Croydon Clinical Commissioning Group

Prescribing Processes for GP Practices

Croydon CCG Medicines Optimisation Team
Updated October 2017

Picture on front cover shows unused medicines returned by just one patient in Croydon

NOTE: All areas updated. New areas are highlighted in yellow

Prescribing Processes for GP Practices

Introduction

'Prescribing' is used to describe many related activities:

- The supply of prescription only medicines (POMs),
- Prescribing medicines, devices and dressings on the NHS
- Advising patients on the purchase of over -the -counter (OTC) medicines and other remedies.
- Providing written information for patients (information prescriptions) or advice given.[1]

This document will cover the points to consider when developing a practice policy for prescribing issues. It should be noted that for the purposes of this document, 'prescribers' will refer to both GPs and Non-Medical Prescribers (NMP) e.g. Practice Nurses, Pharmacists.

The benefits of an efficient Prescribing System include:

- Review of patients' medical condition and earlier detection of change.
- Increased patient/carer involvement and shared decision making.
- Detection of adverse drug reactions (especially if OTC medicines are taken concurrently).
- Early detection of side-effects.
- Decreased medicines wastage/costs.
- Reduced threat of litigation and complaints.

Practices are advised to regularly review their prescribing processes to assure themselves of the quality of their service and minimise the risks from inefficient and unsafe systems.[2]

1. WHY should a medicine be prescribed?

Prescribers should work in partnership with patients to assess, diagnose and prescribe treatment.

- Medicines should be prescribed for an identified patient need. Not for the convenience of carers or social care professionals or in response to patient demand.

- Prescribers must ensure that their prescribing is appropriate, responsible and in the patient's best interest.

- If a patient asks for a treatment that the prescriber considers would not be of overall benefit to the patient, the prescriber should discuss the issues with the patient and explore the reason for their request. If, after discussion, the prescriber still considers the treatment would not be of overall benefit, they do not have to provide the treatment, but should explain their reasons to the patient and explain any other options that are available including the option to seek a second opinion. [1]

2. WHO should add a medicine on to the clinical system?

- Prescribers are responsible for[1]
  - the prescriptions they sign
  - the decisions when they supply or administer medicines
  - the authorisation or instruction to others to do so

- Prescribing clinicians are responsible for adding medications to the clinical system. Guidance provided in the British National Formulary (BNF)[3] on prescription writing should be followed.

- Only named authorised or trained clinicians, including locum prescribers, agreed by the practice, should be able to authorise addition of medicines to the GP clinical system.

- Authorised administration staff should be trained in the use of the GP clinical system, be aware of the practice's prescribing protocol and know their individual responsibilities and limitations.

- Prescribers should avoid treating themselves or those with whom they have a close personal relationship[1].

Tip

Ensure all:

- Prescribers, including locums, are authorised and trained on how to add medications to the GP clinical system.
- All authorised administration staff are trained on the use of the GP clinical system. They should be aware of the contents of the Practice Prescribing Protocol and understand the responsibilities and restrictions that apply to their individual roles.

2.1 Controlled Drugs (CDs)

NOTE: In this document CDs refer to Schedule 2, 3 and 4 CDs, unless specifically specified.

- Prescriptions for CDs should preferably be signed by the doctor who knows the patient best. This especially applies to prescriptions for treatment of Substance Misuse.
- Prescribers should not prescribe CDs for themselves or someone with whom they have a close personal relationship unless:
  - No other person with the legal right to prescribe is available to assess and prescribe without a delay which would put your or your patient's life or health at risk or cause unacceptable pain or distress **AND**
  - The treatment is immediately necessary to save a life, avoid serious deterioration in health or alleviate otherwise uncontrollable pain or distress. [1]
- Information must be sent to the patient's GP about what has been prescribed (unless in the case of prescribing for someone close to the prescriber they object) and a record made including the prescriber's relationship to the patient.

See Appendix 1: Controlled Drugs

2.2 Adding or deleting a prescriber from the practice

When prescribers join or leave GP practices there is a risk that prescribing information and costs will not be correctly attributed unless the correct notifications occur. Wrongly attributed prescribing costs cannot be retrospectively corrected on ePACT data.

Locally, the arrangement in Croydon CCG is as follows:

- GP related changes **MUST** be notified to Primary Care Support England (PCSE) by the GP themselves via form NPL3 (PCSE website). PCSE will then inform the NHS Business Services Authority (NHSBSA).
- For non-medical prescribers changes MUST be notified to Croydon CCG Medicines Optimisation Team who will then notify NHSBSA directly.

NOTE: The NHSBSA central database only records prescribers involved with the practice on a permanent basis; locum or bank prescribers are not included.

About unique identifiers for prescribers

All prescribers are identified in the central database at the NHS BSA by a unique code:

GPs	The unique code is their Doctor Index Number (DIN). Note: This code cannot be used in multiple practices, so if a GP is working in more than one practice at any one time, they must use a separate identifier code for each practice. The additional code is known as a spurious code. If a spurious code is not used, and the doctor's DIN is registered to more than one practice, errors occur which can result in incorrect charging.
NMPs	The unique code is their registration number for their professional body (most commonly the Nursing & Midwifery Council (NMC) number for registered nurses). NMPs who work in more than one location at the same time should ensure that the correct practice code is also printed on the prescription in each role, alongside the prescriber's registration number, thereby ensuring that the cost of the prescribing is charged to the correct practice.

See Appendix 2: Prescribers joining or leaving the practice (for actions required for prescriber changes, to ensure that the central database is kept up to date and prescribing costs are charged correctly)

3. WHICH medicines should be prescribed?

Prescribers should:

- Utilise electronic and other systems to improve safety of prescribing practice[1].
- Seek advice from experienced colleagues, including pharmacists and prescribing advisers, if unsure about interactions or aspects of prescribing and medicines management[1].
- Recognise and work within the limits of their competence. Maintain and further develop knowledge and skills in pharmacology and therapeutics as well as prescribing and medicines management relevant to their role and prescribing practice[1].
- Refer to 'A to Z section in 'Prescribing and Pharmaceutical' on Croydon CCG Intranet for local prescribing support information, prescribing guidelines and shared care protocols.
- Refer to BNF[3] and/or summary of product characteristics (SPC) as first line resources for information not found on the Croydon CCG Intranet.

3.1 New medicines

All prescribers should be aware of their responsibilities to develop their own and the expertise of others in the managed introduction of new medicines.

Note: new medicines may be classified as either medicines 'new' to the market or 'new' to the patient or prescriber.

3.1.1 When a new medicine is recommended or indicated

- For commonly prescribed medicines: check dose, interactions with co-existing medications (including OTC medicines).
- If the medicine is replacing another, remove existing medicine to past drugs on the patient's medication record (PMR) and record the reason for stopping.
- If appropriate, add new medicine to the patient's medication record as either an 'acute', 'repeat' [See 4.1: acute and repeat prescribing] or as hospital prescribed [See Appendix 3: Addition of medicines obtained from outside sources]
- Ensure indication for the new medicine is documented and that this is linked to the medicine.
- For unfamiliar medicines or those not routinely prescribed in Primary Care, check if Croydon Prescribing Committee (CPC) has made a recommendation for prescribing the medicine on the Drug Recommendations Database (DRD) on Croydon CCG Intranet.
- For medicines not listed on the DRD, seek further advice from the Croydon CCG Medicines Optimisation Team [see 5.1 Prescribing on recommendation of colleagues]
- Prescribers should be aware of national guidance e.g. National Institute for Health and Care Excellence (NICE), National Patient Safety Agency (NPSA) and local guidance (CPC recommendations) that impact on prescribing and know where to locate this information. Local decisions, together with South West London (SWL) recommendations, can be found on the Croydon CCG Intranet and ScriptSwitch™ [See Appendix 4: ScriptSwitch™].

3.1.2 Community Pharmacist New Medicine Service (NMS)

Non-adherence is often a hidden problem, undisclosed by patients and unrecognised by prescribers. People make decisions about the medicines they are prescribed and whether they are going to take them very soon after being prescribed the new medicine.[4]

The NMS is a structured interview with an accredited pharmacist, designed to provide early support to patients who are newly prescribed an antiplatelet or anticoagulant therapy OR a medicine for asthma, chronic obstructive pulmonary disease (COPD), type 2 diabetes or hypertension. For each condition/therapy area, a list of medicines has been agreed. The aim of the NMS is to improve the patient's adherence to and maximise the benefits of the medication they have been prescribed.

The service consists of three consultations:

- An initial consultation
- A second consultation 14 days later and
- A final consultation (14 days after second consultation)
- The pharmacist can offer support if non adherence is identified.

Tip

Consider referring patients to the NMS if newly prescribed

- antiplatelet/anticoagulant therapy OR
- medicine for asthma/COPD, type 2 diabetes or hypertension

3.2 Controlled Drugs

When prescribing CDs, prescribers are recommended to note the following:

- The benefits and risks of prescribing, including dependency, overdose and diversion.
- All prescribed and non-prescribed medicines the patient is taking (particularly any centrally acting agents) and whether the person may be opioid naïve.
- Refer to evidence-based sources such as NICE and the BNF for prescribing, when appropriate.
- CDs should be initiated by prescribing in short courses, as 'acute' medicines.
- For palliative care, ensure that that prescribing is in line with local guidance.
- Refer to Opioids Aware: A web-based resource for patient and healthcare professionals to support prescribing of opioid medicines for pain, to support safe and rational use of opioid medicines.
- Consult the Medicines Optimisation Team for advice on CD prescribing issues, and inform them when prescribing unusual or high doses of CDs e.g. diamorphine 100mg or 500mg injections
- Schedule 2 and 3 CDs should be prescribed in line with practice standard operating procedure (SOP). Template available on NHS Croydon Intranet.
- Special care should be taken to select the correct dose and preparation of CDs.
- Palliative care colleagues may request unfamiliar CDs or doses e.g. Alfentanil Injection 1mg in 2ml. **If in doubt, always confirm what is required with the originator of the request BEFORE prescribing.**

Prescribing recommendations in NICE NG46 The safe use and management of controlled drugs **includes**:

1. When prescribing controlled drugs

- Document clearly the indication and regimen for the controlled drug in the person's care record
- Check the person's current clinical needs and, if appropriate, adjust the dose until a good balance is achieved between benefits and harms
- Discuss with the person the arrangements for reviewing and monitoring treatment
- Be prepared to discuss the prescribing decision with other health professionals if further information is requested about the prescription.

2. When prescribing 'when required' controlled drugs

- Document clear instructions for when and how to take or use the drug in the person's care record
- Include dosage instructions on the prescription (with the maximum daily amount or frequency of doses) so that this can be included on the label when dispensed
- Ask about, and take into account, any existing supplies the person has of 'when required' controlled drugs.
- When prescribing, reviewing or changing controlled drug prescriptions, prescribers should take into account the: appropriate route, dose (including when dose conversions or dose equivalence is needed) and formulation (including changes to formulations).
- If guidance on prescribing is not followed, document the reasons why in the person's care record.

3. Document and give information to the person taking the controlled drug or the carer administering it, including information on

- How long the person is expected to use the drug
- How long it will take to work
- What it has been prescribed for
- How to use controlled drugs when sustained-release and immediate-release formulations are prescribed together
- How it may affect the person's ability to drive (see the advice from the Department of Transport on drug driving and medicine: advice for healthcare professionals)
- That it is to be used only by the person it is prescribed for.

4. Inform people who are starting controlled drugs that they or their representative may need to show identification when they collect the controlled drugs.

5. When prescribing controlled drugs in primary care for use in the community, advise people how to safely dispose of:

- Unwanted controlled drugs at a community pharmacy
- Used controlled drugs.

Tip:

Prescribers are recommended to:

- Ensure a SOP in place for prescribing Schedule 2 and 3 CDs. (Croydon Intranet)
- Prescribe in line with National Patient Safety Agency (NPSA) safety recommendations and guidance issued as a result of learning from incidents.
- Refer to the 'Fentanyl patches: safety and prescribing information' memo (Croydon Intranet)
- Identify and report CD concerns and incidents to the CD Accountable Officer (AO).
  See page 47 for details.

NOTE: In accordance with regulations introduced following the 'Shipman' reports, monitoring of CD prescribing at a practice level, using data from the NHSBSA is regularly conducted to identify prescribing of unusual quantities or strengths of CDs.

For further information see Appendix 1: Controlled Drugs

3.3 Specials/ unlicensed medicines

'Specials' are unlicensed medicines which are made to order to meet the needs of individual patients. Community pharmacists may order the medicine from a variety of special order manufacturers. The medicines made may vary in formulation, appearance, consistency, bioavailability, shelf-life and cost.

- The **prescriber** assumes **full and direct personal responsibility** for any adverse effect or harm to the patient resulting from the use of the medicine, In contrast to licensed medicines used within the product licence, the manufacturer takes no responsibility for patient harm arising from the use of 'specials'.
- There is **no standardisation** or consistency between medicines.
- **Costs can vary widely**, even between the same medicines from different manufacturers (from pence to thousands of pounds).
- Prescribing unlicensed 'specials' poses a **higher clinical risk** compared with prescribing a licensed medicine.
- Patients or carers need to know when they have been prescribed a 'special' and should be given appropriate information about what this means for their treatment.

Tip

- Patients prescribed 'specials' should be regularly reviewed to ensure suitability for ongoing prescribing.
- Ensure the practice has a clear process for highlighting these patients for review.
- Prescribe 'specials' as 'acute' medications, if appropriate.
- Some specials may be identified on clinical systems by a "U" and/or cost as 0.00 pence.
- Ensure handwritten prescriptions for specials are scanned into the patient's record AND an alert is added to the patient's note specifying the name of the 'special' prescribed as handwritten prescription.

For further information, see Appendix 5: Specials / Unlicensed Medicines

3.4 Antimicrobial prescribing

- In **severe infections**, it is always important to initiate antimicrobial therapy as soon as possible.
- Antimicrobial resistance poses a significant threat to public health, especially as antibiotics underpin routine medical practice. To help prevent the development of resistance it is important to only prescribe antibiotics when they are necessary, and not for self-limiting mild infections such as colds and most coughs, sinusitis, earache and sore throats.
- Broad spectrum antibiotics (such as co-amoxiclav, quinolones and cephalosporins) should be reserved to treat resistant disease. Broad spectrum antibiotics should generally be used only when narrow-spectrum antibiotics are ineffective. This is because they increase the risk of resistant infections such as resistant urinary tract infections and methicillin-resistant Staphylococcus aureus (MRSA,) as well as increase the risk of Clostridium difficile infections.
- Local Antimicrobial guidelines available on Croydon intranet.
- Professional judgement, as well as involving patients in decisions about their care, is essential in the management of infections.
- Use Shared Decision Making Tools, e.g. treating your infection information sheet, to promote the collaborative decision making between patient and clinician for best treatment strategy.

- There are various resources available to help healthcare professionals to promote appropriate use of antimicrobial agents (available on Croydon CCG intranet). Resources include:
    - Various leaflets and posters, e.g. 'When should I worry?' Self-care fact sheets for patients around coughs, colds, earaches and sore throats.
    - Looped PowerPoint presentation and videos- ideal for display in waiting rooms.

Tip

- Use the Croydon CCG Antimicrobial guidelines
- When antibiotics are necessary, use simple generic antibiotics if possible.
- Lower threshold for antibiotics in immunocompromised or those with multiple morbidities (e.g. diabetes); consider cultures and seek advice.
- Limit prescribing over the telephone to exceptional cases.
- Avoid cephalosporins in patient over the age of 65years.
- Document use of shared decision making tools. Useful READ codes:
    - **8OA9**: Provision of written information about antibiotic therapy
    - **8CE**: Self-help advice leaflet given
    - **8OAN**: Provision of Treating Your Infection self-care patient leaflet with back-up antibiotic prescription issued.
    - **8OAM**: Provision of Treating Your Infection self-care patient leaflet.
    - **8BPO**: Deferred Antibiotic Therapy
    - **8Cak**: Patient Advised to delay filling of Prescription

3.5 ScriptSwitch™

ScriptSwitch™ is a prescribing decision support software system which supports the prescriber by providing information at the point of prescribing or re-authorisation of medicines. Messages include:

- Local decisions (CPC & SWL) on Hospital only/shared-care medicines.
- National decisions and guidance (e.g. NICE).
- Important patient safety information messages e.g. Medicines and Healthcare Regulating Authority (MHRA) drug safety updates.
- Better value alternative medicine recommendations.
- Dosage optimisation information.

Tip:

- Ensure ScriptSwitch™ is enabled for **all prescribers,** including locums and new prescribers to the team.
- All users should be fully trained on how to action ScriptSwitch™ messages, both at the point of prescribing and during a medication review.
- Use of ScriptSwitch™ should be integrated into the medication review process.

For further information, see Appendix 4: ScriptSwitch™

3.6 Conflicts of interest

Department of Health (DoH) Guidance encourages NHS organisations and their staff to consider opportunities for joint working with the pharmaceutical industry (WWI), where the benefits that this could bring to patient care and the difference it can make to their health and well-being are clearly advantageous.[5]

As joint working can often lead to prescribing of particular medicines, prescribers and their staff are reminded of the following, when considering working with the pharmaceutical industry:

- **All collaborative projects with the pharmaceutical industry are considered as joint working**.
- Joint working must be for the benefit of patients or the NHS and preserve patient care.
- All joint working schemes will require approval by the Croydon Primary Care Prescribing Group.
- NHS data (patient or other information associated with the work) is confidential and may also be copyright, therefore may not be shared with pharmaceutical companies.
- Croydon CCG Medicines Optimisation Team should be notified of any pharmaceutical industry sponsorship: hospitality and meetings.

Tip

- Complete and send the Joint Working Framework (WWI Policy) for approval by the Primary Care Prescribing Committee **prior** to undertaking any projects with the industry.
- Record any sponsorship by the pharmaceutical industry for hospitality and education meetings on the notification form.

For further information, contact the CCG Medicines Optimisation Team

4. HOW should a medicine be added on to the clinical system?

General principles

- Medicines should be linked to a documented indication and should have clear dosing instructions. Avoid using 'as required' or 'as directed' instructions.
- The expected length of course, together with any follow up required, should also be clearly documented.
- Medicines should be listed by generic name unless there is a specific reason for a brand name e.g. bioavailability issues - examples include long acting formulations of diltiazem, modified release nifedipine, medicines for epilepsy, tacrolimus capsules. In such cases, to minimise errors, particular care should be taken to ensure that only a clinician changes branded medication to a generic.
- Only authorised and named doctors, nurses or pharmacists working in the practice are able to authorise addition of medicines to the repeat system.
- Ensure medicines are not duplicated (brand/generic, topical/oral NSAID).
- Ensure, where possible, that all medicines run out at the same time i.e. synchronise quantities.
- To reduce the risk of errors and complications, patient's repeat medication records should be regularly reviewed, at least annually.

4.1. Acute and repeat prescribing

4.1.1 Acute prescribing

Medicines requiring patient review prior to prescribing should be prescribed as 'acute' medicines. This may include medicines prescribed when initiating therapy, prescribing short courses or where the patient needs to be reviewed before prescribing again. Medicines only required occasionally e.g. analgesics, or those requiring frequent review e.g. dressings, sip-feeds, should remain as 'acute' medicines.

Medicines should be prescribed as acute drugs until the prescriber has established that the medicine is effective, well tolerated and still required.

Controlled Drugs

All CDs (including benzodiazepines) should ideally be prescribed as 'acute' issues. Careful consideration should be given to deciding if CDs should be available as 'repeats', as this may increase the risk of inadequate monitoring, follow-up and review of the patient. Robust repeat prescribing systems should be in place to ensure appropriate review of prescribing and identify possible abuse or misuse.
The use of management systems allowing patients to receive CD prescriptions without a consultation is not subject to legislation, but it is a clinical decision that should be made on a case by case basis. Best practice would be to require face to face consultations before issue of Schedule 2 and 3 CD prescriptions, wherever practical.

4.1.2 Repeat prescribing

Repeat prescribing can be defined as a 'partnership between patient and prescriber that allows the prescriber to authorise a medicine so that it can be repeatedly issued at agreed intervals, without the patient needing to consult the prescriber at each issue'[2]. Medicines should be added to a repeat prescription, by a qualified prescriber, only when they have been shown to be beneficial for the patient.

4.2 Electronic Prescription Service (EPS)

EPS enables prescribers to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice[6]

- Advantages to GP practices using EPS include:
- End to end audit trail from prescribing to dispensing to the patient
- Tracking of prescription by use of EPS Tracker[7]. This allows General Practice staff and Dispensers to check the status and history of electronic prescriptions.
- Electronic prescriptions take less time to sign
- Decreased administration time and reduction in prescription queries as prescriptions go directly to the pharmacy
- Improved flexibility e.g. prescriptions can be sent directly to the pharmacy following a home visit or telephone consultation

To use EPS, patients **choose** where their prescriber will electronically send their prescriptions. This is called "nomination".

Nomination

- Nomination is not mandatory.
- Patient consent (written or verbal) must be obtained prior to the practice setting up the nomination for prescriptions to be electronically transferred to one specific community or internet pharmacy and/or one dispensing appliance contractor (DAC).
- Patients have a choice of where their prescription is sent. GPs and/or their staff should not persuade or influence a patient to nominate a certain pharmacy.
- Nominations should only be changed or removed at the patient's/representative's request.
- Details, including the person who set/changed/removed the nomination will be recorded via the user's Smartcard.

Patient Prescription Requests:

The general principles remain unchanged from those noted in Section 7.1: Patient Prescription Requests.

Processing patient prescription requests

The practice should ensure that, in addition to the points noted in Section 7: Processing patient prescription requests:

- The practice staff processing prescription requests has the correct roles assigned to their Smartcards to allow them to prepare and send repeat prescriptions electronically to the relevant GP for electronic sign off.

- **Controlled drugs**: Whilst legislation has enabled Schedule 2 and 3 CDs to be sent electronically via EPS and signed with an Advanced Electronic Signature (AES), NHS digital guidance is that practices are advised **NOT** to send Schedule 2 and 3 CD prescriptions electronically via EPS until they have confirmed all community pharmacy system software providers have made the necessary technical amendments to their systems to enable electronic transfer of Schedule 2 and 3 CDs.

Tip

- Ensure that the practice has a defined process for updating patient nominations (addition or removal) for EPS.
    - Consider displaying a poster advising the patient that their prescription will be sent to their nominated dispenser, unless they specify otherwise.
    - Ensure that the right prescription goes to the right place (particularly important when a patient has more than one nomination e.g. pharmacy and DAC).
    - Ensure that practice staff, including prescribers, understand how to produce a paper FP10 prescription for a patient, as a 'one-off' without removing the nomination.
- Currently prescriptions for Schedule 1, 2 and 3 CDs and items NOT included on the dm+d database cannot be sent electronically via EPS.

4.2 Electronic Repeat Dispensing

- Electronic repeat dispensing is a process that allows a patient to obtain repeated supplies of their medication or appliances without the need for the prescriber to hand sign authorised repeat prescriptions each time. This allows the prescriber to authorise and issue a batch of repeat prescriptions until the patient needs to be reviewed. The prescriptions are then available for dispensing at the specified interval by the patient's nominated dispenser.[8] Patients suitable for electronic repeat dispensing are those who:
    - Are on stable therapy.
    - Have long term conditions that are likely to be stable for a period of time.
    - Have **not** had a recent hospital admission.
    - Are not prescribed schedule 2 or 3 controlled drugs.

- Before initiating repeat dispensing, the patient should have a medication review including any blood tests required for monitoring of treatment. The authorisation period of repeat dispensing should be until the next clinical review of the patient but not more than 12 months.
- It is recommended that "prn - when required" medication is prescribed on a separate electronic repeat dispensing prescription from regular electronic repeat dispensing medication as the dispensing intervals may be different to regular medication.
- Patients who require weekly prescriptions should **not** automatically be transferred to repeat dispensing without considering whether they are sufficiently stable.
- Repeat dispensing requires the patient to consent to the introduction of two-way sharing of their information between the dispensing and prescribing site. The patient should be asked to consent, but written consent is not required.
- **Controlled Drugs**: Schedule 2 and 3 CDs cannot be prescribed on repeat dispensing prescriptions. Careful consideration should be given to deciding if Schedule 4 CDs should be prescribed on repeat dispensing prescriptions, as this may increase the risk of inadequate monitoring, follow-up and review of the patient.
- **Community Pharmacist:** Before dispensing the electronic repeat dispensing prescription the community pharmacist must establish that the patient is taking or using their medication appropriately and that there are no reasons why the medication in question should not be supplied.

They should ask the following questions:

- Have you seen any Health Professional (GP, Nurse or Hospital Doctor) since your last repeat was supplied?
- Have you recently started taking any new medicines either on prescription or that you have bought OTC?
- Have you been having any problems with your medication or experiencing any side effects?
- Are there any items on your repeat prescription that you don't need this month?

It is not possible to amend an electronic repeat dispensing prescription. The item or prescription must be cancelled and a new prescription created.

Further information on electronic repeat dispensing, including how to set up electronic repeat dispensing and how to cancel prescriptions can be found via link:
https://www.england.nhs.uk/digitaltechnology/wp-content/uploads/sites/31/2015/06/electronic-repeat-dispensing-guidance.pdf

4.4 Length of supply

- The practice policy should define the usual length of supply, recommended as either 28 or 56 days. It should be noted that there are restrictions on the prescribing of some medicines e.g. CDs [See below and 7.1: Patient Prescription Requests] and some items, like dressings, may require reduced quantities. Prescriptions for contraceptive pills and hormone replacement therapy (HRT) may be prescribed in larger quantities e.g. 6 months. However, larger quantities may generate more wasted medicines.
- Initial supply should be for a small quantity to prevent wastage if the medicine does not suit the patient.
- Where closer monitoring is required because of the nature of the medicine involved, medicine quantities should be limited to a maximum of 28 days' supply. Examples include: benzodiazepines, controlled drugs, antidepressants, antipsychotics, and analgesics.
- Consider prescribing one week or maximum two weeks' supply of medicines for end-stage palliative care, patients at risk of overdose or escalating use of CDs or analgesics.
- Where medicines are required for a defined period, add stop dates to directions.
- Patients may require a 'bridging' prescription until their care has been transferred to the appropriate secondary care setting. **Note:** this is generally done as a last resort to ensure patient safety and continuity of supply. In such cases, the rationale for prescribing the medication should be documented in the patient's notes and the medication prescribed as an 'Acute' drug. [See 5.3 Hospital Only Medicines]
- Weekly (7-day) prescriptions may be appropriate for individual patients living in their own homes requiring weekly monitored dosage systems (MDS) in order to help compliance. **Note**: medicines such as liquids, inhalers and chewable tablets are considered unsuitable for MDS. Medicines, such as weekly alendronic acid, which require specific timings for the dose, should be clearly separated and labelled, if included in a MDS system to ensure it can be safely taken.
- Where a patient has some repeat medicines issued as 7-day prescriptions, care should be taken to ensure that other items e.g. inhalers are **NOT** also issued every 7-days.

- The number of repeats or the period of time before the next review should be documented and the patient informed. Consider using the 'medication review due' date on the prescribing screen.
- Patients going abroad may be given up to a 3-month supply of medication if clinically stable [9] - this is considered to be sufficient length of supply until they can find a new doctor.

- **Controlled drugs**: Additionally, when prescribing CDs, the following should be noted:

    - Prescribers are advised to limit the quantity of Schedule 2, 3 and 4 CDs prescribed on a prescription to a quantity for **up to 30 days'** supply to meet the patient's clinical need. [10]
    - In exceptional circumstances, where the prescriber considers more than 30 days is clinically indicated and would not pose an unacceptable risk to patient safety, a record of the reasons for deviating from the guidance should be made in the patients records and the prescriber should be able to justify the decision, if challenged.

For further information, see Appendix 1: Controlled drugs

4.5 Hand written Prescriptions

- GP clinical systems should be used wherever feasible to issue prescriptions, including CDs.
- If a prescriber issues a handwritten prescription:
    - Following a home visit: it is good practice to update patient's electronic record as soon as possible after the event. Record the supply as 'by hand'. This will ensure the summary care records (SCR) is kept up to date. [Appendix 3: Addition of medicines obtained from Outside sources]
    - For a 'special' not listed on the GP clinical system, ensure the clinical system is updated to reflect that patient is prescribed a special e.g. add screen messages/alert. Consider having a notebook to log details of these patients and their medication. Also any changes, including monitoring requirements, should be clearly documented in the patient's clinical record.
- If handheld portals are used during home visits, the data should be uploaded into the patient's clinical record on return to the surgery.
- If the practice server is connected to remotely from another location (i.e. not the practice computer), the prescriber should ensure the information is updated securely into the patient's clinical record and log off completely before leaving.

Tip

- Scan a copy of the hand-written prescriptions on to the patient's clinical records.
- Add an alert and/or screen message.
- Consider keeping a notebook to record and easily trace all hand-written prescriptions.

5. WHEN should a GP or NMP prescribe?

In line with Department of Health Guidance EL(91)127, the secondary care clinician is expected to retain prescribing responsibility for medicines where the GP does not feel confident in taking on clinical responsibility for the prescribing of a medicine. **The Legal responsibility for clinical care lies with the prescriber who signs the prescription.**

The SWL Interface Policy also includes a responsibility of the provider to ensure the following:

- Adherence to locally agreed formularies, in this case, CPC.
- Prescribing of unlicensed medicines or medicines used outside their licensed indication including 'specials', should usually remain the responsibility of the clinician initiating treatment. The provider will accept full responsibility for the continued sourcing, quality and supply, which should be under the control of the initiating provider's Pharmacy Department.
- Prescribing of "Hospital only" medicines remains the responsibility of the clinician initiating treatment. For example: Medicines requiring on-going specialist intervention and specialist monitoring, where the majority of on-going care, including monitoring is from the provider and the only benefit of transferring care would be to provider costs, clinical trial medicines or where the GP has insufficient information to participate in shared care

5.1 Prescribing on recommendation of colleagues

If asked to prescribe on the recommendation of a colleague, for example following a consultant referral, the prescriber must be satisfied that the medicine is needed, appropriate for the patient concerned and within the limits of their competence.

Legal and clinical responsibility for prescribing lies with prescriber who signs the prescription.

- Robust, reliable and secure communication mechanisms should exist to ensure information about a patient's medicine is available to appropriate professionals responsible for his/her care.
- If the prescriber does not feel confident to take on clinical responsibility, this should be further discussed with Croydon CCG medicine optimisation pharmacist and/or the specialist team who has requested for primary care to prescribe.

5.2 Prescribing medicines under shared care arrangements

For medicines where shared care guideline (SCG) are in place, it is acceptable for primary care to prescribe provided the prescriber feels confident to take on the clinical responsibility for prescribing and any monitoring as stated in the SCG.

- The specialist/consultant should ensure that the primary care prescriber is willing to prescribe **before** mentioning the possibility of shared care to the patient.
- It would not normally be expected that primary care would decline to prescribe on the basis of cost. Likewise, if the patient is to receive the majority of their on-going care through the specialist/hospital, then prescribing must remain with the specialist/hospital and must not be transferred solely on the basis of cost. Refer to SWL interface prescribing policy on Croydon intranet.

- Prescribers not confident to prescribe may consider discussing their decision with the consultant and/or Croydon CCG Medicine Optimisation Team pharmacist prior to declining to prescribe under the shared care agreement.

Tip

- If a copy of the SCG is not received from the specialist team, the prescriber should request a copy and ensure that all parties are in agreement to take on prescribing/ monitoring as specified in the guideline.
- Prescribe medicine in accordance with SCG, ensuring that GP prescribing responsibilities are carried out as recommended.
- Document in the patient's clinical record that the patient is receiving the medication under shared care agreement.
- Check if a shared care guideline is available locally by searching for the medicine on the DRD via the NHS Croydon Intranet.
- Some specialist teams may have their own SCG for a medicine which has not been agreed locally. Prescribers should request a copy of the SCG and send it to the Croydon CCG Medicines Optimisation Team pharmacist for review and further advice.
- Refer to SWL interface prescribing policy (available on Croydon intranet) for specific details about shared care.
- Note: Some medicines may be suitable for primary care prescribing on receipt of a minimum dataset of information, which is outlined in the guidelines e.g. oral antipsychotics, dementia medicines.

5.3 Hospital Only medicines

For some medicines, the prescriber would **NOT** be expected to take on prescribing in primary care. The SWL Hospital Only list and DRD lists the medicines where the specialist or hospital should retain prescribing.

If a medicine is not listed on the SWL Hospital Only or DRD, then prescribers should:

- Assess what information has been provided and consider whether it is sufficient for them to prescribe in primary care safely.
- Be aware of medicines that require initial dose titration under a specialist, and hence would not be suitable for initiation in primary care e.g. amiodarone. However, prescribing in primary care may be suitable when the patient is stabilised on a dose.
- Consider what monitoring is required, who will be doing this and how often.
- Consider when the patient will next be reviewed by the specialist team and whether there is a defined duration.
- Considering contacting the Croydon CCG Medicines Optimisation Team for further advice especially if the new medicine has not yet been considered/ reviewed by the CPC new drugs sub-group.
- Prescribers should only prescribe if they are confident to take on the clinical responsibility for prescribing.

If a decision is made **NOT** to prescribe a medicine, reasons should be documented in the patient's clinical record and the specialist/ hospital informed in writing (template letter- unable to accept prescribing is available on Croydon intranet).

Tip

- Ensure prescribers are aware of the location of DRD and SWL Hospital Only medicines on Croydon intranet.
- Use the template letter 'unable to accept prescribing' to return request to prescribe a hospital only medicine back to the requestor.
- Ensure all prescribers have ScriptSwitch™ enabled, as ScriptSwitch™ messages will alert the prescriber to hospital only prescribing status (however only if the medicine has been discussed by CPC or SWL).

- Add medication issued by the hospital as "hospital prescribed "onto the patient's electronic record. This will ensure that:
  - ALL of a patient's medication is located in one place on clinical system making it easy to locate.
  - The prescriber will be alerted to potential drug interactions.
  - The medicine is identified when searches/reports are conducted on clinical system.
  - The medication will appear in the SCR as being "prescribed elsewhere" with date of issue.
  - Ensure the records are kept up to date especially if hospital issue another supply (update the date of issue), dose or dosage changes or medication stopped or changed.

See Appendix 3: Addition of Medicines obtained from outside sources AND Section 6.3 Taking information from discharge or outpatient letters.

5.4 Prescribing via telephone, video-link or online

Consider the limitations of the medium used for communication and the need for physical examination or other assessments. For patients in a care home or hospice, prescribers should communicate with the patient, or carer if that is not practical, to make the assessment and provide the necessary information and advice. Ensure any instructions are understood and send written confirmation as soon as possible, within 24 hours. Document the conversation in the clinical record.
Note: Care home staff will not implement any dose changes unless they have written confirmation.

5.5 Private referrals

Patients should be given an information letter (link below) at the time of private referral, explaining that, if asked to prescribe by the private consultant, the GP may prescribe an alternative medicine from the same therapeutic group in line with national and local guidance. Referral letters should also include this information.

The practice is **under NO obligation** to continue any medicines initiated privately.

Further guidance and sample letters can be found on the Croydon Intranet. Link: http://nhscroydonintranet.croydonpct.nhs.uk/TeamsAndDepartments/primarycarecommissioning/prescribing/Documents/All%20Other%20Documents/Guidance%20on%20Private%20Prescribing.pdf

5.6 Private Prescriptions

Private prescriptions can be written by NHS prescribers for:

- Medicines which are on the "Blacklist" (Part XVIIIA of the Drug Tariff). Note: Any medicine listed in this section is **not** permitted to be prescribed on an NHS prescription.
- Where patients do NOT fulfil the 'Selected list scheme' (SLS) medicines (Part XVIIIB of the Drug Tariff) criteria. For example, treatments for erectile dysfunction:
    - Patients who do not meet DoH criteria for treatment of erectile dysfunction requesting tadalafil should receive this on a private prescription, but sildenafil prescribed generically may be supplied on an NHS prescription.
    - DoH guidance recommends that one treatment a week will be appropriate for most patients treated for erectile dysfunction[11]
- Anti-malarial medicines used as prophylaxis by individuals travelling abroad, as these are not prescribable on the NHS[12].
- The following vaccinations for travel are not available on the NHS: hepatitis B (including hepatitis B combined with hepatitis A), Japanese encephalitis and tick-borne encephalitis, meningitis vaccines, rabies, tuberculosis, yellow fever. See Travel Vaccine update on Croydon intranet

6. Transfer of Care

6.1 Medicine reconciliation

Medicines reconciliation, as defined by the Institute for Healthcare Improvement, is the process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated. The term 'medicines' also includes over-the-counter or complementary medicines, and any discrepancies should be resolved. The medicines reconciliation process will vary depending on the care setting that the person has just moved into – for example, from primary care into hospital, or from hospital to a care home[13]

- In primary care, carry out medicines reconciliation for all people who have been discharged from hospital or another care setting. This should happen as soon as is practically possible, before a prescription or new supply of medicines is issued and within 1 week of the GP practice receiving the information [13]
- Ensure that medicines reconciliation is carried out by a trained and competent health professional e.g. Doctor, practice pharmacist or nurse with the necessary knowledge, skills and expertise including[13]:
    - Effective communication skills
    - Technical knowledge of processes for managing medicines
    - Therapeutic knowledge of medicine use

- Involve patients and their family members or carers, where appropriate, in the medicines reconciliation process [13]
- The process should include **collecting information** e.g. medical history and other relevant data; **checking** list of medicines against the current prescription; **communicating and clarifying** any changes, omissions and discrepancies to either the patient or the initiating prescriber

6.2 Elective admissions

The practice should ensure that an up to date list of all the patient's current medicines is provided to the hospital for elective admissions. This ensures that medicines prescribed on admission correspond to those that the patient was taking before admission.

Tip

Ensure:

- The patient's medicine, dose, frequency and route of administration is recorded accurately on the patient's medication record (PMR)
- Any medicine the patient receives from an outside source (e.g. from the hospital) is recorded on the PMR of the GP clinical system as 'hospital prescribed' so that it appears on the Summary Care Record (SCR)

See Appendix 3: Addition of Medicines obtained from outside sources

6.3 Taking information from discharge or outpatient letters

The prescriber will ensure that:

- Medicines reconciliation is carried out for all people who have been discharged from hospital or another care setting. This should happen as soon as is practically possible, before a prescription or new supply of medicines is issued and within one week of the GP practice receiving the information.[13]
- Once the discharge summary/letter is received by the GP practice, the information on medication changes is critically reviewed and incorporated into the patient record as soon as possible after receipt. This means that any appropriate changes made to medicines during a patient's stay in hospital are continued as intended by the hospital prescriber. That is medicines started are added onto the clinical record as an acute or repeat medicine and linked to an indication; any medicines stopped are moved to past drugs and the reason is documented; allergies are READ coded rather than free-texted
- Any monitoring requirements stated are clearly documented in the clinical record, together with who is responsible i.e. GP, hospital etc.
- A medication review takes place for appropriate patients; for example those who have had significant changes in medication, those taking high-risk medicines such as methotrexate, warfarin, diuretics, NSAIDs. Consider whether the patient would benefit from a medicine use review (MUR) [See section 8.3 Medicine Use Review] or support through NMS [see 3.1.2 Community Pharmacy New Medicine Service]
- Discrepancies or queries relating to medicines on discharge or outpatient letters from
- Croydon Health Services should be reported to the **Medicines Helpline 0208 401 3059** who will try to resolve the problem. Most hospitals have a medicine helpline for medicine related queries. Check the discharge letter for the phone number.

6.4 Interim Advice Letter

- Patients, who do not require medicines urgently, following an outpatient appointment, may be given an interim advice letter or outpatient medication referral form by the hospital to give to their GP.
- These patients should be informed by secondary care that their medicine is not needed urgently and that they should make a routine appointment with their GP within 10 working days, by which time the GP should have received the full information to enable safe prescribing.
- Prescribers should prescribe in line with local recommendations [See 5.3 Hospital Only Medicines]

7 Processing Prescriptions

7.1 Patient Prescription Requests

- The principles of the repeat prescribing system should be explained to patients when prescription repeat medicines are first issued.
- Patients should be informed that for on-going supplies, they will need to be clinically reviewed by a prescriber at least annually. Failure to attend this review may lead to refusal to prescribe until review.
- Patients should be aware of the practice process for requesting prescriptions for repeat medicines e.g. by use of a notice explaining the practice repeat prescribing process to patients. This may be displayed near the reception area, practice website and/or included in the practice leaflet. All patient information should include key points of the practice repeat prescribing policy , for example:
    - How and when to order prescriptions
    - How and when to collect prescriptions
    - Electronic transmission of prescriptions [See 4.2: Electronic prescription Service]
    - The quantity policy (28/56 days for improved safety and reduced waste)
    - The review policy (how many repeats can be issued / how long before the patient will be seen by the prescriber).
    - Practice policy on what occurs if system is used improperly (review / emergency) and what patients should do if things go wrong

Prescription requests made via:

Written /paper	To reduce transcription errors for paper requests, patients should be encouraged to use the right hand side of the prescription wherever possible to request repeat medicines. Ideally, these should be completed personally by patients.
Telephone	These should not be accepted generally (except in exceptional circumstances for individual patients as agreed by a designated member of staff and noted in the GP clinical system)
Surgery website/ email / patient online	At the practice's discretion, requests may be accepted via the surgery website, an email system or patient online. However, patients should be warned (if applicable) that the transmission of data may not be secure and therefore confidentiality may not be guaranteed. Practice staff should not use unsecured email to respond to queries from patients regarding their prescriptions.
Community Pharmacist	Patients may allow their community pharmacist to request repeat medicines on their behalf. This should be in accordance with pharmacy procedures and each request made by the pharmacy should be on the individual request of the patient to ensure that only medicines **actually** required are ordered. Croydon CCG Medicines Optimisation Team should be informed if practices are aware that community pharmacists are ordering prescriptions **without** contacting the patient to confirm a supply is needed.
Home Care Companies /DAC	Homecare' companies may also request prescriptions on behalf of patients. These may be for appliances such as catheters or nutritional supplements that they deliver directly to the patient. Prescription requests made retrospectively, following delivery to the patient should NOT be accepted. Practices should have processes in place to ensure that any over-ordering is minimised. Croydon CCG Medicines Optimisation

	Team should be informed of any companies repeatedly requesting prescriptions for large quantities or retrospectively ordering items or quantities that may not be required by the patient.

- A turnover time for processing of repeat prescriptions should be specified. This should be long enough for staff to perform the necessary checks, but short enough to be acceptable to patients e.g. two working days from receipt of request.
- Late requests for prescriptions should be highlighted to prescribers in an agreed and timely manner. This may indicate poor adherence to medication, leading to inadequate therapy or adverse effects.
- A system should be set up so that all emergency requests, which will be needed more urgently, are "fast-tracked" to a prescriber.
- Staff should check that a supply of the medicine is due by looking at previous issues. Early requests for antidepressants, benzodiazepines, controlled drugs, and analgesics should be highlighted to prescribers in an agreed manner.
- In order to minimise risk of over-prescribing, prescribers may consider putting flags/alerts on individual patient notes where patients may make early requests for supplies of CDs or other medicines prone to abuse.
- Medication requests should be synchronised, where possible, to minimise the risk of non-adherence or over-use of medicines. Practice staff should highlight any discrepancies in ordering to the prescriber.

Controlled drugs

- Repeat requests for CDs should be subject to a strict Standard Operating Procedure or Protocol within the practice, with clear lines of accountability and responsibility for administrative and clinical staff.
- Prescriptions for Schedule 2 or 3 CDs should NOT be faxed to community pharmacies, nor should requests be made to them e.g. by telephone, to supply Schedule 2 or 3 CDs in emergency (except phenobarbital for treatment of epilepsy). This is because community pharmacists legally require a valid prescription for the supply of Schedule 2 or 3 CDs.
- Scrupulous attention to the detail of robust patient registration processes is required to rule out the possibility of inappropriate issue of CD prescriptions e.g. to deregistered patients. Temporary patient registrations should be completed before patients see prescribers, to ensure that accurate records of prescribing are kept for each patient.

The practice should ensure that:

- A clear protocol is in place for processing prescription requests.
- Only named, authorised and trained staff process requests and generate prescriptions
- Staffs have dedicated time for reviewing patient requests for prescriptions and requests are processed in a quiet location away from distraction.
- Staffs are aware of their limitations when processing patient prescription requests.
- When processing patient prescription requests, staff know how to check for over/under use of medicines and any other checks required e.g. requesting booklets for warfarin, methotrexate or lithium.

Tip

- Ensure practice processes for requesting prescriptions are defined and clarified for patients and practice staff.
- Ensure staffs are aware of their limitations when processing prescription requests.

7.2 Prescription Collection

- Procedures should be in place to verify that any person collecting the prescription on behalf a patient e.g. carer or community pharmacy staff member has the authority to do so.
- Patients enquiring about the possibility of their prescriptions being sent to or collected by a local pharmacy should be given the details of **ALL** the local pharmacies that collect prescriptions on behalf of patients from the practice. This is to ensure that patient choice is maintained and that the practice is not seen to be directing prescriptions to particular pharmacies.
- Where a patient or carer requests that their prescriptions are collected by or sent to a named pharmacy, a written authorisation must be obtained from the patient or carer e.g. by indication on the computer slip. Where the patient or carer wishes this arrangement to carry on for future prescriptions, this must be recorded on the patient record
- The practice and pharmacy must maintain patient confidentiality and ensure that patients are aware of alternative choices e.g. collection services offered by other local pharmacies.
- It is good practice to have a system set up for the recording and destruction of signed prescriptions which have not been collected after a certain time e.g. 3 months.

Tip

- Ensure a secure system is set up for collection of prescriptions so that the right patient / carer / pharmacy, receive the correct prescription.
- As a minimum, the patient name and address must be confirmed by the person collecting the prescription.
- Keep detailed records of prescriptions collected by pharmacies to form an audit trail. This should include information such as the patient name, pharmacy name, medicines prescribed and date/time the prescription was collected.
- Best practice is to obtain signatures for collection of prescriptions for Schedule 2 and 3 CDs, analgesics and benzodiazepines or where a courier service is used by the community pharmacy.
- Use READ code; prescription collected by patient (8BM8) or collected by pharmacy (8BMC)
- Consider READ coding prescriptions not collected after 3 months, with 8B3N- prescription not collected in the patient's clinical record. [See 7.4: Security of prescription forms]

7.3 Lost and duplicate prescriptions

Where original prescriptions are lost, they should only be re-issued after a comprehensive search. The prescriber must be informed of the reason for re-issue **before** he or she signs the replacement prescription.

- Where there are concerns that patients may claim to have 'lost' prescriptions, in order to gain extra supplies e.g. for CDs, the serious nature of 'lost' prescriptions should be reinforced to patients. Patients can be requested to report losses to the police, and advised that re-issues can only be made on presentation of a crime reference number.
- To avoid over-use of medicines and ensure patient need for analgesics etc. is adequately met, the prescriber should be notified immediately if a report is received showing that there has been issue of CDs or prescriptions for CDs by the Out Of Hours services for any of the practice's patients.
- Improper use of the repeat prescribing system (e.g. frequent early requests and/or 'lost' prescriptions) and other problems should be noted in the patient's clinical record to allow audit trail, so that systems can be improved and patients identified.

Tip

- Ensure SOP includes dealing with duplicate requests from patients / lost prescriptions.
- Use READ codes (e.g. 8B3X lost prescription)
- Community pharmacists should be encouraged to return previously lost prescriptions that are not dispensed to the practice for destruction.

7.4 Security of prescription forms

- A record should be kept showing the serial numbers of blank prescription forms and pads received, and how these numbered forms and pads are distributed or used within the practice.
- Blank prescription forms and pads should be stored securely.
- Blank or uncollected prescription forms and pads should be securely destroyed if unwanted e.g. by shredding before putting into confidential waste. It is recommended that a record is made of the serial numbers on the forms prior to destruction.
- Ideally, the destruction of the forms should be witnessed by another member of staff.

For further information, refer to NHS Security management service security of prescription forms guidance[14]

8. Medication Review

Medication review can have several different interpretations and there are also different types which vary in their quality and effectiveness. Medication reviews are carried out in people of all ages. NICE NG5 define medication review as 'a structured, critical examination of a person's medicines with the objective of reaching an agreement with the person about treatment, optimising the impact of medicines, minimising the number of medication-related problems and reducing waste[13]

Practices should consider carrying out structured medication reviews for some groups of people when a clear purpose for the review has been identified. These groups include:

- Adults, children and young people taking multiple medicines
- Adults, children and young children with chronic or long term conditions
- Older people

The practice should determine the most appropriate health professional to carry out a structured medication review, based on their knowledge and skills including all of the following:

- Technical knowledge of processes for managing medicines
- Therapeutic knowledge on medicine use
- Effective communication skills

The medication review may be led by a pharmacist or by an appropriate health professional who is part of the multidisciplinary team [13]

The practice should ensure that:

1	**A clear system is in place to identify patients who require a medication review.** • Use due diary date (medication review due) and/or number of reauthorisations. • For high risk medicines (e.g. methotrexate, warfarin, CDs), place on acute until stabilised or restrict number of reauthorisations or conduct more frequent medication reviews. • Patients on repeat medication will be reviewed every 6 to 12 months. • Patients 75 years and above on four or more medicines should be reviewed every six months[15]
2	**The patient understands the reason for a medication review and what to expect at the review. Ensure procedures are in place for dealing with:** • Vulnerable patients who may be less likely to contact the practice for a medication review • Patients who fail to attend for medication review. This should include a process limiting the number of repeats of each medicine that a patient can obtain by request before it is reviewed. If further requests are made, then the patient should be required to speak to or see a prescriber to obtain further supplies. • Patients being prescribed CDs where medication review is overdue. If appropriate, confirm registration status. Consider reducing quantities prescribed until this is resolved.
3	**A structured approach is used when conducting and documenting a medication review**. During a structured medication review, take into account NICE NG5: • The person's and their family members or carers where appropriate, views and understanding

	about medicines [See 8.1 Shared Decision Making] • The person's and their family members' or carers' where appropriate, concerns questions or problems with the medicines [See 8.1 Shared Decision Making] • All prescribed OTC (including online purchases) and complimentary medicines that the person is taking or using and what these are for • How safe the medicines are, how well they work for the person, how appropriate they are, and whether their use is in line with national / local guidance • Whether the person has had or has any risk factors for developing adverse drug reactions (report in line with yellow card scheme) • Any monitoring that is needed In addition: • Any blood tests required, should be requested prior to the medication review where possible [See 8.2 Monitoring]. • If clinical targets are not being achieved, explore whether the patient is taking the medicine as intended before increasing the dose or adding another medication [See 8.1 Shared Decision Making]. • Remind patients of any DVLA guidelines on fitness to drive whilst taking medication. • Benzodiazepines: During the face to face review address the possibility of dose reduction and discuss referral to the substance misuse team or pain clinic, where appropriate. See support pack on treating patients dependent on benzodiazepines in primary care, available on Croydon intranet. • **Controlled Drugs**: Ensure patients being prescribed CDs are frequently reviewed (at least every 6 months). It is good practice to review patients on **each** occasion **before** prescribing Schedule 2 and 3 CDs. • Ensure written information is given to carers about any changes to medication following the review especially for patients in care homes. • Integrate ScriptSwitch™ into the medication review process. • See Appendix 7: Medication review which includes Suggested READ codes for a Face to Face medication review.

Tools to support medication review

STOPP START TOOL (NHS Cumbria):
http://medicines.necsu.nhs.uk/download/stopp-start-2-cumbria-print-version/

Polypharmacy Guidance for Prescribing July 2014 (All Wales Medicines Strategy Group)
http://www.awmsg.org/docs/awmsg/medman/Polypharmacy%20-%20Guidance%20for%20Prescribing.pdf

Polypharmacy guidance March 2015(NHS Scotland)
http://www.sign.ac.uk/assets/polypharmacy_guidance.pdf

Seven steps to managing polypharmacy (NHS Scotland)
http://www.polypharmacy.scot.nhs.uk/7-steps/

8.1 Shared Decision making[13]

Shared decision making starts with a conversation between the person delivering care and the person receiving care. It allows people the opportunity to be put at the centre of decisions around their medicines by:

- **Exploring** care or treatment options and their risks and benefits
- **Discussing** choices available
- Reaching a decision about care or treatment **together** with their health care professional.

The benefits of shared decision making are:

- Both people receiving and delivering care can understand what's important to the other person, when discussing choices and options.
- People feel supported and empowered to make informed choices and reach a shared decision about care.

- Health care professionals can tailor the care or treatment to the needs of the individual.
- When conducting medication reviews:
- Remember that people have the right to be involved in discussions and make informed decisions about their treatment and care.
- Give relevant information and explain the treatment and care in a way the patient can understand.
- Take into account individual people's needs and preferences
- Support people's choices wherever possible. Each person is an individual, with their own needs, wishes and priorities. Treat everyone you care for with dignity, respect and sensitivity.
- Use patient decision aids in consultations involving medicines where applicable.
- See NICE NG5 for more details

8.2 Monitoring

Prescribers and patients need to be aware of arrangements for monitoring, follow-ups and review, including further consultations, blood tests or other investigations.

- For medicines where a shared care or transfer of care guideline exists, prescribers should follow the monitoring requirements in line with that guideline as agreed **prior** to taking on prescribing.
- For other medicines, prescribers should ensure there is sufficient support, review and information to be able to monitor a medicine and feel confident with the prescribing of the medicine
- Refer to the 'drug monitoring in stabilised patients' document on NHS Croydon Intranet
- Guidance has been issued from the NPSA on specific drugs that need close monitoring: Lithium, Oral Anticoagulants, Methotrexate.
- Consider non-adherence to medication where a patient is not reaching a target e.g. prescribed a statin for secondary prevention, but lipids not at target.

8.2.1 Lithium

In line with the NPSA Patient Safety Alert 'Safer Lithium Therapy' (December 2009), prescribers should ensure patients have a patient information booklet, lithium alert card and record book for tracking blood tests. These are normally issued by the hospital, for patients currently under secondary care and by the GP for patients solely managed in primary care (i.e. not under specialist follow-up).
www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=65426

8.2.2 Oral Anticoagulant

In line with the NPSA Patient Safety Alert 'Making Anticoagulant Therapy Safer' (March 2007) prescribers should ensure patients have a yellow anticoagulant booklet for tracking INR results. These are normally issued by the anticoagulant clinic.

In Croydon, INR STAR is used by CUH anticoagulant clinic and the Boots anticoagulant service. GP practices should ensure they have READ only access to INR Star to view the details of their patients under these services**.**

Warfarin / phenindione /acenocoumarol
The following information should be checked and documented **prior** to each re-issue of prescription to confirm that it is safe for the patient to continue therapy without additional adjustments: indication; target INR; last INR result is within range and within past 12 weeks; appropriate dosing instructions recorded; date of next INR and additional monitoring checks are in place if interacting medications commenced or stopped
http://www.nrls.npsa.nhs.uk/resources/?entryid45=59814

All patients should be informed of the need to produce their yellow book whenever they request a new prescription or collect supplies of anticoagulant medication, unless the information is available on INR STAR.

Direct acting oral anticoagulant (DOAC)
DOACs should be prescribed on receipt of transfer of care documentations, which should clearly state the dose and duration. The quick reference monitoring requirements of DOACs (available Croydon intranet), summarises the monitoring and dosing requirements according to age, weight and renal function (creatinine clearance). It is good practice to set up a system to ensure DOACs are being taken as prescribed and monitoring and dosing is in line with the guidance.

8.2.3 Methotrexate (oral)

In line with the NPSA alerts 03 (2004) & 13 (2006) that referred to reducing the harm caused by oral methotrexate, prescribers should refer to the shared care guideline for oral methotrexate available on Croydon intranet

Tip:

- Ensure prescription clerks are aware on need to request from the patient monitoring booklets for certain medicines **before** processing the prescription request.
- Relevant staff should have READ only access to INR STAR

8.2.4 Medicines that require oral loading doses (and subsequent maintenance doses)

In line with NSPA Guidance on Preventing Fatalities from Medication Loading Doses (NPSA 2010 RRR018; November 2010) care should be taken when prescribing medicines that require high doses initially to ensure a therapeutic response, which is subsequently decreased to a lower maintenance dose. Critical medicines identified include warfarin, amiodarone, digoxin and phenytoin.
http://www.nrls.npsa.nhs.uk/alerts/?entryid45=92305

Tip

Before prescribing these medicines, prescribers should

- Check doses of the critical medicines warfarin, amiodarone, digoxin and phenytoin.
- Identify patients who have received loading doses for the critical medicines listed (including those prior to discharge from hospital) who require dose alteration for subsequent maintenance therapy e.g. amiodarone.
- Challenge doses which seem unusually high and/or abnormal e.g.
  - Warfarin: query any newly initiated therapy at doses greater than 5mg.
  - Amiodarone: query doses higher than 200mg daily (maximum licensed dose for maintenance is 200mg).
  - Digoxin: query doses greater than 250 micrograms daily in adults and greater that 125 micrograms in people over 70 years of age.
  - Phenytoin: query doses greater than 500mg daily.
- Have a process in place to
  - Identify patients on high/abnormal doses of the above medicines.
  - Document any reason for such high doses.

8.3 Medicines Use Review (MUR)[16]

- The Medicines Use Review service consists of accredited pharmacists undertaking structured adherence-centred reviews with patients on multiple medicines, particularly those receiving medicines for long term conditions. National target groups have been agreed in order to guide the selection of patients to whom the service will be offered.

- MURs are not intended to replace the prescriber's clinical medication review but are intended to support patients and practices by helping to ensure medicines are taken safely and effectively.

MURs provide a way to:

- Improve patients' understanding of their medicines.
- Highlight problematic side effects & propose solutions, where appropriate.
- Improve adherence.
- Reduce medicines wastage, usually by encouraging the patient to only order the medicines they require.

An MUR is **NOT**

- A full clinical review;
- An agreement about changes to medicines;
- A discussion about the medical condition beyond that which is needed to achieve the above objectives;
- A discussion on the effectiveness of treatment based on test results.

70% of MURs MUST be carried out on patients in the following national target groups:

- Patients taking high risk medicines from a national list; NSAIDs, anticoagulants [including low molecular weight heparin], antiplatelet and diuretics.
- Patients recently discharged from hospital who have had changes made to their medicines while they were in hospital. Ideally patients discharged from hospital will receive an MUR within four weeks of discharge but in certain circumstances, the MUR can take place within eight weeks of discharge;
- Patients with respiratory disease (asthma and COPD);
- Patients at risk of or diagnosed with cardiovascular disease and regularly being prescribed at least four medicines.

Tip

- Ensure effective communication and reporting processes are in place between the GP practice and community pharmacies providing the service.
- Identify patients in the target groups mentioned above and refer to community pharmacies providing the service.
- Ensure MURs are scanned onto the GP clinical system and READ coded using 8BMF- medication use review done by pharmacist.
- Feedback to the community pharmacist conducting the MUR, to ensure the pharmacy record is updated with relevant information, and that the pharmacist benefits from the constructive evaluation of the recommendations.

8.4 Domiciliary Medicines Review Service

The domiciliary medicines review service is a locally commissioned service conducted by an accredited community pharmacist.
Patient's eligible for this service are housebound patients living in their own home (not a care home) with at least one of the following:

- Adherence concerns
- Recently discharged from hospital
- Concerns of hoarding

The community pharmacist will arrange a visit to the patient's home to discuss any concerns they have with their medicines. Interventions that the pharmacists can make in a domiciliary review are:

- Check the patient is able to physically take all their medicines
- Prescription ordering, collection and delivery service set up
- Supply of medicines reminder charts and other solutions to aid adherence
- Addition of compliance aids
- Supply of large print labels or easy open lids
- Recommend devices to aid inhalers / eye drops use
- Safe removal and disposal of old medicines that are no longer required

Tip

- Ensure effective communication and reporting processes are in place between the GP practice and community pharmacies providing the service.
- Identify eligible housebound patients that may benefit from this service, and make a referral to a community pharmacist providing this service.
- Ensure domiciliary review documentation is scanned onto the GP clinical system and READ coded using 8BMF – medication use review done by pharmacist.
- Feedback to the community pharmacist conducting the domiciliary review, to ensure the pharmacy record is updated with relevant information, and that the pharmacist benefits from the constructive evaluation of the recommendations.

8.5 Safe prescribing

Prescribing errors are common, but harm is usually avoided by professional colleagues intervening before the errors can affect patients. Prescribers should protect patients from risks of harm posed by colleagues' prescribing or other medicine related errors and question any decision or action considered to be unsafe[1].

Yellow Card Scheme
The Yellow Card Scheme is vital in helping the Medicines and Healthcare products Regulatory Agency (MHRA) monitor the safety of the medicines and vaccines that are on the market. All suspected side effects to any medication including vaccines can be reported using the yellow cards online at:
http://yellowcard.mhra.gov.uk/

National Reporting and Learning Service (NRLS)

NRLS is a central database of patient safety incident reports. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care. Practices are encouraged to share the incident with the CCG by ticking the appropriate box once in the NRLS system, to allow sharing of learning and identification of solutions where relevant.

Guidance for GP practices on reporting to NRLS can be found via link:
https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/02/gp-nrls-rep-guide2.pdf

For reporting an incident to NRLS use link:
http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/about-reporting-patient-safety-incidents/

Significant Event

Use of practice significant event procedures, which will help to identify and share any learning, is also recommended, where appropriate

Reporting Controlled Drug (CD) concerns and incidents

Ensure the practice has a SOP in place for dealing with serious untoward CD incidents (e.g. lost or stolen prescriptions) and reporting CD concerns (Template available on NHS Croydon Intranet)

- All staff have a responsibility to ensure any CD concerns are dealt with in accordance with this SOP.
- CD concerns and incidents should be reported to the CD Accountable Officer:
  - William Rial, NHS England London Region CDs Accountable Officer (CDAO) Medical Directorate, Southside, 105 Victoria Street, London SW1E 6QT
    Tel: 0113 807 0791; e-mail: england.londoncdaccountableoffice@nhs.net
  - Concerns and incidents should be reported via on-line reporting system: www.CDReporting.co.uk
  - In addition urgent alerts (e.g. lost or stolen prescriptions) should be highlighted to: england.lon-alerts@nhs.net
- Learning from incidents should be shared with appropriate members of practice staff.

Tip

Ensure processes are in place to

- Report any adverse effects to medications via the yellow card system.
- Report all serious patient safety incidents via the NRLS website.
- Use significant event forms, where appropriate, to report and share learning from any critical incidents that occur in the practice.

8.6 Tools to improve the safety of prescribing

There are a variety of electronic tools available to the prescriber to improve the safety of prescribing. These include:

ECLIPSE RADAR
Eclipse Radar risk stratification software improves safety by identifying those patients most likely to have an emergency admission from a reversible cause. The radar alerts are based on MHRA, NICE, BNF and national guidelines, identifying at-risk patients and feeding prioritised alerts back to GPs on a weekly basis for review.

PRIMIS
The PINCER audit tool (within PRIMIS) identifies at-risk patients who are being prescribed drugs that are commonly and consistently associated with medication errors so that corrective action can be taken to reduce the risk of occurrence of these errors.

The audits provide a snapshot view. If the audit tool identifies any gaps in the practice's information management procedures, these will need to be addressed to improve the future quality of data in the patient's electronic records and ultimately improve patient safety.
Further information available via:
https://www.nottingham.ac.uk/primis/tools-audits/tools-audits/pincer.aspx

Other useful audit tools available within PRIMIS are:

- Case finder (GRASP AF, Heart Failure, Asthma, COPD, Dementia)
- Case Management (Diabetes care, Asthma care)

SOLLIS ACG RISK STRATIFICATION
This tool enables the practice to identify and prioritise patients for review by using one of the several reports available to the user or to build a bespoke report. The tool aids the practice to look at patient data in several ways including number of medicines prescribed.

8.7 Access to medicines information

There are various resources that can be accessed by the prescriber to support the decision on whether or not to prescribe a medication based on local recommendations, these include:

- **ScriptSwitch™:** Prescribing decision support software system which supports the prescriber by providing local prescribing information at the point of prescribing or re-authorisation of a medicine. Where relevant, there are links to the intranet and to specific guidelines[See Appendix 4:ScriptSwitch™]

- **Croydon Intranet:** The main portal for a host of documents in particular the approved shared care guidelines, transfer of care guidelines, interface prescribing policy guidance, information leaflets (e.g. malnutrition, emollients etc)
  http://nhscroydonintranet.croydonpct.nhs.uk/TeamsAndDepartments/primarycarecommissioning/prescribing/Pages/prescribing.aspx

- **Drug Recommendations Database:** The database is presented as a protected excel workbook, enabling prescribers/HCPs to find recommendations made or approved by CPC/SWL. The database contains links to shared care guidelines and other guidance documents on the intranet. The database is updated regularly in line with CPC meetings and is also shared with CUH via the CUH Pharmacy team. The database can be located on the Croydon intranet under 'D' in the A to Z section.

- **CCG Medicines Optimisation Team:**

  - Is available to advise on any medicines related queries, contact your CCG practice support pharmacist.

    *Note: In line with information governance, where practices seek medicines related advice, they are requested **not** to detail any patient identifiable data (i.e. name, address, date of birth, NHS number) in any correspondence sent to the pharmacy team via fax, email or post.*

  - Produce a **monthly newsletter** which i**s** circulated to all GP practices and community pharmacies in Croydon CCG. The newsletter is a collection of news items, including key national guidance, local prescribing initiatives, advice and recommendations which the team believe are of relevance to primary care prescribers and other healthcare professionals and their teams. Every effort is made to ensure that information is correct and prepared from the best available resources available at our disposal at the time of issue**.** The newsletters are accessible via the intranet http://nhscroydonintranet.croydonpct.nhs.uk/TeamsAndDepartments/primarycarecommissioning/prescribing/Pages/PNArchive.aspx

Other general resources include:

- **BNF/BNF for Children** via https://bnfc.nice.org.uk/

- **Summary of product characteristics (SPC)** which provides up to date, approved and regulated prescribing information for licensed medicines. http://www.medicines.org.uk/emc/
- Summaries of product characteristics (SPCs) and patient information leaflets (PILs)

- **NICE** which produce evidence- based guidance, advice and information for health, public and social care professionals https://www.nice.org.uk/

- **MHRA** drug alerts via https://www.gov.uk/drug-device-alerts

8.8 Summary Care records (SCRs)

The NHS is changing how patient information is stored and shared in England, to provide better care for patients. SCRs provide healthcare professionals treating patients in different care settings with faster access to key clinical information.

The SCRs currently displays following information:

- Allergies and adverse reactions
- Acute medication issued in last 12 months
- Current repeats (and date last issued)
- Medication discontinued in last 6 months

For patient safety, it is vital that the patient's medical records are kept up-to-date, including those obtained from 'outside sources' (e.g. specialist, secondary care) [See Appendix 3: Addition of Medication obtained outside sources]

A practice can view the SCRs for a patient from the GP clinical system to ensure it is being displayed correctly [See Appendix 6: Summary Care Records]

Further information on SCR can be found at http://systems.hscic.gov.uk/scr

Enriching SCRs with additional information

A simple and more efficient way to update SCRs with a set of additional information from a patient's GP record is now available to GP practices. Additional Information is added with explicit patient consent and supporting guidance is available via link http://systems.digital.nhs.uk/scr/additional

The 'additional information' content has been defined and reviewed by clinical groups and suppliers. SCRs with additional information incorporate individual coded items and associated free text and will include:

- Significant medical history (past and present).
- Reason for medication.
- Anticipatory care information (such as information about the management of long term conditions).
- Communication preferences (as per the SCCI1605 national dataset).
- End of life care information (as per the SCCI1580 national dataset).
- Immunisations.

9. Prescribing in Care Homes

9.1 READ coding of care home patients

Residents in care homes, residential or nursing homes; should be READ coded as **13FX: lives in a care home**. This will ensure easy identification of care home patients for budget setting and audit purposes.

9.2 The Monthly Medication Cycle

- NICE guidance SC1, recommends that GP practices should ensure that there is a clear written process for prescribing and issuing prescriptions for care home residents. The process may need to be different for interim and urgent prescriptions and the regular monthly repeats.
- It would be good practice to have dedicated trained staff processing the requests from the care home.
- Effective communication is essential, in order to ensure that when any issues are raised they can be dealt with as efficiently as possible.
- Electronic transfer of prescriptions directly to the care home's nominated pharmacy is **NOT** recommended; however there may be circumstances whereby an acute or interim prescription is transferred via this method. In this case, there must be robust systems in place which include informing the pharmacy of the prescription and its urgency.

Most care homes operate a 28 day medication cycle. The process for ordering prescriptions usually starts two weeks **before** the next medication cycle begins. This facilitates the checking stages and allows for any discrepancies to be resolved. The four steps are:

STEP 1	The care home checks the stock levels and current medication regime then requests the medication from the GP practice ***NICE guidance SC1: managing medicines in care homes, recommends that care home providers retain responsibility for ordering medicines from the GP practice. This should not be delegated to the community pharmacy that supplies the medicine.***
STEP 2	The GP Practice issues the requested prescriptions and returns them to the care home.
STEP 3	The care home staff checks the prescriptions against the original requests, then sends them to the community pharmacy for dispensing.
STEP 4	The dispensed items are delivered to the care home and the care home checks the items against the original order and current MAR charts.

9.3 Directions on prescriptions for Care Homes

It is important that there are clear directions to facilitate appropriate administration of medication.

- Do not use the term 'as directed'. For medicines with varying dosages e.g. warfarin the directions could be ' follow the directions in the yellow book'
- All medicines must have a dose e.g. 'one puff twice daily' NOT 'use twice daily'
- Directions for 'when required' drugs should include the indication, when to give, frequency, and maximum daily dose. This is particularly important for psychotropic drugs.
- For variable dose directions it may be necessary to provide further information to clarify when one or two doses should be administered.
- Ensure all topical preparations have directions which include:
    - how the product is to be used e.g. as soap substitute, liberally, sparingly etc.
    - where it is to be used e.g. legs
    - the frequency of use e.g. in the morning after washing; as often as required to alleviate itchiness, three times a day etc.
- Ensure all eye /ear preparations have specific directions about whether it is to be applied to right, left or both eyes/ears. If drops, state number of drops.

In addition:

- Medicines should be linked to a documented indication.
- Medicines should be prescribed generically unless there is a specific reason for a brand name e.g. bioavailability issues - such as long acting formulations of diltiazem, modified release nifedipine, tacrolimus capsules. To minimise errors, particular care should be taken to ensure that only a clinician changes branded medication to a generic.
- Changes made during the month should be documented on the GP clinical systems as well as in the patient records held at the care home.

9.4 Acute and Interim Prescriptions

- It is good practice to make a note of any changes on the patient clinical record as soon as possible after the event if you do not have access to the clinical system whilst at the care home.
- If handheld portals are used during home visits, the data should be uploaded into the patient's clinical record on return to the surgery.
- Prescribers need to ensure that information collated via remote access to the practice server is updated securely in the patient's clinical record.

- If a hand-written prescription is provided, ensure that the name, strength and form of the product and dosing information is recorded in the patient medication record and record that the prescription was issued "by hand" [See section 4.5 Handwritten Prescriptions].
- Any changes in dose of an existing medication should be explained to the care home, specifying whether it is instead of an existing dose or in addition to e.g. furosemide 40mg, new prescription issued for 20mg. Indicate whether it is an increase to 60mg or decrease to 20mg.
- When an 'acute' prescription is started it should be clear to the care home that it is for a

specified period of time. Also there should be a process within the practice to ensure that it is reviewed in a timely manner.

9.5 Reducing Medicine Waste

- Ensure that there are adequate amounts of medication prescribed in order to meet the needs of the patient without creating excess. Prescribe the correct quantity of medicine to fit in with the 28 day supply cycle.
- Medication should be reviewed in a timely manner, to ensure appropriateness of prescribing and to minimise waste resulting from patient refusal or non-adherence.
- When a medication review is conducted, if the change is not urgent, consider implementing the change on the next cycle rather than during a cycle to help reduce waste.
- If the patient medical records held at the GP surgery are not accessible from the care home, ensure that any changes are made as soon as practically possible, e.g. any medicines that have been discontinued are put into past drugs and if treatment is time-limited this is clearly documented.
- If there is an initiative to switch residents to a more cost–effective product, e.g. change in brand of blood glucose testing strip or emollient; ensure this is communicated to the care home staff and that there are robust systems at the practice to ensure multiple prescriptions are not generated.
- It is acceptable for care homes to carry forward 'when required' medicines which have been dispensed in their original packaging, provided they have been stored appropriately, are not expired and there continues to be a clinical need. Care homes should not discard 'when required' medicines at the end of each month and then reorder them. Medicines should only be reordered if there are insufficient supplies.
- If a patient is prescribed insulin pens, calculate how much the 28 day insulin requirement is, and issue the correct number of pens accordingly.

9.6 Medicines Reconciliation

Medicines reconciliation is a process of obtaining an up-to-date and accurate medication list that has been compared to the most recently available information and includes documentation of any discrepancies, changes, deletions or additions. This process should be used for residents newly registered with the care home/practice as well as when they are discharged from hospital.

Care homes should have a documented procedure in place for obtaining information about the resident's medical history and current medication. As the Healthcare Professional, who will be taking clinical responsibility for prescribing for the individual, **it is important that GPs participate in a full reconciliation process i.e. resolving any discrepancies and accurately recording decisions.**

CHECK: To ensure that the medicines, formulation, route, and doses are appropriate

CONSIDER: If the medicine continues to be required or whether discontinuation may be more appropriate.

Particular care should be taken for the on-going prescribing of medicines with potential adverse effects

e.g. benzodiazepines, anticholinergics; those where the number needed to treat is high e.g. aspirin for primary prevention or there are indications of shortened life expectancy.

CLARIFY: Any changes, omissions and discrepancies with either the patient or initiating prescriber (if possible)
COMMUNICATE: Document and date any changes in the patient records at the care home and at the practice. There should be a procedure for handling information from discharge / outpatient letters. The prescriber should ensure that the information on medicine changes are critically reviewed and incorporated into the patient's clinical and medical record.

9.7 Medication Review in Care Homes

One definition of medication review is: "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".[17]

As part of the initial assessment of a new care home patient a clinical medication review should be conducted.

NICE guidance on Managing Medicines in care homes (SC1) recommends:

- GPs should ensure that arrangements have been made for their patients who are residents in care homes to have medication reviews as set out in the residents' care plans.
- Residents should have a multidisciplinary medication review, the frequency of which should be based on the health and care needs of the resident. The resident's safety should be the most important factor.
- The interval between medication reviews should be no more than 1 year.
- Due to their frailty most residents would benefit from more frequent medication reviews.

For each medicine:

THINK: What are we trying to achieve for this resident? What is the therapeutic aim?
CHECK whether:

- There is a current indication (Is the risk versus benefit profile still favourable?)
- The indication is for a side effect from another drug
- The medication prescribed is appropriate for the resident, including whether the resident has any problems taking the medication
- The dose is appropriate
- The medication is time-limited
- The medication is effective for the resident
- Any monitoring is required
- The medication is a cost effective choice

INFORM care home staff of:

- The therapeutic aim of treatment
- Whether treatment is acute or long-term
- What monitoring is required and potential side effects
- When the drug will be reviewed

Appendix 1: Controlled Drugs

Classification of CDs

The Misuse of Drugs Regulations 2001 (and subsequent amendments) divides CDs into five schedules each specifying the requirements governing such activities as import, export, production, supply, possession, prescribing, and record keeping which apply to them.

Schedule 1	Includes drugs such as lysergide which is not used medicinally. Possession and supply are prohibited except in accordance with Home Office authority.
Schedule 2	Includes drugs such as diamorphine (heroin), morphine, nabilone, remifentanil, pethidine, secobarbital, glutethimide, the amfetamines, sodium oxybate, and cocaine and are subject to the full CD requirements relating to prescriptions.
Schedule 3	Includes the barbiturates (except secobarbital, now Schedule 2), buprenorphine, diethylpropion, mazindol, meprobamate, midazolam, pentazocine, phentermine, temazepam, and tramadol. They are subject to CD prescription requirements.
Schedule 4	Includes in Part I benzodiazepines (except temazepam and midazolam, which are in Schedule 3), zaleplon, zolpidem, and zopiclone. Part II includes androgenic and anabolic steroids, clenbuterol, chorionic gonadotrophin (HCG), non-human chorionic gonadotrophin, somatotropin, somatrem, and somatropin. Controlled drug prescription requirements do not apply to Schedule 4 Controlled Drugs.
Schedule 5	Includes those preparations which, because of their strength, are exempt from virtually all Controlled Drug requirements other than retention of invoices for two years.

For further information, see CD and Drug dependence section in the latest BNF.

Who can prescribe?

GP	All CDs in Schedule 2, 3, 4, and 5 (except diamorphine, cocaine and dipipanone for the treatment of addiction – unless they have a special license). **NOTE:** GPs do not require a special license for prescribing diamorphine, dipipanone, and cocaine for patients (including addicts) for relieving pain from organic disease or injury
Nurse /Pharmacist independent prescriber	Are able to prescribe any licensed medicine for any medical condition, including Schedule 2, 3, 4 and 5 CDs (except diamorphine, cocaine and dipipanone for the treatment of addiction).
Supplementary prescriber	A supplementary prescriber is permitted, when acting under and in accordance with the terms of a Clinical Management Plan (CMP), to prescribe CDs in Schedules 2, 3, 4 and 5. **NOTE:** Supplementary prescribers are able to prescribe for substance misuse in accordance with the terms of a CMP, with the exception of dipipanone, diamorphine and cocaine for addiction.

CD prescription requirements

- Each time a CD is prescribed, the prescriber should bear in mind the safety recommendations included in the NPSA Rapid Response Alerts, especially:
    - **Reducing dosing errors with opioid medicines (RRR05 July 2008)** http://www.npsa.nhs.uk/nrls/alerts-and-directives/rapidrr/reducing-dosing-errors-with-opioid-medicines/
    - **Reducing risk of overdose with midazolam injection in adults (December 2008)** http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59896&q=0%c2%acmidazolam%c2%ac

- Schedule 2 and 3 CD prescriptions must comply with additional prescription requirements, which can be found in the **CD and Drug dependence section** of the latest BNF.

- Prescriptions should be written using form FP10 **UNLESS** if prescribing by way of instalment for the treatment of addiction for which an FP10 (MDA) (blue) form should be used for:
    - Any Schedule 2 CD,
    - Schedule 3 CD: Buprenorphine or buprenorphine/naloxone (Suboxone®)
    - Schedule 4 CD: Diazepam

- In **addition** to the prescription requirements for all prescription only medicines, prescribers will ensure that **Schedule 2 and 3** CD prescriptions **must:**

1	**Be signed by the person issuing it with his/her usual signature** **NOTE:** As of 1st July 2015 legislation has enabled Schedule 2 and 3 CDs to be sent electronically via the EPS 2 and signed with an Advanced Electronic Signature (AES) as well as hand signed prescription. However until NHS digital confirm all community pharmacy system software providers have made the necessary technical adjustments to their systems, GP practices are advised **NOT** to send Schedule 2 and 3 CD prescriptions electronically via EPS
2	**Be dated**
3	**Specify the address of the person issuing it (i.e. GP practice address)** The address of the prescriber must be within the UK
4	**Specify the name and address of the patient**
5	**Specify the form of the preparation, even where only one form exists** **e.g.** MST Continus® is not acceptable but MST Continus® **tablets** is.
6	**Where appropriate specify the strength of the preparation.** Where more than one strength of a preparation is available, the strength must be specified on the prescription.
7	**Specify the dose to be taken** e.g. State the dose: 'one' to be taken when required' not 'when required' 'one patch to be applied every 72 hours' not 'every 72 hours'
8	**Specify either the total quantity (in both words and figures) of the preparation, or the number (in both words and figures) of dosage units to be supplied.** The Home Office advises that where a CD is available as a dosage unit, the total quantity on the prescription should be expressed in terms of the number of dosage units, e.g. 10 (ten) tablets, 10 (ten) capsules. For liquids: millilitre (ml) is the dosage unit in which the total quantity should be expressed.

- As a matter of good practice the route of administration e.g. via syringe driver, should also be included on the prescription.
- The prescriber should include the patients NHS number on the prescription form
- Prescribers are strongly advised to limit the quantity of Schedule 2, 3 and 4 CDs prescribed on a prescription to a quantity for **up to 30 days'** supply to meet the patient's clinical need.
- In exceptional circumstances, where the prescriber considers more than 30 days is clinically indicated and would not pose an unacceptable risk to patient safety, a record of the reasons for deviating from the guidance should be made in the patients records and the prescriber should be able to justify the decision, if challenged.
- Any space on the prescription form that has not been written on must be blanked off e.g. by drawing a line through it to reduce the opportunity of fraud.
- Computer systems should be used, where feasible, as an additional method to record and audit the prescribing of CDs, e.g. if a prescriber makes a domiciliary visit and a CD is administered or a handwritten prescription for a CD is issued, it is good practice to make a note in the patient's computer record as soon as possible after the event.
- It is good practice **not** to send prescriptions for written for Schedule 2 CDs via the postal system. The prescriptions should be collected from the GP practice by a healthcare professional, a member of their staff, the patient or their representative. Good practice to obtain the name and signature of person collecting the prescription for audit purposes.
- **NOTE:** Schedule 2, 3 and 4 CD prescriptions are **valid** for 28 days from the appropriate date on the prescription. The appropriate date is defined as "the later of the date on which it was signed by the person issuing it or the date indicated by the prescriber as being the date before which it shall not be supplied".
    - Where a prescriber wishes the 28 day period to start on a date other than the date of signing, he/she may specify a start date from which the period will begin. The start date specified can be more than 28 days from the date of signing/issue.
    - Current legislation does **not** allow for Schedule 2 and 3 CDs to be prescribed under the repeat dispensing scheme.

      NOTE: *This* ***<u>does not</u>*** *relate to the process of issuing a patient with a prescription further to the submission of a repeat prescription request form*

Prescribing for treatment of Substance Misuse

- **FP10 (MDA) (blue) forms** can be used for NHS instalment prescribing of any Schedule 2 CD, buprenorphine (a Schedule 3 CD), buprenorphine/naloxone (Suboxone®) and diazepam (a Schedule 4 CD), for the treatment of drug addiction.
- FP10 (MDA) forms must NOT be used for any other purpose i.e. a single one off dispensing where there is no intention to supply the medication in instalments (in this case use the normal FP10 form for this purpose.
- In addition to the prescription requirements, it is a legal requirement that the prescription contains a direction specifying the amount of medicine per instalment and the interval to be observed between each supply e.g. *"Supply* ***50ml*** *(instalment amount)* ***daily*** *(interval to be observed)* ***from 1st January 2017****."*
- The Home Office has confirmed that an instalment prescription must have both a dose **and** an instalment amount on the prescription (they both have to be specified separately on the prescription).
- The NHS General Medical Service Contracts Regulation 2004 states that if a CD prescription is to be dispensed in instalments the prescription must specify the total quantity of the drug that will provide

treatment for a period NOT exceeding 14 days. Therefore, a maximum of 14 consecutive days' treatment may be ordered on FP10 (MDA) forms.

- The first instalment of an instalment prescriptions for Schedule 2 CDs, buprenorphine, buprenorphine/naloxone (Suboxone®) or diazepam, must be dispensed within 28 days of the appropriate date on the prescription, with the remainder of instalments being dispensed in accordance with the instructions on the prescription (these may run beyond 28 days of the appropriate date).
- It is a legal requirement that each supply against an instalment prescription must be dispensed on the due date specified on the prescription; if this collection date is missed the patient cannot collect that supply on a day other than that specified.
- The use of approved Home Office approved wording on the prescription will enable those supplying CDs to issue the remainder of an instalment prescription when the person has failed to collect the instalment on a specified day or to issue an instalment on the day immediately prior to closure, should the pharmacy be closed on the days when instalments are due.
- The approved Home Office wording can be 'mixed and matched' to express the prescriber's intention.
- The Home Office approved wording is shown below:

1. Please dispense instalments due on pharmacy closed days on a prior suitable day
2. If an instalment's collection day has been missed, please still dispense the amount due for any remaining day(s) of that instalment
3. Consult the prescriber if 3 or more consecutive days of a prescription have been missed
4. Supervise consumption on collection days
5. Dispense daily doses in separate containers

As usual, where this intention is not clear it may be necessary, subject to the professional judgment of pharmacy teams and dispensers, to contact the prescriber.

If the prescription does not contain any Home Office approved wording, a supply can only be made in accordance with the prescriber's instalment direction.

Reporting Controlled Drug (CD) concerns and incidents

- Prescribers are recommended to ensure the practice has a Standard Operating Procedure (template available on Croydon intranet) in place for dealing with serious untoward CD incidents (e.g. lost or stolen prescriptions) and reporting CD concerns.
    - All staff have a responsibility to ensure any CD concerns are dealt with in accordance with this Standard Operating Procedure.
- CD concerns and incidents should be reported to the CD Accountable Officer:
    - William Rial, NHS England London Region CDs Accountable Officer (CDAO) Medical Directorate, Southside, 105 Victoria Street, London SW1E 6QT
      Tel: 0113 807 0791; e-mail: england.londoncdaccountableoffice@nhs.net
    - Concerns and incidents should be reported via on-line reporting system: www.CDReporting.co.uk
    - In addition urgent alerts (e.g. lost or stolen prescriptions) should be highlighted to: england.lon-alerts@nhs.net

- Learning from incidents should be shared with the appropriate members of practice staff.

Appendix 2: Prescribers joining or leaving the practice

Maintenance of prescribers is now the remit of Primary Care Support England (PCSE). Medical prescribers are now called 'Performers'. The forms required can be found at: Performers List – Primary Care Services England OR https://www.england.nhs.uk/joint/.

A significant change is that it is now the responsibility of the GP themselves to complete the forms.

GPs are not lawfully allowed to perform any primary medical services if they have not been added to the National Performers' List (NPL). Anyone can check their NPL status at any time by visiting this link: **https://www.performer.england.nhs.uk/**.

Check whether the GP is already on the Performers List
If GP is not on the performers list they will need to complete the form **NPL1**: National performers list application form. Newly qualified GP's may already be listed on the NPL. Upon completion of training they should email a copy of their Certificate of Completion of Training (CCT), their medical indemnity certificate and their NPL2/3 application forms to **pcse.enquiries@nhs.net**. to inform NHSE of change in status.

GP already on performers list joining &/or leaving practice within the LONDON area: **The same form is used whether working at one practice only or multiple practices.**
1. Complete form NPL3. This can be downloaded at https://www.england.nhs.uk/joint/
2. Ensure that the form is processed correctly by NHSE by completing the field where a reason is requested for submitting the change as follows**:** **For GPs moving from one practice to another:** *Put : "Leaving current practice and moving to new practice"* **For GPs who are remaining at current practice AND require an additional code for prescribing at another practice:** *Put: "Remaining at current practice and will also be prescribing at a new practice. Additional (spurious) code required for prescribing at the new practice"*
3. Email the completed NPL3 change notification form to PCSE at pcse.enquiries@nhs.net, putting NPL 3 in the email subject line. (It is a good idea to keep a copy to refer to if needing to chase PHSE). **Complete and send the form well before the change is due to take place. Twelve weeks is proposed on the website but it may take longer (6-9 months is possible).**

GP already on performers list joining &/or leaving practice from OUTSIDE the LONDON area:
Performer to complete Form NPL2: Moving to a different NHS team
1. All Croydon practices are under the London team. **2.** To find out whether the GP is transferring across area team boundary, check by entering the practice postcode the GP is moving from and the postcode of the practice they are moving to: Search by Postcode

Additional actions by GP practices for:
Joiners • Contact the prescriber's former practice on the day the GP starts or as soon as possible thereafter to confirm that the prescribers name has been removed from their clinical system and that any held-held prescriptions have been destroyed. • If the GP will be generating prescriptions using practice computers, ensure that the clinical system is updated to print the correct details on the prescription. Refer to Prescription form overprint specifications
Leavers • Ensure that your practice computer system is amended so that no further prescriptions are issued bearing the details of the prescriber who has left. • Reassign patients to another GP to avoid problems with repeat prescribing. • Ensure any hand-held prescriptions are destroyed to prevent inadvertent use of them. Record the serial numbers to be destroyed and shred /cut them up in the presence of a witness. Keep a record of the scripts destroyed in case of future query.

Non-Medical Prescribers changes	
Non-medical prescribers use their professional registration number as a unique code linked with the H-code of the practice they are prescribing for. As such it is unlikely that NMP's prescribing can be incorrectly attributed to another practice after moving. However a form must be completed and sent to NHSBSA or the prescriber will not be recognised.	
New NMP joining the practice (for locums/bank staff see below)	
1	• Locate the relevant form from the NHSBSA website via link: | NHSBSA

	• Complete, but **do not sign** the form • Send completed unsigned form to Catherine.wallace@croydonccg.nhs.uk (the CCG Non-Medical Prescribing lead (NMP). NMP lead will sign the form and send to NHSBSA.
2	• If the non-medical prescriber will be generating prescriptions using practice computers ensure that the clinical system is updated to print the correct details on the prescription. Refer to the Prescription form overprint specifications | NHSBSA
Existing NMP leaving the practice	
1	• Locate the relevant form from the NHSBSA website via link | NHSBSA • Complete, but **do not sign** the form • Send completed unsigned form to Catherine.wallace@croydonccg.nhs.uk (the CCG non-medical prescribing lead). NMP lead will sign the form and send to NHSBSA.
2	• Ensure that your practice computer system is amended so that no further prescriptions are issued bearing the details of the prescriber who is leaving to avoid generation of prescriptions bearing the details of a prescriber who no longer works in the practice.
3	• Ensure that any hand-held prescriptions that may have been held by the NMP or stored in the practice are securely destroyed to prevent inadvertent use of them. • Record the serial numbers destroyed and shred /cut up in the presence of a witness. • Keep the record of the scripts destroyed in case of future query**.**

Locum prescribers and bank staff
Locum prescribers should: • Use prescriptions of another prescriber in the practice with the same prescribing qualification. • As good practice, print their name next to their signature on the prescription, so any query that may arise from dispenser or community pharmacist can be directed to the prescriber for clarification. • **NOT** generate prescriptions bearing their details (i.e. name and prescribing code) together with the practice code because these names and codes will not be listed in the NHSBSA organisational database as being linked to the practice.

Appendix 3: Addition of Medicines obtained from 'outside sources'

(E.g. hospital /specialist) onto the GP clinical System

It is vital that all medicines prescribed and issued by 'outside sources' is recorded onto the patient's medication record (PMR) of the GP clinical system.

What is meant by outside source?

This is medication which is prescribed and issued by secondary/tertiary care e.g. olanzapine injection by the Mental Health Team.

Why add medicines prescribed by 'outside source'?

This will ensure:

- **ALL of a patient's medication is located in one place on clinical system so easy to locate.**
- **Clinical system will alert prescriber to potential drug interactions.**
- **Medication will appear in Summary care record (SCR) as being prescribed elsewhere**

Do I need to train staff on what a medicine from 'outside source' is?

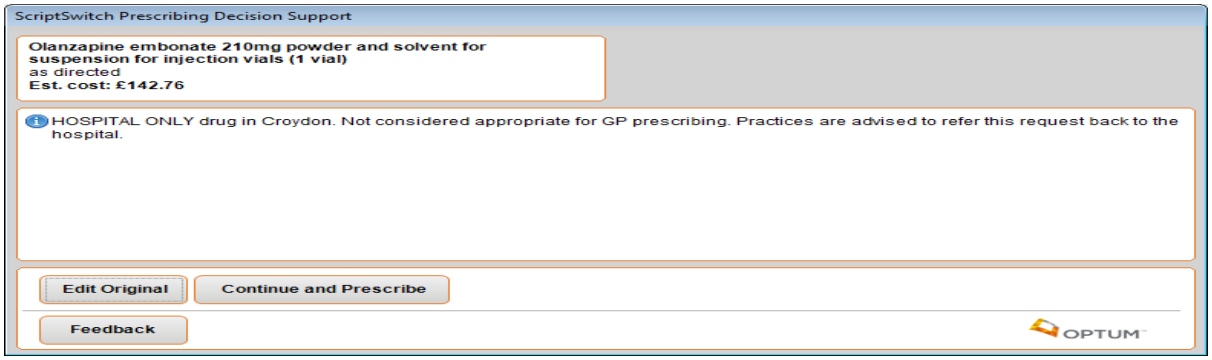
Yes, all staff, including those not involved with processing repeat prescriptions, should understand what a medicine from an 'outside source' is.

These medicines will appear on the medication screen as 'Hospital prescribed'

Practice protocols/procedures should also be updated to include medicines from 'outside sources', as these medicines can still be requested and issued by the practice in the usual way.

How do I add the 'outside' medicine as 'information only'?

When adding an 'outside' medicine to the GP clinical system, a ScriptSwitch™ message may be triggered (e.g. hospital only medicines like olanzapine injection).



At this stage the prescriber should select the **'continue and prescribe'** option. This will allow the prescriber to go back and amend the directions and quantity (e.g. add to the directions 'prescribed by the mental health team')

EMISWEB practices

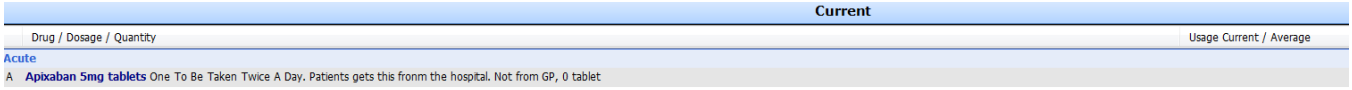
1. Add the medication in the usual way as acute medication.

   Remember to:

   - Add the directions as per last letter from the hospital
   - Include wordings in the directions to reflect medicine is prescribed from elsewhere e.g. obtains from hospital (include name of hospital if possible).
   - Enter quantity of "0".

   To save, select "issue later" option.

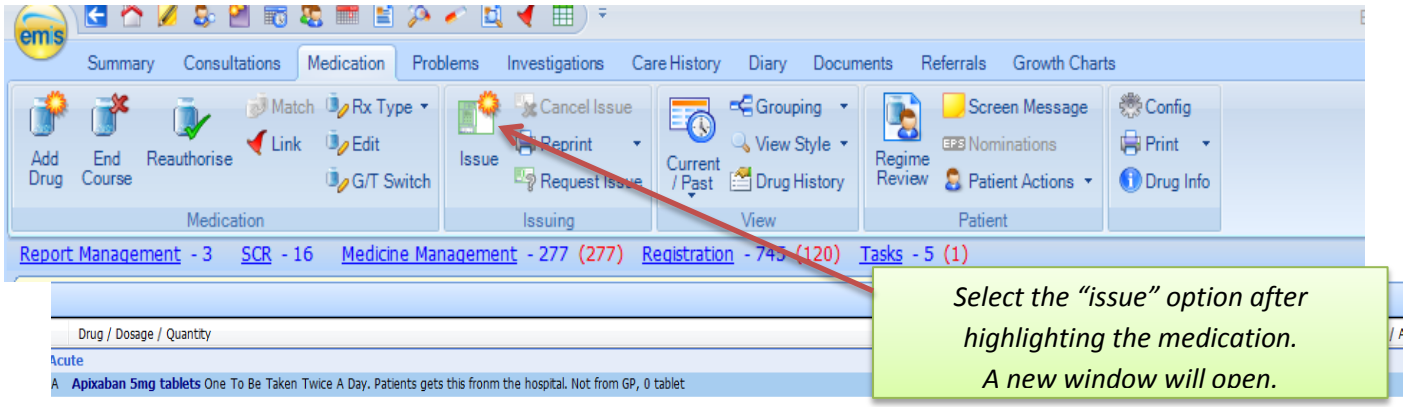
   Note: Medication which appears in the picking list in red and with "alert" preceding it, can only be added by a clinician. Examples include clozapine, methotrexate.



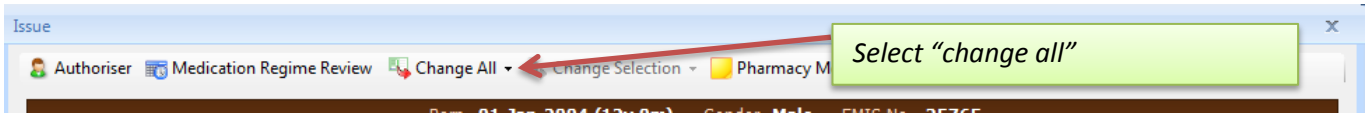
Add:

- *Directions as per hospital letter.*
- *Wordings "the hospital supply this" or similar (include name of hospital if space)*
- *Enter as quantity of "0"*

2. Next highlight the medication from the list and select the "issue " from ribbon.



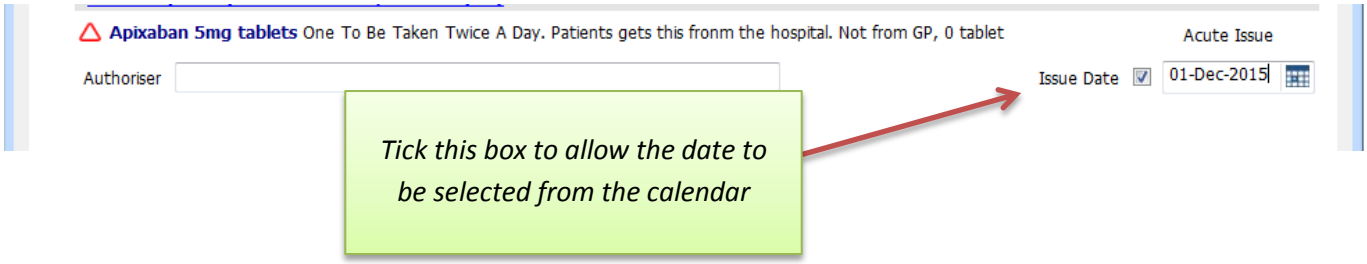
3. Select the" change all" option



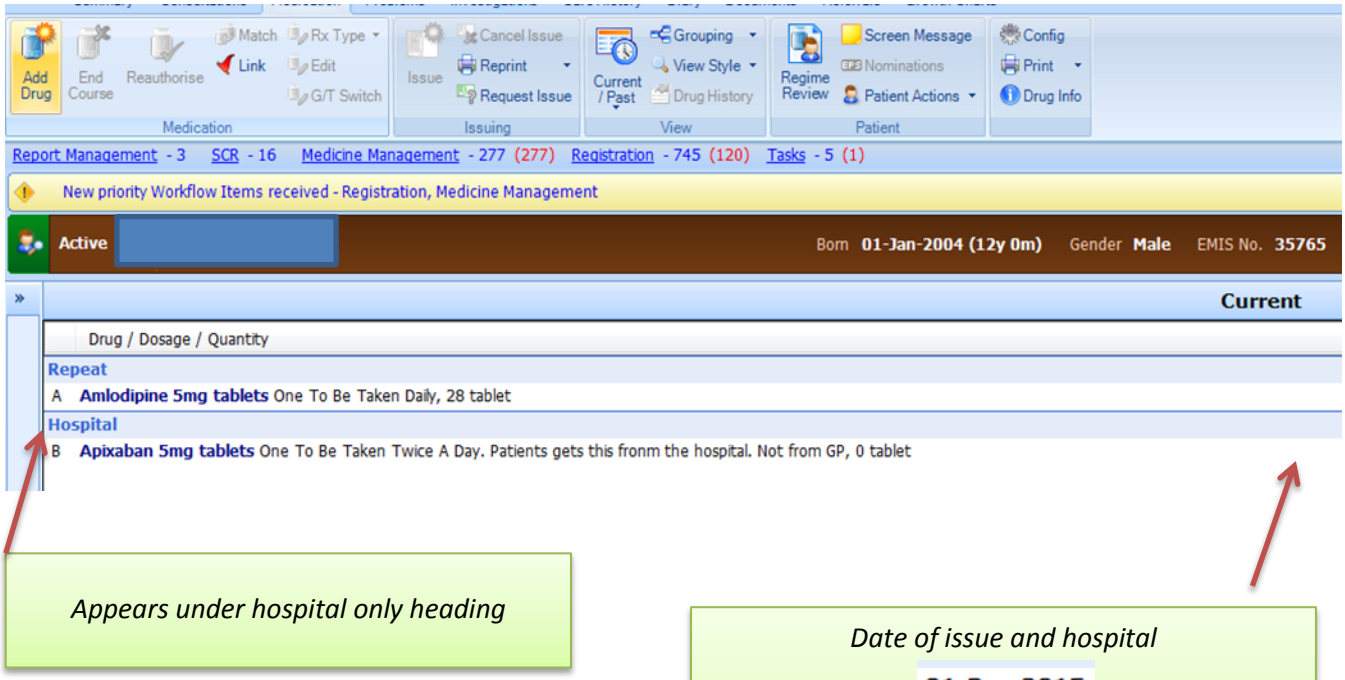
4. From drop down options available -select "hospital no print"

Note: The drop down option also allows recording of prescriptions that are handwritten, OTC, OOH, private

5. Tick the "issue date" box – this will allow you to change the date. Use the date of the last letter / discharge summary which mentions the medication is being supplied by the hospital/specialist. Otherwise it defaults to todays date as date of issue.



6. Next select "approve and complete"
7. The item should appear under a hospital heading after the repeat section.



Medication added in this way will appear in the summary care records (SCR) as "prescribed elsewhere" under acute prescriptions.

Keep records updated, especially if the medication /dose/ dosage or strength changes.

VISION practices:

Step 1: Go to Therapy Add – as you would normally do

Step 2: Source of Drug – change from ‘In Practice’ to ‘By Hospital’

Step 3: Date Prescribed – change to date issued by hospital (obtained from discharge letter). Click in the ‘Date prescribed box’ to change the date.

Step 4: Add drug e.g. Apixaban 5mg

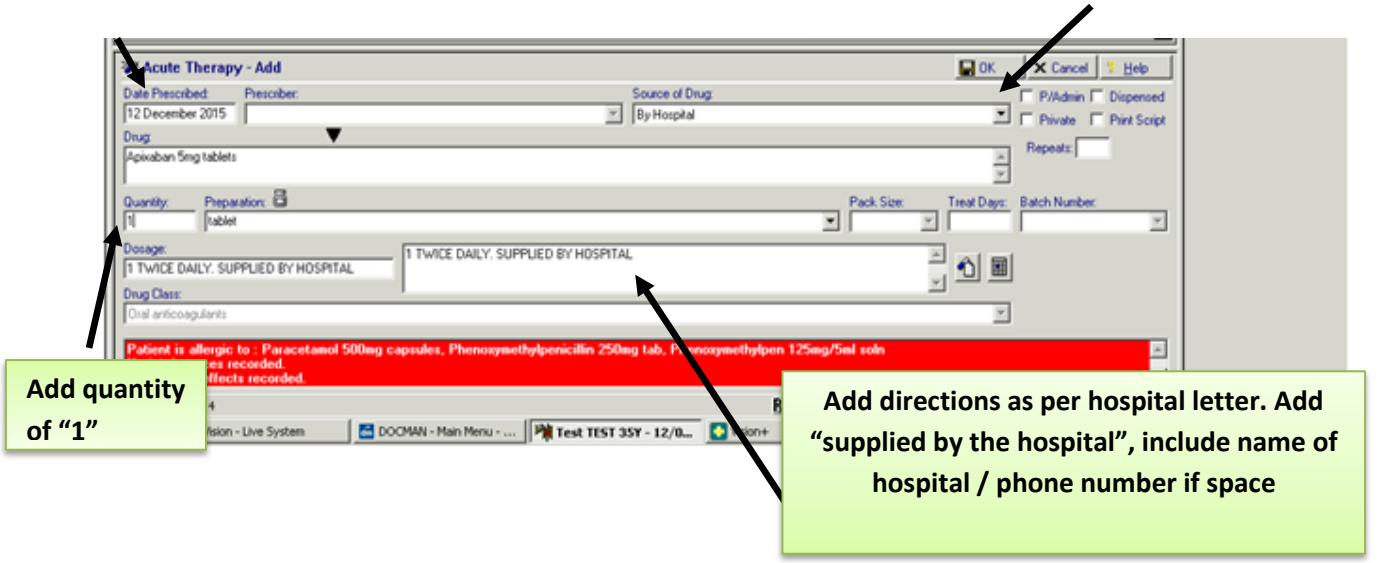
Step 5: Add dosage e.g. One twice daily.

Step 6: In the dosage box add wordings to reflect medication is being supplied by the hospital/specialist e.g. “Supplied by hospital” (add name of hospital and or phone number if space).

Step 7: Add quantity as 1 (one)
Note: Vision will NOT allow you to save if you put in quantity of zero

Change date prescribed to date issued by hospital (obtained from discharge letter)

Select “By Hospital”



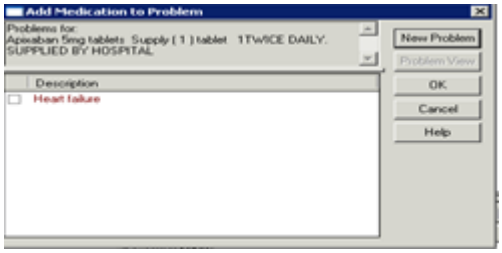
Add quantity of “1”

Add directions as per hospital letter. Add “supplied by the hospital”, include name of hospital / phone number if space

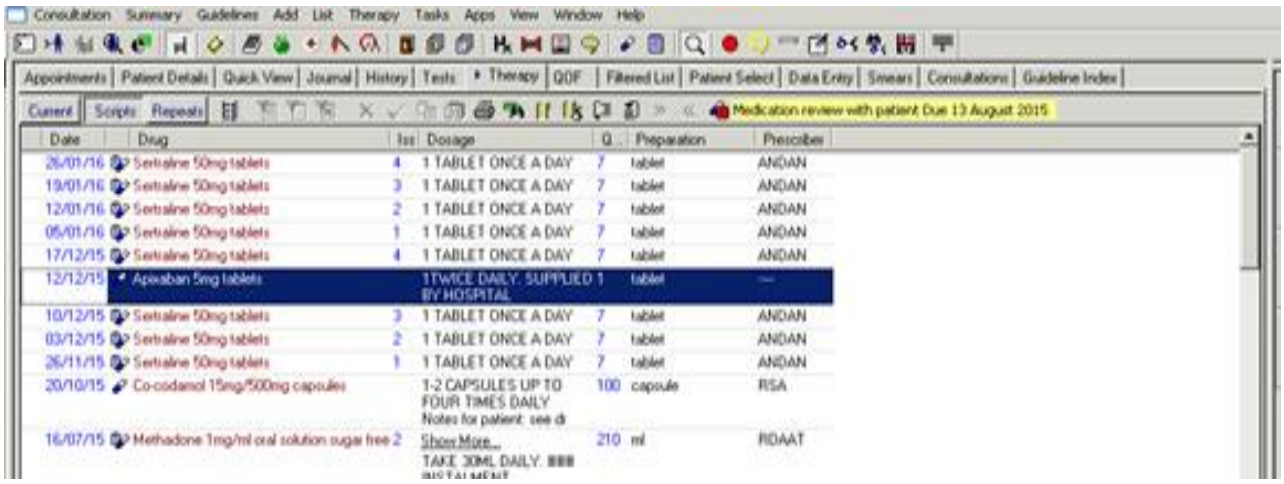
Step 8: Click ok to save changes. Consultation Manager, warning box will open, asking if you wish to proceed, with quantity of 1. Click “yes”

Step 9: Drug Test Results box **may** open, asking if you wish to continue to prescribe for this patient, click ok, if appropriate. Will ask for a reason for you proceeding – enter or click proceed.

Step 10: A ‘add medication to problem’ box **may** open. Good practice to link medication to problem, as this will appear in Summary Care Records.



Step 11: Medication will be added to PMR



Medication added in this way will appear in the summary care records (SCR) as “prescribed elsewhere” under acute prescriptions.

Keep records updated, especially if the medication /dose/ dosage or strength changes.

Appendix 4: ScriptSwitch™

ScriptSwitch™ is a prescribing decision support software system which supports the prescriber by providing information at the point of prescribing or re-authorisation of the medication. Messages include:

- Local decisions (CPC & SWL) on Hospital only/Shared-care medication.
- National decisions and guidance (e.g. NICE).
- Important patient safety information messages (e.g. MHRA drug safety updates).
- Better value alternative drug recommendations.
- Dosage optimisation information at the point of prescribing or re-authorisation.

The practice will ensure that ScriptSwitch™ is being used to its fullest potential by ensuring:

1. ScriptSwitch™ is enabled for **all** prescribers,including locums and new prescribers to the team. (The ScriptSwitch™ manual for your clinical system details on how to do this)

2. ***Note:*** ScriptSwitch™ should not be enabled routinely for any other user. If it is, then the practice needs to ensure clear procedures are in place on how the ScriptSwitch™ message is communicated to the prescriber. The practice should note this may result in the activity being captured twice on ScriptSwitch™ reports.

3. All users of ScriptSwitch™ are fully trained on how to action ScriptSwitch™ messages, including during a medication review. This ensures prescribing activity, as a result of the ScriptSwitch™ message, is correctly captured by the reports.

4. ScriptSwitch™ is fully integrated into the medication review process. This means the prescriber will trigger/activate ScriptSwitch™ messages to appear during a review (The ScriptSwitch™ manual for your clinical system details on how to do this)

5. Medication identified as 'Hospital only' by ScriptSwitch™ is actioned appropriately [**Error! eference source not found.**]

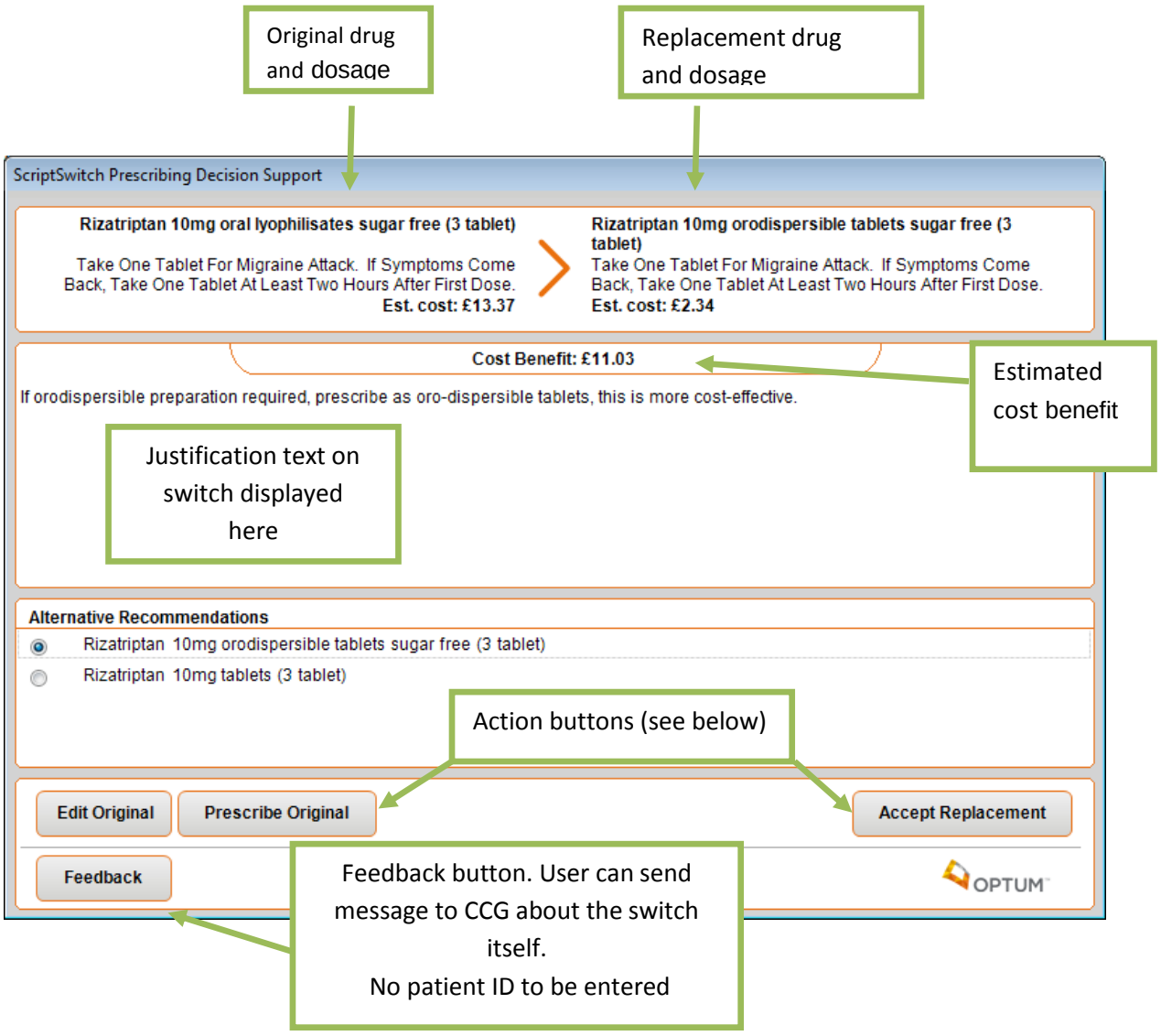
6. Patients are informed of any changes to their medication as a result of a ScriptSwitch™ message that may be actioned without the patient present.

7. ScriptSwitch™ reports are discussed regularly at practice clinical meetings.

Below are examples of different ScriptSwitch™ screens which appear when a medicine is selected by a prescriber which has either a potential alternative medicine or information message. (See your ScriptSwitch™ manual for full details)

ScriptSwitch™ Offer Screen

The screen displays a "switch" message box which needs to be actioned.



The screen may offer a number of alternative medicine options which can be selected by using the mouse to highlight them. These may be based on:

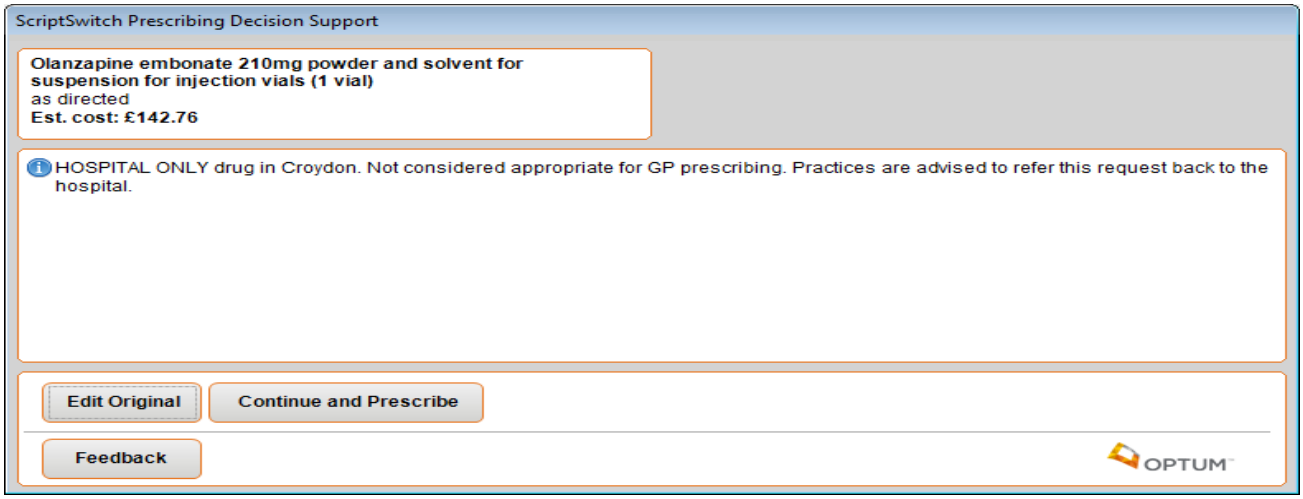
- Alternative medicine
- Same medicine, alternative dosage

After selecting the required option, the following actions are available:

Accept Replacement	Select this to accept replacement offered.
Prescribe Original	Select this to reject the switch being offered i.e. Prescriber wants to prescribe original item.
Edit Original	Select this to return to the original prescribing window (i.e. prescriber wishes to prescribe a different medicine altogether).
Feedback Button	This option allows the prescriber to notify the CCG Medicines Optimisation Team any comments on the switch itself. Note: No patient details should be added to the feedback. The feedback report is received monthly by CCG pharmacy team via ScriptSwitch™.

ScriptSwitch™ Information Screen

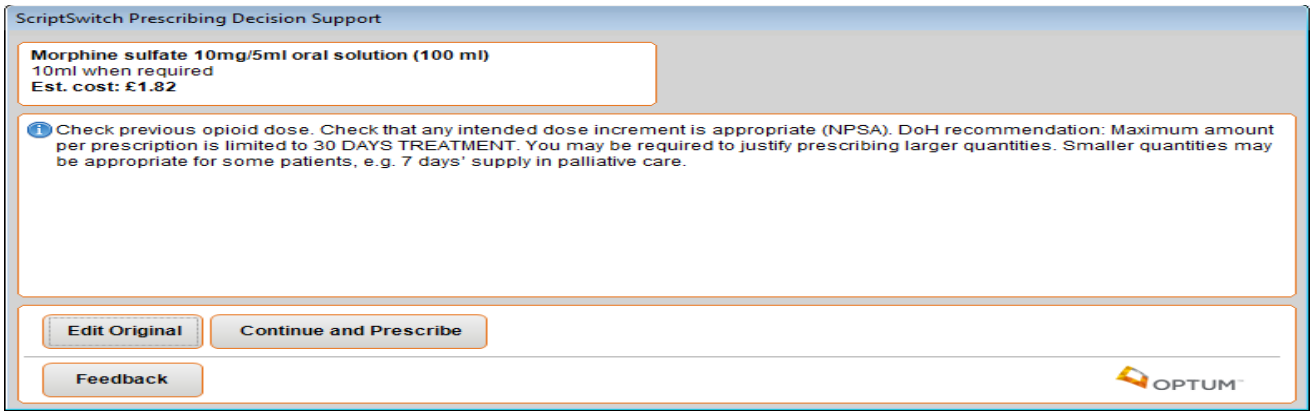
The screen displays an 'Information only' message, which provides additional support to the prescriber.



Continue and Prescribe	This will prescribe the original medicine
Edit original	**This** will allow the prescriber to continue but edit the medicine prescribed. Use this option if patient is obtaining the medicine from an outside source and medicine is being added as 'information only' on to the prescribing screen [See appendix 3: Addition of Medicine obtained from outside sources onto GP clinical system]

ScriptSwitch™ Safety Screen Message

The screen displays a 'safety' message to remind prescribers of any MHRA / NPSA alerts or clinical guidance.



Continue and Prescribe	This will prescribe the medicine.
Edit original	This will allow the prescriber to continue, but edit the original medicine prescribed; i.e. make changes to the dose or quantity of the medicine, as a result of the message.

Tip

- It is good practice to document in the patient's clinical records why a ScriptSwitch™ message was rejected.
- Add a prompt to remind prescribers to activate/trigger ScriptSwitch™ during a medication review.
- Ensure a copy of a ScriptSwitch™ manual for the practice GP clinical system is available to all prescribers.
- ScriptSwitch™ is maintained by the Medicines Optimisation Team at Croydon CCG. Any suggestions or problems should be communicated to the team via your practice support pharmacist or email CROCCG.pharmacyadmin@nhs.net
- Use the feedback button for any comments on the switch.
- Ensure medicines being prescribed by a hospital or specialist is entered on to the GP clinical system. This will ensure:
    - interactions are captured;
    - the medication will appear on SCR;
    - medicines reconciliation is easier
    - ScriptSwitch™ reports capture practice activity correctly.

See Appendix 3: Addition of Medicine obtained from Outside source

Appendix 5: 'Specials'/Unlicensed Medicines[18]

How to identify unlicensed 'specials'

These medicines:

- Usually cannot be found in the BNF or are listed as being 'special order' products.
- May not be listed on the GP clinical system.
- May be identified on the GP clinical systems by a 'U' (EMIS WEB) and/or cost as 0.00 pence.

Additionally:

- A community pharmacy may call and advise that a 'special' has been prescribed.
- Some medicines, although licensed, are not listed in the Drug Tariff. These may show up in ePACT data as 'specials'. Examples include gamolenic acid capsules, calamine lotion. The CCG Medicines Optimisation Team pharmacist will advise on these products.

It is recommended that **BEFORE** prescribing unlicensed 'specials', prescribers should carefully consider the following:

1. Establish a clinical Need

Does the patient still need the medicine? Can this need be met by:

- An alternative licensed medicine, e.g. soluble or dispersible tablets?
- Unlicensed (off-label) use of a licensed medicine e.g. crushing a tablet or opening a capsule?
- Using an alternative medicine within the same therapeutic class for which there is a licensed liquid form?

2. Understand the patient's experience and make a shared decision

Discuss treatment options. Ensure the patient or carer understands the implications of using a 'special'. This should be documented in the patient's clinical record.

- Consider practical implications:
  - quantity prescribed,
  - shelf life of product,
  - time required for community pharmacy to obtain product.
  - Is the patient able to take the medicine themselves or do they need assistance from a carer?
- Ensure the patient or carer is informed that requests for repeat prescriptions need to be presented in good time to allow for possible delays.

3. Identify medicines and preparations

What products could be prescribed, what are the alternatives?

- Consider risks vs benefits.
- What formulation? Tablets/capsules/suspension/solution?
- Is there a need for an exact or specified formulation? E.g. alcohol free
- Is the dose critical?
- Does the drug have a narrow therapeutic window?
- Is it for a child?
- Consider costs of available products.
- Do you need to discuss formulation/suppliers/alternatives with your local pharmacist?
- **Local guidance may be available to guide product selection** http://nhscroydonintranet.croydonpct.nhs.uk/TeamsAndDepartments/primarycarecommissioning/prescribing/Pages/Specials.aspx

4. Monitor and review regularly

- How often will the patient be reviewed? Who will undertake the review?
- Patients on 'specials' should be monitored and reviewed regularly. This is because prescribing unlicensed 'specials' poses a **higher clinical risk** to prescribing a licensed medicine.
- Ensure there is a system in place to highlight these patients.
- Consider prescribing the 'special' as an 'acute' medicine on the PMR.

5. Ensure effective prescribing governance

Make sure all the necessary information is available for safe prescribing and record keeping

If asked to continue prescribing for a patient where the 'special' has been started in secondary care, the prescriber should ensure that they have **all** the information to prescribe safely and appropriately. This includes

- Details of who has recommended the medicine;
- The indication for the medicine;
- Any alternatives that have been tried;
- Evidence for the use of the 'special';
- The expected duration of treatment;
- Monitoring arrangements (who and how often);
- The formulation of the product e.g. tablet/cream/suspension;
- The concentration or strength the of the product;
- The dose and dose frequency of the medicine;
- The source of the original supply (i.e. manufacturer/hospital).

Do not make assumptions about the products the patient is using. If the discharge notification or letter is not completely clear, it is advisable to check with the secondary care prescriber, patient or carer what product they are already using. On occasions, it may be necessary to refer the prescribing request back to the hospital.

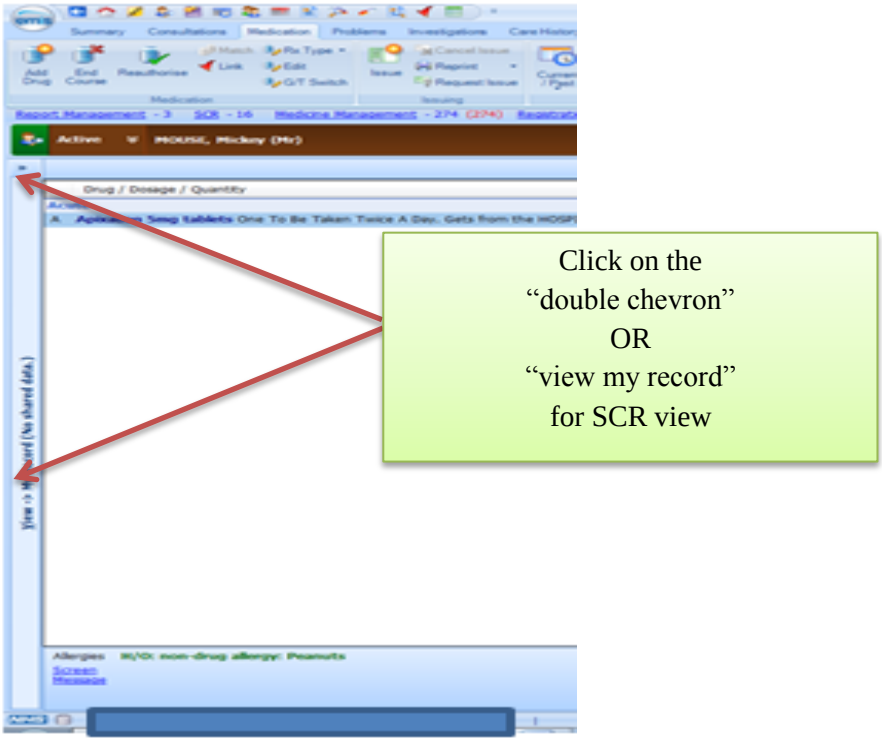
Handwritten scripts for 'specials'

Where the medicine is not listed on the GP clinical system for selection, a handwritten prescription may need to be written. Prescribers should ensure that the name, strength, form and dosing information of the medicine is recorded in the patient's clinical record. Scan a copy of the **prescription into the patient's clinical record.** This ensures an audit trail of the medicine prescribed. Also consider keeping a log of all handwritten prescriptions [See 4.5: Handwritten prescriptions]

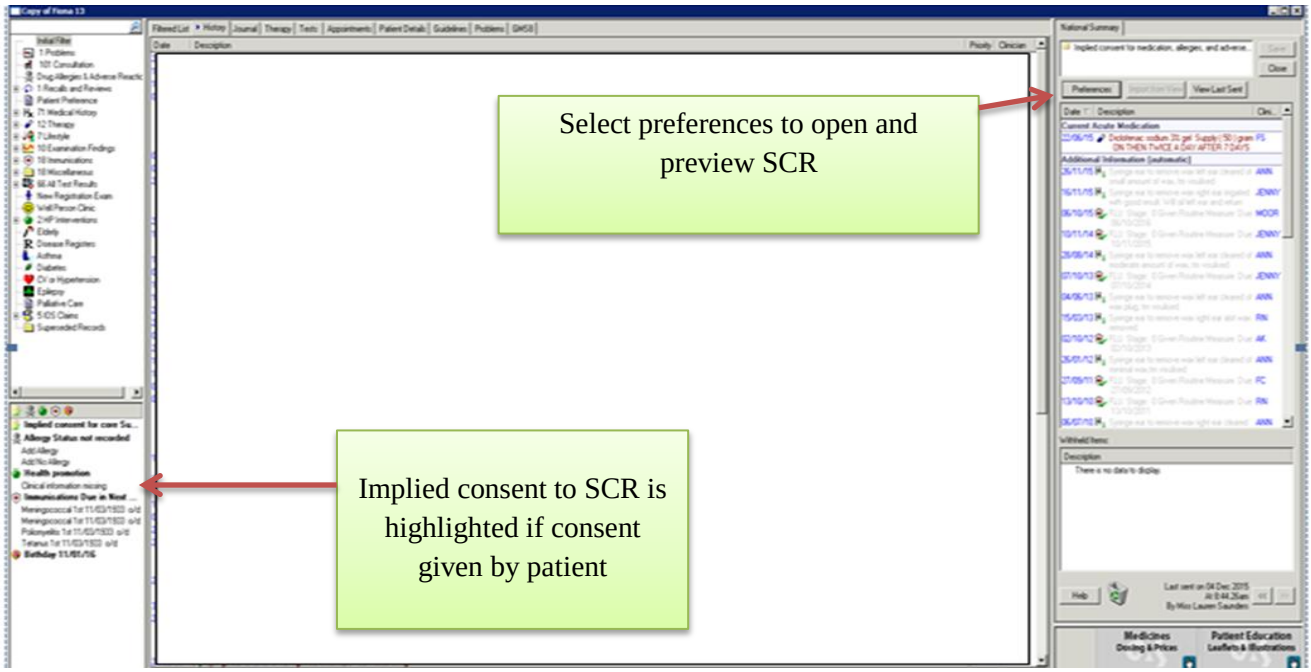
Appendix 6: Summary care record (SCR)

Primary Care clinicians can see what information about a patient is available on the SCR via their clinical system

EMISWEB



VISION



Appendix 7: Medication review

Minimum data set for a face to face medication review

The clinician will ensure that:

- prescribing is in line with the current evidence base and local and national guidance.
- the indication for each medicine is checked and correctly linked to a clinical problem.
- the monitoring of medicine[13] is checked (this includes blood monitoring).
- the efficacy of all medicines is checked.
- the patient's understanding of why they are taking the medicines is checked.
- Compliance/adherence to medicines is checked. This includes overuse and underuse of medication.
- any reported side effects[15] / adverse reactions are checked.
- any changes in doses are clearly documented.
- a reason is specified for any medicine stopped, deleted or deactivated.
- any new medicine started, is linked to an indication and the patient understands both the need for the medicine and any review or monitoring required.
- medicine quantities are synchronised, so that they run out at the same time.
- use of Over the Counter (OTC) medicines (e.g. aspirin, omeprazole, simvastatin etc) is checked.
- ScriptSwitch™ is activated/triggered when medicine on 'repeats' is re-authorised during a medication review
- any changes resulting from the review are agreed with the patient and the impact of any change is monitored[20].
- the patient has the chance to raise questions and highlight problems about their medicines[20].
- the review is documented in the patient's notes[20].
- the medication review is clearly documented on the GP clinical system using READ code 8B3V (medication review done) or other agreed READ code.
- following a review, the next 'medication review due' date is updated on the PMR of the GP clinical system and communicated to the patient.

Suggested READ codes for a Face to Face medication review

FACE TO FACE MEDICATION REVIEW			
Heading	**Read Code**	**Sub heading/picking list**	**READ code**
Medication review with patient	8B3x		
Indication for each medication checked	8BIK		
Medication monitoring	66c	Drug monitoring done	8BIc
		Drug monitoring not required	8BId
		Drug monitoring up to date	8BIf
		Medication monitored in secondary care	66c2
Efficacy of all medication checked	8BIR		
Pt understands why taking ALL medication?	8BIg	Pt understands why taking ALL medication	8BIg
		Pt does not understands why taking all medication	8BIh
Drug overuse checked	8BIm		
Drug underuse checked	8Bin		
Drug compliance checked	8BIq	Drug compliance good	8B3E
		Drug compliance poor	8B3i
		Drug compliance aid requested	8BI0
		Compliance issues discussed with patient	8BIu
Discussion about medication regimen adherence	8CP7	Needs assistance with medication regimen adherence	8BMc
		Adherence to medication regimen	8BPQ
		Uses monitored dosage system	8BIA
Shared decision making	8CI	Shared decision making with patient decision aid	8CI0
		Shared decision making without patient decision aid	8CI1
Has shown side effects from medication	8BIE		plus free text
Drug dosage altered	8B3A		plus free text
Drug treatment no longer needed	8BIY		plus free text
Medication commenced	8B313		
OTC aspirin therapy	8B3T		
All OTC medication checked	8BIl		plus free text

Minimum data set for a medicines management (prescription) review without a patient

The clinician will ensure that:

- prescribing is in line with the current evidence base and local and national guidance
- the indication for each medication is checked and correctly linked to a clinical problem.
- the monitoring of medication[15] is checked (this includes blood monitoring) *For further information, refer to "Drug Monitoring in stabilised patients" document in the A-Z section of the NHS Croydon intranet.*
- the efficacy of all medications prescribed is checked e.g blood pressure within range.
- adherence to medication is checked. This includes overuse and under use of the medicine, identified by checking medicine issue dates.
- repeat medication is synchronised, so that they run out at the same time.
- Discharge and outpatient letter/s received are checked and actioned.
- 'Hospital only' medication is added on as 'Information Only' to the GP clinical system
- ScriptSwitch™ is activated/triggered for messages before the medication is re-authorised.
- changes made as a result of the review, are communicated to the patient/carer and clearly documented on the GP clinical system.
- patients requiring a face to face review are called in.
- patients requiring a medicines use review (MUR) are referred to the community pharmacist *(See Section 7.3: MU*R).

Suggested READ codes for medicines management (prescription) review without patient

MEDICINES MANAGEMENT (WITHOUT PATIENT)	
Medication review without patient	8B3h
Synchronisation of repeat medication checked	8BM2
Drug monitoring up to date	8BIf
Medication monitored in secondary care	66c2
Other medication counselling /advice etc (e.g. telephone advice)	6774
Drug overuse checked	8BIm
Drug underuse checked	8Bin
Medication review due (as due diary entry) Check which READ Code your clinical system uses to print the medication due date onto the RHS of prescriptions	

Abbreviations of Commonly Used Terms

	Definition:
AO	Accountable Officer
AES	Advanced Electronic Signature
BNF	British National Formulary
CCG	Clinical Commissioning Group
CDs	Controlled Drugs
CPC	Croydon Prescribing Committee
DAC	Dispensing Compliance Contractor
DIN	Doctor Index Number
Dm+d	Dictionary of medicines and devices
DoH	Department of Health
DRD	Drugs Recommendation Database
EPACT	Electronic Prescribing Analysis Cost Trend
MHRA	Medicines and Healthcare products Regulatory Agency
MUR	Medicines Use Review
NHSBSA	NHS Business Service Authority
NICE	National Institute of Health and Clinical Excellence
NMS	New Medicines Service
NPC	National Prescribing Centre
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning Service
NSAID	Non-Steroidal Anti-inflammatory Drug
OTC	Over The Counter
PMR	Patient's Medication Record
POM	Prescription Only Medicine
PCSE	Primary Care Support England
PSNC	Pharmaceutical Services Negotiating Committee
RCGP	Royal College of General Practitioners
SCG	Shared Care Guideline
SCR	Summary Care Records
SOP	Standard Operating Procedure
SPC	Summary of Product Characteristics
SWL	South West London
WWI	Working With the Industry

References

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[8] Electronic repeat dispensing guidance May 2015 https://www.england.nhs.uk/digitaltechnology/wp-content/uploads/sites/31/2015/06/electronic-repeat-dispensing-guidance.pdf

[9] NHS Choices: Can my GP prescribe extra medicines to cover my holiday? http://www.nhs.uk/chq/Pages/1755.aspx

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