THE WILLOWS MEDICAL CENTRE

Repeat Prescription and Medication Review Protocol

Document Control

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B. Document Details

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Repeat Prescription and Medication Review Protocol

Introduction

“Repeat prescribing is 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”

NOTE: Where this protocol states GP, this can also mean any other prescriber in the Practice (e.g. nurse practitioner)

The above statement will only exist and be true if a robust prescribing protocol is in place to ensure that the prescriber can monitor both usage and the effects of repeat medication and that the patient undergoes regular medication review.

The National Audit Office states that a good repeat prescribing system should be:
- Accurate;
- Flexible;
- Produce prescriptions promptly; and
- Incorporate effective record keeping, compliance checks and quality assurance.

The production of repeat prescriptions is a team approach with input not only from the GP, but also from the Receptionist and Practice Manager. Effective teamwork is therefore needed to produce high standards of practice and care.

A robust repeat prescribing system has benefits to patients, Practices and the PCT:

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

Benefits to Practices
- Able to manage own workload;
- Fewer queries/complaints;
- Better use of staff time;
- Less stress improves morale;
- Achievement of indicators in the GMS/PMS contract;
- Able to adopt new initiatives.

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

ALL staff 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.

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Repeat Prescribing Process

The Repeat Prescribing process involves the following 3 stages:

1. Production: Key Personnel: Practice Reception Staff.
2. Management Control: Key personnel: Practice Manager or delegated assistant.
3. Clinical Control: Key personnel: General Practitioner / Pharmacist / Dispenser.

Production

The number of hours from requesting a prescription to availability for collection by the patient is 48 hours or less (excluding weekends and bank / local holidays)

QOF - Medicines Management Indicator 8

Making requests

The following personnel are allowed to request repeat prescriptions:

- Patient;
- Carer;
- District Nurse;
- Pharmacist;
- Care Home Staff.

Where practices allow third party requests, they must:

- Assure patient confidentiality
- Ensure the correct information is accurately exchanged, when those making the request are not fully aware of the medications
- Guarantee probity

Receiving requests

Requests should be received by the following methods:

- Counterfoil (preferred);
- Written request;
- ***Insert if appropriate – Website address of your local PCT***;
- Practice website;
- Online via surgery clinical system;
- Verbal requests via a telephone line.

N.B. It is best practice to allow verbal requests on a dedicated telephone line, during designated times, with a member of staff designated to this task. This activity should be located away from the Reception area to maintain patient confidentiality.

Written requests are preferable to oral requests because they are more likely to be accurate, and there is a reduced opportunity for errors and misunderstandings.

A lockable box situated in ***Insert Location*** is available for patients to post their requests and should be emptied on a regular basis.

The patient should be informed when they are able to collect the prescription at the time of request (e.g. by means of a poster / Practice patient booklet, Practice website).

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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 “orange tablets”, or use a description of medication rather than specify the name (e.g. “heart tablets, pain killers”)**

**Production of Repeat Prescriptions**

- The Practice clinical computer system must be used for generating all repeat prescriptions to ensure a clear record of drug supplies to a patient is recorded.
- A list of medications which are not permitted in the repeat system should be clearly visible at the point of repeat e.g. benzodiazepines, antibiotics.
- A counterfoil (medication list) must be generated with every prescription.
- If a prescription or medication requires delivery, patients must make their own arrangements. Practice staff are not to recommend a particular pharmacy. If a patient requests home delivery of their medication, authorisation should be sought from their GP.

**Processing a Request for a Repeat Prescription**

- Check that the items requested are on the patients’ current repeat list. If the patient requests any items not on the list, refer to the GP.
- Verify that the items requested are suitable as repeat medication (See Appendix 2 for list of items that are NOT suitable).
- If the item appears on the repeat list, verify that the name, form, strength and dosage instructions are identical to the request. If there are any discrepancies, refer to the GP.
- If the authorised number of issues has been met, re-authorise for one issue only and refer to GP.
- Verify that the medication review date has not been exceeded – if it has been exceeded, refer to GP to ascertain if s/he wishes to see the patient for a medication review.
- If there is no review date set, follow procedures agreed in the surgery to set a review date.
- Where the prescription requests are earlier or later than expected, (this may indicate over or under use of that item), refer to the prescriber so that they can ascertain why the patient is not using the medication as intended.
- Cancel repeat prescriptions that have not been ordered for one year or more, (exceptions to this rule would be seasonal medications e.g. hay fever).
- Align to 28 days (where appropriate). It is good practice to limit supply of medication to no more than 28 days supply (exceptions include contraception, HRT). The supply of Controlled Drugs should always be limited to a maximum of 28 day’s supply (See Appendix 3 for detailed information on Controlled Drugs Prescriptions).
- Patients receiving their medications in Monitored Dosage Systems should receive a prescription for 28 days supply and not (4x7) days supply, unless clinically appropriate (e.g. benzodiazepine abuse).
Processing a Repeat Prescription

- Once the prescription has been printed, place it into a designated pile to be signed by the GP. (Repeat prescriptions should only be signed by a prescriber who knows the patient, or at least has direct access to the patient’s clinical records.)
- Once the prescription had been signed, it should be returned to the Receptionist for collection by the patient or patients’ representative. For dispensing patients, the prescription should be passed to the dispensary.
- The signed prescription should be stored in a secure, supervised place, out of reach of the public, as it contains confidential information about the patient.
- The name address and date of birth should be checked with the person collecting the repeat prescription to confirm the identity of the patient.
- Any prescriptions being collected by an outside agency (e.g. Community pharmacy), will have been agreed and a signed consent will be in the patient’s notes. This should be checked and verified if the Receptionist is not aware of such an arrangement.
- On no account should the prescription be collected by anybody under 16 years of age.
- Any prescription that has not been collected after 1 month should be highlighted to the prescriber. If it is determined that the prescription should be destroyed, the issue should be deleted from the issue record.
- If a review date is required or overdue, the patient is advised of this and an appointment made.

Management Control

Authorisation

- Within the Practice it should be clearly stated who can add authorised medications to a patient’s repeat medication list (only an appropriately qualified prescriber can authorise repeats e.g. GP, Pharmacist, Non-medical prescriber).
- In line with good practice, medications added to a patient’s repeat list should always be double checked by another authorised member of staff.
- When a medication is first added to a repeat prescription, it should be noted clearly in the patient record why it was started in the first place, and linked to a condition.
- Often newly prescribed medication (until suitability is confirmed) and medication with frequent dose changes would be better set up as an acute prescription.
- The number of repeats, or the period of time, allowed before the next review should be defined.
- In the event that a request is placed for a drug that is not authorised as a repeat item, a prescription MUST NOT be generated:
  - An explanatory note should be attached to the patient’ record; and
  - The GP informed.
If the GP decides to authorise the prescription, ensure any message from the GP to the patient is communicated to the patient, by attaching a note to the prescription.

Compliance check

If a patient is over / under- using medication, a prescription MUST NOT be generated:
  - An explanatory note should be attached to the patient’ record; and
  - The GP informed.
If the GP decides to authorise the prescription, ensure any message from the GP to the patient is communicated to the patient, by attaching a note to the prescription.
Flagging of problems
If there is a query, a prescription **MUST NOT** be generated:
- An explanatory note should be attached to the patient’s record; and
- The GP informed.
If the GP decides to authorise the prescription, ensure any message from the GP to the patient is communicated to the patient, by attaching a note to the prescription.

Urgent requests
- Immediately pass the request to the Receptionist dealing with Repeat Prescriptions highlighting the urgency;
- Approach the GP at the end of surgery.

**Note:** production and management control criteria are still valid

Hospital Discharge Medication / Outpatient Attendance / Home Visits
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 by the GP / pharmacist in conjunction with details of the patient’s current medication.
- Hospital communications must be made available to the GP at the end of the next surgery following their receipt.

Once received by the clinician, hospital communications should be actioned as follows:
- The patient’s clinician has reviewed the letter and decided on appropriate action;
- A medication review has been conducted;
- An appointment or domiciliary visit has been made and:
  - It has been verified that the patient has enough medication;
  - It has been determined if there is any need for an acute prescription;
  - The patient has been asked to bring all their medication to surgery (if applicable);
  - The patient’s review date has been appropriately updated.
- If a patient requests a supply of medication before the hospital communication has been received, a faxed copy must be requested from the hospital. The urgency placed upon this request should be guided by the duration of the patient’s remaining supply;
- Sight of medication dispensed to the patient is not a suitable means of verifying amendments made to a patient’s regimen. In particular, Reception Staff must not use the labels of such items, to transcribe a request for a repeat prescription;
- The clinician should indicate that the patient’s computer records have been updated by signing and dating the discharge letter. Checks should include:
  - Duplication of same drug;
  - Dose;
  - Form;
  - Quantity.
- To verify any changes, the read codes medication changed (.8B316) or medication commenced (.8B313) should be used.
- Delete medication that has been discontinued;
- Align medication to 28 days;
- This process should not be done by a Receptionist.
Any alterations to a patient’s medication, made outside of a practice consultation, (e.g. home visit), must be updated at the earliest opportunity by the GP.

Handwritten prescriptions must be entered onto the computer system at the earliest opportunity. This will:
- Reduce inadvertent duplication of prescribing;
- Reduce the possibility of unintentional drug interactions; and
- Provide an audit trail.

If a patient requests a supply of medication that has been issued on a handwritten prescription, but is not on the computer record:
- Attach an explanatory note to the patient’s record;
- Approach the GP at the end of surgery.

Patients should be given information explaining the repeat prescribing system.

**Patient information**
- A poster explaining the Practice repeat prescribing policy should be displayed in the reception area and the message reiterated face to face when necessary;
- A Practice repeat prescribing leaflet should be available, located at the point where repeat prescriptions are collected;
- The message section of the counterfoil should be used to inform the patient of the repeat prescribing policy.

**Quality Assurance**
An audit of the repeat prescribing system should be conducted annually

**Clinical Control**

**General**
- A “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.
- A recall system should also be in place to ensure that patients who do not order their medication are also reviewed.
- Where possible, reviews should be conducted in person; however in certain circumstances, telephone consultations may be acceptable

**Initiation**
- The prescriber must be satisfied that drug treatment is appropriate and necessary.
- Consideration should be given to non-drug treatments and lifestyle interventions.
- The patient must be reviewed at least once before granting a prescription repeat status.
- Medication should be prescribed to only cover the period until assessment of suitability.
- Patient sensitivities and significant interactions should be considered.
- Prescribing should be generic, unless there is good reason not to do so. Exceptions include:
  - Modified release nifedipine;
  - Modified release diltiazem;
  - Lithium;
  - Modified release theophylline;
  - Anticonvulsants.
A more comprehensive list is available in [Appendix 1](#).

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• The dose and frequency must be specified:
  ➢ The instruction “as directed” should not be used;
  ➢ The instruction “when required” should not be used alone.
• The patient should be given an explanation of what is being prescribed and why.
• The patient understands whether the drug is an addition to or replacement for current medication should be verified.
• Common adverse effects should be discussed; consider if the patient might be concerned by the manufacturer’s patient information leaflet.
• An explanation as to how the drug(s) is administered (and demonstrated, if appropriate).

**Authorisation**
• The GP must have an allocated time set aside each day for signing / reviewing repeat prescriptions.
• The prescriber should be satisfied:
  ➢ The drug is effective (look for objective evidence);
  ➢ Long term treatment is needed;
  ➢ The patient is concordant;
  ➢ No important adverse effects are experienced.
• Only prescriptions for patients with stable, chronic conditions should enter the repeat system.
• Prescribe 28 days supply at a time.
• The prescriber should check the following:
  ➢ Drug name, strength, form and dose;
  ➢ Indication for each drug;
  ➢ Monitoring plan,
  ➢ Date of next review.
• Repeat prescriptions should be reviewed and signed by the 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.
• A system should be in place for distributing a GP’s prescriptions during cases of absence.

**Medication Review**

**Preparation**
• A medication review requires consultation between the patient and a healthcare professional on an individual basis with respect to their illness and their medication
• The patient’s medical record should be checked to identify if the patient has been reviewed by another healthcare professional; consider whether the consultation is necessary for existing co-morbidities
• If a review is necessary, the Receptionist should be asked to:
  ➢ Make an appointment or arrange a domiciliary visit within one week;
  ➢ Ensure the patient has sufficient medication; an acute prescription may be necessary;
  ➢ Request the patient brings all of their medication to the review consultation.
The Medication Review process

- 12 months should be adopted as the standard review interval: 6 months for patients over 75 years on four or more repeat prescriptions. ***Dispensing Practices ONLY – if you are participating in the DSQS (Dispensary Services Quality Scheme), a DRUM (Dispensing Review of the Use of Medication) may also be undertaken to specifically check compliance and concordance***.
- Compare the patient’s medication to the intended drug regimen and resolve any discrepancies (advise patient to return unwanted medication to a pharmacy).
- Examine the effectiveness of each drug and consider:
  - Cessation;
  - Read code Drug Rx stopped – medical advice (8B35)
    - Cancel item: reason - Discontinued by prescriber at medication review;
    - Therapeutic substitution (to formulary item);
  - Read code Medication changed (8B316) or
    - Drug changed to cost effective alternative (8Blr)
    - Generic substitution
  - Read code Medication changed to generic (8B3o)
- Dose adjustment
  - Read code Prescription dose change (66R5-1)
- Document any side effects / ADRs / allergies in the patient’s record.
- Ensure necessary tests are being carried out at appropriate intervals i.e. U&Es, LFTs etc.
- An entry should be made in the patient’s medical record at the time of medication review to indicate that it has occurred, noting any changes.
- Ensure the patient is informed of the next review date.
- Discuss the patient’s treatment:
  - Is the drug being taken properly?
  - How does the patient feel about the treatment?
  - Ensure the patient understands the purpose of each drug.
  - Are there any side effects?
  - Is the patient taking any drugs you are not aware of e.g. OTC medication, alcohol?
- Update the computer, including review date and print a new paper record
- Clearly record:
  - Drug name, strength, form and dose;
  - Indication for each drug;
  - Monitoring plan;
  - Read code Drug monitoring up to date (8Blf) or Drug Monitoring not required (8Bld) DRUM carried out (XaMhk) or DRUM declined (XaMzC) if appropriate
    - Number of issues authorised;
    - Date of next review.
- Provide the patient with an updated, printed medication list and a review date.

Specific patient groups

- Medication review / monitoring must be included in the protocol(s) of chronic disease management clinic(s).
- The healthcare professional conducting the clinic may re-authorise existing medication only (unless they hold the relevant prescribing qualification). Any amendments to a regimen must be made by the GP.
- The GP is notified of the re-authorisation.
- Clinic and medication review dates should coincide in order to ensure attendance.
**Domiciliary visits**
- The GP must update the patient’s computer and paper records immediately upon return to surgery.

**Patient information**
- 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 using their counterfoil.
- The timing of the review date should also be advised to them.
- This process should be documented in the Patient’s medical record.

**Recent Initiatives**

**Repeat Dispensing** was introduced as part of the new pharmacy contract as an essential service.

The aim of the service is to allow patients to request and collect their medication directly from the community pharmacy of their choice.

In essence the prescriber can issue a master repeat prescription, followed by a series of batch prescriptions (up to 12), with only the master prescription requiring a signature.

The batch prescriptions are then stored at the community pharmacy. (see also Repeat Dispensing Protocol)

**Electronic Prescription Service (EPS)** is a new service that will make it easier for GPs to issue prescriptions and more convenient for patients to collect their medicines.

Using EPS means that prescriptions by GPs and other prescribers will be transferred electronically to the pharmacist nominated by the patient. The prescriptions will also be sent automatically to the Prescription Pricing Authority. This service will be introduced in a staged release process - more details can be obtained at: [www.connectingforhealth.nhs.uk](http://www.connectingforhealth.nhs.uk).

**Insert if applicable**

**Online ordering of medication** is available to patients who wish to register their repeat medication details on the ***Insert Practice Website / Clinical System Online Ordering Address***.
Appendix 1

**Items not suitable for generic prescribing**

Some drugs should be prescribed by BRAND name - not by GENERIC name due to differences in product formulations.

Formulary choices are in bold.

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<table>
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<tbody>
<tr>
<td>1. Lithium</td>
<td>Camcolit / Priadel L iskonium</td>
</tr>
<tr>
<td>2. Drugs for Epilepsy</td>
<td>Where available, generic versions of anti-epileptic medications can be used except where this is advised against in the current BNF (registration is required to access this information) (i.e. certain carbamazepine and phenytoin preparations.) – Formulary Liaison Group</td>
</tr>
<tr>
<td>3. Nifedipine</td>
<td>(non formulary Adalat, Adipine, Coracten)</td>
</tr>
<tr>
<td>4. Diltiazem</td>
<td>Tildiem, Slozem (non formulary Adizem, Angitil, Dilzem)</td>
</tr>
<tr>
<td>5. Isosorbide Mononitrate SR</td>
<td>Isib XL, Isotard, Monomax (Elantan LA, Imdur, Isodur, Ismo Retard, Monosorb)</td>
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<tr>
<td>6. Mesalazine</td>
<td>Asacol, Pentasa, (non formulary Salofalk)</td>
</tr>
<tr>
<td>7. Sulfasalazine</td>
<td>Salazopyrin, (non formulary Sulazine EC)</td>
</tr>
<tr>
<td>8. Theophylline</td>
<td>Nuelin SA, Slo-Phyllin, Uniphyllin</td>
</tr>
<tr>
<td>9. Aminophylline</td>
<td>Phyllocontin</td>
</tr>
<tr>
<td>10. Oxycodone</td>
<td>OxyNorm, OxyContin (m/r)</td>
</tr>
<tr>
<td>11. Verapamil</td>
<td>Securon, Half Securon, (non formulary Cordilox, Univer, Verapress MR, Vertab SR)</td>
</tr>
<tr>
<td>12. Morphine SR</td>
<td>MST</td>
</tr>
<tr>
<td>13. Fentanyl Patches</td>
<td>Fentanyl, Durogesic D-trans patch</td>
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Appendix 2

Items not suitable as repeat medication

- Aciclovir
- Antibacterial/ antifungal lozenge or mouthwash
- Antibiotics
- Canesten preparations
- Chloramphenical ear drops/ointment
- Hypnotics (other than long term existing patients, providing they have been counselled
- Methotrexate (only under shared-care protocol) – see NPSA alert [http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59800&q=0%c2%acMETHOTREXATE%c2%ac](http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59800&q=0%c2%acMETHOTREXATE%c2%ac)
- Ondansetron
- Pseudoephedrine
- Very potent topical steroids
- Zyban
- Warfarin – see NPSA alert [http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59814&q=0%c2%acWARFARIN%c2%ac](http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59814&q=0%c2%acWARFARIN%c2%ac)
Appendix 3

Controlled Drug Prescriptions

Schedule 2 and 3 controlled drugs (except temazepam)

CD prescriptions may be computer-generated or handwritten. Prescribers may issue computer-generated prescriptions for all CDs. Only the signature has to be in the prescriber’s own handwriting.

Alterations are best avoided but if any are made, they should be clear and unambiguous. If an error is made, best practice is for the prescriber to cross out the error, initial and date the error then write the correct information.

A prescription for Schedule 2 and 3 CDs (with the exception of temazepam and preparations containing it) must contain the following details:

- Written so as to be indelible e.g. written by hand, typed or computer generated
- The patient’s full name, address and where appropriate, age. An email address or PO Box is not acceptable. ‘No fixed abode’ is acceptable as an address for homeless people.
- The name and form of the drug, even if only one form exists
- The strength of the preparation, where appropriate (if more than one strength exists)
- The dose to be taken
- The total quantity of the preparation, or the number of dose units to be supplied both in words and figures.

The Practice will adopt best practice and ensure that the quantity for prescriptions of Schedule 2, 3 & 4 drugs will be limited to a quantity necessary for up to 28 days clinical need, unless there is a genuine need or exceptional circumstances where the prescriber believes a supply of more than 28 days medication is clinically indicated and would not pose an unacceptable threat to patient safety.

In this event, the prescriber will:

- Make a note of the reasons for this in the patient’s notes.
- Be ready to justify his / her decision if required.
- Signed by the prescriber with their usual signature (this must be hand written) and dated by them (the date does not have to be hand written). The date can be either the date of signing OR the date the prescriber wishes the prescription to start.
- The address of the prescriber must be stated on the prescription and must be within the UK (does not include the Channel Islands or the Isle of Man)

Temazepam and Schedule 4 and 5 controlled drugs

- Prescriptions for temazepam and for Schedule 4 and 5 CD’s are exempt from the specific prescription requirements of the Misuse of Drugs Regulations 2001. However they must still comply with the general prescription requirements as specified under the Medicines Act.

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## Repeat Prescribing - Risk Assessment Tool

<table>
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<tr>
<th>QUESTION</th>
<th>SCORES</th>
<th>YOUR PRACTICE SCORE</th>
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<tr>
<td>Is there a written protocol?</td>
<td>Yes = 0 ; No = 1</td>
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### Production

<table>
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<th>Request</th>
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| How are requests taken? | Telephone = 2  
Telephone for housebound = 0  
Written / post / fax / internet = 0  
Right hand side FP10 = 0 |
| If a request is hand-written, is it accepted on: | Right hand side FP10 = 0  
Other = 1 |
| If a request is taken verbally, does the same person generate the script? | Yes = 0 ; No = 1 |

<table>
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<td>Is there a dedicated member of staff doing the repeats designated and trained?</td>
<td>Yes = 0 ; No = 1</td>
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<td>Are all scripts computer generated?</td>
<td>Yes = 0 ; No = 2</td>
</tr>
<tr>
<td>What is the turnaround time?</td>
<td>&lt; 48 hours = 0 ; &gt; 48 hours = 1</td>
</tr>
<tr>
<td>Is there designated time set aside for doing the repeats?</td>
<td>Yes = 0 ; No = 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Are the paper notes/ made available for queries (where appropriate)?</td>
<td>Yes = 0 ; No = 1</td>
</tr>
<tr>
<td>Is there a set time for signing?</td>
<td>Yes = 0 ; No = 1</td>
</tr>
<tr>
<td>Are the appropriate resources available (e.g. computer) when signing?</td>
<td>Yes = 0 ; No = 1</td>
</tr>
<tr>
<td>Do all Practitioners perform a check before signing?</td>
<td>Yes = 0 ; No = 1</td>
</tr>
</tbody>
</table>

### Misc

| What happens when a prescription is lost? | Reprint = 0 ; Reissue = 1 |
| What happens when prescriptions are not collected? | Recorded = 0 ; Not recorded = 1 |
| If a prescription is reprinted, is this documented? | Yes = 0 ; No = 1 |

**Maximum Production Risk Total = 16**

Your Practice’s Production Risk Total =
## MANAGEMENT

### Authorisation

| Who authorises the repeats? | Receptionist = 2  
|                            | Nurse = 0  
|                            | Doctor = 0  
|                            | Nurse Specialist = 0 |

| What is the process for reauthorisation? | GP/prescriber notified = 0  
|                                         | GP/prescriber not notified = 2 |

| How many issues are usually made? | 0-6 = 0  
|                                  | 6-12 (for stable patients) = 0  
|                                  | 1-12 (for unstable patients) = 2 |

### Compliance

| Is compliance checked before prescription issued? | Yes = 0  
|                                                | No = 1 |

| Is there a standard written procedure for over / under compliance? | Yes = 0  
|                                                                | No = 1 |

#### 1. Housekeeping

**Using a random sample of 20 repeat prescription requests:**

| Out of the sample, were there any branded items that should be generic? | Yes = 0  
|                                                                        | No = 1 |

| Out of the sample, were there any items that required dose optimisation? | Yes = 0  
|                                                                        | No = 1 |

| Out of the sample, were there any double items? | Yes = 2  
|                                                | No = 0 |

| Out of the sample, were there any items that had not been collected for 6 months or more? | Yes = 0  
|                                                                                         | No = 1 |

| Out of the sample, were there any dosage instructions missing? | Yes = 0  
|                                                              | No = 1 |

| Are the test results up to date? | Yes = 0  
|                                | No = 1 |

| Were all quantities equivalent? | Yes = 0  
|                                | No = 1 |

**Maximum Management Risk Total = 16**  
**Your Practice’s Management Risk Total =**
## CLINICAL

### Acute Prescription Requests

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>From agreed protocol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who issues acute requests?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receptionist</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receptionist from agreed protocol</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Can previously authorised acute prescriptions be issued by Receptionists?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Yes from agreed protocol</td>
<td></td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

### Discharges

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who makes the decision to add / delete medication from the repeat?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>From agreed protocol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who updates the repeat prescription screen?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receptionists not checked by doctor after update</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receptionist but doctor / practitioner checks after update</td>
<td></td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

### Medication Review

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who carries out medication reviews?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Pharmacist</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Not been reviewed at appropriate intervals</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Is there a procedure for highlighting when medication review is due?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

### Maximum Clinical Risk Total = 11

| Your Practice’s Clinical Risk Total = |

### Maximum Risk Score = 44

| Your Practice’s Total Risk Score = |

The audit is scored up to 44 points: *higher score = higher risk*

- **1-5 low risk** - audit to be repeated every 2 years
- **6-10 still low risk** - audit to be repeated every 18 months
- **11-20 Medium risk** - audit to be repeated every 12 months
- **21 or above high risk** - audit to be repeated every 6 months

If there are dramatic changes to a Practice (such as a high turnover of staff, new computer system or new Practice Manager), then it is recommended that a further risk assessment be carried out 3 months after that change was implemented.