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Consultation at: LLR Medicines Optimisation Committee & LPC/Area Team Primary care  

Approved by: LLR Medicines Optimisation Committee  

On: 25th March 2015  

Review Date: 25th March 2016  

Directorate responsible for Review: LLR Prescribing & Medicines Optimisation  

Policy Number: ELR MM 014.
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1. EXECUTIVE SUMMARY
Repeat prescribing plays a significant part in the supply of medicines to patients in primary care. Two-thirds of prescriptions generated in primary care are for patients who have requested a repeat supply of medicines they take regularly; this represents some 80% of medicines costs. It is estimated that 2.4 million prescriptions are issued each day in England, meaning that approximately 1.92 million prescriptions are issued each day for repeat items. It is therefore important to general practice staff and patients that an efficient and effective repeat prescribing system is in place.

A poorly designed system, or one that is not well managed, can cause frustration to patients, practice staff and other health care professionals. It can waste precious time, as well as leading to an increase in the likelihood that mistakes could be made, thus putting patients’ health at risk.

2. Aim
To provide guidance to pharmacy contractors and GP practices on the following services:

- 3rd party repeat medication ordering (third party refers to any person or company ordering on behalf of the patient, this could be relatives, carers, care agencies, pharmacies, external suppliers: this list is not exhaustive)
- 28/56 day prescribing
- Prescribing for patients using Monitored Dosage Systems (MDS) and to provide clear guidance for all stakeholders on the situations where the provision of 7 day prescriptions is and isn’t appropriate.

It is hoped that these guidelines will provide a framework & promote a robust systems for the management of these services.

3. Scope
These guidelines apply to all parties within LLR:
This includes

- Community Pharmacist (CP) & their staff
- GP practice receptionists
- Patients
- Dispensing Doctors
- GPs
- All prescribers e.g. Nurse prescribers, District Nurses
- Care Staff e.g. Community Carers, District Nurses, Care Home staff
- Secondary Care colleagues
4. 3rd Party Repeat Medication Ordering

- Background
- Rationale
- Definition
- General Principles
- General Practice Responsibilities
- Community Pharmacist Responsibilities
- Standard Operating Procedure
- Repeat Dispensing Service
- Best Practice guidance for ordering medication to reduce wastage in Care Homes
- Best Practice guidance for ordering appliances and Oral Nutritional Supplements
- Secondary Care Responsibilities

**Background**

The gross annual cost of NHS primary and community care prescription medicines wastage in England is currently in the order of £300 million per year. It includes an estimated £90 million worth of unused prescription medicines that are retained in individuals’ homes at any one time, £110 million returned to community pharmacies over the course of a year, and £50 million worth of NHS supplied medicines that are unused by care homes.

The study showed that the most common causes of waste are:

- therapies being stopped or changed because, for example, of ineffectiveness and/or unwanted side effects
- patients’ conditions progressing, so that new treatments are needed and others become redundant
- factors relating to repeat prescribing and dispensing processes, which may independently of any patient action or inaction cause excessive volumes of medicines to be supplied
- care system failures to adequately support medicines taken by vulnerable individuals living in the community or institutions, who cannot independently adhere to their treatment regimens.

The report also recommends that understanding, monitoring and managing the varied, complex and changing processes by which medication is requested, written, verified, issued, collected, checked and dispensed is central to efficient and effective waste management.\(^1\)

**Rationale**

- There is a growing trend for community pharmacy to take on a greater role in the management of repeat prescription ordering for patients, which is driven by the needs of our aging population.
• Systems which are in place to manage repeat ordering need to be robust to prevent ordering of unwanted and unneeded items.

• As part of its duty to the taxpayer, the CCG is determined to prevent unnecessary waste.

• Any suspicions of fraud will be investigated by the CCG.

• Following discussions with the LPC it has been agreed that these guidelines should be produced and circulated.

• These Good Practice Guidelines have been prepared and agreed by ELR CCG, LMC and LPC.

Please ensure that all relevant staff has access to this guidance.

Definition:

A pharmacy prescription collection service is where the pharmacy representative acts as an agent on behalf of the patient to, collect, dispense and/or deliver the medication to the patient. The agent follows the same procedure as would a relative or friend submitting a prescription on behalf of the patient, collecting it and then having it dispensed. The pharmacy offering a prescription service should do so in compliance with the General Pharmaceutical Council (GPhC), Standards of conduct, ethics & performance (July 2012).

General Principles

1. Where a patient is capable of ordering their own repeat medication they should as a rule be encouraged to do so. Deviation from this will require the patient’s informed consent and choice.

2. Written permission from patients is required to allow a pharmacy to collect prescriptions on the patient’s behalf. This is normally obtained by the pharmacy and a copy produced for the GP if requested.

3. GP practices provide a variety of methods for patients to request repeat medicines.

4. Where the Electronic prescribing system (EPS) is used, the GP practice will have a record of the nominated pharmacy recorded on the system. Any amendments made to prescribing in the period the scripts are held in the spine or nominated pharmacy will allow surgeries to cancel the scripts to enable the appropriate re-issue.

5. Paper based methods of requesting repeat medicines should utilize the most recent printed repeat prescription request slip wherever possible.

6. The prescription repeat slip, which is generated by the prescriber, is the property of the patient and should normally be given to the patient (the patient may give permission to the pharmacy to retain this)

7. Repeat requests should not, other than in exceptional circumstances, be submitted to a GP practice more than **five working days** before the current supply runs out.

8. Where repeat slips are used, the patient, or carer or representative is required to indicate on the repeat slip which items they require and then sign and date the form.

   > It is **not** good practice to do this at the time of issuing the previous month’s supply as this can lead to unnecessary waste and stockpiling.
It is not acceptable to routinely add items to the repeat slip.

9. Patient and pharmacy staff will confirm that every item requested is required at time of dispensing before the patient leaves the pharmacy.

10. It is the responsibility of all Health Care Professionals to ensure the appropriate use of resources, that waste is reduced and that clinical risk is minimized

GENERAL PRACTICE RESPONSIBILITIES

- Have a repeat prescribing policy and procedures that are regularly reviewed to take into account changes in prescribing arrangements (e.g. supplementary prescribing, repeat dispensing arrangements) and practice developments.
- Repeat prescribing is overseen and managed by an appropriately trained individual, with deputy and cover arrangements and advisable that one person is trained to deal with all 3rd party requests for prescriptions, this minimises unnecessary duplication, and with enhanced training to provide this empowers a named staff which will reduce waste and minimise potential delay in ordering. This member of staff may also be responsible for contacting patients to ascertain if request quantities are needed on a regular basis.
- All members of staff, including locum prescribers, are trained and fully aware of how the practice repeat prescribing system works, and are aware of their individual responsibilities
- Check the prescription repeat request for accuracy and on-going clinical needs.
- Review the need of having PRNs on the repeat request, add indication for PRN
- Medicines prescribed 'as directed' should clearly define purpose and how the medicines is to be used to ensure medicines use is optimized and reduced patient harm
- Repeat prescribing items should have a clearly defined appropriate interval of reauthorisation for repeats, with a proper system to call patients for review. Regular clinical and medication reviews take place, including an assessment of concordance
- Process repeat requests as outlined in the practice repeat prescribing policy (normally 2 working days).
- Reconcile and align medicines when patients move between healthcare settings, particularly discharge from hospital, and amend repeat prescription list accordingly within 2 weeks of discharge.
- Communicate with appropriate community pharmacy any issues with repeat prescribing systems.
- It is important that patients are aware that they have a choice as to where their prescription can be dispensed.
- Patients should be advised on the importance of only requesting items they actually need by the pharmacy.
- Practices should be vigilant about the number of requests for repeat prescriptions from 3rd parties, as well as the quantities requested e.g. Care Home requests, do they need all the PRN medication each month?
- Partnership with the patient is utilised to ensure maximum concordance and satisfaction with the treatment option, and early feedback of any potential problems
- Information is readily available to help patients and carers understand the system (ordering, collecting prescriptions, how to request help, reviews, etc.), and considers the needs and convenience of carers, including those looking after more than one patient. Comments received are carefully considered and, where appropriate, acted upon.
- Quality is regularly assessed. Learning from adverse incidents, including complaints
and ‘near-misses’ are used to improve and develop the system.

- Adverse incidents involving black triangle drugs are reported via the ‘Yellow Card Scheme’
Community Pharmacist responsibilities

- The Standards for registered pharmacies (Sep 2012) from the GPhC underpin principles which should be followed. Some of the key standards to note relevant to these guidelines:

  ✓ 1.2. The safety & quality of pharmacy services are reviewed & monitored
  ✓ 1.4 Feedback & concerns about the pharmacy, services & staff can be raised by individuals & organisations, and these are taken into account & action taken where appropriate
  ✓ 2.6 Incentives or targets do not compromise the health, safety or wellbeing of patients & the public, or the professional judgement of staff
  ✓ 4.2 Pharmacy services are managed & delivered safely & effectively

- The Standards of conduct, ethics & performance (Jul 2012) from the GPhC should be followed. Some of the key standards to note relevant to these guidelines:

  ✓ 1.1 Make sure the services you provide are safe & of acceptable quality
  ✓ 1.6 Do your best to provide medicines & other professional services safely & when patients need them
  ✓ 3.6 Get consent for the professional services you provide & the patient information you use
  ✓ 6.1 Act with honesty & integrity to maintain public trust & confidence in your profession
  ✓ 7.6 Be satisfied that appropriate standard operating procedures are in place & are being followed
  ✓ 7.7 Make sure that you keep to your legal & professional responsibilities and that your workload or working conditions do not present a risk to patient care or public safety.

- Not to contact the prescriber to provide retrospective prescriptions to cover a non-urgent situation
- Each time a patient collects medication, confirm that it is the correct items they were expecting
Where pharmacies submit prescription repeat requests on behalf of patients, the preferred system is as follows:

Check patients has received the correct medication  

Mark required medication from repeat slip for next time **not more than 5 days in advance** of the due date  

Sign the repeat slip & state number of items ordered  

Provide patient with a date for collecting/delivering their next medication  

File repeat slip within the pharmacy  

Submit repeat slip to GP practice no more than **FIVE** days before patients due date  

For patient requests in person: Follow steps 4, 6 & 1  
For telephone/online requests: Follow steps 4, 6, 1 & 5
Standard Operating Procedures (SOPs)

Please ensure that all the relevant staff in your pharmacy are aware of the need, on each occasion to discuss with their patients and verify the points above

GPhC standards highlight that appropriate SOPs are in place & are being followed. Pharmacists that run a “managed repeat” service on behalf of patients must produce SOPs to cover such services & should carry out this service in accordance to it.

Managed Repeat SOPs should include the following steps and stipulations:

a. A patient should give signed authorisation for a community pharmacy to order repeat medication on their behalf. A copy of this signed authorisation should be kept by the pharmacy and be made available for verification if the need arose
b. Confirmation of which repeat items, should be obtained directly from the patient/carer by a suitably qualified person (PRN medication (e.g. creams, paracetamol tablets, inhalers etc) should be ordered by patients as & when they require them)

This check must not be delegated to delivery drivers or other unqualified staff, unless they have been suitably trained to follow the necessary SOP

c. How, when and by whom this confirmation is obtained should be recorded and records retained so that in the event or a complaint a comprehensive audit trail is in place. (Confirmation can be for example, either a dated signature from the patient, or a dated record of a phone call to a patient with a signature from the member of staff making the call or adequate computer records).
d. Repeat prescription requests submitted on behalf of a patient by a pharmacy to a practice must bear the pharmacy name and address and be in a clear format.

Repeat Dispensing Service

This service allows patients to collect their regular repeat prescription medicines directly from their local pharmacy for an agreed period of time, without having to go back to their GP.

If poorly delivered it can pose a risk to patients and will generate unnecessary waste. To ensure this doesn’t happen ensure robust SOPs are in place for the delivery of this service and ensure patients are asked the following questions each time they collect their medication:

- Have you seen any other health professional since your last prescription was issued?
• Were there any medication changes?
• Are you having any problems with your medication or experiencing any side effects?
• Do you have any items available on repeat, which you would like deleted, or do not need on this occasion?
• Are you taking any over-the-counter medicines, herbal remedies or food supplements at the moment?
• Have any new problems / symptoms developed recently?

In order to prevent waste that could be inadvertently generated from EPS batch prescription issues, the above principles should be applied each month prior to downloading the month’s prescription token. Community pharmacies are encouraged to ensure these are addressed in the SOP as part of EPS service delivery. GP practices should also ensure their procedures to handle changes to medication and reconciliation of medication following discharge from hospital and patients in hospital allow these patients to be highlighted so a block or change to EPS prescriptions can be made to avoid unnecessary supply of unnecessary medication.

Using the pharmacist referral form (Appendix 1), notify the GP practice of any safety/inappropriate use of medicines.

In order to have multi stake holder ‘buy in’ to adhere to good practice guidance a suggested Repeat prescription management charter has been included as appendix 5. This could be used at local levels for GP surgeries, community pharmacies and patients to agree to.

Please see the PSNC website for additional information on the Repeat Dispensing Service.

**Best Practice guidance for ordering medication to reduce wastage in Care Homes**

Care homes have a key role in helping reduce medicines waste. Within care homes residents are often on numerous medicines and may administer their own medicines or more frequently staff may assist or prompt residents with their medicines. Having good procedures for ordering, storage and administration of medicines can help reduce wastage.

The care home manager, community pharmacist and GP surgery should develop relationships which ensure that they understand respective systems, processes and needs. Key contacts should be built within the homes to enable any issues to be resolved.
Best Practice Medication Cycle for Care Homes

Timeline

Week 1

- Start the medication cycle on the agreed day of the week (Day 1)

Week 2

- **Care home require new monthly order for repeat medications:**
  Medicines needed for the following month are identified by a designated staff member (or deputy) from MAR charts, as well as discussions with care staff. Stock levels of “When required”, “Externals” and “Sip feeds” must be checked.

- ONLY order what is required referring to a copy of current MAR charts

- Medication order is sent to GP Practice using the repeat slip or electronically online by the care home on agreed day of medication cycle

1. Prescriptions are generated by designated GP practice staff – consider retaining a copy of the Care Home request at the practice for 1 month
2. If surgery is using EPS, the prescriptions are electronically sent to the nominated pharmacy

1. Prescriptions are sent by the surgery to the care home for checking (Collected by care home or by pharmacy)
2. If using EPS then the care home can collect the prescription tokens from the pharmacy and check their order against it.

Week 3

- Prescriptions are checked – any discrepancies are resolved as soon as possible with the GP practice

Week 4

- Pharmacy dispenses prescriptions – any discrepancies are resolved with the care home or GP practice

- Dispensed items are sent to care home at least 2 working days prior to the new medication cycle starting

- Medication is checked (resolving any discrepancies as soon as possible) and ready to administer to service user on Day 1 of the new medication cycle
Rationale for Medication Cycle process

- **Start the medication cycle on the agreed day of the week (Day 1)**
  Agree with the Community Pharmacy and GP practice the starting day of the medication cycle. This will be the same each month.

- **Care home requires new monthly order for repeat medications**
  The ordering cycle starts during week 2 to allow time to complete the checking process and delivery of medication in time for the new medication cycle to start.

- **Medicines needed for the following month are identified by designated staff member (or deputy) from MAR charts as well as discussions with care staff. Stock levels of “When required”, “Externals” and “Sip feeds” must be checked.**
  This part of the process takes into consideration in-house expiry dates and carrying forward appropriate medications to the next medication cycle. Adequate protected time should be given for this task which should take place in a quiet area without disturbance. The designated staff member must be familiar with all aspects of service user’s medications. A competent deputy should be appointed to cover for absence.

- **Only order what is required referring to a copy of current MAR charts.**
  The right hand side (RHS) of the prescriptions received from the community pharmacy with the previous months order should be checked alongside current MAR chart. MAR charts are checked for any changes, eg doses/medications that have been changed, stopped or newly started. Any hand written alterations by the prescriber and any additional notes should be observed (reverse of MAR, carer’s notes, etc) for any entries made regarding medication which state reasons for omissions/PRN administration/any other relevant information regarding medication. It is vital that the care home keeps a copy of the order.

- **Prescriptions are generated by designated practice staff.**
  Consider retaining a copy of the care home request at the GP practice for 1 month. This will help resolve any subsequent discrepancies. The GP practice should nominate a designated member of staff to liaise with the care home and community pharmacy. This person fully understands the ordering process of the care home. Job shadowing opportunities could be offered to care home/GP practice/community pharmacy staff to gain full understanding of each role. If the surgeries are using EPS then the prescription will be sent electronically to the pharmacy. The surgery can check what medication was authorized for care home residents on their clinical system if there are any discrepancies.-see Appendix 4 for Leicestershire position statement on use of EPS for care home repeat ordering

- **Prescriptions go back to the care home for checking (collected by care home or by pharmacy)**
  A designated care home staff member has protected time to check prescriptions either from the GP practice against the order prior to the pharmacy receiving them OR if EPS in place then the care home can collect the prescription tokens from the pharmacy and check these against their order prior to the pharmacy dispensing the medication.
Prescriptions are checked against the order
Any discrepancies are resolved with the GP practice as soon as possible. Each prescription is matched to the order and checked in case there have been any changes made by the GP during the interim period. Any discrepancies are resolved with the GP practice. Consider making a copy of the prescriptions before sending them to the pharmacy.

Pharmacy dispenses prescriptions
Any discrepancies are resolved with the care home or GP practice. Sufficient time is allowed for the pharmacy to dispense the medications. Processing time is pre-arranged to ensure timely delivery of medication and to allow for the dispensed items to be checked accurately by the care home prior to the medication cycle starting.

Dispensed items are sent to care home at least 2 working days prior to the new medication cycle

Medication is checked and ready to administer to the service user on Day 1 of the new medication cycle
Upon receipt, the medications must be checked and booked in by a designated care home staff member. Any discrepancies are resolved with the community pharmacy, including any delay in delivery. The new MAR charts are compared with the existing charts. If changes have been made in the interim, the new MAR charts are amended and alterations signed and dated by 2 members of staff, adding a reference for the amendment e.g. note from prescriber, endorsing the date the prescriber altered the medication.

CARE HOME STAFF RESPONSIBILITIES

- The care home staff should check stock each month and order only what is needed to cover the next 28 day cycle for each resident
- A photocopy should be made of what has been ordered before sending the request to the GP surgery so any queries can be looked into.
- Care home to check the prescriptions issued by the surgery against what they ordered before the pharmacy dispense them.
- There should be no 3rd party ordering by the pharmacy on behalf of the care home as they are unlikely to check stock levels with the home.
- Regular medicines should be ordered together once a month.
- It is acceptable to carry over regular medicines where there is a suitable supply left and the items are within their expiry date or where failing to carry the supply over will leave a patient without any medicines. Where a large quantity of medicine is being carried over each month, the patient’s usage should be investigated.
- Community pharmacies should communicate with the care home if there are any supply issues with medication and advice when it will be available. If it will be a long term problem then an alternative should be looked into with the GP.
- The care home should communicate with the community pharmacy if an item is no longer needed, any dose changes or new medications added.
When required (PRN) medicines

It is often difficult to predict how much when required medication a patient will need in the 28 day cycle. This can result in significant amounts of medication being wasted only for a replacement supply to be ordered the following month. The following procedures have therefore been suggested to prevent such wastage:

- It is acceptable for homes to retain ‘when required’ medicines and carry these forward onto the next MAR sheet. Therefore they should not be reordered every month.
- It is best for PRN medicines to be dispensed for residents in original containers. Medicines that have been dispensed for residents in their original packaging may be retained until the expiry date printed on the pack or strip, providing the PRN medicine is being given for the original condition for which the prescription occurred.
- If the patient is regularly refusing to take the PRN medication or takes very little each month then the GP should be asked to review the need for this medication or prescribe smaller quantities.
- Creams and ointments that are used on a when required basis can cause wastage as their usage is poorly recorded on the MAR charts and these are often stored in the resident’s room away from the rest of the medication. They can be used until the expiry dates so don’t need to be ordered every month.
- Some medicines that are required for a small period of time (1-2 days) to treat minor ailments such as paracetamol for headaches can be obtained from the homely remedies stock medication rather than requesting a months supply on an individual basis on prescription.

Other causes for medication wastage within the care homes:

- No directions on prescriptions leading to confusion over how often to give a medicine to the resident in the care home and also confusion about the quantity required and length of treatment.

  *Always check that each medication on repeat prescription has directions on them – if not return to the surgery to amend, ensure the community pharmacist is also aware of this problem so that they can also alert the GP surgery if they come across a prescription like this.*

- Please refer to appendix 5 for LLR position statement for EPS prescription issues to care homes
- Interim prescriptions – when a medication is changed or started mid 28 days cycle
• The prescription request should only be for enough tablets to last them until the new prescription cycle request so that the resident’s medicines are synchronised to all run out at the same time i.e. request a prescription for only 14 tablets.

• Medication can get lost in transit when a resident is transferred into hospital for a short period or they go in without any of their medicines from the home resulting in a new supply being issued by the hospital to them.

• Apply the Green bag scheme in care homes – These bags are available through surgeries and pharmacies to enable patients to safely transport and store their medication if referred or admitted into hospital. Hospital clinicians and pharmacists can then see immediately what medicines the patient is taking. This helps both staff and patients to manage their medication more safely and effectively. Patients’ own medicines will also be used for their treatment whilst in hospital which will reduce any unnecessary waste, saving thousands of pounds.

• Usually a minimum of 2 weeks supply of medication is given to all patients that are discharged from hospital. However often these are not used by the home and a request is made for a full cycle of medication for the resident post discharge to the GP.

• The home should make use of this medication supplied by the hospital until it runs out.

• The care home staff should check for any changes to the residents medication post discharge and inform the surgery of these changes so that their medication list can be updated on the GP clinical system without delay.
Best Practice guidance for ordering appliances and Oral Nutritional Supplements

It is important that patients are aware that they have a choice as to which Dispensing Appliance Contractor (DAC) or pharmacy contractor dispense their prescription.

Where a patient is on a repeat prescription service, at the time of each repeat request for appliances or oral nutritional supplements (ONS) the pharmacy contractor or DACs must:

1. Confirm that the patient is prescribed and actually requires the item(s)
2. Confirm the quantity required
3. Provide appropriate advice to patients on only requesting those items which they actually need to ensure that unnecessary supplies are not made.

DACs and pharmacy contractors must not dispense appliances or ONS before receiving a valid prescription except in an emergency supply. In this exceptional circumstance, urgent supplies may be dispensed by the contractor before receiving the prescription only at the request of the prescriber and the prescriber must undertake to give the pharmacy contractors or DAC a prescription within 72 hours. Pharmacy contractors or DACs must not contact prescribers to provide retrospective prescriptions to cover a non-urgent situation.

In the case of appliances, DACs and pharmacy contractors must also provide, where necessary, a reasonable supply of wipes and disposal bags for Part IX A (qualifying items), Part IX B and Part IX C items. A marker has been placed in the Drug Tariff next to those categories to indicate with which items wipes and disposal bags must be supplied – These items do not need to be prescribed.

Patients requesting ONS or issued ONS on TTO’s post discharge from secondary care without dietetic advice should be assessed using a nutritional screening tool available on the LMSG website (www.lmsg.nhs.uk) or referred to community dieticians. ONS should only be prescribed when first line dietary advice including food fortification has failed to improve weight or food intake within a maximum of 4 weeks. ONS supplements should be prescribed on acute prescription and for no more than 3 months without reassessment or dietetic follow-up. DACs and pharmacy contractors should ensure patients have received reassessment or dietetic follow-up before dispensing.

SECONDARY CARE RESPONSIBILITIES

✓ All patients are encouraged to bring in their regular medicines from home.
✓ Upon admission: -
✓ Medicines are checked to ensure their quality suitability for use as part of the medicines reconciliation process.
✓ Suitable medicines are stored in a locked bedside cabinet and used during
their in-patient episode.

✓ Drug chart (paper or electronic) is endorsed with POD (Patients own medicines) and quantities. If the patient has a further supply at home this is indicated on the chart.

✓ Details of nursing homes and community pharmacies are recorded on the medicines management section if the patient has a compliance aid.

✓ Upon discharge: -
  o PODs are checked for changes
  o Medicines are re-labelled with changes to instructions if safe to use.
  o A supply is made if
    ❖ no is POD available or none at home
    ❖ quantity of POD is less than 14 days
    ❖ Strength or dosage is different and re-labelling is not a safe option.
    ❖ Feeds are given for three days only
    ❖ Minimal analgesics and laxatives which are being taken as required – the frequency of use is checked and the need to continue.
  o Request is made to patients to remove and destroy all medicines which are no longer required.

    Compliance aids – 2 week supply is made and the community pharmacy is contacted to make them aware that the patient is leaving hospital and the changes to their medication. The discharge letter is faxed to the community pharmacy as a record of discharge.
  o Compliance reminder card completed for patients who request one /assessed as needing assistance understanding their medicines.
5. 28/56 DAY PRESCRIBING

Background

- Previously the CCG’s has always encouraged 28 day prescribing, as the most appropriate prescribing period for the majority of patients. This period helps to facilitate continuity, monitor dosage compliance and prompt regular reviews of the appropriateness of a prescribed drug. The broad adoption of 28 day prescribing also allows the synchronization of multiple repeat medications.

- Limiting the prescribing period to 28-days was one of a series of measures which was taken to address the huge quantity of waste medicines returned to community pharmacies. These medicines cannot be reused. An audit of unwanted medicines returned to our community pharmacies indicated that 30% of the returns were due to changes in medication during the prescription interval.

- So at that time after consideration of the benefits of limiting the duration of repeat prescriptions issued, the LLR CCG’s strongly recommended that GPs prescribe for 28 days, with majority of GPs prescribing in this way, so for most patients there was no change.

Rationale

- Moving on from this after a discussion with the Medicines Management Strategy Group is was felt as a Clinical Commissioning Group (CCG); GPs should be given the flexibility of whether they prescribe as 28/56 days.

- Numerous queries from GP practices regarding a CCG policy on this

- New evidence has emerged which supports both 28 or 56 day prescribing

Advantages and disadvantages

Benefits of 28 day prescribing:

- Prompts regular reviews of the appropriateness of a prescribed drug, e.g. in a care home
- Easy to synchronize multiple repeat medication if patient is out of sync
- Helps to reduce Medicines Waste
- Less storage space required in patients home especially if they are on numerous medicines
Disadvantages of 28 day prescribing:

- Additional cost for those patients who pay for their prescriptions
- Additional supply costs e.g. dispensing fees
- Some patients feel it doesn’t allow them to have sufficient ‘reserves’ of medicines
- More prescriptions to sign

CONCLUSION

One size doesn’t fit all, so to provide GP practices the freedom to choose dependent on their current in house policies and practice population.

See Appendix 2: Letter to all prescribers regarding 28/56 day prescribing

6. PRESCRIBING FOR PATIENTS USING MONITORED DOSAGE SYSTEMS

Background

- MDS are devices which hold medicines in compartments for patients who have difficulties in remembering to take their regular medication.

- The legislation now no longer requires the Community pharmacist to carry out an assessment under the Equality Act – all that is required, is that they make a reasonable adjustment, if this is what is needed in order to allow the person to access the service e.g. providing an easy open container would overcome the obstacles to accessing medicines.

- The PSNC and the Department of Health have already agreed funding to support patients with disabilities. This has been made available as part of the new contract funding arrangements, the decision was taken to distribute payment as part of the Practice Payment for Community Pharmacist, as it was assumed that the demand for support under the DDA would be closely related to dispensing volume.

- A plan to develop a multi-stakeholder guidance on the use of Multi-compartment aids is currently in progress and information about this will be sent out once this is available
Rationale

- To ensure all patients receive the same quality of medical care, so it doesn’t result in unnecessary health implications as a result of missed medication.

- Some Community Pharmacist have requested 7 day prescriptions from prescribers when providing medicines via MDS.

- For patients requiring medicines in MDS as an adjustment under disability legislation, the prescriber may decide to prescribe in 7 day quantities, to minimise the amounts of waste that would occur on medication changes.
ADDITIONAL INFORMATION

- There is no fundamental link between dispensing in an MDS and the period of treatment covered by a prescription. A prescription for 28 days supply might be supplied in an MDS, and a prescription for seven days might be supplied in the original manufacturer’s carton.
- Once medicines have been dispensed by a pharmacist, whether in an MDS or in Manufacturer’s cartons, then no further changes to what has been dispensed should be made by a pharmacist. If a prescribed medicine is no longer required, the prescriber should inform the patient of that clinical decision, and ensure that the patient understands that previously dispensed medicine should not be administered.
- If the medication was provided in a MDS and the patient does not have the ability to identify and discard the medicine, when opening each compartment, then the whole MDS would need to be replaced. This is potentially very wasteful as all the medicines contained in the MDS will need to be re-prescribed. The NHS terms of service for pharmacies does not require pharmacists to modify previously provided MDS trays.
- If the patient requires an MDS because of a disability, then the pharmacist must make that adjustment. It is not permitted under the terms of service, for a pharmacist to turn away a prescription, simply because the pharmacist does not want to dispense the medicines in MDS because of the cost of the equipment and the time commitment.
- The NHS Pharmacy Terms of Service do not impose a requirement to dispense into compliance aids or to dispense in instalments (other than instalment prescriptions for the treatment of substance misusers). Therefore a prescription ordering 28 days treatment should be dispensed on one occasion as the NHS requires the medicine to be dispensed on the one occasion, for one dispensing fee. It is for the pharmacy contractor to decide whether it is appropriate to dispense into MDS and this decision is not influenced by the period of treatment.
- If a prescription for 28 days treatment is issued for a patient who satisfies the DDA criteria, and the pharmacy contractor decides that the adjustment required is an MDS, then 4 x 7 day MDS containers or 1 x 28 day MDS container should be prepared and supplied to the patient on one occasion.
SUMMARY
For majority of patients for whom MDS is appropriate, a 28 day prescription should be supplied.

Where 28 day prescriptions are supplied, the pharmacy will dispense and issue all 4x1 weeks supply to the patient, often in a single delivery. If there is a medication change midway, then all tablets will need to be discarded & a new prescription would need to be issued, which would result in waste, in such situations 7 day prescriptions would be suitable.

7 day prescriptions will only be issued on GP agreement and will not be routinely accepted. 7 day prescriptions should be issued only on prescriber agreement of need, for reasons of patient safety, pharmaceutical stability or medication regimen not yet stabilised.

Where the stability of medication is considerably shortened by dispensing in to MDS. For some drugs this is as short as 7-14 days. The medicines in the MDS are enclosed in compartments with a transparent clear covering which makes them unsuitable to store light sensitive drugs over a long period of time compared with standard amber coloured dispensing containers. Due to tests carried out on moisture permeability in 1993, the Pharmaceutical Society states that medicines should not be left in sealed MCAs for longer than 8 weeks, after which they must be returned to the pharmacy for disposal. For a list of drugs which should not be put into compliance aids please see the LMSG website. ³
7. References and Acknowledgements:

There has been extensive involvement and commitment to produce these guidelines and acknowledgement to various people and organizations for their valuable input:
- City CCG
- West CCG and Rupinder Gill, Medicines management team, West CCG
- East Leicestershire and Rutland CCG
- Claire Elwood/Bhavisha Pattani9 Chief/acting chief pharmacist, UHL
- Nina Lakhani and LPT
- Leicester city council and Leicestershire county council

References:


8. SUPPORT & ADDITIONAL CONTACTS

CCG Medicines Quality teams

Additional Guidance: Supporting people in care homes: CPPE pack
Appendix 1

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<tr>
<th>Pharmacist Referral</th>
<th>Patient name</th>
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<tr>
<th>Date:</th>
<th>PLEASE SEND YOUR RESPONSE TO PHARMACIST WITHIN FIVE WORKING DAYS</th>
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Surgery………………………………… Dear

Doctor

I am reporting the following regarding the above patient using the repeat dispensing service.

- Erratic collection of repeats – too often/not often enough
- Compliance problems
- Side effects of medication
- Potential Adverse Drug Reaction
- Medication no longer required
- Query dosage regimen
- Query benefit of therapy
- Monitoring needed
- Batch issues lost

Required information/other relevant comments:

Recommended action:

Attach print out of current medication where appropriate

I would be grateful if you would consider the above issues and let me know whether you feel the action is appropriate.

Signature: ______________________________ Date: __________________

GP response (to be faxed to pharmacy once completed)

Recommended action accepted | Yes/No
Patient's records changed | Yes/No
Pharmacist informed | Yes/No

Signature: ______________ Date: ________
Appendix 2

September 2013
Re: 28/56 day prescription communication

Dear Colleagues

We have had numerous queries on whether as a CCG we should be advocating 28 day prescribing or not.

Previously as LCR PCT we were actively encouraging 28 day prescribing for many reasons, however as a CCG we feel, we should give GPs the flexibility on whether you would like to prescribe as 28 days or not.

There are many pros & cons to 28 days prescribing. We will provide this information to you and let you decide what you feel would be appropriate for your practice & your patients.

Benefits of 28 day prescribing:

- Prompts regular reviews of the appropriateness of a prescribed drug, e.g. care home patients
- Shorter prescribing intervals can result in less waste when medicines are stopped or changed
- Encourages patients to only order what they need
- Easier to synchronize multiple repeat medications so that all medications run out at the same time
- Less storage space required in patients home especially if they are on numerous medicines.
- Discourages stock-piling of medicines which is both wasteful and dangerous.

Disadvantages of 28 day prescribing:

- Additional cost for those patients who pay for their prescriptions
- Additional supply costs e.g. dispensing fees
- Some patients feel it doesn’t allow them to have sufficient ‘reserves’ of medicines
- More prescriptions to sign
Following on from this it is apparent that the one size fits all rule cannot be applied & so we have decided to leave it up to practices on whether they wish to adopt a 28/56 day cycle depending on their patient population. Currently many practices operate a compromise system where a combination of 28 and 56 day prescribing is used depending on set criteria within the practice. This may be the most favorable solution.

Kind regards

Head of Prescribing
Appendix 3: Examples of medicines waste
APPENDIX 4: Leicestershire Statement on the Electronic prescribing service (EPS) and care home repeat ordering

Background:

The quality and safety issues around care home repeat ordering processes and their relevance to EPS were discussed at the EPS Board meeting in February 2014.

The good practice recommendations from NICE and DoH waste steering group advice that issued prescriptions should be sent to the care homes for a 2nd check was debated. It was also noted that as a result of this guidance some CCGs have taken the cautionary measure of delaying EPS for care home patients. It was therefore agreed that ordering processes and the impact of EPS will be audited in EPS live practices to ascertain the impact of EPS on the care home ordering processes within LLR.

However, it was also acknowledged that although EPS would make checking prescriptions prior to ordering from the pharmacy impossible, the risk of errors would be reduced if there were already robust ordering processes in place between the GP practice and the care home. Consequently the final agreement was that:

Position Statement

Individual GP practices should make the decision whether to proceed with EPS for their care home patients, AFTER taking into consideration

1) How robust the individual care home ordering processes

2) The good practice guidance recommendations from NICE Managing medicines in care homes guidance published March 2014 & the DOH advice recommends:

- care home providers should retain responsibility for ordering medicines and not delegate to the supplying pharmacy

- care home providers should retain records of ordering for checking received orders

Approved by: LLR Medicines Optimisation Committee
Date: 26/03/14 Committee

Please contact your CCG prescribing team, if you have any queries.
# APPENDIX 5-
Repeat Prescription Management Code of Practice
Best Practice for Patient, Practice and Pharmacy - AGREEMENT CHARTER

## Guiding Principles:
- Patient will make their own repeat medicines request whenever possible. Deviation from this will require the patient’s informed consent and choice. Practice will provide a variety of methods for patients to request repeat medicines.
- Patient and pharmacy will confirm that every item requested is required at time of dispensing.
- Paper-based methods of requesting repeat medicines should utilise the most recent printed repeat prescription request slip (right hand side of FP10 (prescription) form) wherever possible.
- All parties will communicate regularly and work together to ensure the accuracy of practice-held records and minimise unnecessary waste of NHS resources.

## Practice agrees to:
1. Provide and promote different methods to allow as many patients as possible to request repeat prescriptions themselves, including email / web-based systems.
2. Keep Patient Medication Records (PMR) current, particularly in respect of the list of authorised repeat medication, and paying particular attention to ‘when required’ medicines.
3. Include relevant information of pharmacies authorised to manage or collect repeat prescriptions in PMR for each Patient as appropriate.
4. Ensure that the patient is made aware of their regular medication review dates, and undertake regular reviews.
5. Routinely provide patients with a single copy of their current printed repeat prescription request slip (right hand side of FP10 form).
6. Respond promptly to communication from patient or pharmacy concerning repeat items e.g. no longer required, excessive quantity, dosage clarification.
7. Fulfil repeat prescription requests within a reasonable timescale in accordance with Practice Repeat Prescribing Protocol.

## Pharmacy agrees to:
1. Encourage all patients who are capable to request repeat prescription themselves.
2. Where this is not practical, obtain informed consent in writing from each patient or their carer to act as their representative to manage repeat prescription requests.
3. Agree with patient or representative exactly which repeat medicines are required on every occasion at the time the prescription request is sent to the Practice.
4. Use the printed repeat prescription request slip (right hand side of FP10 form) when requesting on behalf of a Patient wherever possible.
5. Clearly marking on above: Pharmacy details and date of request (pharmacy stamp); tick items required; cross through items not required this time; include patient (or representative) signature as confirmation of consent.
6. To keep comprehensive records of all requests, so that there is an audit trail for every prescription from Patient’s request to receipt of delivered (or collected) prescription.
7. On day of dispensing, confirm that every medicine prescribed is required by patient, and notify practice of ‘Not Dispensed’ medicines, to maintain accuracy of practice records.
8. Ensure that patient is made aware of their regular practice medication review dates.

## Patient agrees to:
1. Be responsible for requesting own repeat prescriptions whenever this is possible.
2. When requesting repeat medicines, only to request regular items that will be required within the next 5 days, and ‘when required’ items that are likely to be required before the next ‘regular’ repeat.
3. Keep the most recent printed repeat prescription request slip and use it to request the next supply as above (unless using email / web-based systems).
4. To discuss with the practice / pharmacy any repeat medicines that they do not want to continue to take or are stockpiling to minimise waste.
5. Provide confirmation in writing that the Pharmacy is authorised to manage or collect repeat
prescriptions for them, and to discuss relevant Medicines Management issues with the Practice.
6. Inform pharmacy / practice as soon as possible of any changes affecting their regular medicines, to ensure that Patient Medication Records are kept up to date.
7. Attend medication review at practice and Medicines Use Review at pharmacy when requested

I have read and agree to Repeat Prescription Management Code of Practice.

GP Practice:
Signed on behalf of GP practice: __________________ Date:______________

Community pharmacy name:
Signed on behalf of community pharmacy:______________ Date:______________

Patient name:
Signature: __________________ Date:______________