NHS
Brighton and Hove
Clinical Commissioning Group

Repeat Prescribing Pack

for Practice Administrators

PRACTICE DETAILS	
Practice Name	
Name of Prescribing Lead	
Name of Medicines Management Co-ordinator	

MEDICINES MANAGEMENT TEAM DETAILS	
MMT email address	BHCCG.MedicinesManagement@nhs.net
CCG telephone number	01273 238700 and ask to be put through to the MMT
CCG MMT website	www.gp.brightonandhoveccg.nhs.uk/prescribing

Please feedback any comments on this pack to the MMT email address above.
Any suggestions on how we can improve the content are gratefully received.

Prepared by	BH CCG MMT	Version	2
Date	April 2017	Review	March 2019

NOTES

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Why we have put this pack together?

There is no formal training for processing repeat prescriptions and yet practice administrators are the gatekeepers to patients obtaining their medications with a budget of **£39 million** within Brighton & Hove.

We understand the internal pressures and recognise the increase in workload as people are living longer with more long-term conditions, which is usually treated by medication.

It is thought that as many as half of all patients with chronic conditions end up using their medicines in a way that is not fully effective. Medicines used inappropriately can cause harm.

- Medication problems are implicated in 5-17% of hospital admissions which is similar to the number of people admitted with cancer and heart attacks.
- It is estimated that there are approximately 3,500 deaths on U.K. roads every year and 40,000 deaths due to adverse drug events
- Medication errors have been estimated to cost the NHS £500 million a year in additional days spent in hospital.

Hopefully, with this pack we can empower practice staff to process repeat prescriptions efficiently (reducing the practice workload), safely (reducing harm to the patient) and cost effectively (reducing waste).

Who should use this pack?

This pack is designed for practice staff who, as part of their duties, are involved in the ordering or generating of repeat prescriptions. While it is appreciated that terminology for staff may differ from practice to practice and that exact roles and responsibilities also differ, we shall refer to this group as ***"prescribing clerks"*** throughout the training packs.

This pack can be used by:

- New staff as an aid to induction training
- A refresher for all staff currently undertaking repeat prescribing duties

How should it be used and what is needed from the practice?

This pack will need to be used in conjunction with:

- Training on the practice computer system which generates prescriptions
- Hands on training with a period of supervision
- Identified support from a nominated experienced prescribing clerk or practice manager
- Access to the latest resources listed below. I.e. BNF (British National Formulary)
- An element of protected time within the practice
- PrescQIPP training webinars

Resources

BNF www.medicinescomplete.com/mc/bnf/current/
The British National Formulary gives general guidance on prescribing including how prescriptions should be written. The content is divided into chapters on specific disease states with a comprehensive index. The BNF provides information on all licensed drugs. This is also a good resource for checking brand names (although not all brands are listed).
BNFC www.medicinescomplete.com/mc/bnfc/current/
As above, but for children.
Brighton Joint Formulary http://www.gp.brightonandhoveccg.nhs.uk/joint-formulary
The Joint Formulary (JF) is developed with the collaboration of the following organisations: Brighton and Sussex University Hospitals NHS Trust, Sussex Partnership NHS Foundation Trust, Sussex Community NHS Foundation Trust, Brighton & Hove CCG, High Weald Lewes Havens CCG. The JF is published in BNF chapters. It comprises a list of drugs recommended for use in the local health economy. Each drug is categorised to facilitate prescribing choice. The majority of medications prescribed locally should be listed in the JF as these have been approved and considered as the most appropriate and cost effective choice.

Need help?

If you or your practice wishes to clarify any of the issues in these training packs, or get help with training or support material, please do not hesitate to contact one of the members of the CCG Medicines Management Team. (Contact details on the front cover of the booklet.)
Or your practice may have a pharmacist who can assist you.
The team will review the packs every two years, so your practice may want to consider using the reissued packs as a refresher course.

Types of Prescription

Prescriptions in general practice fall into two basic types: **Acute and Repeat**. Repeat prescriptions account for 75% of all items prescribed, and more than 80% of prescribing costs therefore, practices need a system for managing them effectively.

Acute prescriptions are those which:

- Are given only once and usually for a short duration, for example, a course of antibiotics
- Are given for a trial period and may either be stopped or transferred to a repeat

Repeat prescriptions can be re-issued without the patient needing to see the doctor each time and can be divided into two types: **Standard repeat prescriptions** and **repeat dispensing prescriptions**.

Managing repeat prescribing well is an important element in improving both the quality and the cost-effectiveness of prescribing, and it has a significant impact on the workload of the practice.

Standard repeat prescriptions

The doctor will indicate on the computer system a review date or how many times any particular medicine can be repeated before it needs to be re-authorised, for example, six issues of one month supply. In this scenario, the patient can come back for a repeat prescription six times without seeing the doctor. When that time is up, the medicine will need to be reviewed and re-authorised, if appropriate, by the Prescriber.

Repeat dispensing - paper prescriptions

A standard repeat prescription requires a prescriber's signature every time a patient needs a fresh supply of prescribed medications. Repeat dispensing allows a single signed master prescription (marked RA) which has to be signed by the prescriber, and the required number of batch issues (marked RD) which do not need to be signed and which show the words 'Batch 1 of x', 'Batch 2 of x' etc. in the box regularly used for the prescriber's signature.
Up to 12 months can be issued for patients with stable long-term conditions where a patient's medicines are unlikely to change. This allows items to be dispensed in instalments by a pharmacist of their choice. The patient will return to the pharmacy for repeat supplies, without having first to visit the surgery. These arrangements will make it easier and more convenient for patients with chronic conditions to obtain repeat prescriptions. It will also speed up services and reduce the workload of GP practices in producing and signing repeats.

Repeat dispensing - electronic prescriptions (eRD)

Repeat dispensing works with both paper based prescribing and also with the Electronic Prescription Service (EPS). At the start of an electronic repeat dispensing regime, all issues are covered by a single electronic prescription and a prescription token is printed, stating the number of issues in the regime. Patients may wish to keep the prescription token for the duration of the regime, as a reminder of the item(s) prescribed, the number of issues and the nominated pharmacy. Alternatively, where medications are delivered by the pharmacy, the pharmacy may wish to retain the prescription token for the records. Note: Repeat dispensing can be used for monthly scripts as well as 7 day prescriptions.

Retrospective Prescriptions

No products should be supplied to a patient without a signed prescription. Retrospective prescriptions will not be issued by the prescriber except in an emergency situation at the request of the patient/patient's carer or clinical specialist. Pharmacies or Dispensing Appliance Contractors (DACs*) must not request retrospective prescriptions for items already supplied. There is no obligation for prescribers to provide a retrospective prescription and therefore prescribers should strongly consider refusing requests for retrospective prescriptions unless as a result of an emergency situation (see NHS (GMS) regulations 2004, Schedule 5, para 39 (6) and corresponding PMS regulations.
*DACs are businesses that dispense appliances (usually stoma and continence products).

NB: Only doctors and other qualified prescribers are authorised to transfer a medicine from an acute status to a repeat status, or to start any medicine. Review dates for medicines (i.e. no more issues left) should not be over-ridden. They are there for the patient's safety and to ensure that they get the best treatment.

Synchronisation

Often where patients are on a number of items, they will run out at different times. When this happens, the patient will do one of two things:

- They will visit the surgery each time they run out of an item and order only what they have run out of. This means that they will request a repeat more often. Ordering in this way is very inefficient and means the practice and the patient's time is wasted. Lack of synchronisation results in an increase in practice workload.

Or

- They will order everything on the prescription regardless of whether all the items are needed. If the patient over orders as a result of non-synchronisation, this will result in wastage or hoarding.

Synchronisation means organising the prescription so that all the items, if taken as per instructions, run out at the same time, so reducing wasted patient and practice time and also reducing wastage of precious NHS resources.

For example;

Ranitidine 150mg tablets	**One to be taken once a day Give 50 tablets**
Amlodipine 5mg tablets	**One to be taken once a dayGive 28 tablets**

This patient may come back after 28 days to request another prescription, and if they order both items 22 ranitidine tablets will be wasted or hoarded. Otherwise they may order each item at different times through the month with multiple visits thereby increasing the practice workload.

We need to ensure all the items on the list are supplied to last the same length of time e.g. 28 days. If the review date or the number of issues before the medication needs to be reauthorised could also be synchronised, then this would reduce workload further.

Once synchronisation is achieved, the prescription will still need to be regularly monitored, as all sorts of things can happen to put it out of sync again e.g.

- The patient doesn't take the tablets as directed
- A new item is initiated which is out of sync.
- "When required" medicines may be used up quickly or hardly at all

All members of the practice team need to work closely together and with the patient to achieve synchronisation. The prescribers will need to take it into consideration when initiating new items. Community Pharmacists may also be able to help you look at this issue.

<u>We advise that permission is obtained from your prescribing lead before you make any synchronisation amendments to patients prescriptions. There may also be an element of training and supervision before staff are confident to carry out this action.</u>

Benefits of Synchronisation of Patients' Medication

The table below highlights the reduction in workload based on patients receiving four items on two monthly prescribing over one year:

	Before synchronisation	After synchronisation
No of patients	Requests for prescription	Requests for prescription
1	24	6
20	480	120
100	2,400	600
2,000	48,000	12,000
4,000	96,000	24,000

Waste of medicines

Wastage can occur for several reasons, these include:

- Changes in the patients' medication, either by the doctor or hospital
- Patients no longer using medication prescribed, but still ordering it
- Medication supplied on repeat, but not ordered by patient
- The wrong medication being ordered in error
- Prescribing excessive quantities of medication
- Poor repeat prescribing policies in the GP practices (ordering errors, lack of control of third party providers; no over/under ordering polices; poor relationships with pharmacies etc.)
- Pharmacies/third party providers ordering on behalf of patients
- Hospital admission/discharge especially to care/residential homes.(poor medicine reconciliation)
- The patients need more education regarding ordering medicines/stock control/over and under ordering
- Adverse effects or side effects of medicines thus stopping and wasting a full 28 day supply
- Out of date medicines
- Death of patients.

It's not just oral medication which is prone to wastage. Items which are commonly over ordered/wasted include:

- Dressings (see page 20 for more information)
- Sip feeds
- Stoma appliances and continence products
- Blood glucose testing strips
- "when required" medicines: Medicines labelled 'when required' should be supplied in a quantity that is likely to last a month. This quantity should be decreased on subsequent prescriptions if there is excessive overstock at the end of a month.

Some of the risks listed below will also contribute to wastage.

Receiving two drugs with the same action
If a patient is tried on a new painkiller without the old one being crossed off the repeat list, the patient may end up taking 2 drugs with a similar action resulting in overdose.

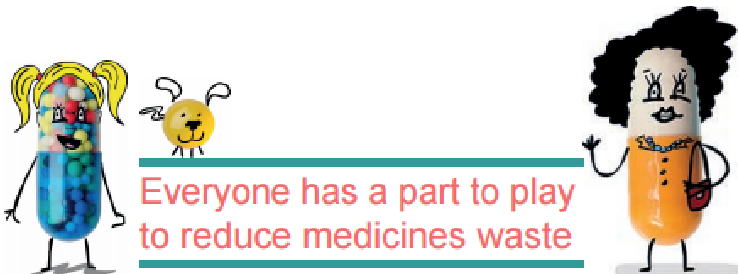
Hoarding
Patients may hoard medicines by requesting repeat prescriptions more often than are needed. If the frequency of requests are not monitored, patients can end up getting much more medicine than they need.

Poisoning
When patients hoard medicines it increases the risk of them taking the wrong medicine or medicines that are out-of-date. Children are at risk of accidentally poisoning themselves and confused elderly people are also very much at risk.

Patients should be advised to return any unused or unwanted medicines to a community pharmacy for safe disposal. (Not to their GP surgery.) Some patients believe they are saving the NHS money by bringing their medicines back to the pharmacy, but this is not the case as the law does not allow medicines to be reused once returned from patients, even if the packaging is intact. Patients should check their prescription bag before they leave the pharmacy and return any unwanted items inside the pharmacy. This is the only way medicines can be re-used.

Patients should be advised to take their medicines with them when they go into hospital. ALL pharmacies in Brighton and Hove should have supplies of the green bags to give to patients, particularly the frail elderly, just in case they should need to go to hospital. This helps prevent missed doses, medicine errors and waste.

The key is to educate patients to only order what they need as this reduces waste.



‘Generic’ and ‘Brand’ Prescribing

What is a Generic medicine?

The generic or non proprietary name of a medicine is the actual drug name rather than the company or brand name. Brand names often have the symbol ® after them. For example:

- Ranitidine is the generic name and Zantac® is the brand name
- Paracetamol is the generic name and Panadol® is the brand name

There may be more than one brand of a drug available, so if we look at paracetamol, which is the generic name for the medicine, there are several brands available e.g. Panadol®, Disprol®, Calpol®.

When a medicine is prescribed by its generic name, the pharmacist is free to dispense any brand, which contains the correct medicine. If a brand is specified on the prescription, the pharmacist can only give that particular brand. Prescriptions should be written generically whenever appropriate (NB: See section on inappropriate generic prescribing below). This is because it is:

<u>Good practice</u>: it is good clinical practice and less confusing to use the generic name. Generic names are used almost exclusively during medical teaching, in independent scientific publications and internationally. Brand names can vary.

<u>Cost effective</u>: use of generic medicines produces significant cost savings for the NHS without reducing quality. This is because the manufacturers of generic drugs did not bear the costs of discovering or developing the drugs they make. They do not advertise their products on the same scale as brand manufacturers and so products of the same quality as the branded version can be made more cheaply.

What is a Branded medicine?

Patients and even healthcare workers often perceive that brands are of a higher quality, because they are heavily promoted and marketed and often packaged in a more attractive way. However, the drugs in generic preparations have to undergo the same rigorous testing as those in the branded medicines and therefore contain exactly the same quality and quantity of a drug.

While the basic explanation of generics is simple, it is often necessary to find alternative ways of describing the difference between the brand and the generic depending on the patient to whom you are speaking. Patients may well ask you about this issue or you may take the opportunity to explain any changes to them e.g.

- If the patient has brought the packaging of the branded product into the surgery, you can point out that the generic name they have just been prescribed is also printed on the branded packaging, usually just under the brand name.
- Patients may have been told that generic products are cheaper and that the practice is just trying to save money. This is true but the most important thing to add is that money saved in this way is then used to further benefit patients, for example to reduce waiting lists in hospital or to pay for community services.

This scenario can be likened to when patients themselves are shopping. They usually have a limited sum of money to spend and so they shop around to get best value for money. They don't always buy the most expensive products as often a less expensive item is of the same quality. Conversely, they don't waste their money buying inferior goods that don't work just because they are cheaper - neither do the doctors.

Exceptions

To every rule there is always an exception and although most drugs should be prescribed generically, there are some, which should be prescribed by brand. The issue is a complicated one, but there are three basic reasons for branding a particular medicine:

Clinical: This may be due to variations in the way the drugs are designed to be absorbed into the body, that can result in differences in the way they affect a patient or other clinically significant reasons.

The following should ALWAYS be prescribed by brand:

- Diltiazem (e.g.Tildiem®, Adizem®, Angitil® and Slozem®)
- Nifedipine (e.g. Adalat®, Adipine®, Coracten®)
- Lithium citrate & carbonate (e.g. Priadel®, Camcolit®)
- Ciclosporin (e.g. Neoral®)
- Theophylline & Aminophylline (e.g. Slo-phyllin®, Uniphyllin Continus®)
- Mesalazine (e.g. Asacol®)
- Mycophenolate (e.g. Arzip®, Cellcept®,)
- Tacrolimus (e.g. Modigraf®, Adoport®, Prograf®, Advagraf®)
- Carbamazepine (e.g. Tegretol®)
- All inhalers should be prescribed by brand name e.g. Qvar®, Clenil Modulite® Seretide®, Sirdupla®, Airflusal®

Practicalities: In some cases, it can simply be impractical or confusing to prescribe generically or there is no recognised generic name, for example, multi-ingredient products (such as skin creams and indigestion remedies, like Peptac®), oral contraceptives, HRT, insulins, inhaler devices. Prescribing some products generically can cause prescriber/patient confusion, leading to patients getting different products. Prescribing insulins by brand is safer.

Cost: Occasionally it is more cost-effective to prescribe a branded drug and therefore the Medicines Management Team change patients from the generic preparations. Example oxycodone capsules to Shortec capsules.
For an up to date list please contact the Medicines Management Team.

The MMT advise practices of where cost savings can be made through the 'CityScripts' prescribing newsletter and the 'OptimiseRx' prescribing decision support tool.

Formulations of Medicines

Medicines can come in a variety of different forms. These include:

- Tablets (Soluble, Dispersible, Effervescent, Enteric coated (E/C), Film coated (F/C), Oro dispersible, Buccal, Sublingual)
- Capsules (Sprinkle capsules)
- Liquids (Syrups, Solutions, Suspension)
- Lozenges
- Powders
- Inhalers (Metered dose inhalers (MDI), dry powders for inhalation, turbohalers, breath actuated MDIs, accuhalers, autohalers, easybreathe)
- Topical (Creams, Ointments, Gels, Pastes, Lotions)
- Suppositories/Enemas
- Pessaries/Vaginal tablets
- Sprays
- Drops (eye, ear, nose)
- Patches
- Implants
- Injections

Liquids, soluble/effervescent/dispersible tablets are generally prescribed to those who have difficulty swallowing, or for children.

Modified Release Preparations

Most conventional oral drug products, such as tablets and capsules, are formulated to release the active drug immediately after oral administration. We call these immediate-release (IR). In the formulation of conventional drug products, no deliberate effort is made to modify the drug release rate.

The pattern of drug release from modified-release (MR) dosage forms is deliberately changed from that of a conventional (immediate-release) dosage formulation to achieve a desired effect or better patient compliance.

Types of MR drug products include:

- extended release (ER)
- slow/sustained release (SR)
- long acting (LA)
- Retard
- XL

Some medicines are designed to release the drug into the body at different rates and it is important to select the right one.

What makes a prescription legal?

The following lists the legal requirements for a prescription. If any of the following are not present, the pharmacist could be committing an offence if the prescription is dispensed.

Paper prescriptions

- Must be written in indelible ink
- Be dated
- The full name & address of the patient should be stated
- The age of children under 12
- It should be signed in ink by the prescriber

Computer generated prescriptions

In addition to the above legal requirements, the following recommendations are made for computer-generated prescriptions:

- The age and date of birth should be printed onto the prescription and for children under 5, age should be stated in years and months (most computer systems will print the age for all patients automatically)
- Names of medicines should come from the dictionary held in the computer memory
- The prescription should be printed in English without abbreviations. Where prescriptions have been entered without the drug directory, common Latin abbreviations may occur (e.g. 1 tds. - See page next page)
- Unused space on the prescription should be cancelled so that nothing else can be added (this is usually done automatically by the computer)
- Hand-written alterations should only be made in exceptional circumstances – it is preferable to print out a new prescription. Any alterations must be made in the prescriber's own handwriting, and must be countersigned. The computer record must be updated to reflect any change.

EPS Prescriptions

- Electronic prescriptions do not require a signature in indelible ink as prescribers will enter a pin number which is the signature for the prescription.
- The prescriber's name, address and telephone number must be printed at the bottom of the prescription. These should be the details of the prescriber responsible for the prescription (who will normally sign it).

Common Abbreviations used in directions

Although directions should preferably be in English and without abbreviations, it is recognised that some Latin abbreviations are used. In particular you may see these on handwritten prescriptions.

Prescription Abbreviations	
Abbreviation	**Meaning**
a.c.	Before food
b.d.	Twice a day
$\overline{c}$ (c with a line above)	With
c.c	With food
IM	Intramuscular
Inj.	Injection
IV	Intravenous
Mane	Morning
mcg	Microgram
mdu / asd	As directed
mg	Milligram
mL	Millilitre
Nocte	Night
o.d.	Daily
o.m. / a.m.	Morning
o.n. / p.m.	Night
p.c.	After food
p.o.	Orally / by mouth
p.r.	Per rectum
p.v.	Per vagina
prn	When required / as necessary
q.d.s. / q.i.d.	Four times a day
q.q.h.	Every four hours
s.c. / sub.cut.	Subcutaneous
Stat.	Immediately
t.d.s. / t.i.d	Three times a day

Prescribers may also use roman numerals to state how many to take i.e.
i bd = 1 twice a day. iii qds = 3 four times a day. iv prn = 4 when required.

Inhalers

Inhalers are one of the items which patients most often over order, ending up with piles of wasted inhalers all over the place! It is difficult to monitor the use of them as they are sometimes used when required and different inhalers have different numbers of doses in them. However, it is important to try to monitor their use for two reasons:

1. If a patient is using excessive amounts of an inhaler it may mean that their condition is not controlled and that a change to their prescription would give them better treatment.
2. Over ordering causes wastage and some inhalers are up to £60 each.

How many inhalers should patients have?

This all depends on:

- The number of doses in the individual inhaler
- The actual dose the patient is on

You should allow for a few extra puffs and extra inhalers here and there for additional supplies for work, school etc. but not consistently 2-3 times the required number of inhalers every month!

Inhaler Usage Guide

Please use this as a guide to see how long a patient's inhaler should last and when they should need to reorder.

Number of doses per inhaler	Number of doses per day	Period inhaler should cover (approx.)
200	One puff 2 x a day	100 days (3 months)
200	Two puffs 2 x a day	50 days (6-7 weeks)
200	Two puffs 3 x a day	30 days (4 weeks)
200	Two puffs 4 x a day	25 days (3-4 weeks)
120	One puff 2 x a day	60 days (8 weeks)
120	Two puffs 2 x a day	30 days (4 weeks)
100	One puff 2 x a day	50 days (6-7 weeks)
100	Two puffs 2 x a day	25 days (3-4 weeks)
60	One puff 2 x a day	30 days (4 weeks)
60	Two puffs 2 x a day	15 days (2 weeks)
50	One puff 2 x a day	25 days (3-4 weeks)

PREVENTERS To be used daily		
GENERIC NAME	***BRAND NAME***	***DOSE IN CONTAINER***
Beclometasone	Clenil Qvar	200
Budesonide	Pulmicort Easyhaler	50, 100 or 200 100 or 200
Beclometasone / formoterol	Fostair	120
Fluticasone	Flixotide	120 or 60
Fluticasone / salmeterol	Seretide Sirdupla	120 or 60 120
Budesonide / formoterol	Sybimcort DuoResp	120 120
Salmeterol	Servent	120 or 60
Formoterol	Oxis Easyhaler	60 120
Ipratropium	Atrovent	200
Tiotropium	Spiriva	30 or 60
Aclidinium	Eklira	30 or 60
REVLIVERS- to be used when required		
GENERIC NAME	***BRAND NAME***	***DOSE IN CONTAINER***
Salbutamol	Ventolin Salamol Airomir Salamol Easibreathe	200 or 60
Terbutaline	Bricanyl	200

Useful links:
Joint Formulary inhaler guide - http://www.gp.brightonandhoveccg.nhs.uk/file/7001
Contact details to order training materials e.g. placebo inhalers - http://www.gp.brightonandhoveccg.nhs.uk/file/8501

Glyceryl Trinitrate sprays (GTN)

There is a similar issue with GTN sprays, which are used to relieve the symptoms of chest pain in patients with angina. Generally speaking, patients should not be ordering a spray every month, as they are either over ordering or it is an indication that their angina is not well controlled and they need to see the doctor to have their therapy altered.

ONPOS

ONPOS stands for Online Non-Prescription Ordering System. The system was launched late 2013 across Brighton and Hove and it replaces the need for prescriptions to be generated for most dressings/wound care supplies.

The main reasons for implementing ONPOS was:

- Improve patient care (get the right dressing to the patient quicker)
- Minimise admin time spent on dressings (no need for admin staff to process requests from patients/community nurses and print prescriptions)
- Minimise clinical time spent on dressings (no need for GP to sign prescriptions for dressings)
- Reduction in waste
- Formulary compliance

The ONPOS process:

Practice Nurse (For patients seen by the nurses in the surgery)
Nurses/HCAs order dressings on the ONPOS system (online) and send the order to a pharmacy listed on the system. The pharmacy supplies the dressings to the surgery and these dressings are held as stock within the practice. These can used on patients when they have an appointment or patients may be given a supply from the stock to go home with.

Community Nurse / Nursing Home (For patients whose care is in the community)
Community nurses and nursing home nurses also have access to ONPOS. Requests from them for dressings that are not listed on ONPOS (non-formulary) may be sent to the surgery, as in these cases a prescription is required. A clinical reason for why they have requested a non-formulary dressing should be documented on the patients' record.

Other cases where an FP10 may be issued is where the patient self-cares with minimal clinical input. However, these prescriptions must be reviewed regularly and patients reviewed clinically to ensure the chronic wound is being managed appropriately.

If you are unsure on the process, your practice nurse may be able to help you or for further support please contact the medicines management team.

Stoma Pouch Prescribing Guidelines

Please use this as a guide to see how long a patient's prescription should last and when they should need to reorder.

STOMA POUCH PRESCRIBING GUIDELINES		
Type	**Frequency of change**	**Average quantity per month**
ILEOSTOMY		
One-piece drainable pouch	Pouch changed every 1 - 3 days	10 - 30 pouches
Two-piece drainable pouch	Baseplate changed 2 - 3 times a week Pouch changed every 1 - 3 days	8 - 12 baseplates 10 - 30 pouches
COLOSTOMY		
One-piece closed pouch (including minicaps)	Pouch changed 1 - 3 times a day	30 - 90 pouches
Two-piece baseplates closed pouch (including minicaps)	Baseplate changed 2 - 3 times a week Pouch changed every 1 - 3 days	8 - 12 baseplates 30 - 90 pouches
UROSTOMY		
One-piece urostomy pouch	Pouch changed every 1 - 3 days	10 - 30 pouches
Two-piece urostomy pouch	Baseplate changed 2 - 3 times a week Pouch changed every 1 - 3 days	8 - 12 baseplates 10 - 30 pouches
Open night drainage bag	Bag changed weekly	4 bags
Single use drainage bag	Bag changed daily	30 bags
CONVEX PRODUCTS		
Convex products should only be used on the recommendation of the Stoma Care Nurse.		
SUPPLEMENTARY ITEMS		
Additional items may be essential for problem solving with stomal complications or to extend wear time and increase confidence. These include; • barrier cream • skin protector wipes/spray • powders • adhesive remover • washers and pastes • deodorants • retention strips • support garments Please refer to the Brighton and Hove CCG Stoma Care Accessories Formulary (see front cover for website) for the preferred choices and prescribing guidelines of these items.		
The quantities listed above are guidelines only. Some patients may require a higher or lower quantity than stated. *If there are any prescribing concerns please refer to the patient's Stoma Care Clinical Nurse Specialist for details or an assessment. Email: stomacare.department@bsuh.nhs.uk*		

Electronic Prescription Service

EPS enables prescribers to send electronic prescription messages to a nominated dispenser of the patient's choice via the NHS spine. This makes the prescribing process safer and more efficient for clinicians/ practice staff and more convenient for patients. This service has been rolled out with all practices now live.

For further information about EPS, please contact BHCCG.MedicinesManagement@nhs.net

FAQ's

Q1. ***Once a practice is enabled with EPS, do patients have to nominate a pharmacy?***

A1. No, nominating a pharmacy is NOT mandatory. These patients will still receive their prescriptions via the paper FP10 route. However, patients will need to nominate to use EPS.

Q2. ***Can we switch all our patients who have a prescription collection service listed to the same nominated pharmacy?***

A2. No, patients now have the choice of nominating any EPS enabled pharmacy in the country and you can't assume that they will still want to use their local pharmacy (although most will). Patients MUST also understand and agree that their information can be shared electronically between practice and pharmacy (verbal consent required).

Q3. ***Can we set nominations at the practice before going live with EPS?***

A3. Yes, if you use EMIS Web, a nominated pharmacy can be added to patient's records. TPP SystmOne does not allow this function until system is live with EPS. You can however redirect patients to a pharmacy, as they are able to nominate from their end. Patients cannot currently nominate 2 community pharmacies but they may also nominate a DAC (dispensing appliance contractor) as well as community pharmacy.

Q4. ***Will using EPS reduce admin/clinician workload?***

A4. Yes, it is very likely to reduce workload:

- No need to prepare and sort prescriptions for signing, sorting and distribution.
- No need to record prescriptions collected by pharmacies as these cannot be lost – no reprinting duplicate scripts! There is an audit trail (via EPS tracker*) from point of processing prescription to final stage of pharmacy claiming payment for the prescription. *Pharmacies should be encouraged to use the EPS tracker before contacting the surgery as they have equal access to this web-based tool.
- Less prescription queries from dispensers as prescription information will be standardised.
- Prescriptions can be cancelled electronically up to the point of dispensing – no paper prescriptions to find and destroy!
- Once familiar with EPS, the ability to cancel prescription electronically will support more repeat dispensing for those patients who are on stable medication regimes, thus reducing workload. Prescribers can choose to authorise prescriptions for up to 12 months.
- Clinicians can electronically sign prescriptions (via pin on smart card) in bulk.
- Queries/monitoring requirements on prescription requests can be sent electronically to clinicians within their workflow. The clinician will already be in the patients' records to deal with the query. There will be an audit trail in the patient's notes, recording the action taken (no more scrappy bits of paper with queries needed!)

Q5. ***If a patient has a nomination in place, can everything on their medication record be sent electronically?***

A5. To send a prescription electronically, the following criteria must be met:

- Patients PDS record must be synchronised with data held on spine. Mismatches must be addressed before prescriptions can be sent via EPS.
- Medication and quantity must be mapped to the NHS DM+D* (*Dictionary of Medicines and Devices –standardises identification of medicines and medical devices for recognition by GP clinical systems & pharmacy dispensing systems)
- The prescribing is not a private prescription
- Controlled Drugs. Although, there has been a legislation change effective from 1.7.2015 that now allows the sending of controlled drugs electronically. Clinical system providers will advise of when their systems will be able to support this change.

NOTES

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With acknowledgements to Wigan Borough, Suffolk & East Staffordshire CCGs

The latest version of this document is available here:

http://www.gp.brightonandhoveccg.nhs.uk/file/757

If this document is printed, you should assume that it's out of date.