West Essex Clinical Commissioning Group

THINK! BEFORE GENERATING REPEAT PRESCRIPTIONS

Some Safety tips for Staff Generating Repeat Prescriptions

GENERAL GUIDANCE

Ensure patients are aware of how the practice's repeat prescription system works and the procedures to follow when making a repeat prescription request.

Ensure any requests made are identical to the name, dose and directions on the patient's repeat record.

When a request is made – check if the drug is on the patient's repeat prescription list. **Only appropriately qualified prescribers should make changes to a repeat prescription.**

The following patient groups require frequent reviews with the GP *(this list is **not** exhaustive)*

- Patients over 65 years of age
- Patients on multiple medicines
- Patients recently discharged from hospital or OPD
- Patients on high-risk medicines such as warfarin, NSAIDs, insulin

Repeat prescription requests should be dealt with accurately, securely and within an agreed timeframe.

1. *WARFARIN*

- Ensure the patient is receiving regular INR monitoring *(see opposite)*
- The dose should be expressed in **mg** and not in the number of tablets to be taken
- If a specific dose is prescribed, ensure the prescription is checked by the prescriber
- Inform the prescriber if NSAIDs (including aspirin 75mg daily) or clopidogrel are concurrently prescribed on the repeat prescription
- Ensure the patient informs the anticoagulant clinic of any acute prescriptions e.g. antibiotics
- 5mg warfarin tablets should not normally be put on repeat unless there are exceptional circumstances. We have had a number of incidents where patients have taken the 5mg instead of 500mcg tablets

*Repeat prescriptions of anticoagulants should only be issued if the prescriber has checked that the patient is regularly attending the anticoagulant clinic, that the INR test result is within safe limits, and that the patient understands what dose to administer. **Reviewing the patient-held record** when the repeat prescription is requested, and **discussing the anticoagulant treatment at this time**, is one method of doing this.*
(NPSA, Patient Safety Alert, 28 March 2007)

2. *INSULIN*

- Ensure you are familiar with the different types of insulin formulations available
- Insulin brands generally use a number to describe the composition e.g. NovoMix 30® - do **NOT** confuse this number with the dose to be administered *(see opposite)*
- **Ensure the word 'units' is not abbreviated – e.g. 10 UNITS instead of 10U or 10IU**
- Ensure the right container is prescribed (pre-filled pens or cartridges)
- Ensure the patient's blood glucose is regularly monitored

25 units Humalog® was incorrectly prescribed for a patient who was usually on Humalog mix 25®. The '25' in the name of the product was mistaken for the number of units to be given.

3. NSAIDS

- When a request is made and an NSAID is included, **ensure the patient still requires the NSAID**
- If the patient is elderly and/or will be on an NSAID long-term, attach a note to the prescriber on the prescription – 'does the patient need gastroprotection?'
- If the patient is pregnant, **REFER** to the prescriber
- Inform the prescriber if the patient is concurrently on aspirin 75mg daily
- 'As directed' or only 'when required' directions should be avoided
- NSAIDs interact with many medicines, these include anticoagulants (e.g. warfarin), antidepressants (e.g. citalopram), sulfonylureas (e.g. gliclazide), lithium, methotrexate

4. ANTIEPILEPTICS

- **Ensure continuity of the same brand or the same generic preparation**
- If the patient is pregnant, **REFER** to the prescriber
- Antiepileptics interact with multiple medicines, ensure you bring to the prescriber's attention that the repeat prescription contains an antiepileptic (ensure you are familiar with the common antiepileptics)
- **Ensure to include if the preparation is modified-release (M/R)**

5. LITHIUM

- Inform the prescriber where a repeat prescription contains lithium as the drug interacts with many medicines.
- Patients should have regular blood tests. If there are no documented lithium levels in the notes or the levels recorded are older than 3 months, **ensure it is brought to the prescriber's attention.**
- Ensure the patient is having regular tests to measure renal function.

National Institute for Health and Clinical Excellence (NICE) standard: ***one blood level measurement every three months.***

6....ARE THEY ALL NEEDED?

Over-ordering can lead to over-use with the potential for adverse effects, stock-piling and waste.
Look for: all items ordered every month including:

- 'prn' medication
- painkillers,
- blood glucose testing strips,
- lancets,
- relieving inhalers,
- all strengths of warfarin
- dressings & appliances
- 'as directed' items
- Regularly ordering ahead of due date
- Discrepancy between quantity ordered and issue duration

Confirming that items not used or taken regularly are required will reduce wastage.
Over ordering should be referred to the prescriber.