCT and to avoid waste. The use of repeat dispensing where appropriate will reduce work and inconvenience of both patients and prescribers by making full use of community pharmacists to manage prescriptions.

6.6 For patients who have been assessed (by PCT approved assessment) as needing help with their medicines and who find 28 days of medicines difficult to cope with, it
would be appropriate to prescribe 7 days at a time. This could be done using repeat dispensing.

6.7 Newly prescribed treatments and those with frequent alterations would be better set up as an acute prescription. It is prudent to prescribe smaller quantities in these situations.

6.8 Prescriptions for HRT and contraception and other preparations in set packs e.g. Didronel PMO, are suitable for 3 months duration. Prescriptions for care homes are recommended to be a maximum of 28 days in duration and there are other situations where less than 28 days is appropriate e.g. for terminally ill patients.

6.8 Quantities should be in multiples of 28 and quantities for all items for individual patients should be synchronised. Medications should have instructions and 'as directed' is not acceptable (except for dressings, test strips etc see appendix one for suggestions).

6.9 There should be clear arrangements for setting up repeats for new patients, following home visits, after outpatient visits and discharge from hospital. Care must be taken to check the discharge form / hospital letter for dose changes, drugs stopped and started.

6.10 There should be a system for urgent requests.

6.11 The repeat prescribing policy should be available at all times to clinical staff and receptionists.

6.12 For all repeat medication, the indication for the drug should be recorded either electronically on the computer or clearly written in the patient records. (Quality and Outcomes Framework Records Indicator 9)

6.13 Clear guidelines must be set for removing old items from the repeat. If an item is prescribed as a replacement for an existing repeat, the old item must be removed from the repeat.

7.0 ORDERING AND PRODUCING REPEAT PRESCRIPTIONS

Dedicated individuals who become familiar with the system, patients, care homes and pharmacists, rather than many different members of staff should do prescription generation. Staff should be trained on the elements of good practice and how to spot poor compliance. Each practice should have a written procedure for repeat prescription ordering.

7.1 There should be a clear method of ordering repeat prescriptions and patients should be able to obtain written details of the system. Accessibility issues should be considered.

7.2 Patients should know how long prescriptions take be generated and what happens at weekends and holidays. Prescriptions should be available within 24 - 48 hours.
7.3 Practices should not accept requests for prescriptions from community pharmacists unless the pharmacy is acting for a patient as part of the Repeat Medication Service (a service operated in co-operation with local prescribers). This requires the patient or carer’s request for the service to be recorded in writing and allows the pharmacist to order prescriptions on their behalf after assessing with the patient which items are required.

7.4 Requests to practices should preferably be made in writing using the repeat request slip. Email and faxed requests are acceptable if the practice is in agreement and in accordance with practice procedures. Telephone requests may be acceptable if repeat prescriptions are on a computer, otherwise the potential for error exists. For patients who are unable to access any part of this process, arrangements should be made for them or their carers to obtain repeat prescriptions without compromising safety issues.

7.5 The procedure should state the number of repeats allowed before review OR a review date, the latter being the best option. Ideally this should be aligned to any monitoring arrangements.

7.6 The procedure should state what happens when the number of repeats has expired or the review date has passed without the patient being formally reviewed.

7.7 The prescriptions should preferably be signed by the doctor who is responsible for the patient rather than the duty doctor. Any alterations made by hand should be added to the computer record by the clinician (Written amendments are not acceptable if using the repeatable prescription system).

7.8 When producing the repeat, attention should be made to any messages on the repeat screen, and should be acted on accordingly.

7.9 The doctors should be alerted and the patients’ records should be available to the doctor if;

7.9.1 the review date has passed
7.9.2 the number of repeats has expired
7.9.3 the requested item is not on the computer
7.9.4 the request differs from that on the computer
7.9.5 the request is significantly earlier or later than expected following a compliance check.
7.9.6 the item has been previously prescribed as an acute

7.10 A clinical record of current medication should be available on computer or in the patient’s notes. A record should be kept of each issue and patients should have a record.

7.11 The completed prescriptions should be stored where patients cannot reach them.

7.12 There should be checks to ensure that the person collecting the prescriptions is authorised to do so. Community pharmacists may collect on behalf of patients if they have been authorised by patients to do so. Although there is no legal requirement, it is good practice for controlled drug prescriptions to be signed for.
This will facilitate any investigation of controlled drugs prescriptions should a problem or dispute arise.

7.13 The prescription box should be regularly cleared of uncollected prescriptions and occasional audits performed to determine the reason for non-collection. The issue should be cancelled on the patient’s notes.

8.0 ELECTRONIC TRANSFER OF PRESCRIPTIONS (ETP)

ETP will enable electronic prescriptions to be generated, transmitted, received and once dispensed, sent to the reimbursement agency. It will allow patients to nominate specific dispensers should they wish to. Eventually, most paper prescriptions will be replaced by electronic ones. Procedures and training programmes will be necessary to ensure all staff are familiar with the system and software. All staff will require a Smartcard to operate the system.

9.0 REPEAT DISPENSING SCHEMES

The participation in this scheme will depend on whether the computer system is able to produce batch prescriptions. Procedures and staff training must be in place. All community pharmacists are able to offer this service.

10.0 REVIEW OF REPEAT PRESCRIBING PROCEDURES

10.1 The prescribing system should indicate which clinician has initiated the prescription.

10.2 The prescribing system should indicate which clinician is responsible for the regular medication review (usually the clinician who set up the repeat prescription).

10.3 Regular medication review should be set by the number of repeats allowed or preferably a review date. The review date should be set at a maximum of 15 months (QOF medicines indicators 11 and 12). A full medication review should be documented on the computer using a recognised read code (8B3h / 8B314 - 8B3S / 8B3V) and in the notes. It is recommended that the review date is set on an individual basis based on clinical condition. See section 11 on medication review.

10.4 Practices should have an agreed mechanism dealing with repeat requests for patients who have not attended for review. See Appendix Two of the revised document

10.5 For batch prescriptions as part of the Repeat Dispensing Service, the community pharmacist should be stated on the clinical system.

11.0 MEDICATION REVIEW

Medication review should cover all drugs available as repeats and account should be taken of the various clinicians involved e.g. a medication review by an asthma nurse may not cover all drugs prescribed. Points to cover include:
• the continued effectiveness and need for the drug
• the appropriateness of the dose and presentation
• patient’s understanding of the treatment
• monitoring, tests, examinations and follow-up
• a check for side-effects, drug interactions and contra-indications
• discontinuing items not needed
• appropriate frequency of requests
• all prescriptions being for the same length of time
• use of over-the-counter medications

For QOF medicines 11 it is expected that at least a level 2 medication review will occur as detailed in the document A Guide to Medication Review 2008. Further information on medication review can be found on the National Prescribing Centre website, following the links to the Medicines Partnership. (www.npc.co.uk)

12.0 AUDIT

Every year an audit of 10 - 20 prescriptions should be undertaken to ensure the procedure is followed. QOF indicators will also show if the practice has a robust repeat prescribing system.

13.0 REFERENCES

1. Medicines and Older People (supplement to the NSF for Older People). 2001. DH, London
APPENDIX ONE

Suggested acceptable prescriptions for 'as directed'

Dressings
Appliances including stoma, hosiery, trusses, catheters etc
Blood and urine testing strips
Lancets, syringes etc
Gluten free products

Difficult Items for Instructions

Examples;
Aqueous Cream - apply regularly to dry skin
Steroid creams - apply sparingly once or twice a day
Warfarin - take as directed in yellow book
Epoetin - state exact dose as quoted on the consultants' letters
Viagra - do not take more than one dose in 24 hours
Drops for ear, eyes and nose - instil 2-3 drops 3-4 times a day to the
……………………state right/left/both eye, ear or nose. Always add the dose given in the
ophthalmologists' letter for eye drops.
APPENDIX TWO – Patients Failing to Attend for Review of Repeat Medication

The General Medical Council (GMC) in its publication ‘Good Medical Practice’\(^1\) 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 for e.g. children.

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 (harder for inhalers)*
   - Text message
   - Using practice extended hours to offer appointments
   - Email alerts

*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 patient living abroad for the winter months.

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

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

References: