All Wales Medicines Strategy Group

Grŵp Strategaeth Meddyginiaethau Cymru Gyfan

CEPP National Audit:

Repeat Prescribing

1.0 BACKGROUND

"Repeat prescribing is a partnership between patient and prescriber that allows the prescriber to authorise a prescription so it can be repeatedly issued at agreed intervals, without the patient having to consult the prescriber at each issue."[2]

In Wales, during the period April 2010 to March 2011, there were 70.1 million items dispensed, equivalent to 22.2 items per head of the population registered with a GP[3]. Repeat prescribing is said to account for 60–75% of all primary care prescriptions and around 80% of prescribing costs[2]; therefore, based on the above figure, this would amount to around 48.9 million repeat items prescribed during 2010/11. In addition, the Welsh Government document "*Reducing Medicines Waste"* (2010) states that the cost of unwanted medicines in Wales each year is around £50 million, with £12.9 million due to 'prescribing something not needed' or 'over supply'[4]. It is therefore vital that an efficient and effective repeat prescribing system is in place.

An effective repeat prescribing system is considered to make a valuable contribution to medicines management at the practice; this is recognised within the General Medical Service (GMS) contract by the inclusion of several quality indicators relating to medicines management[5]. Benefits of an effective system include:

- Improved quality of prescribing and medicines use
- Improved patient safety
- Improved patient convenience and access to medicines needed
- Appropriate and efficient use of practice staff time and skills
- Managed workflow
- Waste reduction

Although it is important to have an efficient and effective repeat prescribing system that utilises practice repeat prescribing policies, having trained staff and encouraging an environment of effective, two-way, blame-free communication between administrator and clinician is just as important, as demonstrated by a recent ethnographic case study published in the BMJ[6]. The study highlights the social complexity of the task of repeat prescribing and found that there is often a gap between formal practice protocols and the actual activity of repeat prescribing, but that the explicit and tacit knowledge of administrative staff sometimes, but not always, bridged this gap.

2.0 REPEAT PRESCRIBING MODEL

The repeat prescribing process as outlined by Zermansky in 1996[7] is still relevant today and essentially comprises three key stages:

1. **Production:** Involves receiving requests and producing the prescription and is usually delegated to a receptionist or prescribing clerk who has undergone the relevant repeat prescribing training:
    - The request should originate from the patient or patient's carer.
    - Written requests, including repeat re-order slips and electronic requests, are preferable to oral/telephone requests as they are more likely to be accurate and there is reduced opportunity for error and/or misunderstanding.

- Patients requesting items that are not on the repeat list need to be referred to a GP.

2. **Management control:** This is usually the responsibility of the practice manager or delegated assistant and comprises four elements:
    - **Authorisation check:** The practice policy should clearly state who is authorised to add medication to a repeat list (e.g. GP, non-medical prescriber, pharmacist) and the number of authorisations allowed before review.
    - **Compliance check:** To identify patients who are under- or over-using their medicines and refer them to a GP.
    - **Review date:** To ensure that all patients have a clear indicator for when therapy should be reviewed.
    - **Flagging:** To ensure that the patient is aware of when their medicines need to be reviewed and notify a GP of any queries, e.g. review date overdue, over/under ordering, non-repeat requests.

3. **Clinical control:** This is the responsibility of the GP or other qualified prescriber and involves two tasks:
    - **Authorisation:** The decision that a drug is suitable for repeat prescribing, i.e. the prescriber is satisfied that the drug is effective, well tolerated and still required.
    - **Medication Review:** A holistic review of the patient and all medication to check concordance, effectiveness, tolerability and appropriateness, and to decide whether treatment should be continued, changed or stopped. The 'NO TEARS' tool can be used as a prompt to aid efficient medication review[8]. (Also see WeMeReC bulletin November 2005: Medication Review for the 10 minute consultation[8])

2.1 Repeat dispensing

This is a process by which patients can obtain repeat medication over a defined period, up to a maximum of 12 months, without the need to contact the practice for each occasion. Patients with chronic conditions that are likely to remain stable for the duration of the repeatable prescription are most likely to benefit from the repeat dispensing service

2.2 Repeat prescribing best practice standards

Some prescription items are generally not recommended for repeat prescribing (e.g. weight loss drugs, nicotine replacement therapy, or benzodiazepines) and also there are certain generics which should be brand prescribed (e.g. carbamazepine)[9]. In general, there are recognised standards pertaining to repeat prescribing which have formed part of the medicines management programmes in Wales[9–11]. The National Prescribing Centre has also produced guidance on repeat dispensing[12].

2.3 Reducing medicines waste: Actions for GPs and other prescribers[4]

The Welsh Government toolkit for reducing medicines waste includes the following key points:

- Do include compliance checks when reviewing medicines.
- Do review your repeat prescribing system.
- Do archive unrequested medicines where appropriate.
- Do consider repeat dispensing.

- Do stop unnecessary treatments.
- Do add clear dose instructions ('PRN' can be used if the dose instructions are made clear by specifying the dose interval, the maximum number of doses per day and/or the condition for which the dose should be taken/given, e.g. give one when required up to four times a day for pain).
- Do synchronise repeat prescription quantities.
- Don't prescribe more than is needed (Welsh Government supports 28-day prescribing as standard duration of a prescription, but consider smaller quantities for acute scripts).
- Don't allow acute medicines to be included on repeat list.

3.0 DATA COLLECTION TOOLS FOR AUDIT

3.1 Audit aim

To improve the quality of repeat prescribing policies and systems by giving practices the opportunity to reflect on their repeat prescribing procedures, and to observe how current repeat prescribing reflects the practice policy and best practice standards. The resulting comparison will allow practices to recognise and implement any necessary changes to their repeat prescribing process and policy.

3.2 Audit method

1. Complete Form 1: Repeat Prescribing Policy.
2. Complete Form 2: Repeat Prescription Data Collection:
    - Randomly choose recently printed repeats for approximately ten patients/WTE GP and review their repeat records. Fifty patient/scripts should give a representative sample.
3. Complete Form 3: Data Collection Summary Sheet (using the data from Form 2).
4. Practice to analyse data, identify changes needed and develop action plan to implement changes. Record on Form 4: Action Plan Summary Sheet.
5. Submit copies of Forms 1, 3 and 4 to the health board locality office by [insert date].

Form 1: Repeat Prescribing Policy

Practice:

Audit period:

Question	Yes/No/Comments
Does the practice have a written repeat prescribing policy?	Yes/No If Yes please attach a copy
Has the policy been reviewed in the last three years?	Yes/No
Is there an agreed time limit for processing repeat prescriptions?	Yes/No What is it?
Are additions/deletions to the repeat, including outpatient prescriptions and hospital discharges, **only** made by a GP, nurse or pharmacist?	Yes/No If No specify who else does this
Does the policy state the maximum number of repeat issues or the maximum length of time between reviews allowed?	Yes/No What is it?
Does the policy specify what to do if the patient requests a repeat which needs to be re-authorised?	Yes/No Please specify or reference in attached policy
Does the policy specify what to do if the patient requests an item which is not on repeat list?	Yes/No Please specify or reference in attached policy
Does the policy have specific details relating to repeat requests for high risk drugs, e.g. warfarin, lithium, DMARDs and controlled drugs?	Yes/No
Does the policy include details for flagging and recalling patients for medication review?	Yes/No
Are the notes/computer record clearly marked with date of present/future repeat medication review?	Yes/No
Does the policy state a system to review and archive repeats not requested for six months or more?	Yes/No Please specify
Does the policy include a process for adding prescriptions written during home visits to the repeat prescribing record?	Yes/No
Does the policy specify arrangements for communication between GP and community pharmacist or other healthcare professionals (e.g. designated GP and/or time to contact for prescription queries)?	Yes/No Please specify or reference in attached policy
Have non-clinical staff responsible for generating repeat prescriptions attended a repeat prescribing training course approved by the health board?	Yes/No
All staff have signed to say they are aware of and understand the practice repeat prescribing policy?	Yes/No

Form 2: Repeat Prescription Data Collection

Review approximately 10 patients per WTE/GP or 50 repeat prescriptions (photocopy page as necessary).

Part 1: Enter number of items with reference to computer screens of randomly selected patients

Part 2: Answer Y = Yes or N = No

Part 1	Patient										Total number of items (A)
	1	2	3	4	5	6	7	8	9	10	
Number of items on repeat											
Number of items with acceptable specified dose/instructions *'PRN' or 'MDU' alone are not acceptable*											
No of items not ordered in last 6 months (excluding seasonal preparations, e.g. hayfever medication)											
Number of PRN oral or topical analgesics including NSAID items											
Part 2	**Patient**										**Number of 'Yes' (B)**
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Are all repeat quantities appropriate for a maximum of 28 day's use? (Estimate for topicals, inhalers, warfarin)											
Are all quantities equivalent? (Exclude PRN items)											
Are the repeats authorised for a maximum of 12 months?											
Are all regular repeats (i.e. excluding PRN items) being ordered together?											
Are repeats being issued after the authorisation period has expired?											
Is there a record of a medication review, with documented evidence of discussion about repeat medications and outcome of review, in the past 12 months?											
Are there any items prescribed as generic that should be prescribed by brand? (*When using this audit an up to date list cf BNF could be added for easy reference, see Appendix 1*)											
Are there any items for which the dose could be optimised? (*eg 2x5 mg switched to 10mg)*)											
Are there any duplicate items on repeat?											

Form 3: Data Collection Summary Sheet

Practice:

Date audit completed:

(Your practice can agree to set your own standards if you do not wish to accept the suggested audit standards)

Total number of patients reviewed **(C)** =

Part 1	**Total number of items: (A) as on Form 2**	**Practice %: (A)/(D) x 100**	**Suggested standard**	**Practice standard** (if not using the suggested standards)
Total number of items on repeats sampled **(D)**				
Total number of items with acceptable specified dose/instructions (*'PRN' or 'MDU' ALONE are not acceptable).*			90%	
Number of items not ordered in last 6 months (excluding seasonal preparations, e.g. hayfever medication)			< 10%	
Number of patients and % of patients sampled with PRN oral or topical analgesics including NSAID items (A and A/C) on repeat list[13,14].			No suggested standard (could be a practice discussion point)	
Part 2	**Number of 'Yes': (B) as on Form 2**	**Practice %: (B)/(C) x 100**	**Suggested audit standard**	**Practice standard** (if not using the suggested standards)
All repeat quantities are for a maximum of 28 days			90%	
All quantities on repeat are for equivalent duration (*excluding items intended as PRN as quantity may be less)*			100%	
All repeats are authorised for a maximum of 12 months			90%	
All regular repeats are being ordered together			90%	
Repeats are being issued after the authorisation period has expired			10%	
There is a record of medication review, with documented evidence of discussion about repeat medication and outcome of review, within last 12 months			90%	
There are items prescribed as generic which should be prescribed by brand			0%	
There are items on repeat where the dose could be optimised			10%	
There are duplicate items on repeat?			0%	

Form 4: Action Plan Summary Sheet

1. What did the practice discover from carrying out this audit? *(This could include any significant/specific events or problems identified during the course of the audit.)*

2. How robust are the processes the practice currently has in place? *(You may wish to record this on a scale of 1 [not robust] to 5 [very robust].)*

Score:

3. What discussion/activities did the practice undertake as a result of the audit? *(E.g. a review of practice prescribing policy or a discussion about medication reviews*)

4. What changes have the practice agreed to implement as a result of this audit?

This audit was completed by:

Name(s):_____

Signature(s): _____

Practice (name and address): _____

_____

References

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APPENDIX 1. Medicines to be prescribed by brand name.

Some medicines need to be prescribed by brand due to, for example, critical bioavailability or the availability of a modified-release or complex formulation. In a few cases, this is crucial to the patient receiving a safe and effective therapeutic dose. In the case of immunosuppressants, the Medicines and Healthcare products Regulatory Agency (MHRA) has issued safety warnings recommending brand prescribing due to bioavailability differences between brands[15,16]. With some modified release preparations, variation between brands can lead to differences in clinical effects, e.g. lithium, theophylline, nifedipine and diltiazem. The following medicines should therefore be prescribed by brand:

Medicine(s)	Note
Antiepileptic medicines	Loss of seizure control has been reported in patients after switching brands of antiepileptic medicines. Continuity of the same brand, or the same generic preparation, is recommended[17]. (For individual antiepileptic agents, see below.)
Carbamazepine Sodium valproate	Brand prescribing is only necessary if prescribed for epilepsy; brand continuity is not essential for other indications.
Phenytoin	On the basis of single dose tests, there are no clinically relevant differences in bioavailability between available phenytoin sodium tablets and capsules, but there may be a pharmacokinetic basis for maintaining the same brand of phenytoin in some patients[18]. (See also 'Antiepileptic medicines' above.)
Lamotrigine	Generic and branded products are bioequivalent[19]. (See also 'Antiepileptic medicines' above.)
Ciclosporin Tacrolimus Mycophenolate	CHM advises that oral tacrolimus products should be prescribed and dispensed by brand name to avoid the risk of medication errors[20].
Lithium	The NPSA publication "Safer Lithium Therapy" requires a lithium alert card to be issued to patients, specifying the brand of lithium to be prescribed with the dosage[21].
Aminophylline Theophylline	The BNF states that the rate of absorption varies between preparations, so patients should be maintained on the same brand[18].
Diltiazem MR Nifedipine MR	For diltiazem and nifedipine, the BNF states that these should be prescribed by brand name, as different versions of modified release preparations containing more than 60 mg diltiazem hydrochloride may not have the same clinical effect[18].
Beclometasone CFC-free inhalers	The MHRA has advised that CFC-free beclometasone inhalers should be prescribed by brand name. This also applies to combination products[22].
Morphine MR	For MR oral morphine preparations, the BNF states that dosage requirements should be reviewed if the brand is changed[18].
BNF: British National Formulary; CHM: Commission on Human Medicines; IR: immediate release; MHRA: Medicines and Healthcare products Regulatory Agency; MR: modified release; NPSA: National Patient Safety Agency	