

## Guidance for Writing a Practice Prescribing Policy

Prescribers are responsible for any prescriptions that they sign. Prescribers must only prescribe medicines when they have adequate knowledge of the patient's health and must be satisfied that the medicine serves the patient's need.

A Practice Prescribing Policy will help make sure that all prescribers practise safe prescribing and should include:

- Guidance on repeat prescribing.
- Guidance on recording non-general practice prescribed medicines.
- Guidance on systems for Medicines reconciliation.
- Guidance on reporting of incidents related to medicines.

The GMC have published [Good practice in prescribing and managing medicines and devices](#) which provides detailed advice on how to comply with the principles of safe prescribing set out in Good Medical Practice, 2013.

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| <p><b>1</b> In 'Good medical practice' (2013)<sup>1</sup> we say:</p> <ul style="list-style-type: none"> <li>■ <b>12</b> You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.</li> <li>■ <b>14</b> You must recognise and work within the limits of your competence.</li> <li>■ <b>16</b> In providing clinical care you must:           <ul style="list-style-type: none"> <li><b>a</b> prescribe medicine or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health, and are satisfied that the medicine or treatment serve the patient's needs</li> <li><b>b</b> provide effective treatments based on the best available evidence</li> <li><b>f</b> check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving, including where possible self-prescribed over-the-counter medications.</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>■ <b>18</b> You must make good use of the resources available to you.</li> <li>■ <b>19</b> Documents you make to formally record your work, including clinical records, must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.</li> <li>■ <b>21</b> Clinical records should include:           <ul style="list-style-type: none"> <li><b>a</b> relevant clinical findings</li> <li><b>b</b> the decisions made and actions agreed, and who is making the decisions and agreeing the actions</li> <li><b>c</b> the information given to patients</li> <li><b>d</b> any drugs prescribed or other investigation or treatment</li> <li><b>e</b> who is making the record and when.</li> </ul> </li> </ul> |
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The guidance applies to all prescribing in whatever setting the interaction takes place, including remote consultations.

## Section 1

It is recommended that the principles above are noted in the Practice Prescribing Policy and the more detailed sections below are included. Specific clinical situations around prescribing may also be found in the [Medicines Management Guides to Prescribing](#) found on the PAD and practices may wish to include these in their own policy, for example, [prescribing diazepam for flight anxiety](#).

### Keeping up to date and prescribing safely

- Prescribers will recognise and work within the limits of their competence and keep their knowledge and skills up to date.
- Prescribers will make use of electronic and other systems that can improve the safety of prescribing, for example by highlighting interactions and allergies and by ensuring consistency and compatibility of medicines prescribed, supplied, and administered.

### Deciding if it is safe to prescribe.

- Medicines will only be prescribed if there is adequate knowledge of the patient's health, and the prescriber is satisfied that the medicines serve the patient's needs.
- Prescribers will ensure that the mode of consultation meet the individual needs of the patient and support safe prescribing.
- Prescribers will ensure that they have enough information about the patient to prescribe a treatment that meets their needs establishing a dialogue and obtaining consent.

### Sharing information after providing care

- Prescribers will contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means all relevant information will be shared with colleagues involved in patient's care within and outside the team.

### Controlled drugs and other medicines where additional safeguards are needed.

- Some categories of medicine may pose risks of serious harm or may be associated with overuse, misuse, or addiction. When prescribing, care will be taken and relevant clinical guidance followed, such as drug safety updates on the risk of dependence and addiction associated with opioids. Information on prescribing of control drugs can also be found [here](#).

### Prescribing for yourself or those close to you

- Wherever possible, prescribers will avoid prescribing for themselves or anyone they have a close personal relationship with.

## **Prescribing remotely**

- If prescribing remotely the prescriber will communicate with the patient, or if that's not practicable, the person caring for them, to make the assessment and to provide the necessary information and advice. Any instructions, such as how to administer the drug or monitor the patient's condition, will be clear and understanding confirmed with written confirmation sent to them as soon as possible.

## **Prescribing at the recommendation of a colleague**

- If prescribing based on the recommendation of another doctor, nurse or other healthcare professional, the prescriber will be satisfied that the prescription is needed, appropriate for the patient and within the limits of the prescriber's competence.

## **Section 2 Policy on Repeat Prescribing**

Repeat prescribing has been defined as "a partnership between patient and prescriber that allows the prescriber to authorise a prescription so it can be repeatedly issued at agreed intervals, without the patient having to consult the prescriber at each issue"<sup>1</sup>.

[Guidance for Repeat Prescription Management](#) including Repeat Prescribing Standards is available on the PAD and the practice repeat prescribing policy should be checked against these standards.

It is recommended that the policy includes the following sections which should be amended as appropriate for each practice.

### **1. Introduction**

1.1. A good repeat prescribing system should be accurate, flexible and produce prescriptions promptly, as well as incorporating effective record keeping, compliance checks and quality assurance.

1.2. The production of repeat prescriptions is a team approach with input not only from the prescriber, but also from other members of the practice team, which may include clinical pharmacists, pharmacy technicians, pharmacy care coordinators, prescription clerks and receptionists. Effective teamwork is therefore needed to produce high standards of practice and care.

1.3. A robust repeat prescribing system has benefits to patients, practices and the ICB.

Benefits to patients:

- Better access to their medication.
- Defined process.
- Full instructions on dosage etc.
- Reduced risk of errors.

Benefits to practices:

- Ability to manage own workload.

- Fewer queries/complaints.
- Better use of staff time.
- Less stress improves morale.
- Achievement of prescribing indicators.
- Ability to adopt new initiatives.

#### Benefits to the ICB

- Less waste.
- Assurance that medicines are used in a safe, effective, and appropriate manner.
- Reduced risk of adverse incidents.

## 2. Purpose / Scope

2.1. The purpose of this policy is to set out the practice policy for prescribing medication on a repeat basis.

2.2. The policy includes all activity within the practice by all staff involved in the repeat prescribing process both clinical and non-clinical.

2.3. The policy will be reviewed and updated annually by the practice.

## 3. Definitions

3.1. Where the term “repeat prescribing” is used, this refers to the supply of “batch” prescriptions/ “batch” dispensing as well as the supply of standard prescriptions for repeat supplies of medicines.

3.2. Where this policy states GP, this can also mean any other qualified prescriber in the Practice (e.g., nurse practitioner, clinical pharmacist etc)

## 4. Deciding to prescribe items on a repeat basis

4.1. The decision to transfer a drug from an acute prescription to a repeat prescription will always be made by the **qualified prescriber** or clinical pharmacist following the approval of a prescriber after consideration of safety and clinical appropriateness.

4.2. Care should be taken to ensure the repeat record is accurate, quantities for each drug are synchronised where possible (to reduce waste medicines), and the appropriate review dates are entered.

4.3. Drugs prescribed should be linked to medical conditions within the clinical system where possible and where appropriate.

## 5. Requests for a repeat supply of medication

5.1. The following personnel are allowed to request repeat prescriptions (**practice to define who and circumstances**):

- Patient
- Carer

- District and specialist nurses
- Pharmacist / pharmacy team
- Care home staff

5.2. Where practices allow third party requests, they must:

- Ensure patient confidentiality is maintained.
- Ensure the correct information is accurately exchanged, when those making the request are not fully aware of the patient's medications / health condition.
- Ensure the request is genuine.

5.3. Requests may be received by one of the following methods: (practice to define)

- On-line (preferred)
- Right hand side of prescription
- In writing (other than counterfoil)
- Email request
- Telephone – this method is not recommended as it is unsafe. However, there may be a few patients where the practice has agreed a specific arrangement, and this should be clearly documented in their notes with the reason.

5.4. A lockable box is situated in the practice reception for patients to post their requests in. It should be emptied daily.

5.5. The following information must be obtained before a request is processed:

- Patient's full name
- Patient's address or date of birth
- Name/strength/ form and dosage of medication(s)

Any queries arising from the request should be clarified at this stage *N.B. It is NOT acceptable for a patient to request "all repeats" or their "blue tablets", or use a description of medication rather than specify the name (e.g., heart tablets, pain killers)*

5.6. The patient or his/her representative must have an active role in requesting the repeat prescription and should be encouraged to indicate on the repeat request slip which medications are required. If the form has been left blank and it is not otherwise obvious which medications are required, then the patient should be contacted (if possible).

5.7. Community pharmacy staff (and dispensing staff in dispensing doctor surgeries) could routinely ask patients if they require all their prescribed medication. This will reduce the potential for medicines to be stockpiled and/or wasted.

5.8. Where prescribing and dispensing for patients residing in care homes, checks should be made that all the medicines requested are required, particularly in relation to medicines that are "when required".

5.9. Patients should allow at least (practice to add) xxx hours for repeat prescriptions to be processed. Where it has been requested that the prescription is sent to the patient by post, the turnaround time should be one week. See section 8.4 for dealing with urgent requests.

5.10. Patients should be encouraged to speak to a member of the practice team if they have concerns about taking any of their medicines, or if they do not take them as prescribed. This will allow the patient's medication record to be updated by the appropriate member of staff to accurately reflect the medicines the patient is taking. It may also indicate that a medication review is required to review compliance.

5.11. Prescriptions should not be supplied more frequently than at the interval agreed with the patient, without prior agreement (e.g., holiday). There is a guide available for reference on Surrey Prescribing Advisory Database (PAD) regarding [prescribing situations and issues](#).

### 5.12. Telephone requests

In the interest of patient safety, telephone requests for repeat medication will only be accepted under exceptional circumstances at the discretion of the practice (**practice to define**). A separate phone line or restricted times for ordering repeat medication; telephone to be next to a computer so the request can be processed whilst the patient is on the phone; ideally telephone and computer should be in a separate area to the main reception (**practice to define**). The request should be repeated back to the patient to confirm the request and ensure the request is written down accurately.

## 6. Production of repeats

6.1. When the quantity of repeat medicines has been changed the GP should be alerted by the practice staff

6.2. Prescriptions should not be "directed" to any pharmacy or appliance contractor. The GMC makes this clear in their Good Practice in Prescribing Medicines (2006) guidance: *"You should respect patients' freedom to choose where to have their prescribed medicines dispensed. You must not pressurise patients to use a particular pharmacy in any event, either personally or through an agent"*.

The patient should nominate the pharmacy or appliance contractor of their choice to dispense their prescriptions.

## 7. Processing a request for a repeat prescription

7.1. Check that the items requested are on the patients' **current** repeat list. If the patient requests any items not on the list, this must be referred to a **xxxxxxx (add list here)**. Verify that the items requested are suitable as repeat medication.

7.2. If the requested item appears on the repeat medicines list, check the name, form, strength, and dosage instructions are identical to the request. Any discrepancies must be referred to a **xxxxxx (add list here)**.

7.3. If the authorised number of issues has been met, do not issue the prescription but refer the request to **xxxxxxx (add list here)** for review.

7.4. Check medication review date has not been exceeded – refer to xxxxxx (add list here) to see if he/she wishes to see patient / update review. If there is no review date set, follow procedures agreed in the surgery to set a review date.

7.5. Where prescription requests are earlier or later than expected and may indicate over or under use of that item, refer the request to xxxxxx (add list here) so that they can find out why the patient is not using the medication as intended.

7.6. Refer requests for repeat medicines that have not been ordered for one year or more to xxxxxx (add list here) for consideration of removing from the repeats list, exceptions are seasonal medications e.g., hay fever.

7.7. Align supply to 28/56/84 days (where appropriate – to be defined by practice and which patient groups e.g., practice may choose to prescribe for 84 days in the case of HRT or contraception. It is good practice to limit supply of newly prescribed medication to no more than 28 days' supply, or ideally less to minimise wastage.

7.8. The supply of schedule 2 and 3 controlled drugs (CDs) should always be limited to a maximum of 30 days. Further guidance can be found [here](#).

7.9. Any decision to prescribe seven-day prescriptions should be made solely on clinical grounds. It may, for example, be appropriate to prescribe only seven days at a time for an unstable patient rather than risk generating a lot of waste, or where it is important for patient safety, but **not** to fund the cost of supplying a monitored dosage system. Guidance on [Medicines Compliance Aids](#) can be found on the Surrey PAD.

#### **7.10. Processing repeat prescriptions.**

7.10.1. Staff generating repeat prescriptions are in a quiet, dedicated area where interruptions are kept to a minimum.

7.10.2. Practice staff issuing repeat prescriptions ensure clear dose instructions are included on prescriptions, including instructions for use of as needed (PRN) medicines. ('PRN' can be used if the dose instructions are made clear by specifying the dose interval, the maximum number of doses per day and/or the condition for which the dose should be taken/given, e.g., give one when required up to four times a day for pain). Exceptions to this such as warfarin should be explicitly stated in the practice policy.

7.10.3. Messages generated by a prescribing support system (for example OptimiseRx) are patient specific and only appear when a medication is added to the system at initiation or is processed for reauthorisation of a drug. Practice staff must ensure that messages are passed on to the person signing or reauthorising the prescription as they may highlight important safety issues.

7.10.4. All prescriptions generated are checked by a prescriber, who has direct access to the patients' medical record if required, before signing.

7.10.5. The practice repeat prescribing policy should describe how security of access to prescriptions and computerised prescribing systems is enforced and monitored.



7.10.6. If a review date is required or overdue, the patient should be advised of this by (**practice to define how this is done**) and requested to make an appointment.

7.10.7. Most prescriptions are now generated electronically however in the case that a prescription is printed/ handwritten practice should ensure that:

- Repeat prescriptions ready for collection are stored in a secure place.
- Staff verify that the person collecting the prescription is either the patient, or a known or authorised representative of the patient.
- Staff verify that the person collecting the prescription is either the patient, or a known or authorised representative of the patient and this is recorded for a controlled drug e.g., a hypnotic, opioid.
- The practice has a system for checking uncollected prescriptions as a minimum every three months and alerting the Prescriber that the prescription is uncollected.

## **8. Management Control**

### **8.1. Authorisation**

8.1.1. Only an approved list of practice clinical staff can add new medications, reauthorise medications or make changes to a patient's repeat medication list.

8.1.2. The [guidance](#) on safe and appropriate repeat prescribing set out by the Pharmacists' Defence Association (PDA) recommends only a qualified prescriber can authorise repeats and indicate the number of repeats allowed. It states that '*a reauthorised NHS repeat prescription for three, six, or twelve months is a new prescription and should be generated on the system by a prescriber*'.

The practice may have in place a procedure whereby a named, non-prescribing pharmacist can add new medications, reauthorise medications or make changes to a patient's repeat medication list, following a medication review within their agreed boundaries of practice. A qualified prescriber can then approve and electronically sign these prescriptions. Delegated activities for non-prescribing pharmacists should be set out in Standard Operating Procedures (SOP) which include exclusion as well as inclusion criteria and state that the doctor is ultimately responsible for the work covered by the SOP. The PDA also produced Advice and FAQ for prescribing and non-prescribing pharmacists in primary care. Relevant information from this [FAQ](#) (e.g., page 7) may be adapted into the practice SOP.

8.1.3. When a medication is first added to a repeat prescription, it should be noted clearly why it was started in the first place, use the linking facility in the clinical system to do this. The practice should have a mechanism in place to clearly identify to prescribers tasked with signing/authorising prescriptions, that any given prescription has been added to the clinical system by either a prescriber or a non-prescriber (following prescriber approval).

8.1.4. Often newly prescribed medication (until suitability is confirmed) and medication with frequent dose changes would be better set up as an acute prescription.

8.1.5. The number of repeats, or the period of time, allowed before the next review should be defined, this must be done by the prescriber or a non-prescribing pharmacist within the approved list (see 8.1.1). As a minimum, all patients should have an annual medication review (**any additional criteria to be defined by the practice**).



8.1.6. If a request is placed for a drug that is not authorised as a **repeat** item, a prescription must **not** be generated. The patient's GP should be informed. If the GP decides to authorise the prescription, ensure any message from the GP to the patient is communicated to the patient, (practice to define how this is done).

## 8.2. Compliance check

8.2.1. If a patient is significantly over or under using medication, a prescription must **not** be generated.

- The GP /prescriber/clinical pharmacist should be informed; and
- An explanatory note should be attached to the patient' record (practice to define how this is done)

8.2.2. If the GP decides to authorise the prescription, ensure any message from the GP to the patient is communicated to the patient (practice to define how this is done).

## 8.3. Flagging of problems

8.3.1 If there is any query about the request for repeat medication, the prescription must **not** be generated.

- The GP should be informed; and
- An explanatory note should be attached to the patient' record (practice to define how this is done)

8.4.1. If the GP decides to authorise the prescription, ensure any message from the GP to the patient is communicated to the patient (practice to define how this is done).

## 8.4. Urgent requests

Ensure to pass the urgent request to the prescription team highlighting the urgency. Prescription team to assess the urgency and take appropriate action.

## 8.5. Hospital Discharge Medication / Outpatient attendance / Home Visits

8.5.1. Patients who have been discharged from hospital or seen in outpatients often have their medication changed. This can potentially lead to serious problems if strict procedures are not followed. The discharge medication/hospital letter must be reviewed and actioned by the GP and or approved members of practice pharmacy team **in conjunction** with details of the patient's current medication.

[NICE quality standard QS120](#) states that people discharged from a care setting should have a reconciled list of their medicines in their GP record within 1 week of the GP practice receiving the information, and before a prescription or new supply of medicines is issued.

8.5.2. Non-clinical staff should not examine medication dispensed to the patient as a means of verifying amendments made to a patient's regimen. In particular, reception staff must not transcribe from the labels of such items, to request a repeat prescription.

8.5.3. If a patient requests a supply of medication before the hospital communication has been received, the GP secretary/administrative team should request for a copy. The urgency placed

upon this request should be guided by the duration of the patient's remaining supply and clinical need.

8.5.4. The GP or clinical pharmacist should indicate that the computer records have been updated when reconciling medications from the discharge letter. Checks should include:

- Duplication of same drug or same drug class.
- Duplication of drug by brand and generic name.
- Delete medication that has been discontinued.
- Appropriate dose and dosage form.
- Appropriate quantity.

8.5.5. Any changes to medicines should be entered into the patient's medical record by the GP or approved clinical staff performing the medicines reconciliation process. Use of SNOMED codes below will enable information relating to the medicines reconciliation process to be placed into the consultation. Appropriate free text can then be added if required for clarification. Please note this list of SNOMED codes is not exhaustive. Other codes can be added from the SNOMED code picker on the GP clinical system.

- **430193006** Medicines reconciliation.
- **266712008** New medications commenced.
- **182838006** Medication changed.
- **730021000000104** Post hospital discharge medication reconciliation with patient.

8.5.7. Where possible, all medication supplies should be aligned so that the supplies all run out together, to simplify the repeat process.

8.5.8. Any alterations to a patient's condition or medication, outside of a practice consultation, (e.g., home visit), must be updated in the patient's medical record at the earliest opportunity by the GP.

8.5.9. Handwritten prescriptions must be entered onto the computer system at the earliest opportunity to reduce inadvertent duplication of prescribing, to reduce the possibility of unintentional drug interactions and to provide an adequate audit trail. Where unable to enter onto the patient's medical record, for example specials that are not available on formulary, this should be written onto the patient's consultation notes and a copy of the prescription scanned into their documents.

8.5.10. If a patient requests a supply of medication that has been issued on a handwritten prescription, but is not on the computer record:

- The GP should be informed; and
- An explanatory note should be attached to the patient's record (practice to define how this is done)

## **9. Clinical Control**

### **9.1. General**

9.1.1. Medication review is the periodic review of the patient at which the continuing need for acceptability and safety of medication on the repeat prescription are considered.

9.1.2. A medication review dates should be set by the prescriber for all patients receiving repeat prescriptions.

9.1.3. A system should also be in place to ensure that patients who do not order their medication are also reviewed. (To be defined by practice - For example electronic record can be automatically tagged to indicate underuse, and a prompt for staff to open that record and assimilate the information).

9.1.4. Ideally medication review should be conducted by the prescriber or clinical pharmacist face to face with the patient, telephone consultations may also be used.

9.1.5. Practice staff should inform the prescriber when a patient fails to attend a medication review when requested to do so.

## **9.2. Initiation**

9.2.1. The prescriber must be satisfied that drug treatment is appropriate and necessary.

9.2.2. Consideration should be given to non-drug treatments and lifestyle interventions.

9.2.3. The patient must be reviewed at least once before granting a prescription repeat status.

9.2.4. Medication should be prescribed to only cover the period until assessment of suitability.

9.2.5. Patient sensitivities, allergies and significant interactions should be considered. Drug allergy status should be recorded as drug allergy, none known or unable to ascertain. If a drug allergy is recorded information should be included about the drug involved, type of reaction including severity and when the reaction occurred.

9.2.6. Prescribing should be generic, unless there is a specific clinical reason for prescribing by brand (for example, drugs with a narrow therapeutic range). Medicines to be prescribed by brand can be identified on the [PAD](#). Specialist Pharmacy Services (SPS) [Specialist Pharmacy Services \(SPS\)](#) also have information on examples medicines to be prescribed by brand name in primary care.

9.2.7 The dose and frequency must be specified:

- The instruction “as directed” should not be used.
- The instruction “when required” should not be used alone.

9.2.8 The patient should be explained what is being prescribed and why. The patient understands whether the drug is an addition to or replacement for current medication should be verified. An explanation as to how the drug(s) is administered (demonstrated, if appropriate).

9.2.9 Common adverse effects should be discussed; consider if the patient might be concerned by the manufacturer’s patient information leaflet.

9.2.10 Shared care and high-risk medicines should be monitored according to the schedules available on the PAD. The prescriber should include within the patients record a plan of what

regular medication monitoring is required, the frequency of monitoring and indicate what action should be taken if a patients' medication requires monitoring prior to issuing a repeat prescription.

### **9.3. Authorisation of repeat prescriptions**

9.3.1. Allocated time should be set aside each day for signing / reviewing repeat prescriptions.

9.3.2. In order to authorise the request for repeat medication, the prescriber should be satisfied that:

- The drug is effective (look for objective evidence).
- The patient is concordant.
- There is no short- or longer-term risk of important adverse effects.
- There is no short- or longer-term risk of interaction with other medication.
- The drug is for a stable, chronic condition – other items should not enter the repeat system.

9.3.3 The prescriber should check the following:

- Drug name, strength, form, and dose.
- Indication for each drug.
- Whether appropriate monitoring has been undertaken, and if an adjustment to medication is required in response to results of monitoring,
- Date of next review.

9.3.4 Repeat prescriptions should wherever possible be reviewed and signed by the GP who knows the patient. The patient's medical notes should be available if needed. All drugs requested within the system should be regularly reviewed.

9.3.5 A system should be in place for distributing a GP's prescriptions during cases of absence.

## **10. Security**

10.1. The practice should follow the Surrey Heartlands [Recommendations On The Safe & Secure Management Of NHS Prescription Stationery In GP Practices](#) available on the PAD.

10.2. Blank prescriptions must never be signed by a prescriber, for later completion by practice staff.

## **11. Information for patients**

- All patients should be given a verbal explanation of the Practice repeat prescribing policy at their New Patient Review Appointment.
- The patient should also be shown how to order prescriptions (practice to define how this is done).
- The timing of the review date should also be advised to them.

- A practice repeat prescribing leaflet should be available.

## **12. Patient Safety Incidents**

12.1. Research shows that organisations which regularly report more patient safety events / incidents usually have a stronger learning culture where patient safety is a high priority. Prescribing events / incidents and near misses should be reported by the prescriber following [local guidance](#).

## **13. Duties/responsibilities and accountability (practice to define)**

### **GP**

- Responsible for overall clinical control and accountability.
- Signing prescriptions and all legal requirements for prescription writing are met.
- An appropriate cost-effective drug is chosen.
- Possible interactions with other medications are considered.
- The medicines are added to the repeats when appropriate.
- Appropriate quantities are prescribed.
- Suitable number of authorisations are set before a review is needed.
- Where possible the amount given is synchronised with other medicines on repeat
- The most appropriate strength is prescribed.
- The drug is written generically (or branded where appropriate).
- Clear instructions are given on the prescription.
- Patients have the opportunity to discuss the likelihood of benefit and risks of harm of the therapy.
- Handwritten prescriptions or alterations made away from the surgery are also electronically recorded.
- On ordering a prescription, the prescriber should act on any problems highlighted with under or over-ordering of prescriptions as appropriate.
- Additions, deletions, and other changes to prescriptions.
- Re-authorising repeat medicines when appropriate to do so.
- Perform an annual full clinical medication review.
- Report and investigate medication related safety incidents.

### **Practice Manager**

- Overall management control of repeat prescribing system.
- Overseeing training of practice staff.
- Liaison with local community pharmacists.
- Security and storage of prescription forms.

### **Prescription Team**

- Day to day running of the system,
- Following practice policy and protocols for repeat prescribing,

*Ordering Repeats:*

- To ensure that the patient has clearly indicated what items they need. Where possible when this has not been done the patient or their representative should be contacted to confirm, rather than just providing all the items.
- Only select the items the patients have requested.
- To discourage patients from over ordering or hoarding medicines.

*Generating Repeats:*

- Staff are responsible for making sure this is completed in a safe manor with attention to detail and must refer on any queries which they are unable or unauthorised to handle.
- The last issue should always be checked before another issues is made to check for under or over ordering.
- Staff must check the correct prescription reaches the correct patient by checking their name and address.

*Flagging up Problems/Potential Changes:*

- Generic and inappropriate Generic Prescribing.
- Prescriptions with no directions or as directed with no specific instructions.
- Items which are not normally allowed on long term repeat as agreed in the practice policy.
- To make sure all requests for repeats are appropriate.
- To consider/recommend synchronisation where appropriate in order to reduce waste.

*Review & Re-authorisation:*

- Re-enforcing with the patient the need to attend regular reviews.
- Flagging up certain issues and mentioned above.

## **Practice/PCN Pharmacy team**

Practice to define roles and responsibilities of all pharmacy professionals based on competencies and to specify any exclusion criteria that may apply.  
e.g., Ensuring a list of approved personnel who can re-authorise repeat prescriptions.

## **14. Training and Continuing Professional Development**

14.1 All staff involved in the production of repeat prescriptions must have access to the electronic version of the British National Formulary.

14.2. **ALL** staff involved in repeat prescribing must undertake repeat prescribing training. It would be advisable for new staff to shadow a trained member of staff for at least one month, or until senior staff feel they are competent. Training is also available via the ICB Medicines Optimisation teams.

14.3. Practice staff who write or are involved in the preparation of repeat prescriptions should be appropriately trained the practice protocols for repeat prescribing, including their responsibilities, accuracy and when to refer the request for a repeat prescription to a GP.

### **Section 3 - Recording of non-general practice prescribed medicines**

All non-general practice prescribed medicines (hospital only, RED drugs, specialist drugs) should be recorded in the patient's medication record to ensure that the records are complete and accurate following [local guidance](#).

ALL healthcare professionals have a responsibility to ensure that 'non-general practice Prescribed Medications' 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. 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.