Repeat prescribing: 10 tips to develop a safer system

Liz Price

Failure of repeat prescribing systems can contribute to patient harm. Here, the author suggests 10 tips to be incorporated into general practice systems to help prevent avoidable risks.

The management of repeat prescribing is an area of indisputable risk within general practice. Over two-thirds of prescriptions issued in primary care each year are repeats, while a study in 2012 by the GMC revealed that there were GP prescribing or monitoring errors found in 1 in every 20 prescriptions.¹

General practices tend to have evolved systems that are heavily reliant on both their patient IT system and the human-user interface. Patient IT systems differ in the way they allow the user to process repeats and the safety features that they offer.

Likewise, every practice contains a range of individuals who have varying degrees of knowledge, skills and experience, working in different environments and team types. As a result, each practice will have unique risks.

Avoiding prescribing errors

MDDUS (The Medical and Dental Defence Union of Scotland) is a medical and dental defence organisation providing access to professional indemnity and expert medico- and dentolegal advice for doctors, dentists and other healthcare professionals throughout the UK.

At MDDUS, we see patterns associated within claims of negligence each year where these systems have failed and contributed to patient harm. These patterns highlight areas of avoidable risk and, in order to improve the safety of their repeat prescribing systems, practices should consider including some of the following key elements.

Written policy

Have a written policy that includes the responsibilities of each individual associated with each part of the process. Each user, including the GPs, should understand the risks associated with their role and the safety features within the patient IT system, and use the system consistently. These risks should include human factors – considerations such as the minimising of interruptions and distractions during the processing of repeats.

Clinical responsibility

There should be clinical responsibility for any changes to the repeat prescribing record, including adding new medicines and reconciling the record after discharge from secondary care.

In 2010, the National Patient Safety Agency (NPSA) and NICE reported that 30–70 per cent of patients experience a...
medication error when their care is transferred.\textsuperscript{2} Often discharges are illegible and include complex changes to a patient’s prescribing regimen.

A Royal Pharmaceutical report in 2011\textsuperscript{3} found that the likelihood of an elderly patient leaving hospital on the same medicines that they were admitted on is less than 10 per cent. In addition, between 28 and 40 per cent of medicines are discontinued, 45 per cent of medicines are new at discharge and 60 per cent of patients have three or more medicines changed during their stay in hospital.

GMC guidance states that: ‘any changes to the patient’s medicines are critically reviewed and quickly incorporated into their record’. If these tasks are delegated, the GMC guidance states that: ‘only staff who are competent to do so prepare repeat prescriptions for authorisation’. Before delegating, there should be a critical clinical review, with specific detailed instruction. The system should include a clinical check after completion to minimise the associated risk.

\textbf{Accuracy}

Ensure the information entered for each scription is accurate. New items should be provided in line with the practice’s prescribing policy (ie one-monthly or two-monthly scripts) and, where appropriate, to coincide with existing items to increase efficiency and reduce waste. Review periods should be appropriate for the medication type and patient. In the majority of practices, the review period defaults to six months; however, a shorter period may be appropriate for some medicines.

Accurate information ‘in’ translates to accurate information ‘out’ and so prompts about early or late requests for medications should be more meaningful.

\textbf{Monitoring over- and underuse of medications}

Following on from the above, the patient IT systems should be used to monitor over- and underuse. This could indicate nonadherence for a variety of reasons and, for some medications, there is a higher risk related to this. If necessary, the patient should be asked to come in for a review consultation.

This is backed up by the GMC, who state specifically that: ‘you should consider whether requests for repeat prescriptions received earlier or later than expected may indicate poor adherence, leading to inadequate therapy or adverse effects’.\textsuperscript{4}

\textbf{Allergies}

All known allergies should be coded consistently. Many patient IT systems have safety features that include warnings to prevent prescribing where there is a known allergy. These are often only effective where the allergy is appropriately coded.

\textbf{Making changes}

Changes to repeat prescriptions should not be made by hand. The existing scription should be cancelled, changed and re-issued. When cancelling prescriptions, a reason should be documented in the record at the time – most systems prompt for this. In addition, any prescriptions issued by hand should be entered as ‘given’ into the repeat record. This is most applicable where the prescriber has seen the patient at home or in a nursing home.

\textbf{Nonrepeat requests}

Items requested that are not on the repeat record should be treated with care. Risk can be reduced where a message is passed to the prescriber to review the request and provide a scription themselves if appropriate. If the task is delegated, the aforementioned GMC guidance applies and these items should be flagged to the GP signing the prescriptions as non-repeat.

\textbf{Reviews}

Medication reviews should be undertaken appropriately. GMC guidance states that: ‘the patient’s condition is monitored, taking account of medicine usage and effects and that: at each review, you should confirm that the patient is taking their medicines as directed, and check that the medicines are still needed, effective and tolerated. This may be particularly important following a hospital stay, or changes to medicines following a hospital or home visit’.

\textbf{Uncollected prescriptions}

Review uncollected prescriptions before destruction. Any prescriptions that are not collected should be recorded as ‘not collected’ on the patient IT system. This ensures that safety prompts from the system are as accurate as possible.

Special attention should be given to uncollected acute prescriptions as there may be a risk associated. These should be given back to the prescriber for critical review before destruction as it may be that the patient should be reminded or asked to attend the surgery for further review.

\textbf{Collection}

It is possible, in most practices, for patients to collect their own – or another person’s prescription – by simply providing a name and address. Receptionists should ensure that other prescriptions are not visible to the patient or carer, and that they do not disclose to the patient that a friend or relative’s prescription is also awaiting collection without prompt.

\textbf{Conclusion}

It is not possible to completely rid a complex system of risk. However, by incorporating the tips above into the IT system, GPs should be able to mitigate many of the known and avoidable risks and ensure the system is more robust, and thereby improve patient safety.

\textbf{References}


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