Advice on Recording Medicines Prescribed by Teams Other than the Primary Care Team on General Practice Clinical Systems

Why is this important?

ALL healthcare professionals have a responsibility to ensure that 'Non-Primary Care Prescribed Medicines' are recorded in a patient's electronic medical records to ensure the accuracy of the Summary Care Record (SCR). The SCR provides vital information about medicines to other healthcare professionals when patients transfer between different care settings. Including information such as the organisation which is prescribing the medication and the brand prescribed will support clinicians in a different care setting to gain any information needed to improve patient care. Whilst Primary Care is the only setting in which the SCR can be altered, it is the responsibility of ALL clinicians involved in patient care to ensure that GPs are equipped with adequate information to allow changes to be updated in a timely manner.

There are many medicines which are prescribed and / or supplied directly to patients by healthcare providers outside of the GP practice e.g., by hospitals, mental health trusts or private clinics. Typically, these include specialist drugs which have been designated as **RED** drugs by the Area Prescribing Committee. Practices are actively encouraged to ensure that the prescribing of **RED** drugs remains with the specialist to ensure patient safety is maintained.

It is important to ensure that all clinical staff are aware of the patient's current medication prescribed elsewhere when:

- making clinical decisions - for example immunosuppression can increase the risk of an infection
- avoiding interactions or other risks when new medication is prescribed
- providing a comprehensive drug history to other services on admission (medicines reconciliation).
- recognising any adverse events associated with the non-Primary Care prescribed medication and taking appropriate actions.

Whilst it is important that GP practices have a record of these medicines on their clinical system it is equally important that GP practices **do NOT inadvertently issue prescriptions for them.**

Which non-Primary Care prescribed medicines should be recorded?

Ideally all non-Primary Care prescribed / hospital only prescribed medicines should be recorded in the patient's medication record. Medicines of particular concern are those used in:

- Rheumatology e.g., etanercept
- Dermatology (systemic drugs)
- Multiple Sclerosis
- Transplants
- Cystic fibrosis
- Mental health e.g., clozapine
- Gastroenterology e.g., infliximab
- Hepatitis
- Cancer
- HIV
- Clinical trials
- Zoledronic acid infusion

GP practices are not expected to record all the specific chemotherapy administered for cancer treatment as it is not available on the clinical system and it changes too often to be up to date. However, SNOMED codes are available to use in the "Problems" section to indicate **chemotherapy started: 722480002** and **date**

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chemotherapy stopped: 413944007. This will transfer to the SCR and will provide a more accurate summary for other clinicians treating the patient.

It is recommended that any specialist services prescribing / supplying **RED** drugs have a section on the discharge summary (template) or clinic letter which highlights this and reminds practices to update the patient's clinical record. Local examples include:

- The patient is being prescribed the following **RED** medicine(s) [insert name of medicine/dose/frequency]; please enter this medicine(s) on the GP patient record (so that it will appear on the Summary Care Record). *Or*
- GP to kindly add [insert name of medicine/dose/frequency] onto the patient's clinical record. This will ensure that if they are admitted to the care of another healthcare provider who uses the SCR to ascertain their medicines, the healthcare professional will be aware that this individual is receiving this medicine.

Who is responsible for recording hospital only medicines?

Organisations should ensure that medicines reconciliation is carried out by a trained and competent healthcare professional with the necessary knowledge, skills and expertise, ideally a pharmacist, pharmacy technician, nurse or doctor. Medicines reconciliation must follow a robust and clearly documented standard operating procedure which clearly defines staff members' roles and responsibilities**. Care must be taken to add the correct medicines to a patient's clinical record especially when adding unfamiliar medicines.**

What happens when a non-Primary Care prescribed medicine is stopped?

Information about hospital prescribed medicines should be reviewed annually, as a minimum, to ensure it is up to date. It is important to have a system for maintaining and updating medication lists of non-practice prescribed medications.

When a non-Primary Care prescribed medicine is stopped or changed by the specialist team, this must be altered on the GP system. **END** the course of any treatments that have been stopped, ensuring reason is documented and then **ADD** any new drug as stipulated in the most recent hospital letter.

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Instructions for adding non-practice prescribed drugs to the General Practice clinical system

EMIS

Go to consultation page in EMIS Web. Select add consultation. This brings up a consultation box

- In comments section type “Hospital Prescription” and select SNOMED code for this term
- Once code entered, next to it add any free notes you wish for example, name of consultant etc
- In “problem” section enter diagnosis
- Still in the consultation box, select medication and another pop up appears allowing you to add medication
    1. Select ‘Add Drug’ icon and enter medication name (if in red then this means you do not have authority do this and then please ask a prescriber with authority to action this or Practice Manager to change your authority)
    2. Dose: “Hospital only medicines. (Insert prescribing organisation e.g hospital). Do not dispense this Rx”
    3. Quantity: 0
    4. Duration: 0
    5. Rx Types: Select Repeat so shows on medication list on EMIS. DO NOT add as an Acute medication or it will not show on the SCR after 12 months. (Note: It will not print on right hand side of prescription for patient)
    6. Reauthorisation: 1
    7. Review Date: optional but useful if you know the treatment is short term and not life long
    8. Select ‘Issue’. This will open another window.
        - Select the button marked “store” and this will switch the printer button off
        - Go to the ‘Change All’ tab and select ‘Hospital (No Print)’ from the drop-down menu
        - For some medicines a box will come up saying that you cannot issue the prescription with the quantity of 0 and if you want to issue 0 you need to change to “record medicine in notes” function in drop down in “Change All”. If you follow these instructions and then go back and save as “Hospital (No Print)” then the quantity of 0 is accepted
        - Then click on ‘Approve and complete’
    9. You will then go back to the consultation that you have open.
    10. Click save
    11. Then check medication tab to see medication records in hospital only section on that page

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SystmOne

The SystmOne clinical system has the facility to record non-practice medication prescribed elsewhere (not the GP
practice) on the patient's clinical record:

- The system will flag up potential interactions when a drug treatment is subsequently prescribed that interacts

with the non-practice medication. Please note that interactions with patient's current medication will not be highlighted at the point of recording the non-practice medication but only when the GP practice prescribes subsequent acute/repeat medications.

- The prescription cannot be inadvertently issued when recorded in this way.
- The non-practice medication will not be printed on the right-hand side of the repeat prescription ensuring that

the patient will not be able to order a repeat prescription for this non-practice medication from their repeat slip.

- The drug will remain on the record until manually removed.

1. Once in the patient record, the READ code XaIng (hospital prescription) can be used to document that the patient has a 'non-practice' prescribed medicine
2. Go to 'medication' on the clinical tree, right click and select 'record other medication'
3. A new window titled 'select drug or appliance' will open
4. Search for the new medication and select the appropriate drug
5. A new window titled 'record other medication' will appear
6. Under 'medication source' select 'hospital medication'
7. Complete the other required details of the non-practice drug
    - 'Dose': indicate the source of supply of the non-practice drug e.g., "HOSPITAL PRESCRIPTION FOR INFORMATION ONLY. (Insert prescribing organisation e.g hospital) DO NOT ISSUE, DO NOT DISPENSE". This wording is recommended to warn the patient/pharmacist in the event a prescription is issued by mistake, however practices may choose to use their own wording.
    - 'Quantity': Enter 0 or if this is not possible the lowest possible quantity should be entered e.g., 1 tablet, 1mL
    - In the 'script notes' enter details of who is responsible for prescribing e.g., DO NOT ISSUE - PRESCRIBED AND SUPPLIED BY HOSPITAL" (or SPECIALIST CLINIC etc.)
    - Leave the end date box empty
    - In the 'administrative notes' section enter details of who is responsible for prescribing e.g. DO NOT ISSUE - PRESCRIBED AND SUPPLIED BY HOSPITAL" (or SPECIALIST CLINIC etc.)
8. The medication will now be displayed on the patient's record as 'other medication'. Be aware that medications added will not show on the SCR after 12 months so will need to be reviewed and reinstated if appropriate.
9. Click on 'OK' and 'Save Patient Record'

References : General Medical Council. (2022). *Good practice in prescribing and managing medicines and devices.* Available: Good practice in prescribing and managing medicines and devices (gmc-uk.org)
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