**Prescribing Policy**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Version:** | **Review date:** | **Edited by:** | **Approved by:** | **Comments:** |
| v1.16 | 14/06/2022 | Sultan Mohamed | Munira Mohamed | Policy updated by PI |
| v1.18 | 24/10/2023 | Sultan Mohamed | Munira Mohamed | Policy updated by PI; KLOE removed |
|  | 15/01/2024 | Sultan Mohamed | Munira Mohamed | minor changes |
|  | April 2025 |  |  | Next review |
|  |  |  |  |  |

**Table of contents**

[1 Introduction 3](#_Toc134074061)

[1.1 Policy statement 3](#_Toc134074062)

[1.2 Status 3](#_Toc134074063)

[2 Policy 3](#_Toc134074064)

[2.1 Accountability 3](#_Toc134074065)

[2.2 Guidance 4](#_Toc134074066)

[2.3 The Medicines Act 1968 4](#_Toc134074067)

[2.4 Recording prescriptions 4](#_Toc134074068)

[2.5 Electronic Prescription Service 5](#_Toc134074069)

[2.6 Repeat prescribing 5](#_Toc134074070)

[2.7 Prescribing and safeguarding 6](#_Toc134074071)

[2.8 Electronic Repeat Dispensing (e-RD) 6](#_Toc134074072)

[2.9 Requesting a repeat prescription 7](#_Toc134074073)

[2.10 Non-medical prescribing 9](#_Toc134074074)

[2.11 Generic prescribing 12](#_Toc134074075)

[2.12 Prescribing unlicensed medicines 13](#_Toc134074076)

[2.13 Processing a repeat prescription request 14](#_Toc134074077)

[2.14 Urgent requests 15](#_Toc134074078)

[2.15 Emergency prescriptions 15](#_Toc134074079)

[2.16 Lost prescriptions 16](#_Toc134074080)

[2.17 Medication review 16](#_Toc134074081)

[2.18 Failure to attend for review 17](#_Toc134074082)

[2.19 Control and monitoring 17](#_Toc134074083)

[2.20 Patients discharged from hospital 18](#_Toc134074084)

[2.21 Prevention of misuse 18](#_Toc134074085)

[2.22 Timely intervention 18](#_Toc134074086)

[2.23 Continued control 19](#_Toc134074087)

[2.24 High risk drug monitoring 19](#_Toc134074088)

[2.25 Covert medication 20](#_Toc134074089)

[2.26 Prescription security 20](#_Toc134074090)

[2.27 Ordering of prescription forms 21](#_Toc134074091)

[2.28 Delivery and storage 21](#_Toc134074092)

[2.29 Issue 22](#_Toc134074093)

[2.30 Prescriptions issued at another UK nation 23](#_Toc134074094)

[2.31 Private prescriptions 25](#_Toc134074095)

[2.32 Prescription requests from dentists 26](#_Toc134074096)

[2.33 Loss and theft 27](#_Toc134074097)

[2.34 Prescriptions lost by patients 28](#_Toc134074098)

[2.35 Current and out-of-date prescription forms 28](#_Toc134074099)

[2.36 Reporting NHS prescription form incidents 28](#_Toc134074100)

[2.37 Reporting adverse reactions 28](#_Toc134074101)

[2.38 Medicines optimisation 29](#_Toc134074102)

[2.39 Medicines optimisation – peer review 29](#_Toc134074103)

[2.40 Controlled drugs 29](#_Toc134074104)

[2.41 Audit 29](#_Toc134074105)

[2.42 Useful contact information 30](#_Toc134074106)

[3 Summary 31](#_Toc134074107)

[Annex A – Medication synchronisation template 32](#_Toc134074108)

[Annex B – Repeat prescription flow diagram 33](#_Toc134074109)

[Annex C – Sample letter for monitoring 34](#_Toc134074110)

[Annex D – Repeat medication ordering proforma 35](#_Toc134074111)

[Annex E – Prescription log 36](#_Toc134074112)

[Annex F – Recommended high-risk drug monitoring frequencies 37](#_Toc134074113)

[Annex G – Prescription security risk assessment 50](#_Toc134074114)

[Annex H – Reporting form for the loss or suspected theft of prescriptions 52](#_Toc134074115)

# Introduction

## Policy statement

The purpose of this document is to ensure that all prescribers within Sheerwater Health Centre understand the requirement to maintain currency and to work within their professional boundaries[[1]](#footnote-1) to deliver safe and effective clinical care.

This document refers to the legislative acts associated with prescribing, and it explains the activities intrinsically linked to prescribing including but not limited to:

* The supply of prescription-only medicines
* The prescribing of medicines, devices and dressings
* The provision of advice to patients regarding the purchase of over-the-counter medicines

This policy is to be read in conjunction with the referenced legislation and guidance.

## Status

The organisation aims to design and implement policies and procedures that meet the diverse needs of our service and workforce, ensuring that none are placed at a disadvantage over others, in accordance with the [Equality Act 2010](https://www.legislation.gov.uk/ukpga/2010/15/contents). Consideration has been given to the impact this policy might have regarding the individual protected characteristics of those to whom it applies.

This document and any procedures contained within it are non-contractual and may be modified or withdrawn at any time. For the avoidance of doubt, it does not form part of your contract of employment. Furthermore, this document applies to all employees of the organisation and other individuals performing functions in relation to the organisation such as agency workers, locums and contractors.

# Policy

## Accountability

All clinicians authorised to prescribe within Sheerwater Health Centre are aware that it is the clinician who signs the prescription who will be held accountable should an error or incident occur. Prescriptions issued on the recommendation of a non-prescriber, i.e., a nurse or allied healthcare professional, remain the responsibility of the named, authorised prescriber.

Clinicians must only prescribe medicines, devices or dressings when they are satisfied that they have sufficient knowledge of the patient’s health and that they are content that the prescription is fully justified.

## Guidance

All authorised prescribers are to follow the information and guidance provided in the British National Formulary (BNF), whilst also taking into consideration the guidance published by NICE (England).

If prescribers have any uncertainty regarding strength, dosage, interactions, or other elements of prescribing, they are to seek the appropriate guidance from suitably experienced colleagues, a pharmacist or a prescribing adviser.

## The Medicines Act 1968

The [Medicines Act 1968](http://www.legislation.gov.uk/ukpga/1968/67) regulates the licensing, supply and administration of medicines.

The Act defines three categories of medicine:

1. Prescription Only Medicines (POM) which are available only if prescribed by an appropriate practitioner
2. Pharmacy Medicines (P), available only from a pharmacist but without a prescription
3. General Sales List (GSL) which are medicines that can be bought from any shop without a prescription

The Act controls the supply of drugs but does not define any offence of simple possession, as possession of a POM without a prescription is only an offence if the drug is also controlled under the [Misuse of Drugs Act 1971](http://www.legislation.gov.uk/ukpga/1971/38/contents). Therefore, possession of a prescription only antibiotic without a prescription is not an offence.

The Medicines Act protects the use of how drugs can be administered, and an example is that, unless instructed, the pharmacist or dispensary cannot alter the dose or change the form of a POM, for example, by crushing or opening a capsule. To do so would be a breach of the 1968 Act.

This policy both alludes and conforms to *The Medicines Act 1968 and its subsequent amendments* throughout.

## Recording prescriptions

All prescriptions (where practically possible) are issued and printed electronically using EMIS Web clinical system. This information is retained in the patient’s electronic healthcare record and ensures that all staff involved in the care of the patient are aware of current medications and can avoid prescribing any medication that may be contraindicated. Handwritten routine prescriptions are not normally written at this practice unless circumstances dictate otherwise, i.e., power failure or other noteworthy events.

It is imperative that accurate records are always maintained and extant guidance stipulates that the following are to be recorded:

* Relevant clinical findings
* Advice/information given to the patient
* Planned actions and confirmation that said actions have been discussed with the patient and are agreed
* Medicines prescribed

When recording the prescription on EMIS Web system, the prescriber will ensure that the prescribed medication is recorded as acute, repeat or current.

Clinicians undertaking home visits are to take with them printed patient summaries which include details of patient medications and known allergies. The clinician can use the summary to record notes, particularly details of handwritten prescriptions, the information from which can be added to the patient’s healthcare record on return to the practice. It is the responsibility of administration staff to prepare the summary printouts for the clinicians.

## Electronic Prescription Service

The Electronic Prescription Service (EPS) enables prescriptions to be sent to pharmacies from Sheerwater Health Centre electronically, making the prescribing and dispensing process more efficient for staff and patients alike. Patients can choose the pharmacy where they would like their prescription to be sent; this is referred to as “nomination” and can be set, changed or cancelled as required.

Further information regarding the EPS is [available here](https://digital.nhs.uk/services/electronic-prescription-service/electronic-prescriptions-for-prescribers). Any questions relating to EPS can be directed to [enquiries@nhsdigital.nhs.uk](mailto:enquiries@nhsdigital.nhs.uk)

## Repeat prescribing

The purpose of a repeat prescription is to authorise the repeated issue of medicines at agreed intervals, without the patient attending a consultation with the prescriber.

Only a GP can authorise the transfer of medication from an acute prescription to a repeat prescription. The decision to do so will take into consideration:

* The effectiveness of the medication
* How well the patient has tolerated the medication
* If the medication is required on a long-term basis

The GP will only prescribe evidence-based medicines so long as they have adequate knowledge of the patient’s health and are satisfied that they meet the patient’s needs. The GP will also determine the number of repeat authorisations before a review is required.

Prior to transferring from acute to repeat prescriptions, the GP is to recall the patient and review the factors stated above, whilst informing the patient about the repeat prescribing process at Sheerwater Health Centre.

To maintain effective control over repeat prescribing, when adding a medication as a repeat an appropriate coded reason must be given. Clinicians are to make certain that the repeat record is correct, quantities are synchronised (to minimise wastage) and review dates are entered. A letter to patients regarding synchronisation can be found at [Annex A](#_Annex_A_–).

## Prescribing and safeguarding

Consideration must be given to safeguarding concerns with both children and vulnerable adults when prescribing.

Firstly, the prescriber is to consider capacity and as to whether the patient can understand the instructions needed for the medication to be taken safely. When a person is found to lack capacity, the best interests of the patient must be considered and a decision must be reached to also include supporting those who are relevant to the patient, such as families and carers as well as other professionals. To whatever extent possible, the person must also be involved, with genuine value placed on their wishes and beliefs.

If the individual has made an Advance Decision to refuse treatment directly relevant to the medication suggested or has a Lasting Power of Attorney (POA), then the decisions afforded through these legal mechanisms must be respected as the person’s voice.

If there are concerns the Advance Decision or the decisions of a POA is putting an individual at significant risk, then further advice is to be sought. Additionally, a referral may be made to appoint an Independent Mental Capacity Advocate (IMCA) who can represent the patient.

Further information to the above can be found within the following:

* Safeguarding Policy
* Mental Capacity Act Policy
* DNACPR Policy

To further support this subject, this [link](https://www.pharmacyregulation.org/regulate/article/focus-safeguarding-children-and-vulnerable-adults) from the Royal Pharmaceutical Council (RPC) provides some case studies as to how they are committed to supporting this area. Further useful links can also be found in this document.

Furthermore, if covert administration is to be considered, refer to [Section 6.25](#_Covert_medication).

* 1. **Electronic Repeat Dispensing (e-RD)**

e-RD is a process that allows a patient to obtain repeated supplies of their medication or appliances without the need for the prescriber to hand sign authorised repeat prescriptions each time. This allows the prescriber to authorise and issue a batch of repeat prescriptions until the patient needs to be reviewed. The prescriptions are then available for dispensing at the specified interval by a patient’s nominated dispenser.

**Who is suitable for e-RD?**

Any patient suitable for a repeat prescription could be suitable for e-RD. This includes but is not limited to:

* Patients on stable therapy
* Patients with long term conditions
* Patients on multiple therapy e.g., hypertension, diabetes, asthma etc.
* Patients who can appropriately self-manage seasonal conditions

Whilst all the above patient groups are suitable for electronic repeat dispensing, the

additional functionality allows the patient suitability to be broadened based upon

clinical assessment.

e-RD requires the patient to consent to the introduction of two-way sharing of their information between the dispensing and prescribing site.[[2]](#footnote-2) The patient should be asked to consent but written consent is not required.

A patient must have their dispensing site nomination recorded for any prescription to be sent electronically.[[3]](#footnote-3)

Resources available to support e-RD implementation are available including:

* [e-RD Handbook](https://www.nhsbsa.nhs.uk/sites/default/files/2020-07/Electronic%20Dispensing%20Handbook_Digital_WEB_S-1589995676.pdf)
* [Electronic Repeat Prescribing (e-RD): An Overview – video](https://youtu.be/zzaNeAaelAo)
* [e-RD guidance](https://www.england.nhs.uk/digitaltechnology/wp-content/uploads/sites/31/2015/06/electronic-repeat-dispensing-guidance.pdf)
* [e-RD e-learning course](https://learning.necsu.nhs.uk/nhs-digital-electronic-repeat-dispensing-elearning/)
* [What e-RD means for patients – video](https://www.nhsbsa.nhs.uk/sites/default/files/2020-04/Meet%20Mo%20Electronic%20Repeat%20Dispensing%20Final%20Script_1.pdf)
* [Electronic Repeat Dispensing in Response to COVID-19 slideshow](https://www.nhsbsa.nhs.uk/sites/default/files/2020-04/eRD%20in%20response%20to%20Covid%2019%20Webinar%20April%202020%20FINAL.pdf)
* [GDPR roles and responsibilities guidance document](https://www.nhsbsa.nhs.uk/sites/default/files/2020-05/GP%20CCG%20and%20NHSBSA%20Provider%20Assurance%20GDPR%20Roles%20and%20Responsibilities%20.docx)
* [Benefits of e-RD](https://www.nhsbsa.nhs.uk/sites/default/files/2020-03/eRD%20-%20Benefits.pdf)
* [e-RD patient suitability guide](https://www.nhsbsa.nhs.uk/sites/default/files/2020-03/Patient%20suitability%20guide%20%28V0.1%29%2003.2020.pdf)
* [e-RD cancelling and synching prescriptions](https://www.nhsbsa.nhs.uk/sites/default/files/2020-03/Cancelling%20a%20prescription%20guide%20%28V0.1%29%2003.2020.pdf)
* [e-RD patient pathway](https://www.nhsbsa.nhs.uk/sites/default/files/2020-03/eRD%20pathway%20guide%20%28V0.1%29%2003.2020.pdf)
* [Key messages for patients](https://www.nhsbsa.nhs.uk/sites/default/files/2020-03/eRD%20key%20messages%20for%20patients.pdf)
* [Key messages for dispensers](https://www.nhsbsa.nhs.uk/sites/default/files/2020-03/eRD%20-%20Key%20messages%20for%20dispensers.pdf)
* [e-RD patient flyer](https://www.nhsbsa.nhs.uk/sites/default/files/2020-05/eRD%20leaflet%20A5%20%28V6%29%20%28Local%29%2005.2020.pdf)
* [e-RD patient poster – COVID-19 version](https://www.nhsbsa.nhs.uk/sites/default/files/2020-05/eRD%20poster%20-%20No%20Logo%20%28V4%29%2005.2020.pdf)
* [Waiting room slides](https://www.nhsbsa.nhs.uk/sites/default/files/2018-10/eRD%20waiting%20room%20slides%20v2%20%28Oct%202018%29%20%28plasma%29_1.pptx)
* [Content for your website or bulletin](https://www.nhsbsa.nhs.uk/sites/default/files/2020-08/eRD%20-%20Website-Bulletin%20copy.pdf)
* [Patient letter template](https://www.nhsbsa.nhs.uk/sites/default/files/2020-05/eRD%20-%20Letter%20to%20patient%20-%20COVID-19%20version_0.docx)
* [Patient email message content](https://www.nhsbsa.nhs.uk/sites/default/files/2020-05/eRD%20-%20Email%20to%20patient%20-%20COVID-19%20version_0.pdf)
* [Patient text message content](https://www.nhsbsa.nhs.uk/sites/default/files/2020-05/eRD%20-%20Text%20message%20content%20-%20COVID-19%20version.pdf)
* [Social media content](https://www.nhsbsa.nhs.uk/sites/default/files/2020-05/eRD%20-%20Social%20media%20content%20-%20COVID-19%20version.pdf)

## Requesting a repeat prescription

At Sheerwater Health Centre, the following are permitted to request repeat prescriptions:

* Patients
* Nominated representatives, i.e., carers
* District nurses and/or specialist nurses
* Pharmacists

It is imperative that confidentiality is always maintained; therefore, all staff must ensure that:

* They do not divulge information unnecessarily
* The request is appropriate and genuine
* The person requesting the repeat prescription is authorised to do so

Patients can request repeat prescriptions in the following ways:

* Online
* In writing
* Using the prescription counterfoil (usually the right-hand side of the prescription) and posting it in the box adjacent to the reception

Patients must be advised that requests for “all repeats” or requests with limited information are likely to result in a delay in the process. In such instances, staff will need to contact the patient to discuss their exact requirements.

The following medications are not appropriate for repeat prescribing:

* Antibiotics, antivirals and antifungals for acute infections
* Cholecalciferol (Vitamin D)
* Hypnotics
* Benzodiazepines
* Nutritional supplements
* Oral or topical corticosteroids
* Antipsychotics (in the elderly)
* Strong opioids

Patients (or their representatives) are to understand that they are responsible for requesting repeat prescriptions in a timely manner, allowing at least 48 hours for the request to be processed, excluding weekends and public holidays.

The opportune questioning of patients by dispensing staff and prescribers will help to minimise wastage and will reduce cost. Staff should encourage patients to inform them if they are no longer taking their medication. The relevant GP can then discuss this with the patient and determine if the medication is still required and update the patient’s healthcare record accordingly.

Prescriptions for patients in care/nursing homes should be monitored to ensure that all medicines requested are actually required, particularly PRN medicines. If PRN medicines are routinely requested, a review should be conducted to determine the actual need for these medicines.

Repeat prescriptions are not to be issued more frequently than the agreed time interval. However, there may be occasions when this might be necessary, e.g., if the patient is going on holiday; this requires prior agreement and approval from an authorised prescriber.

The default supply period for repeat medications is as follows:

* 28 days for patients in care/nursing homes
* 56 days for all other patients
* 84 days for patients who are stabilised on medication and comply with review procedures

Schedule 2 and 3 controlled drugs (CDs) will be limited to a maximum supply of 30 days.

There may be a requirement to issue medication in seven-day blister packs, e.g., for those who have difficulty in managing their medication. In such instances, it is feasible to issue four packs at any one time. Requests for seven-day blister packs are to be submitted to the practice and will be referred to the patient’s GP for action. Seven-day blister packs should be issued when:

* There is a clear clinical need for restricting the quantity of medication that a patient holds at any one time, e.g., concerns about overdose or misuse
* There are frequent changes to the medication regime and using seven-day quantities will help to minimise waste because of medication changes
* A Monitored Dosage System (MDS) device is required to be supplied on a weekly basis to support the medication compliance of a particular patient

There may be exceptions to the above supply limitations and these will be managed on a case-by-case basis and in consultation with the prescriber.

## Non-medical prescribing

A range of non-medical healthcare professionals can prescribe medicines for patients as either independent or supplementary prescribers.

Independent prescribers are practitioners responsible and accountable for the assessment of patients with previously undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing. They are recommended to prescribe generically, except where this would not be clinically appropriate or where there is no approved non-proprietary name.

Supplementary prescribing is a partnership between an independent prescriber (a doctor or a dentist) and a supplementary prescriber to implement an agreed Clinical Management Plan for an individual patient with that patient’s agreement[[4]](#footnote-4).

This section is aligned to:

* The CQC’s [GP Mythbuster 95 – Non-medical prescribing](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-95-non-medical-prescribing)
* Royal Pharmaceutical Society – [A Competency Framework for all prescribers](https://www.rpharms.com/resources/frameworks/prescribing-competency-framework/competency-framework#Competency)
* [NICE Non-medical prescribing](https://bnf.nice.org.uk/guidance/non-medical-prescribing.html)
* [RCN Non-medical prescribers](https://www.rcn.org.uk/get-help/rcn-advice/non-medical-prescribers)

A range of non-medical healthcare professionals are permitted to prescribe medicines for patients as an independent or supplementary prescriber.

Non-medical prescribers (NMP) can:

* Give patients quicker, more efficient access to medicines
* Make best use of healthcare professionals’ skills
* Help address demand and workforce issues

In the UK, a range of non-medical healthcare professionals can qualify as NMPs. In general practice, most NMPs are pharmacists or nurses. They could also be, for example, paramedics or physiotherapists.

NMPs can be independent or supplementary prescribers.

1. Independent prescriber are practitioners responsible and accountable for

* The clinical assessment of patients
* Establishing a diagnosis
* Decisions about the patient’s clinical management
* Prescribing

It should be noted that independent prescribers are recommended to prescribe generically except where this would not be clinically appropriate or where there is no approved non-proprietary name.

1. Nurse

Nurse independent prescribers can prescribe any medicine for any medical condition and are able to prescribe, administer and give directions for the administration of Schedule 2, 3, 4 and 5 Controlled Drugs.

This extends to [diamorphine hydrochloride](https://bnf.nice.org.uk/drug/diamorphine-hydrochloride.html), dipipanone or cocaine for treating organic disease or injury but not for treating addiction. Nurse independent prescribers must work within their own level of professional competence and expertise.

1. Pharmacist

Pharmacist independent prescribers can prescribe any medicine for any medical condition. This includes unlicensed medicines, subject to accepted clinical good practice.

A pharmacist independent prescriber is also able to prescribe, administer and give directions for the administration of Schedule 2, 3, 4 and 5 Controlled Drugs. This extends to [diamorphine hydrochloride](https://bnf.nice.org.uk/drug/diamorphine-hydrochloride.html), dipipanone or cocaine for treating organic disease or injury but not for treating addiction.

This group must work within their own level of professional competence and expertise.

It is the responsibility of the Practice Manager at Sheerwater Health Centre to ensure that independent prescribers have the necessary skills and knowledge to carry out the role.

The [Royal Pharmaceutical Society (RPS) competency framework for all prescribers](https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Prescribing%20Competency%20Framework/RPS%20English%20Competency%20Framework%203.pdf?ver=mctnrKo4YaJDh2nA8N5G3A%3d%3d) sets out the following steps prior to and after issuing any prescription:

* Assess the patient
* Identify evidence-based treatment options available for clinical decision making
* Present options and reach a shared decision
* Prescribe
* Provide information
* Monitor and review

Prescribing governance is detailed as:

* Prescribe safely
* Prescribe professionally
* Improve prescribing practice
* Prescribe as part of a team

All prescribers at Sheerwater Health Centre must take individual responsibility for their prescribing decisions and should recognise that there are certain areas of practice where remote prescribing is unlikely to be suitable, for example when prescribing medicines likely to be subject to misuse or abuse or injectable cosmetic treatments.

In summary, an independent prescriber can prescribe any medicine for any condition within their clinical competence.

1. A supplementary prescriber is a voluntary partnership between an independent prescriber and a supplementary prescriber. They implement an agreed clinical management plan (CMP) for a specific patient with the patient’s consent.

Supplementary prescribing can only be used after:

* Assessment and diagnosis by an independent prescriber. This must be a doctor or dentist
* The independent and supplementary prescribers develop a written CMP together. The CMP lists medicines that can be prescribed for the patient.

Qualifications to become a NMP must include:

* Being registered with the relevant professional regulator
* Having their prescribing qualification annotated on the register

To gain this, NMPs must undertake an accredited non-medical prescribing programme at a higher education institution. These programmes provide the knowledge, skills and training to prescribe safely and competently.

Dos and don’ts:

* NMPs should work to the Royal Pharmaceutical Society’s – A Competency Framework for All Prescribers
* NMPs should not prescribe outside their competency
* Practices should have systems to make sure NMPs are working within their competence
* All NMPs must have adequate medical indemnity. This is part of the requirements of registration with their professional body. This indemnity should include their NMP role.

The [Clinical Negligence Scheme for General Practice in England and Wales](https://resolution.nhs.uk/services/claims-management/clinical-schemes/general-practice-indemnity/clinical-negligence-scheme-for-general-practice/) covers everyone providing NHS services for general practice and includes NMPs although this does not cover non-NHS work. It does not provide legal representation for inquests and disciplinary investigations.

Who can prescribe what?

The Pharmaceutical Services Negotiating Committee (PSNC) guidance document titled [Who can prescribe what](https://psnc.org.uk/dispensing-supply/receiving-a-prescription/who-can-prescribe-what/), provides a useful list showing the level of prescribing ability specific to each healthcare professional.

## Generic prescribing

Medicines are available in both generic and branded forms, yet generic medicines are much less expensive to the NHS. Generic prescribing lessens the risk of error as each drug has only one agreed name. At Sheerwater Health Centre, all drugs are to be prescribed generically using their approved name as specified in the BNF.

On occasion there may be a requirement to prescribe a specific manufacturer’s product, such as some modified or controlled-release drugs for example. In such instances, the prescriber should discuss the requirement with the practice lead for prescribing who is Dr A Mohamed.

## Prescribing unlicensed medicines

[GMC guidance](https://www.gmc-uk.org/-/media/documents/prescribing-guidance-updated-english-20210405_pdf-85260533.pdf) states that the term ‘unlicensed medicine’ is used to describe medicines that are used outside the terms of their UK licence or that have no licence for use in the UK. Unlicensed medicines are commonly used in some areas of medicine, such as in paediatrics, psychiatry and palliative care. They are also used, albeit less frequently, in other areas of medicine.

Prescribing unlicensed medicines may be necessary where:

* There is no suitably licensed medicine that will meet the patient’s need. Examples include (but are not limited to) where:
  + There is no licensed medicine applicable to the particular patient. For example, if the patient is a child and a medicine licensed only for adult patients would meet the needs of the child
  + A medicine licensed to treat a condition or symptom in children would nonetheless not meet the specific assessed needs of the particular child patient, but a medicine licensed for the same condition or symptom in adults would do so
  + The dosage specified for a licensed medicine would not meet the patient’s need
  + The patient needs a medicine in a formulation that is not specified in an applicable licence
* A suitably licensed medicine that would meet the patient’s need is not available. This may arise when, for example, there is a temporary shortage in supply
* The prescribing forms part of a properly approved research project
* There is a serious risk to public health and the MHRA has temporarily authorised the sale or supply of an unlicensed medicine, such as a vaccine or treatment, in response

When prescribing an unlicensed medicine, prescribers must:

* Be satisfied that there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy
* Take responsibility for prescribing the medicine and for overseeing the patient’s care, monitoring and any follow up treatment, or ensure that arrangements are made for another suitable doctor to do so
* Make a clear, accurate and legible record of all medicines prescribed and, where prescribers are not following common practice, their reasons for prescribing an unlicensed medicine

In addition to the above guidance, prescribers at Sheerwater Health Centre must ensure that patients are given sufficient information about the medicines that are being prescribed. This enables them to make an informed decision.

Some medicines are routinely used outside the terms of their licence, for example in treating children. In emergencies or where there is no realistic alternative treatment and such information is likely to cause distress, it may not be practical or necessary to draw attention to the licence. In other cases, where prescribing unlicensed medicines is supported by authoritative clinical guidance, it may be sufficient to describe in general terms why the medicine is not licensed for the proposed use or patient population.Prescribers must always answer questions from patients (or their parents or carers) about medicines fully and honestly.

Any clinician intending to prescribe unlicensed medicines where that is not routine or if there are suitably licensed alternatives available, this should be explained to the patient along with the reasons for doing so.

## Processing a repeat prescription request

All staff involved in the repeat-prescribing process should be suitably trained and understand their roles and responsibilities and the processes to be followed. Time is allocated for the GP to process repeat prescriptions daily. To avoid any unnecessary errors, all repeat prescriptions are to be generated using EMIS Web system and the following should be checked:

* The patient’s name, date of birth and address
* That the medication requested is an authorised repeat medication
* That the drug name, strength, dose and form are identical to that on the repeat list
* That the repeat medication review date has not been exceeded

In the following situations, the repeat request must be referred to a GP if:

* The review date has been exceeded
* The number of repeat issues has been met
* Requests are received earlier or later than indicated (this may be due to poor use by the patient)
* A repeat has not been requested for one year, the exceptions being seasonal medications
* No repeat date has been set

The process after verification is as follows:

* The prescription should be generated and passed to a GP for signature (ideally the GP who sees the patient regularly) who will:
  + Ensure that the correct patient is issued with the correct prescription
  + Ensure that the correct dose is prescribed
  + Ensure that appropriate directions for use are shown, not “as directed”
  + Review the patient’s record, medicine usage and effects
* The GP returns the prescription to the admin room
* The prescription is retained securely until it is collected
* Storage is to be away from areas accessible to patients and, when the practice is closed, they are to be secured in administration room
* Staff must cross-reference the information on the prescription with the person collecting it (confirming the name, address and date of birth of the patient)
* The prescription is given to the patient or their representative

Prescriptions not collected after 28 days are to be discussed with the prescribing clinician then shredded and the patient’s health record updated.

Children under 16 are not permitted to collect prescriptions unless a prior written agreement has been arranged between the parents or guardians of the patient and the practice manager/prescriber.

## Urgent requests

Requests for urgent repeat prescriptions (less than 48 hours) are to be reviewed by the duty doctor who is to ascertain if the medication is needed that same day. If this is deemed to be the case, the request is to be processed without delay. The patient is to be advised to call back to collect their prescription.

For patients who repeatedly request urgent repeats, the practice manager is to be informed.

A flow chart depicting the repeat prescription process can be found at [Annex B](#_Annex_B_–).

## Emergency prescriptions

Should any patient request an “urgent or emergency prescription” then current NHS E advice is for the patient to contact their prescriber immediately to arrange a prescription.

Additionally, NHS E advises that an alternative is for the patient to attend a pharmacy in an emergency, although this is subject to the following conditions.[[5]](#footnote-5)

The patient must have been prescribed the medicine before by a doctor, dentist, nurse independent prescriber, optometrist independent prescriber or other healthcare professional who is registered in the UK. In addition to this, the pharmacist:

* Will usually need to see the patient face-to-face
* Must agree that the patient needs the medicine immediately
* Will usually need evidence that the patient has been prescribed that medicine before
* Must be satisfied with the dose that is most appropriate for the patient to take

The pharmacist may provide an emergency supply of up to 30 days' treatment for most prescription medicines. The following exceptions to this rule are:

* Insulin, an ointment, a cream or an asthma inhaler as only the smallest pack size will be supplied
* The contraceptive pill as only enough for a full treatment cycle will be supplied
* Liquid oral antibiotics as only the smallest quantity to provide a full course of treatment will be supplied
* Permitted controlled medicines (controlled drugs) as only up to five days' treatment will be provided (see below)

Only a limited range of controlled medicines can be prescribed in an emergency, such as those for epilepsy (phenobarbital). Many commonly used controlled medicines, such as morphine or diamorphine, cannot be supplied without a prescription by a pharmacist in an emergency.

Even if the pharmacist is unable to give the patient an emergency supply of a medicine, they will advise the patient how to obtain any essential medical care they may need.

## Lost prescriptions

In the case of a patient stating that they have lost their prescription form, Sheerwater Health Centre will comply with the NHS Counter Fraud Authority [Management and control of prescription forms](https://cfa.nhs.uk/fraud-prevention/fraud-guidance#controlPrescriptionForms) guidance.

The loss is to be reported immediately to Nine Taylor (the Practice Manager) who will record the following details:

* Date and time of loss (if known)
* Date and time the incident was reported
* Location or locations where the loss may have occurred

If the lost prescription was for a controlled drug, the CDAO is to be informed and extra security precautions taken, such as asking the prescriber to sign prescriptions in a specific colour, ensuring that the local pharmacies are made aware of this, thereby preventing the lost prescription from being used.

All losses are to be recorded by means of a significant event report.

## Medication review

The review period for repeat medication rests with the prescriber. Medication reviews should be carried out at least annually or, in cases of complex repeat prescriptions, every six months.

The objective of a medication review is to optimise the use of medicines, reduce wastage and ultimately reach an agreement with the patient about what is required for their continued care. The review process maintains collaboration between the prescriber and the patient, allowing the patient to obtain further prescriptions for medicines at agreed intervals.

At Sheerwater Health Centre, a recall system is in place to ensure that patients who do not order their repeat medications are contacted, and a review is arranged. This information is recorded in the patient’s healthcare record.

The individual undertaking the review is to ensure that:

* The prescribed medication is appropriate for the patient’s needs
* The medication continues to be effective
* All monitoring and chronic disease reviews have been completed
* The medication is the most cost-effective choice
* There are no drug interactions or side effects
* The patient remains compliant
* The review is recorded in the patient’s healthcare record appropriately
* The appropriate read code is used
* The review date is amended

Medication reviews should be conducted by the clinician with the patient present. Telephone consultations are also considered acceptable for this process.

## Failure to attend for review

Attempts should be made to contact the patient to determine the reason why they have not attended their review. All communication attempts must be recorded on EMIS Web system. There are several reasons why the patient may not have attended their review and prescribers should check that:

* The patient is still a member of the practice (they may have moved)
* The patient has not been admitted to hospital or reviewed by another clinician (possibly within secondary care)
* It is appropriate to contact the patient (it may be necessary to contact a carer)

Every attempt must be made to contact the patient and to arrange a review.

## Control and monitoring

Only a qualified prescriber has the authority to issue repeat prescriptions and determine the number of repeats permitted, after which time the patient must undergo a medication review.

Clinical control is the sole responsibility of the clinician; this can also include the practice nurse for several patients (e.g., diabetes, asthma and contraception).

At Sheerwater Health Centre, the practice manager is responsible for overseeing the daily processing of all repeat prescription requests.

## Patients discharged from hospital

Patients who are discharged from hospital may have been issued with additional medication or their regular medication strength/frequency may have been amended.

It is therefore essential that such patients are reviewed and, where appropriate, an appointment made or home visit arranged. The patient’s prescriber should review all discharge summaries and letters. They are then responsible for updating the patient’s repeat medication record and removing any discontinued drugs accordingly. Furthermore, they are also to verify that the patient has sufficient medication, if there is any need for an acute prescription and that the patient’s review date has been appropriately updated.

## Prevention of misuse

Regular reviews will help to prevent the misuse of repeat prescriptions and, at Sheerwater Health Centre, patients are monitored to ensure that repeat requests are appropriate. Any requests deemed to be either over or underused will be referred to the patient’s GP.

Staff should be aware of the following non-specific signs that may indicate misuse:

* Taking higher doses than prescribed or running out of prescribed medication before expected
* Continually “losing” medication so more prescriptions have to be written
* Seeking prescriptions from more than one healthcare professional, e.g., doctor, nurse, non-medical prescriber or from more than one practice
* Requesting a specific drug claiming that other medications “don’t work” or that he/she is allergic to them
* Stealing, forging or diverting prescriptions
* Appearing to be intoxicated, sedated or experiencing withdrawal
* Excessive mood swings or hostility
* Increase or decrease in sleep
* Evidence of craving or other signs of dependence

Staff may also bring to the attention of the prescriber any concerns or uncertainties they have about a patient and their repeat prescription.

Clinical staff must also be aware of the specific signs that may indicate misuse of certain drugs such as opioids, hypnotics, anxiolytics and stimulants.

## Timely intervention

The clinician, in all instances, will recall the patient and discuss their medication usage with them, providing guidance and assurance regarding the use of their repeat prescription medication.

Early intervention is key in potential misuse cases; it will enable the clinician to manage the patient more effectively before the situation worsens. The following actions may be taken when attempting early intervention:

* The clinician may conduct more frequent medication reviews
* Facilitate longer clinical appointments to discuss medication with the patient
* Agree with the patient the medication required for repeat prescribing
* Direct the patient to the available literature regarding their medication
* Discuss the case with a peer or specialist to determine the most appropriate management
* Consider issuing the patient with a medication record/diary to monitor usage
* Refer the patient to the relevant substance misuse specialists for support and guidance

## Continued control

After early intervention, if patients are still considered to be misusing, they will receive, following their appointment with the GP, a letter (see [Annex C](#_Annex_C_–)) aimed at providing further guidance and reassurance to the patient that the team are going to continue to provide ongoing support for the patient. The letter will detail the patient’s obligations to manage their medication appropriately. The patient is required to sign and return the letter to the practice which is to be scanned into their healthcare record.

To monitor the use of medication by the patient, the patient will also be issued with a repeat medication ordering pro forma (see [Annex D](#_Annex_D_–)) which is to be presented each time they wish to submit a repeat prescription. The patient will need to attend the practice to submit a repeat request as staff will need to sign/monitor the form.

Should a patient raise a concern about their prescription, they are to be allocated an appointment to discuss their concerns with their usual GP. At all times, the patient’s GP maintains responsibility for the medication prescribed.

All patients who are under formal medication reviews will have an alert added to their healthcare record, ensuring that all staff are aware in case the patient is seen by a different clinician or locum.

## High risk drug monitoring

The purpose of regular monitoring for a range of drugs classified as “high risk” is to ensure that patients continue to receive the appropriate dose whilst reducing the potential risk of adverse effects. There are several drugs that have potentially dangerous side effects and to maintain patient safety, they must be monitored efficiently.

GMC guidance, [Good practice in prescribing and managing medicines and devices](https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices) states that prescribers should only prescribe medicines when they have adequate knowledge of an individual’s health and are assured that medicines remain safe and necessary for the individual. This also applies when shared care arrangements are in place and the legal responsibility to ensure safety rests with the person signing the prescription.

The CQC will use searches on the clinical system to determine the effectiveness of high risk drug monitoring at Sheerwater Health Centre. [CQC GP Mythbuster 12: Accessing medical records and carrying out clinical searches](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-12-accessing-medical-records-during-inspections) provides further detailed information.

The table at [Annex F](#_Annex_F_–) shows the recommended regular monitoring periods for high-risk drugs. Further guidance can be sought from NICE document titled [Safe prescribing of high-risk drugs](https://www.nice.org.uk/sharedlearning/safe-prescribing-of-high-risk-drugs)

## 2.25 Covert medication

Covert administration is when medicines are administered in a disguised format.

The medicines could be hidden in food, drink or through a feeding tube without the knowledge or consent of the person receiving them. As a result, the person is unknowingly taking a medicine. Every person has the right to refuse their medicine, even if that refusal appears ill-judged to staff who are caring for them.

Covert administration is only likely to be necessary or appropriate where:

* A person actively refuses their medicine
* That person is judged not to have the capacity to understand the consequences of their refusal. Such capacity is determined by the Mental Capacity Act 2005
* The medicine is deemed essential to the person’s health and wellbeing

Covert administration of medicines should be a last resort. Reasonable efforts must be made to give medicines in the normal manner. Alternative methods of administration should also be considered. This could include, for example, liquid rather than solid dose forms.

Administering medicines in food or drink can alter their therapeutic properties and effects. They could become unsuitable or ineffective. Always take advice from a healthcare professional to make sure that medicines are safe and effective.

Clinical records must be maintained when medicines are administered covertly. This is particularly important for people with fluctuating capacity[[6]](#footnote-6).

## Prescription security

A prescription form should be considered an asset that has a financial value; it is in effect a blank check open to potential misuse. The theft of prescription forms and their resulting fraudulent misuse, potentially involving third parties, is a serious concern.

The following security processes are required at Sheerwater Health Centre:

* A prescription log should be maintained on each site detailing information about prescriptions ordered, received and taken for use
* All staff should be made aware of prescription security procedures through training. A list of those staff members who have been trained, and date of training, must be kept. Processes must be in place to ensure that new staff, locums and GP trainees are made aware of the procedures
* Only appropriately trained staff should be allowed to generate prescriptions
* Passwords should not be shared. Computer-generated prescriptions can be identified by an audit trail
* An annual review should be carried out to ensure that appropriate systems are in place and are being adhered to
* If there is any concern about the security of the existing printer, consideration should be given to fitting a security device to the printer to prevent the theft of forms from the printer tray or only printing prescriptions in the dispensary, away from areas to which patients have access

It is recommended by [NICE](https://www.nice.org.uk/guidance/ng5/chapter/Introduction) that a designated member of staff has overall responsibility for overseeing the ordering, receipting and storing of prescriptions. Furthermore, a deputy should be nominated to oversee the process in the absence of the designated person.

At Sheerwater Health Centre the designated person is Nine Taylor (the Practice Manager) and the nominated deputy is Louise Gray.

[NHS Counter Fraud Authority: management and control of prescription forms: A guide for prescribers and health organisations (March 2018)](https://cfa.nhs.uk/resources/downloads/guidance/Management_and_control_of_prescription_forms_v1.0_March_2018.pdf) provides support on the following:

* Destroying spoiled or duplicate prescriptions
* Sending prescriptions by post
* Transferring prescriptions from one site to another (for example to a branch surgery)
* Locum access to prescriptions
* Alerts, investigations and sanctions
* Audit
* Security of computer systems
* Missing or lost prescription forms
* Forged prescriptions
* Reporting incidents

Further reading including what is expected to be compliant can be sought from [CQC GP Mythbuster No 23: Security of blank prescription forms](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-23-security-blank-prescription-forms).

## Ordering of prescription forms

Prescription forms can only be ordered through Xerox UK Ltd. The registered individual at Sheerwater Health Centre for ordering purposes is the practice manager. Should there be a requirement to change the registered person, a template is to be requested from Xerox UK Ltd via email: [nhsorders@xerox.com](mailto:nhsorders@xerox.com) and submitted once completed to the same address.

## Delivery and storage

At Sheerwater Health Centre, a risk assessment ([Annex G](#_Annex_G_–)) will be undertaken to ensure potential threats are mitigated and that suitable security measures are in place8.

Delivery of prescription stock should be checked thoroughly against the order and delivery note. Staff are only permitted to sign for the delivery if the packaging seal is unbroken. Barcodes on the boxes include the product code, quantity and the first and last serial numbers in the range.

If there are any irregularities at the delivery stage, the delivery driver should be asked to remain on site if possible whilst the supplier is contacted to check the details of the delivery. It is recommended that at least two members of staff are available to check deliveries8.

Once the stock has been checked, it is to be stored in the controlled stationery cupboard located within the practice manager’s room. This area is restricted and remains locked when not in use. Keys for access to this area are strictly controlled.

When making visits, clinicians are to retain effective control over prescription forms in order to prevent loss or theft. Prescriptions should be carried in lockable cases and not left in vehicles. It is recommended7 that clinicians record the serial numbers of all prescriptions taken on home visits prior to leaving the practice, taking with them only a limited number of prescriptions.

As per the NHS CFA guidance, all systems should be auditable and allow the “history” of a prescription to be traced from receipt of the blank form to when it was prescribed. The template at [Annex E](#_Annex_E_–) can be used to record the history of the prescription. The record will be maintained by the practice manager and stored securely. The record includes:

* Date of delivery
* Name of the person accepting delivery
* What has been received (quantity and serial numbers)
* Where it is being stored
* When it was issued
* Who issued the prescription forms
* To whom they were issued
* The number of prescriptions issued
* Serial numbers of the prescriptions issued
* Details of the prescriber

There is a clear audit trail in place for prescription forms so that it is known which serial-numbered forms have been received and which have been issued to each prescriber. If a prescriber leaves the organisation (e.g., resigns, retires or dies), the nominated responsible person will recover all unused prescription forms on the last day of their employment or on the notification of their death.

Records are to be retained for a minimum of three years. At Sheerwater Health Centre, only minimal stocks of prescriptions are held. All prescribers are aware of their individual responsibilities regarding the safeguarding of prescriptions.

## Issue

All issues of prescription stock are recorded in the prescription log by the responsible person. Clinicians are only permitted to hold one pad of prescriptions at any one time and should note the serial numbers of the first and last prescription in the pad they are issued.

Forms should not be left unattended or unsecured at any time in the organisation or in a car. All forms/pads should be kept in a locked drawer/cabinet in the organisation when not in use and in a locked bag when removed from the organisation. In exceptional cases, when handwritten forms are necessary, these should be secured when a practitioner leaves the room regardless of the reason or length of time

Under no circumstances are prescriptions to be left in printers overnight.

Locums will be given sufficient prescription forms to meet the requirements of their clinical sessions. At the end of their session/assignment at the practice, they are to return all unused forms to Nine Taylor (the Practice Manager). A limited number of forms should be taken for home visits or other use outside the organisation.

It is the responsibility of the clinician to maintain effective security of the prescriptions in their possession.

## Prescriptions issued at another UK nation

Prescriptions that are issued from one UK nation can be collected in another. The following section details the processes and differences when issued a prescription from one UK nation and the medication collected from another:

1. England

The table below shows where charges will be incurred should a Scottish, Welsh or Northern Irish prescription be presented in England.

|  |  |
| --- | --- |
| **Origin of prescription** | **Charges** |
| Scotland | Collect prescription charges according to English rules, unless the patient qualifies for exemption |
| Wales | Collect prescription charges according to English rules, unless the patient presents a Welsh prescription charge entitlement card |
| Northern Ireland | No prescription charge |

1. Scotland[[7]](#footnote-7)

Patients who live in England but are registered with a GP practice in Scotland will not be charged for a prescription(s) presented for dispensing in Scotland. They will not require any entitlement card as they will have been issued with the Scottish prescription form (GP10).

If a patient presents a Scottish prescription for dispensing at a pharmacy in England, they will be required to pay the English charge unless they fall within one of the exemption categories listed in the equivalent English regulations.

Any Scottish prescription form (GP10) presented for dispensing in England will be charged at the English rate per item, unless the patient qualifies for exemption. Any Scottish prescription from presented for dispensing in Wales or Northern Ireland will be charged the rate in force at the time. Currently this is no charge.

Patients presenting prescriptions written in England will be charged at the English rate per item. The only exceptions are for Entitlement Card holders or those who qualify for exemption.

Patients presenting a prescription(s) written in Wales or Northern Ireland for dispensing in Scotland will not be charged under current arrangements.

1. Wales[[8]](#footnote-8)

NHS prescriptions are free of charge if the patient has:

* A GP who works for NHS Wales, and;
* Your prescription is dispensed by a pharmacy which is employed by NHS Wales

If the patient lives in England and has a GP in Wales, they can get prescriptions free of charge as long as the prescription is dispensed by a pharmacy employed by NHS Wales. If the patient chooses to have their prescription dispensed in England, they will need to qualify for free prescriptions under the English criteria.

If the patient lives in Wales and has a GP in England, they may still be able to get prescriptions free of charge by having an exemption card. Further information is available on the [NHS Wales Help with Health Costs website](https://gov.wales/low-income-scheme-help-nhs-health-costs).

Patients can apply for exemption cards to the following address:

NHS Prescription Card Exemption

NHS Wales Shared Services Partnership

Cwmbran House

Mamhilad Park Estate

Mamhilad

PONTYPOOL

NP4 0YP

If the patient has an NHS prescription dispensed in England, they will be charged at the rate set by the Department of Health and Social Care in England.

If the patient has been referred by their Local Health Board to a hospital in England and is given an English prescription, they will have to pay the current rate set by the Department of Health and Social Care, even if they take it to a Welsh pharmacy. However, provided the patient are a Welsh resident, they may claim this fee back from the NHS Wales Shared Services Partnership if you have proof of payment.

1. Northern Ireland[[9]](#footnote-9)

Prescriptions written by GPs are dispensed free of charge in Northern Ireland. The patient does not need to qualify for free prescriptions.

Pharmacists in Northern Ireland will not charge patients from England, Scotland or Wales for prescriptions.

If the patient takes a Northern Ireland issued prescription to a pharmacy in England, Scotland or Wales, the pharmacist will not charge for dispensing this.

## Private prescriptions

Should any patient undergo private specialist treatment, the consultant will invariably prescribe medication and request that the practice organises an NHS prescription to be issued for the medication. By doing it this way, will save the patient having to pay for it privately.

Alternatively, the patient may request that the GP transfers the private prescription to an NHS FP10 prescription.

At Sheerwater Health Centre, should a letter be received from a private consultation advising or suggesting a course of action, then it may be appropriate for an initial FP10 prescription and ongoing treatment to be issued following agreement from their GP. As the prescriber will take clinical responsibility for monitoring, the GP must ensure that they are able and content to accept this responsibility. However, there may be occasions when the GP is requested by a private consultant to prescribe medication they would not usually prescribe:

* **Specialist medication**

If the medication is specialist in nature and is not a routine drug for GP prescribing, it is for the individual GP to decide whether to accept clinical responsibility for the prescribing and monitoring.

* **Non-formulary**

If the medication is not part of the local joint prescribing formulary, it is not recommended to be transferred onto the NHS. In this instance, the GP may wish to offer the patient a clinically suitable formulary alternative.

* **Unlicensed or off-label**

There is greater clinical responsibility on the GP prescribing unlicensed or off-label treatment. The GMC guidance titled [Prescribing unlicensed medicines](https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/prescribing-unlicensed-medicines) provides advice on this subject and should be consulted prior to considering any transfer of prescriptions from private to NHS.

* **Red/Grey list or blacklisted**

Drugs that are included in these categories are considered less suitable for prescribing.

Furthermore, should the GP either:

* Believe that the medication is not clinically appropriate
* Not agree with the treatment plan
* Not have access to full written details from the private clinician

Then it would be reasonable for the GP to decline to prescribe. At Sheerwater Health Centre, we will follow the local formulary and prescribing guidance, furthermore, will liaise with the Medicines Management team at Surrey Heartlands ICB for further advice or agreement.

When a GP needs to write at private prescription from this organisation, the BMA advises that GPs may write private prescriptions for patients for drugs not available through the drug tariff. However, GPs do not charge their registered patients for providing such a prescription.

Further reading on GPs prescribing private prescriptions can be sought from [BMA](https://www.bma.org.uk/advice-and-support/gp-practices/prescribing/prescribing-in-general-practice).

## Prescription requests from dentists

[Kent LMC](https://www.kentlmc.org/adviceforgpsforrequeststoprescribesedativepriortodentalprocedures) advises that “dentists should not direct patients to GPs requesting they prescribe sedating medications, such as diazepam.If a dentist wishes to prescribe sedating medications for anxious patients, that dentist should be responsible for issuing the prescription. The dental practitioner’s formulary, which is the list of drugs a dentist can prescribe, is found on the[BNF dental practitioners formulary](https://bnf.nice.org.uk/dental-practitioners-formulary/)*,*includes Diazepam Tablets and Oral Solution.

If the dentist is treating a patient within their practice NHS contract, then the prescription should be on a FP14D form. Dentists do not have EPS.If the dentist is treating a patient privately, they should issue a private prescription.

Dentists may contact a GP for information or advice, if, for example the patient has a complex medical history.”

The [BMA recommend](https://www.bma.org.uk/advice-and-support/gp-practices/gp-service-provision/patients-presenting-with-dental-problems)s the following:

* If, after seeing a dentist, a patient asks their GP for an NHS prescription, the GP should investigate the patient’s condition and accept [sole responsibility for that prescribing decision](https://www.england.nhs.uk/wp-content/uploads/2018/03/responsibility-prescribing-between-primary-secondary-care-v2.pdf) before issuing an NHS prescription.
* If a legitimate need for an NHS prescription cannot be established, it should not be provided.
* GPs should be cautious about accepting a patient’s understanding of dental advice and should be satisfied that what they prescribe is appropriate to the patient’s condition.

The [BMA](https://www.bma.org.uk/advice-and-support/gp-practices/gp-service-provision/patients-presenting-with-dental-problems) also advises that Local Medical Committees (LMCs) and Local Dental Committees (LDCs) should establish positive working relationships that will help to resolve any issues that may arise between individual GP and dental practices.

## Loss and theft

Any irregularities with prescription stock are to be reported immediately to Nine Taylor, the Practice Manager who will in turn inform the Controlled Drugs Accountable Officer (CDAO) and the police accordingly. The CDAO is [insert name/contact details].

Any report of theft or loss must include the following details:

* Date and time of loss or theft
* Date and time the incident was reported
* Location of theft or location/s where the loss may have occurred
* Serial numbers
* Quantity

|  |  |
| --- | --- |
| **Organisation** | **Reporting actions** |
| NHS England and Wales Counter Fraud Authority | [Online reporting form](https://reportfraud.cfa.nhs.uk/)  Telephone 0800 028 4060 |
| NHS Scotland Counter Fraud Services | [Online reporting tool](https://forms.theiline.co.uk/nhss-counter-fraud-services)  Telephone 0800 0151628 |
| NHS Northern Ireland Counter Fraud and Probity Service | [Reporting tool](https://cfps.hscni.net/report/)  Telephone 0800 0963396 |

Other useful contact details:

* Local Counter Fraud Specialist [insert name/contact details]
* Police (if appropriate)

For security purposes and to prevent the lost or stolen stock being used, the prescriber to whom the stock relates is to be advised to sign prescriptions in a specific colour, ensuring that the local pharmacies are made aware of this.

Appropriate checks should first be carried out to ensure that the discrepancy is not linked to a simple error with the central stock record (such as incorrectly entered serial numbers or a prescriber having been issued with a pad but this not being recorded). If the discrepancy cannot be resolved, then the matter should be escalated.

A reporting form for the loss or suspected theft of prescriptions can be found at [Annex H](#_Annex_H_–).

## Prescriptions lost by patients

Should a patient report that they have lost a prescription, a risk assessment should be undertaken prior to a replacement prescription being issued. This will ensure that the reported loss is genuine and not an attempt to commit prescription fraud. Should the prescription be for CDs, the CDAO is to be informed to make certain that the medication is dispensed to the correct patient without incident.8

## Current and out-of-date prescription forms

Examples of current and out-of-date prescription forms can be found [here](https://www.nhsbsa.nhs.uk/sites/default/files/2017-03/Current_and_out_of_date_prescription_forms_v5_Jan_16.pdf). Information provided at this link is from the NHS BSA Prescription Services.

## Reporting NHS prescription form incidents

When reporting an incident to the NHSCFA, as much detail as possible is to be given, this includes:

* Practice name
* Reporter’s contact details
* Date and time of incident
* Where the incident occurred
* Type of prescription form
* Serial numbers
* Quantity
* Details of individual from whom forms have been stolen
* Whether the police have been notified
* Have local pharmacies and practices been notified?

Such incidents can be reported online at [NHSCFA](https://cfa.nhs.uk/reportfraud) or by telephone 0800 0284060.

## Reporting adverse reactions

If a patient has a serious adverse reaction to a drug, it should be reported to the MHRA and a Significant Event raised. Reactions are to be reported using the [MHRA “yellow card” scheme](https://yellowcard.mhra.gov.uk/).

## Medicines optimisation

Medicines optimisation is defined as “a person-centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines”. The Royal Pharmaceutical Society has introduced four guiding principles for medicines optimisation:[[10]](#footnote-10)

* Aim to understand the patient’s experience
* Evidence-based choice of medicines
* Ensure the use of medicines is as safe as possible
* Make medicines optimisation part of routine practice

Further guidance can be found at: [NHS England Medicines Optimisation](https://www.england.nhs.uk/medicines-2/medicines-optimisation/).

## Medicines optimisation – peer review

Medicines Optimisation Peer Review is a mechanism used to encourage prescribers in their decision-making processes to deliver safe, evidence-based, cost-effective prescribing.

Medicines optimisation meetings involve up to six practices within North West Surrey occurring on an annual basis. Attendance at the meeting consists of one prescriber and a member of the practice management team as well as the regional pharmacist.

Data can be retrieved from the Medicines Optimisation dashboard, enabling users to develop plans to enhance patient outcome and service delivery. Further information relating to the dashboard can be found at: [NHS Medicines Optimisation Dashboard](https://www.england.nhs.uk/medicines/medicines-optimisation/dashboard/)

## Controlled drugs

Detailed information that can support the management of controlled drugs can be found in the Controlled Drugs Policy.

## Audit

Prescribing is the most common intervention in the NHS across all sectors and, after staffing costs, it accounts for the second highest area of NHS expenditure. Prescribing makes up a large portion of a GP’s clinical care of a patient and is the most common therapeutic approach offered to patients.[[11]](#footnote-11)

Clinical-based audits should include the following information:[[12]](#footnote-12)

* Title
* Reason for the audit
* Criterion or criteria to be measured
* Standard/s set
* Preparation and planning
* Results and date of data collection one
* Description of change/s implemented
* Results and date of data collection two
* Reflections

Conducting a prescribing audit will enable the practice to review current prescribing performance and patterns. The benefits of a prescribing audit include, but are not limited to:

* Improving patient safety
* Reviewing clinicians’ prescribing practices
* Achieving QOF
* Reducing prescribing costs
* Improving patient outcomes
* Reducing wastage
* Minimising non-compliance

Prescribing audits will be discussed at practice meetings to ensure that all prescribers are aware of any planned changes to enhance service delivery.

All legal and ethical guidelines should be adhered to and the confidentiality of the patient or service user, staff and health service provider should be protected at all times.[[13]](#footnote-13)

For further detailed information, see the organisation’s Clinical Audit Policy.

## Useful contact information

**NHS Protect**

Fourth Floor, Skipton House, 80 London Road, London, SE1 6LH

Telephone: 020 7895 4500

Email: [generalenquiries@nhsprotect.gsi.gov.uk](mailto:generalenquiries@nhsprotect.gsi.gov.uk)

Website: [www.nhsbsa.nhs.uk/Protect.aspx](http://www.nhsbsa.nhs.uk/Protect.aspx)

**NHS Fraud and Corruption Reporting Line**

0800 028 40 60

**NHS Pharmacy Reward Scheme**

0800 068 6161

**NHS Print Contract Management Team**

[nhs.print@nhs.net](mailto:nhs.print@nhs.net)

**Prescription form suppliers, Xerox (UK) Ltd**

Customer service

Telephone: 0300 123 0849

Email: [nhsorders@xerox.com](mailto:nhsorders@xerox.com)

# Summary

Prescribers within Sheerwater Health Centre have significant responsibility for prescribing. Accountability rests with the authorised prescriber who has signed the prescription.

Adhering to the direction provided in this policy will ensure that clinicians are fully aware of their responsibilities, reduce risk and ensure the delivery of safe and effective clinical care.

# Annex A – Medication synchronisation template

Dear [insert name of patient],

The aim of medication synchronisation is to order all of your repeat medication at the same time each month, rather than multiple requests throughout the month. Synchronising saves time for you, your GP and pharmacy staff.

To initiate the synchronisation of your medication, when you next need to request an item on repeat, count all the tablets you have and annotate the table accordingly. Your GP will issue a “one-off” prescription of the tablets you need to synchronise all your medication to within a day or two.

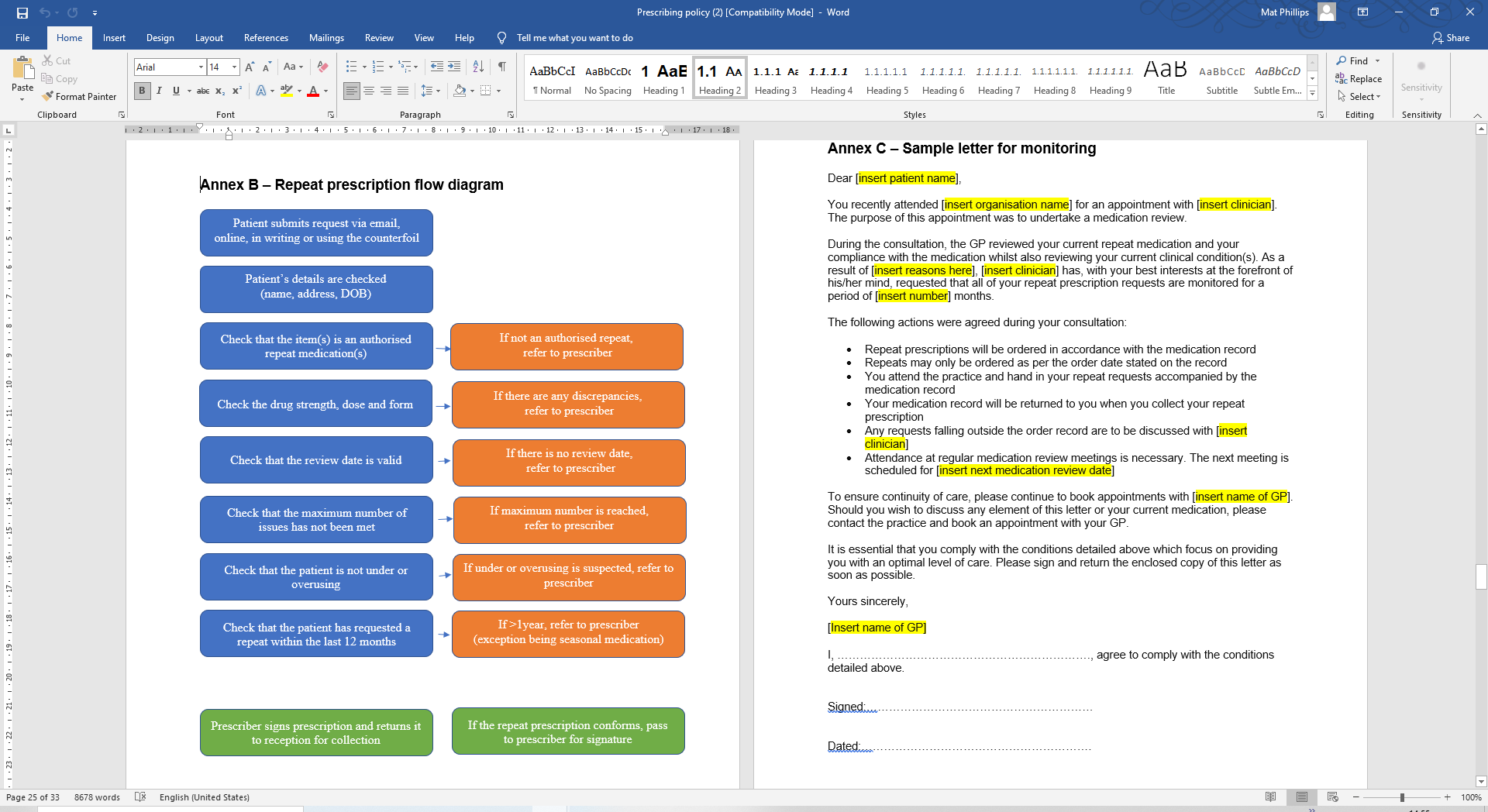
Please complete the table below and submit it with your next repeat prescription.

✂-------------------------------------------------------------------------------------------------------------

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient name** |  | **Clinical number** |  |
| **Date of birth** |  | **Contact number** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of medication** | **Strength** | **Dose** | **Quantity remaining** |
| Aspirin | 75mg | Once a day | 8 |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

# Annex B – Repeat prescription flow diagram



# Annex C – Sample letter for monitoring

Dear [insert patient name],

You recently attended Sheerwater Health Centre for an appointment with [insert clinician]. The purpose of this appointment was to undertake a medication review.

During the consultation, the GP reviewed your current repeat medication and your compliance with the medication whilst also reviewing your current clinical condition(s). As a result of [insert reasons here], [insert clinician] has, with your best interests at the forefront of his/her mind, requested that all of your repeat prescription requests are monitored for a period of [insert number] months.

The following actions were agreed during your consultation:

* Repeat prescriptions will be ordered in accordance with the medication record
* Repeats may only be ordered as per the order date stated on the record
* You attend the practice and hand in your repeat requests accompanied by the medication record
* Your medication record will be returned to you when you collect your repeat prescription
* Any requests falling outside the order record are to be discussed with [insert clinician]
* Attendance at regular medication review meetings is necessary. The next meeting is scheduled for [insert next medication review date]

To ensure continuity of care, please continue to book appointments with [insert name of GP]. Should you wish to discuss any element of this letter or your current medication, please contact the practice and book an appointment with your GP.

It is essential that you comply with the conditions detailed above which focus on providing you with an optimal level of care. Please sign and return the enclosed copy of this letter as soon as possible.

Yours sincerely,

[Insert name of GP]

I, …………………………………………………………., agree to comply with the conditions detailed above.

Signed:……………………………………………………

Dated:…………………………………………………….

# Annex D – Repeat medication ordering proforma

|  |  |
| --- | --- |
| **Patient name** |  |
| **Date of birth** |  |
| **Address** |  |
| **GP** |  |

This pro forma is to be submitted alongside every repeat prescription and will be returned upon collection of your prescription. The order date shown below is the earliest date that you may submit your request. Should you need to discuss this, please book an appointment with the GP named above.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medication**  **(generic name)** | **Strength and form** | **Direction** | **Quantity issued** | **Next order date** | **Issued by**  **(initial and sign)** | **Date**  **authorised** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

# Annex E – Prescription log

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date ordered** | **Ordered by (initials)** | **Quantity ordered (inc. order number)** | **Date received** | **Quantity received** | **Received by (initials)** | **Serial numbers**  **received** | **Stored by**  **(initials)** | **Serial numbers issued** | **Issued to**  **(initials)** | **Signature and initials of recipient** |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |

# Annex F – Recommended high-risk drug monitoring frequencies

Guidance provided by [Specialist Pharmacy Services (SPS)](https://www.sps.nhs.uk/home/guidance/drug-monitoring/?https://www.sps.nhs.uk/home/guidance/drug-monitoring/https://www.sps.nhs.uk/home/guidance/drug-monitoring/). Note only baseline tests have been listed. For ongoing requirements or additional considerations, refer to the specific SPS link

|  |  |  |
| --- | --- | --- |
| **Drug** | **Initial baseline tests** | **Date SPS reviewed** |
| [ACE inhibitors and angiotensin II receptor blockers](https://www.sps.nhs.uk/monitorings/ace-inhibitors-and-angiotension-ii-receptor-blockers-monitoring/) | Baseline:   * Blood pressure * Estimated glomerular filtration rate or Serum creatinine (for creatinine clearance) * Serum potassium * Serum sodium * Urea | 24 June 2021 |
| [Acetylcholinesterase inhibitors](https://www.sps.nhs.uk/monitorings/acetylcholinesterase-inhibitors-monitoring/) | Baseline:   * Estimated glomerular filtration rate: For galantamine and rivastigmine only * Liver function tests * Serum potassium for galantamine | 5 July 2021 |
| [Alfacalcidol](https://www.sps.nhs.uk/monitorings/alfacalcidol-monitoring/) | Baseline:   * Alkaline Phosphatase * Parathyroid hormone * Serum calcium ideally corrected calcium for protein binding * Serum creatinine (for creatinine clearance) * Serum phosphate * Urea and electrolytes * Vitamin D (25-hydroxy vitamin D level) | 5 July 2021 |
| [Amiodarone](https://www.sps.nhs.uk/monitorings/amiodarone-monitoring/) | Baseline:   * Chest x-ray * ECG * Urea and electrolytes * Serum potassium * Liver function tests particularly transaminases * T3 * T4 * Thyroid stimulating hormone   Once   * Thyroid peroxidase antibodies | 5 July 2021 |
| [Azathioprine](https://www.sps.nhs.uk/monitorings/azathioprine-monitoring/) | Baseline   * ALT or AST * Blood pressure * Calculated glomerular filtration rate or Serum creatinine (for creatinine clearance) * Cervical screening check this is up to date * Full blood count * Height * Liver function tests * TPMT assay * Weight * Vaccination status * Varicella Zoster Virus Immunity · if no history of chicken pox, shingles or varicella vaccination | 13 July 2021 |
| [Carbamazepine](https://www.sps.nhs.uk/monitorings/carbamazepine-monitoring/) | Baseline   * Body mass index * Full blood count * Liver function tests * Urea and electrolytes * Serum creatinine (for creatinine clearance) or estimated glomerular filtration rate | 6 July 2021 |
| [Carbimazole](https://www.sps.nhs.uk/monitorings/carbimazole-monitoring/) | Baseline:   * Free T3 * Free T4 * Full blood count including white cell count (WCC) * Thyroid stimulating hormone * Liver function tests * White blood cell differential | 6 July 2021 |
| [Ciclosporin](https://www.sps.nhs.uk/monitorings/ciclosporin-monitoring/) | Baseline:   * Blood pressure required at least twice before starting treatment * Serum creatinine (for creatinine clearance) · required at least twice before starting treatment or calculated glomerular filtration rate * Cervical screening check up-to-date * Lipids * Liver function tests * Serum magnesium * Serum potassium especially in renal dysfunction (risk of hyperkalaemia) * Vaccination status   Refer to link for additional specialist baseline requirements | 13 July 2021 |
| [Corticosteroids](https://www.sps.nhs.uk/monitorings/corticosteroids-monitoring/) | Baseline:   * Blood pressure * Body mass index * Bone mineral density in adults expected to be on prednisolone at a dose equal or greater than 5mg/day, or equivalent, for over 3 months * Height in children and adolescents * Optometrist exam for glaucoma or cataract * Risk factor assessment check for pre-existing conditions potentially exacerbated by steroids * Serum potassium * Weight   Refer to link for risk factor assessments that are required to be considered | 15 July 2021 |
| [DOACs (Direct Oral Anticoagulants)](https://www.sps.nhs.uk/monitorings/doacs-direct-oral-anticoagulants-monitoring/) | Baseline:   * Baseline clotting screening * Body weight * Full blood count * Liver function tests * Serum creatinine (for creatinine clearance) Cockcroft and Gault is recommended for calculating creatinine clearance for DOACs * Urea and electrolytes | 5 July 2021 |
| [Digoxin](https://www.sps.nhs.uk/monitorings/digoxin-monitoring/) | Baseline:   * Serum calcium * Serum creatinine (for creatinine clearance) * Serum magnesium * Serum potassium * Thyroid function tests - May require dose amendment in thyroid disease * Urea and electrolytes | 14 July 2021 |
| [Dronedarone](https://www.sps.nhs.uk/monitorings/dronedarone-monitoring/) | Baseline:   * ECG * Liver function tests contraindicated if severe hepatic impairment * Urea and electrolytes * Serum creatinine (for creatinine clearance) or estimated glomerular filtration rate do not initiate if CrCl or eGFR less than 30ml/min/1.73m2 * Serum magnesium correct as necessary before initiation * Serum potassium correct as necessary before initiation | 14 July 2021 |
| [Eplerenone](https://www.sps.nhs.uk/monitorings/eplerenone-monitoring/) | Baseline:   * Estimated glomerular filtration rate contraindicated if eGFR less than 30mL/min/1.73m2; reduce starting dose to 25 mg on alternate days if eGFR 30–60 mL/minute/1.73 m2 * Serum potassium contraindicated if over 5.0 mmol/L * Electrolytes | 14 July 2021 |
| [Furosemide](https://www.sps.nhs.uk/monitorings/furosemide-monitoring/) | Baseline:   * Blood pressure * Electrolytes * Serum creatinine (for creatinine clearance) | 14 July 2021 |
| [Hydrocarbamide](https://www.sps.nhs.uk/monitorings/hydroxycarbamide-monitoring/) | Baseline:   * Estimated glomerular filtration rate avoid if less than 30 mL/minute/1.73 m2; half dose if less than 60mL/minute/1.73m2 * Full blood count contraindicated if platelet count less than 100 x 109/L * Liver function tests avoid in severe impairment; caution in mild to moderate * Uric acid   Further baseline tests required for Sickle cell disease. Refer to link. | 15 July 2021 |
| [Hydroxychloroquine](https://www.sps.nhs.uk/monitorings/hydroxychloroquine-monitoring/) | Baseline:   * Albumin * ALT or AST * Blood pressure * Full blood count * Height * Serum creatinine (for creatinine clearance) or calculated glomerular filtration rate * Weight * Vaccination status | 15 July 2021 |
| [Leflunomide](https://www.sps.nhs.uk/monitorings/leflunomide-monitoring/) | Baseline:   * ALT or AST * Albumin * Blood pressure * Full blood count * Height * Liver function tests * Platelet count * Serum creatinine (for creatinine clearance) or calculated glomerular filtration rate * Vaccination status * Weight * White blood cell differential | 15 July 2021 |
| [Levothyroxine](https://www.sps.nhs.uk/monitorings/levothyroxine-monitoring/) | Baseline:   * ECG * Free T4 * Thyroid function tests * Thyroid stimulating hormone | 15 July 2021 |
| [Lithium](https://www.sps.nhs.uk/monitorings/lithium-monitoring/) | Baseline:   * Body weight or body mass index * Cardiac function especially in patients with cardiovascular disease or at risk who may require ECG * Estimated glomerular filtration rate * Serum calcium * Thyroid function tests patients should be euthyroid before initiation * Urea and electrolytes | 17 July 2021 |
| [Mercaptopurine](https://www.sps.nhs.uk/monitorings/mercaptopurine-monitoring/) | Baseline:   * Full blood count * Liver function tests * Urea and electrolytes * TPMT assay * Serum creatinine (for creatinine clearance) or estimated glomerular filtration rate | 24 June 2021 |
| [Mesalazine](https://www.sps.nhs.uk/monitorings/mesalazine-monitoring/) | Baseline:   * Full blood count * Liver function tests * Serum creatinine (for creatinine clearance) or estimated glomerular filtration rate * Urea and electrolytes * Urine dipstick | 5 July 2021 |
| [Methotrexate](https://www.sps.nhs.uk/monitorings/methotrexate-monitoring/) | Baseline:   * Albumin * Blood pressure * Body weight * Chest x-ray or Screening for lung disease physical examination and lung function may also be necessary on case-by-case basis * Full blood count * Height * Hep B or Hep C - if chronic viral hepatitis, consider antiviral treatment prior to initiation * HIV * Liver function tests consider delayed initiation if results abnormal * Serum creatinine (for creatinine clearance) or estimated glomerular filtration rate avoid in severe renal impairment; reduce dose if moderate   Refer to link for additional specialist baseline requirements | 5 July 2021 |
| [Minocycline](https://www.sps.nhs.uk/monitorings/minocycline-monitoring/) | Baseline:   * Full blood count * Liver function tests · If history suggests abnormal * Serum creatinine (for creatinine clearance) or estimated glomerular filtration rate if history suggests abnormal | 5 July 2021 |
| [Mycophenolate mofetil](https://www.sps.nhs.uk/monitorings/mycophenolate-mofetil-monitoring/) | Baseline:   * Pregnancy test two tests 8-10 days apart in women of child bearing potential; exclude before initiating * Albumin * ALT or AST * Blood pressure * Full blood count * Height * Liver function tests * Serum creatinine (for creatinine clearance) or calculated glomerular filtration rate * Vaccination status * Weight | 5 July 2021 |
| [NSAIDs](https://www.sps.nhs.uk/monitorings/nsaids-monitoring/) | Baseline:   * Blood pressure particularly before COX-II inhibitors * Estimated glomerular filtration rate * Full blood count * Serum creatinine   Liver function tests if hepatic impairment | 22 June 2021 |
| [Nitrofurantoin](https://www.sps.nhs.uk/monitorings/nitrofurantoin-monitoring/) | Baseline:   * Estimated glomerular filtration rate * G6PD deficiency contraindicated if deficiency * Liver function tests * Porphyria · contraindicated | 5 July 2021 |
| [Penicillamine](https://www.sps.nhs.uk/monitorings/penicillamine-monitoring/) | Baseline:   * Albumin * ALT or AST * Full blood count * Urinalysis * Urea and electrolytes * Serum creatinine (for creatinine clearance) or estimated glomerular filtration rate | 5 July 2021 |
| [Phenytoin](https://www.sps.nhs.uk/monitorings/phenytoin-monitoring/) | Baseline:   * Full blood count * HLAB\* 1502 allele in Han Chinese or Thai origin patients * Liver function tests * Urea and electrolytes * Vitamin D | 22 June 2021 |
| [Pioglitazone](https://www.sps.nhs.uk/monitorings/pioglitazone-monitoring/) | Baseline:   * Full blood count * HbA1c * Liver function tests do not initiate if ALT greater than 2.5 upper limit of normal or other evidence of liver disease * Urinalysis to detect macroscopic haematuria; if present, investigate before starting * Weight | 5 July 2021 |
| [Spironolactone](https://www.sps.nhs.uk/monitorings/spironolactone-monitoring/) | Baseline   * Serum creatinine (for creatinine clearance) or estimated glomerular filtration rate * Urea and electrolytes | 5 July 2021 |
| [Statins](https://www.sps.nhs.uk/monitorings/statins-monitoring/) | Baseline:   * ALT or AST * Blood pressure * Body mass index * HDL cholesterol (non-fasting) * non-HDL cholesterol (non-fasting) * Serum creatinine (for creatinine clearance) or estimated glomerular filtration rate * Thyroid stimulating hormone * Total cholesterol (non-fasting) * Triglycerides (non-fasting) | 8 July 2021 |
| [Sulfasalazine](https://www.sps.nhs.uk/monitorings/sulfasalazine-monitoring/) | Baseline:   * Albumin * ALT or AST * Blood pressure * Full blood count · to include differential white cell count and platelet count * Height * Weight * Serum creatinine (for creatinine clearance) or calculated glomerular filtration rate | 8 July 2021 |
| [Tacrolimus](https://www.sps.nhs.uk/monitorings/tacrolimus-monitoring/) | Baseline:   * Blood pressure * Clotting screening * ECG for hypertrophic changes * Fasting blood glucose * Full blood count * Liver function tests * Plasma proteins * Serum creatinine (for creatinine clearance) or estimated glomerular filtration rate * Urea and electrolytes - potassium is particularly important | 14 July 2021 |
| [Theophylline](https://www.sps.nhs.uk/monitorings/theophylline-monitoring/) | Baseline:   * Liver function tests * Urea and electrolytes – potassium is particularly important * Smoking status - advise patients to seek advice if likely to change | 13 July 2021 |
| [Valproic acid and Sodium valproate](https://www.sps.nhs.uk/monitorings/valproic-acid-and-sodium-valproate-monitoring/) | Baseline:   * Body mass index * Clotting screening · including bleeding time and coagulation tests * Full blood count * Liver function tests * Platelet count * Pregnancy test - see advice on valproate use by women and girls   Note: Only specialists can initiate or recommend initiation in adults and children. | 15 July 2021 |
| [Warfarin](https://www.sps.nhs.uk/monitorings/warfarin-monitoring/) | Baseline:   * Blood pressure * Clotting screening * Estimated glomerular filtration rate or Serum creatinine (for creatinine clearance) * Full blood count * Liver function tests * Thyroid function tests | 16 July 2021 |

# Annex G – Prescription security risk assessment

**Risk assessment and control form**

Brief task description: [Prescription security]

Practice name: [Insert organisation name] Risk assessment reference: [Insert local reference number]

Date completed: [Insert date completed] Relevant documents reference: [Insert supporting document name/reference numbers]

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **General risk description**  **(Hazard /Consequence)** | **Hazard rating** | **Likelihood**  **(including relevant people, environmental and data factors as well as existing control measures)** | **Likelihood rating** | Risk rating | Additional control measures required | **To be implemented By who?**  **By when?** | **Residual risk**  ***(Risk after all additional controls are implemented)*** |
| Prescription forms are assets with financial value, were a staff member to leave forms unsecured, theft may occur and the forms fraudulently misused | 3 | There is a designated member of staff with overall responsibility for the ordering, receipting and storing of prescriptions  Delivery and receipt of prescription stock is conducted in accordance with the Prescribing Policy  Once stock is checked (at the point of receipt), it is stored in the controlled stationery locker  This area is restricted and remains locked when not in use, with access controlled  Prescriptions are issued to individual clinicians and this is recorded in the prescription log | 2 | 6 | To carry out spot checks to ensure all staff store prescriptions in locked drawers when leaving their room unattended  Nominate a designated deputy to support the nominated individual  Provide new members of staff with an induction to ensure that they are aware of the Prescribing Policy and existing control measures | Practice manager - ongoing  Practice manager by end May 2023  Practice manager -ongoing |  |

**General Administration**

|  |  |  |
| --- | --- | --- |
| **Risk assessor’s name:** | **Contribution to risk assessment by:** | **Manager approval** |
| [Insert name of risk assessor] | [Insert name of any contributors] | [Insert name of manager] |
| **Risk assessor’s job role:** | **Contributor’s job role:** | **Date of approval** |
| [insert job role] | [Insert job role] | [Insert date] |

|  |  |  |  |
| --- | --- | --- | --- |
| **This document was reviewed/updated by:** | **Job role:** | **On date:** | **Next planned review due:** |
| [Insert name of assessor] | [Insert job role] | [Insert date] | [Insert date] |

|  |  |
| --- | --- |
| **Risk Review Profile** | **Recommended risk assessment and risk controls review periodicity.**  ***Guidance note:*** *The principle of review is that the more significant the risk level, the more often it must be reviewed.*  **Always review if an incident has occurred:** |
|  | If the risk is 15 – 25 (Very high) – Review at least every 1 – 3 months |
|  | If the risk is 8 – 12 (High) – Review at least every 6 – 12 months |
|  | If the risk is 4 – 6 (Moderate) – Review at least every 12 – 18 months |
|  | If the risk is 1 – 3 (Low) – Review at least every 18 – 24 months |

# Annex H – Reporting form for the loss or suspected theft of prescriptions

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Practice |  | | Date reported |  |
| Contact name (print) |  | | Contact phone number |  |
| Contact address |  | | | |
| Date & time of theft/loss |  | | If date/time is not known, tick here | |
| Name of the person reporting theft/loss (if different from above) |  | | Telephone number |  |
| **Full details of the loss** | | | | |
| Include the following information:   * Date and time loss/theft first reported * Place where loss/theft occurred * Type of prescription stationery * Quantity of prescriptions lost/stolen * Additional items stolen, e.g., hand stamps |  | | | |
| **Details of prescription form(s) lost or stolen** | | | | |
| Name of prescriber(s) |  | | Personal code(s) or identification number(s) |  |
| Address (as it would appear on the script) |  | | | |
| Serial numbers lost or stolen | From |  | | |
| To |  | | |
| Details of type of form stolen | i.e., printer forms or handheld pads | | | |
| **Reporting** | | | | |
| Has this incident been reported to the police? | Yes | No | Crime number |  |
| Name and police station of investigating officer |  | | | |
| Does this incident involve any prescriptions for controlled drugs? | Yes | No | If this incident involves controlled drugs, has the CDAO been informed? |  |
| Name |  | | Position |  |
| Signed |  | | Dated |  |

1. [BMA Good practice in prescribing and managing medicines and devices](http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp) [↑](#footnote-ref-1)
2. [www.england.nhs.uk](https://www.england.nhs.uk/digitaltechnology/wp-content/uploads/sites/31/2015/06/electronic-repeat-dispensing-guidance.pdf) [↑](#footnote-ref-2)
3. [systems.hscic.gov.uk](http://systems.hscic.gov.uk/eps/library/faqs/nomination) [↑](#footnote-ref-3)
4. [bnf.nice.org.uk](https://bnf.nice.org.uk/guidance/non-medical-prescribing.html) [↑](#footnote-ref-4)
5. [www.nhs.uk](http://www.nhs.uk) [↑](#footnote-ref-5)
6. [www.cqc.org.uk](https://www.cqc.org.uk/guidance-providers/adult-social-care/administering-medicines-covertly) [↑](#footnote-ref-6)
7. [www.nhslothian.scot](https://www.nhslothian.scot/YourRights/PrescriptionCharges/Pages/default.aspx) [↑](#footnote-ref-7)
8. [www.england.nhs.uk](https://www.england.nhs.uk/ourwork/part-rel/x-border-health/xb-faq/#q13) [↑](#footnote-ref-8)
9. [www.nidirect.gov.uk](https://www.nidirect.gov.uk/articles/prescriptions) [↑](#footnote-ref-9)
10. [NICE Medicines Optimisation Clinical Guidelines](https://www.nice.org.uk/guidance/ng5/documents/medicines-optimisation-draft-guideline2) [↑](#footnote-ref-10)
11. [Prescribing Analysis and Audit](https://patient.info/doctor/prescribing-analysis-and-audit) [↑](#footnote-ref-11)
12. [RCGP Clinical Audit](https://gmpcb.org.uk/wp-content/uploads/RCGP_Quick_guide_09_Clinical_Audit.pdf) [↑](#footnote-ref-12)
13. [Clinical Audit Guidelines](http://www.hse.ie/eng/about/Who/ONMSD/Practicedevelopment/NursePrescribing/Guidance-for-Clinical-Audit.pdf) [↑](#footnote-ref-13)