



# Guidelines for Good Prescribing in Primary Care

Version 2.2 – May 2019

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**Acknowledgements to:**

NHS Blackburn with Darwen

NHS East Lancashire

NHS North Lancashire

NHS Derby City and NHS Derbyshire County

VERSION CONTROL		
Version	Date	Amendments made
Version 1	October 2013	Initial document
Version 2	November 2016	Incorporation of new NICE/RPS prescribing competency framework. Travel information update Malaria information update Updated RAG rating information – tabulated Reference updates Incorporation of NPSA alert RE: LMWH January 2016 Management of patients visiting from overseas updated Minor typographical errors updated
Version 2.1	December 2017	Travel vaccine information amended in line with NHSE LVM recommendations.
Version 2.2	May 2019	Private prescribing section (chapter 19) rewritten – approved at LMMG May 2019. 'Green – restricted' added to the colour classification list.
Review date	November 2019	

## **1. INTRODUCTION**

The purpose of this guidance is to outline recommendations for prescribing within primary care in Lancashire. It is intended to provide information on current best practice including providing advice on prescribing situations which are not always clear so as to ensure a consistent approach by primary care prescribers across Lancashire. All prescribers are encouraged to follow this guide.

## **2. BACKGROUND**

Primary Care prescribers in England write over 900 million prescriptions per annum at a cost of almost 9 billion pounds to the NHS (2011 data). [1]

Suitably trained and registered nurses, pharmacists, physiotherapists, podiatrists, optometrists and radiographers are now eligible to prescribe within their competencies either as supplementary prescribers, prescribing in partnership with a doctor, or as independent prescribers.

## **3. PRESCRIBING WITHIN THE 'COMPETENCY FRAMEWORK FOR ALL PRESCRIBERS'**

In 2012 a single competency framework for all prescribers was published jointly by the National Prescribing Centre and the National Institute for Health and Clinical (now 'Care') Excellence (NICE). The framework was due for review by NICE in 2014. NICE and Health Education England (HEE) approached the Royal Pharmaceutical Society to update the framework on behalf of all prescribing professions within the UK (including the Royal College of Physicians and Royal College of General Practitioners). [2]

The framework was implemented to support all prescribers to prescribe effectively. It is endorsed by NICE and by all the relevant professional bodies. The intention of the framework is to ensure that prescribers, regardless of their professional background, adhere to the same set of standards.

The scope of the competency framework is:

1. It is a generic framework for any prescriber regardless of their professional background;
2. It must be contextualised to reflect different areas of practice and levels of expertise;
3. It reflects key competencies required by all prescribers;
4. It applies equally to independent and supplemental prescribers.

The competency framework sets out what 'good' prescribing looks like. There are ten competencies split in to two domains. Within each of the ten competency dimensions there are statements that describe the activity or outcome prescribers should be able to demonstrate. [2]

The two domains and associated competencies are:

1. The consultation (competencies 1 – 6):
  1. Assess the patient;
  2. Consider the options;
  3. Reach a shared decision;
  4. Prescribe;
  5. Provide information;
  6. Monitor and review.
2. Prescribing governance (competencies 7 – 10):
  7. Prescribe safely;
  8. Prescribe professionally;
  9. Improving prescribing practice;
  10. Prescribe as part of a team.

Central to each of these two domains is the 'patient'. Each competency is further divided into specific actions and behaviours that each prescriber, regardless of professional background, would be expected to carry out in order to prescribe competently.

The full document, which included the full list of behaviours and actions, can be found at:

<http://www.rpharms.com/support-pdfs/prescribing-competency-framework.pdf>

#### **4. RESPONSIBILITY FOR PRESCRIBING**

Medicines may only be prescribed by registered doctors, dentists or non-medical prescribers. The person issuing the prescription is **clinically responsible** for the intervention. Medicines should be prescribed when they are necessary, and in all cases the benefit of the medicine should be considered in relation to the risk involved.

Special care should be taken with patients who have disabilities, those for whom English is a second language, or have religious or cultural beliefs that may be a barrier to understanding or taking their medication. Measures should be undertaken to address any barriers for example supplying information in different formats or supplying medication in appropriate forms.

#### **5. SHARING INFORMATION WITH COLLEAGUES**

## 5.1 General information on transfer of care

You should contribute to the safe transfer of patients between healthcare providers and between health and social care providers: [3] [4]

- You should share all relevant information with colleagues, including information about the patient's current and recent use of medicines, other conditions, allergies and previous adverse reactions to medicines.
- Provide relevant information with the patient or as soon as possible on admission to hospital whether an emergency or not.
- Check the completeness and accuracy of the information accompanying a referral
- After an episode of care is complete, the patient's GP should be informed of any changes to patient's medicines (existing medicines changed or stopped and new medicines started), with reasons; length of intended treatment; monitoring requirements; any new allergies or adverse reactions identifies, unless the patient objects or if privacy concerns override the duty, for example in sexual health clinics.
- Consider whether the information you have is sufficient and reliable enough to prescribe safely
- Ensure that a patient's medicines following discharge are reviewed and quickly incorporated into the patient's records and checked by a clinician.

It is important that, when patients are transferred from hospital to general practice on a medicine that is not frequently prescribed in primary care, this should only take place with full local agreement and the dissemination of sufficient information to individual GPs. This could take the form of an agreed shared care management guideline. Clear processes and good communication are pivotal to effective shared care and GPs will need to be aware of their responsibilities when writing prescriptions for specialist medicines. Legal responsibility for prescribing lies with the doctor who signs the prescription. This is a particularly important consideration if a GP is intending, or has been asked to prescribe an unlicensed medicine or a licensed medicine either for an off-label indication or a dose outside that recommended in the Summary of Product Characteristics. (See advice from MHRA in section 8). Local commissioners could be asked to pursue any specific difficulties.

## 5.2 Shared Care of Medicines

Responsibilities for continuing care or treatment should be based on the patient's best interests. All parties including the patient should agree to this. Effective communication of all relevant information and continuing liaison are essential. [3] [5]

Shared Care Agreements (sometimes called Shared Care Guidelines) are developed when sophisticated or complex treatments that were initiated in secondary care are then transferred for prescribing by a GP. All LMMG new medicines reviews that are agreed for use with a RAG status of: 'Amber1' or 'Amber2' should have an associated shared care agreement in place and available for use on individual CCG websites for local arrangements. GPs are not obliged to enter into a shared care agreement where one exists.

The following is taken from the Midlands Therapeutic and Review Advisory Committee policy on Effective Shared Care Agreements with emphasis added.

Successful shared care arrangements enable the combination of the best of both primary and secondary care for the benefit of the patient. They allow the seamless transfer of patient treatment from the secondary care sector to general practice. Effective shared care relies on Effective Shared Care Agreements including the following aspects:

- Individual, patient-by-patient arrangements - Effective Shared Care Agreements should be patient specific and encompass all aspects relevant to that particular patient.
- A reasonably predictable clinical situation - Clinical responsibility should be considered for transfer to primary care **only** where it is agreed that the patient's clinical condition is stable or predictable.
- Willing and informed consent of all parties - This includes patients, carers and doctors. Consenting parties must have sufficient, accurate and timely information in an understandable form. Consent must be given voluntarily.
- A clear definition of responsibility - The shared care arrangement should identify the areas of care for which each partner has responsibility and where, if appropriate, the specialist resources are available to the GP. This should be patient specific.
- A communication network - Agreed communication should include a telephone contact number for use when problems arise, and fax and email numbers if appropriate. Progress reports should be produced to an agreed time-scale with regular review.
- A clinical summary - This should include a brief overview of the disease and more detailed information on the treatment being transferred for which each partner has managerial and clinical responsibility. At a minimum, it should identify the product's licensed indications, therapeutic classification, dose, route of administration and duration of treatment, adverse effects (their identification, management, importance and incidence), monitoring requirements and responsibilities, clinically relevant drug

interactions and their management, storage and reconstitution of product, peer-reviewed references for product use, and contacts for more detailed information.

- Emergency support - Contact numbers should include those for out-of-hours queries.
- Training - Any training required by GPs and their staff should be identified and provided to a satisfactory standard by the specialist department seeking the shared care arrangement.

The issue of patient safety is always paramount.

### 5.3 Traffic Light Scheme /RAG Scheme/Colour Classification for medicines

#### Colour classification for medicines [6]

Medicines across Lancashire are classified by colour which depicts whether a medicine is funded or not and if funded where the prescribing responsibility lies across the whole health economy. The Lancashire Medicines Management Group consider individual new medicines or new indications for licensed medicines taking into account the safety and monitoring requirements of a medicine before assigning its colour classification:

<b>GREEN Medicines</b>		
Appropriate for initiation and on-going prescribing in both primary and secondary care. Generally, little or no routine drug monitoring is required.		
<b>GREEN (Restricted) Medicines</b>		
Appropriate for initiation and ongoing prescribing in both primary and secondary care provided: <ul style="list-style-type: none"> <li>○ Additional criteria specific to the medicine or device are met, or</li> <li>○ The medicine or device is used following the failure of other therapies as defined by the relevant LMMG pathway.</li> </ul> Generally, little or no routine drug monitoring is required.		
<b>AMBER Medicines</b>		
<b>Amber0</b>	<b>Amber1</b>	<b>Amber2</b>
Suitable for prescribing in primary care following recommendation or initiation by a specialist.  Little or no specific monitoring required.  Specialists should fully discuss the recommended treatment with the patient, including: rationale, side effects and monitoring.  Patient may need a regular review, but this would not exceed that required for other medicines routinely prescribed in primary care.  Brief prescribing document or information sheet may be required.  Primary care prescribers must be familiar with the drug to take on	Suitable for prescribing in primary care following recommendation or initiation by a specialist.  Minimal monitoring required.  Specialists should fully discuss the recommended treatment with the patient, including: rationale, side effects and monitoring.  Patient may need a regular review, but this would not exceed that required for other medicines routinely prescribed in primary care.  Full prior agreement about patient's on-going care must be reached under the Shared Care Agreement (or Shared Care Guideline).	Initiated by specialist and transferred to primary care following a successful initiation period and stabilisation of dose.  Specialists should fully discuss the recommended treatment with the patient, including: rationale, side effects and monitoring.  Significant monitoring required on an on-going basis.  Full prior agreement about patient's on-going care must be reached under the Shared Care Agreement.  Monitoring requirements are suitable for enhanced service or are retained by the hospital.

<p>prescribing responsibility or must receive the required information from specialist colleagues where necessary.</p> <p>When recommending or transferring care of amber0 classified medicines, specialists should ask primary care prescribers to take over prescribing responsibility, and if agreed, should give information about the indication, dose, whether use is off-label and instruction on any necessary dose adjustments to allow them to prescribe with confidence.</p>	<p>Primary care prescribers are advised not to take on prescribing of these medicines unless they have been adequately informed by letter of their responsibilities with regards monitoring, side effects and interactions and are happy to take on the prescribing responsibility.</p> <p>A copy of locally approved Shared Care Guidelines should accompany the letter that outlines these responsibilities. Primary care prescribers should reply to specialist colleagues as soon as possible by letter so that arrangements can be made for the transfer of care.</p>	<p>These medicines are considered suitable for GP prescribing following specialist initiation and stabilisation of therapy, according to a locally agreed Shared Care Agreement which will be provided with the written request to prescribe.</p> <p>On-going communication between the primary care prescriber and specialist is expected.</p> <p>Amber Level 2 medicines require significant monitoring for which an enhanced service may be suitable. (Subject to local commissioning arrangements).</p>
<b>RED Medicines</b>		
<p>Medicine is prescribed by the specialist service for the duration of the treatment course.</p> <p>Primary care initiation or continuation of treatment is not recommended unless exceptional circumstances exist such as a specialist GP.</p> <p>Red medicines are those where primary care prescribing is not recommended. These treatments should be initiated by specialists only and prescribing retained within specialist services. They require specialist knowledge, intensive monitoring, specific dose adjustments or further evaluation in use. If however, a primary care prescriber has had particular recognised formal training in the specialist area and has specialist knowledge in prescribing such a drug, it would not always be appropriate for them to expect to transfer that prescribing responsibility back to a secondary care specialist service.</p> <p>Primary care prescribers may prescribe RED medicines in exceptional circumstances to patients to ensure continuity of supply while arrangements are made to obtain on going supplies from the specialist service. However it is important to remember that many RED drugs are not commissioned by CCGs and are the responsibility of NHS England. It is important to ascertain the commissioning responsibilities before undertaking the prescribing. Many of the RED drugs would also present a significant cost pressure on GP prescribing budgets.</p>		
<b>BLACK Medicines</b>		
NOT recommended for use by the NHS in Lancashire.		
Includes medicines that NICE has not recommended for use and NICE terminated Technology Appraisals.		
Includes medicines for which there is insufficient evidence of their effectiveness.		
<b>GREY Medicines</b>		
Medicines which have not yet been reviewed or are under the review process.		
GPs and specialists are recommended not to prescribe these drugs.		
This category includes drugs where funding has not yet been agreed.		

#### 5.4 Multiple prescribers prescribing concurrently for a patient

Some medicines, described under the colour classification system above as red drugs, are prescribed and issued or administered solely by specialist services. These medicines may not appear on the GP prescribing system. Prescribers must be aware of any “RED” medicines being prescribed for a patient to avoid drug interactions or contraindications and potential patient harm e.g. patients prescribed and given biologics by specialist rheumatology services being called for or given a live vaccine such as shingles vaccine. Healthcare professionals providing a medicine under a Patient Group Direction also need to be aware of any “red” classified medicines that the patient may be taking or receiving.

## **5.5 Medicines as Part of a Hospital Trust initiated Clinical Trial**

Prescribing of medicines as part of a hospital trust initiated clinical trial or the continuance of a hospital initiated clinical trial should remain with the hospital. The hospital should have a clear exit strategy for patients being treated in a clinical trial. Continued prescribing will not be taken over by primary care clinicians unless formal approval of the drug has been made through local decision making processes.

## **5.6 High Cost Medicines**

Prescribers also need to be aware that high cost medicines prescribed by secondary or tertiary care specialist services that are not included in the Payment by Results tariff may be funded by another funding stream other than primary care, such as NHS England, Cancer Drugs Fund [7]

Secondary care prescribers initiating high-cost medicines should ensure that a local CCG or national position (e.g. NICE TA) has been agreed before initiating treatment. Where high-cost drugs have been approved for use the provider trust must ensure a 'Blueteq' form has been completed where available.

## **6. MEDICINES AND HOSPITAL ADMISSION**

### **6.1 Medicines Before and During Hospital Admission**

One Stop dispensing [8] requires patients to take all their current medicines with them on admission to hospital. Where appropriate, patients continue on their own medicines during their in-patient stay, and any new medicines are dispensed and labelled for that particular patient as an original pack and ready for discharge. Usually a month's supply is dispensed. This supply is used whilst they are an in-patient, and the remainder taken home on discharge when ordered on the discharge prescription.

By operating these systems, confusion is hopefully avoided as:

- Patients continue with the medicines with which they are familiar,
- Wastage is reduced, and
- Unnecessary duplication of medicines on discharge is avoided.

Please ensure that patients know to take their medicines into hospital with them for planned admissions.

The Message in a Bottle (MIAB) scheme promoted by Lions Clubs in case of accidents at home encourages people to keep their personal and medical details, on a standard form, in

a standard bottle, in their fridge door to save the Emergency Services valuable time identifying the patient, their emergency contacts, any special medication and allergies.

#### LCI 105EA - Message in a Bottle Project

### **6.2 Medicines for Discharge**

Whichever system for discharge medicines is operated, hospitals should ensure that patients have sufficient medication to take home at discharge which allows the patient enough time to organise a new prescription from their GP. Time allowed needs to take into consideration the time taken for: the GP to receive the discharge note, the patient to arrange an appointment with the GP or to obtain a prescription via the GP process, and time to enable dispensing particularly for items that are not commonly available. This should also include a time allowance for weekends.

The minimum number of days on discharge should be agreed with the CCG. Evidence and research shows that this time frame and thus number of days of medication on discharge should be 14 days, however care should be taken in some clinical areas e.g. suicide risk. If medication is required to be dispensed on discharge, it should ideally be in original packs labelled for discharge as this both saves time and ensures that the dispensing complies with national directives.

### **6.3 Medicines Reconciliation**

Medicines reconciliation is defined by The Institute for Healthcare Improvement (IHI) 2007 [9] as “being the process of identifying the most accurate list of a patient’s current medicines – including the name, dosage, frequency and route – and comparing them to the current list in use, recognising discrepancies, and documenting any changes, thus resulting in a complete list of medications, accurately communicated”.

Medicines reconciliation [10] following hospital admission or specialist appointment requires clinical judgement and should only be undertaken by competent health care staff. [11] The level of therapeutic knowledge required would normally be achieved by prescribers, pharmacists or suitably experienced pharmacy technicians or nurses.

Non-clinical staff should only undertake administrative aspects of reconciliation and good checking processes by those with clinical knowledge should always be in place.

Non-clinical staff should not generate acute or new repeat prescriptions and only assist in genuine repeat prescriptions working in accordance with robust policies and procedures.

## **7. UNLICENSED MEDICINES AND MEDICINES OFF-LABEL**

Medicines prescribed should preferably be licensed and licensed for the indication for which they are prescribed. Doctors can prescribe unlicensed medicines, or licensed medicines for unlicensed uses (off-label). [3] However when a prescriber chooses to prescribe a product outside the terms of its license, the product liability passes to the prescriber and they are legally responsible for the medicine and any ensuing consequences. An unlicensed medicine may be prescribed on the basis of an assessment of the individual patient, for medical reasons and it is necessary to do so to meet the specific needs of the patient.

The hospital pharmacy department may be better placed to oversee continued sourcing, quality and supply of unlicensed medicines however commissioning implications do need to be taken into consideration.

Doctors may receive queries from pharmacists dispensing unlicensed or off label medicines, or other health professionals involved in the care of patients for whom they have been prescribed, to check that they have followed the above guidance. This is because they also have a duty of care around these medicines. [12]

**Advice to Prescribers from the MHRA [41]**

- Always consider prescribing an alternative licensed medicine within its licensed dose and indications instead of an unlicensed or off-label medicine.
- Be satisfied that there is a sufficient evidence base and/or experience of using the medicine to demonstrate its safety and efficacy
- Take responsibility for prescribing the medicine and overseeing the patient's care, including monitoring and follow-up.
- Record the medicine, reason for prescribing and that you discussed the relevant safety and efficacy issues with the patient and received their consent unless it is current practice to use the medicine out with its license.

## 8. BASIC RULES FOR GENERATING ALL PRESCRIPTIONS

With responsibility for spending large sums of public money, it is essential that the greatest care is taken when a prescription is issued. Correct, legible, prescriptions with accurate instructions for patients that are for reasonable quantities of medicines mitigate for the dangers of:

- Errors in prescribing
- Waste
- Dangers of overdose
- Accidental poisoning
- Poor compliance
- Habituation and dependence
- Deterioration of medicines due to domestic storage problems

Illegible prescriptions can lead to serious inaccuracies in medicine dosage and instructions creating a risk to patient safety; as well as inappropriate quantities that promote waste.

Where the patient is prescribed a drug dependant on a delivery device or piece of equipment e.g. an inhaler device or nebuliser, the patient should be instructed carefully on the use and maintenance of the device. It is important to check that the device continues to be used correctly as inadequate technique can be mistaken for a lack of response to the drug but also lead to generation of waste.

The BNF and BNF for children chapters 'Guidance on Prescribing' provides extensive advice on prescribing and are the main source documents for the points itemised below. The GMC Good practice in prescribing and managing medicines and devices [3] also adds useful insight.

**Prescriptions in any format must only be authorised by suitably qualified medical, dental and non-medical independent (within their areas of competency) and supplementary prescribers (within the scope of an approved clinical management plan).**

Ensure prescriptions, whether computer generated or in exceptional circumstance hand written are legible, indelible, dated, state the name and address of the patient, the address of the prescriber and the type of prescriber.

In addition:

1. Ensure prescriptions are authorised by the prescriber, but only after completion. DO NOT sign blank prescription forms

2. Always complete the age box as a matter of good practice. This is a legal requirement for children under 12 years of age.
3. Ensure that the strength of each item is stated. Avoid unnecessary decimal points e.g. use 300mg NOT 0.3g. Use of the decimal point is acceptable to express a range e.g. 0.5 to 1g.
4. Ensure that the quantity to be dispensed is clearly stated
5. Ensure that clear directions are given for each item prescribed. These should be in English without abbreviation. Avoid “as directed”
6. Never abbreviate drug names.
7. Always prescribe generically except where there are bioavailability issues, compound preparations or specific formulations recommended by the British National Formulary (BNF) or in accordance with local formulary.
8. Ensure the term ‘units’ is used in all contexts and never abbreviated to ‘u’ or ‘iu’ Never abbreviate micrograms or nanograms.
9. Avoid adding additional handwritten items to computer generated prescriptions.
10. All alterations and additions must be initialled by the prescriber. However, it is preferable to cancel the incomplete or incorrect prescription and generate a fresh accurate version.
11. Always document prescriptions on the patient’s electronic records. [3] Where this is not possible due to the environment of the prescribing, document the prescriptions on a repeat prescription card system. This will help to ensure that unnecessary duplicate repeat prescriptions are avoided and will assist in preventing drug misuse.
12. Ensure that repeat prescriptions are reviewed regularly. This is a key recommendation of the National Service Framework (NSF) for Older People. The NSF states that all people over 75 years should normally have their medicines reviewed at least annually and those taking four or more medicines should have a review 6 monthly. The Quality and Outcomes Framework (QOF) of the GMS contract only requires that a medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines.
13. Do not include too many items on one form. The number on computer generated forms need be limited only by the ability of the printer to produce clear and well-demarcated instructions with sufficient space for each item and a spacer line before each fresh item. Practices may adjust their systems to set a limit on the number of items per prescription form e.g. 3 items

14. Where an urgent prescription has been telephoned to a pharmacy, the FP10 must be with the pharmacist within 72 hours. This is a legal requirement. Controlled Drugs cannot be supplied in this way, except phenobarbital or phenobarbital sodium prescribed for epilepsy.
15. Prescribe within the limits of your professional expertise and competence [3]
16. Do not prescribe for yourself or for anyone with whom you have a close personal or emotional relationship, other than in an emergency. [3] An emergency is when treatment is immediately necessary and no other prescriber is available.
17. Each patient who requires a medicine each MUST have his or her own prescription. This is a legal and contractual requirement
18. DRUGS NOT AVAILABLE FOR PRESCRIBING ON THE NHS: It is a breach of the Terms of Service for both doctors and pharmacists to prescribe and dispense drugs, medicines and other substances listed in Part XV111A of the Drug Tariff. Such prescriptions are disallowed for payment.

The regulatory requirements for general prescriptions are described in The Human Medicines Act 2012.

### **Relationship with Practice and Community Pharmacists**

Foster a good working relationship with your local community pharmacist(s) and practice pharmacist or local Medicines Management team for the patient's benefit. They will be able to help you with advice about drug interactions and other pharmaceutical advice. Alternatively the Medicines Information Services (details in the BNF) also provide independent advice.

### **9. GUIDELINES FOR QUANTITIES TO BE ISSUED**

Practices may like to consider having a practice policy for prescribing including quantities to be issued on prescription

1. Acute prescription: Normally no more than one or two weeks supply for acute conditions, where applicable. For many infections, a short course of only 3-5 days is likely to be appropriate
2. Repeat prescription: Normally no more than 28 days' supply of medicines for non-acute conditions. 28 day quantities are regarded as best practice pertaining to safe repeat prescribing systems.
3. The decision to provide a longer quantity has to be balanced against patient need (including financial considerations), safety and the potential for waste. Pre-payment certificates may help some patients financially and repeat dispensing may offer convenience for patients on regular stable medication.

a) Conditions where longer supplies / repeat dispensing might be considered for well stabilised patients under regular review are:

- Hypertension
- Epilepsy
- Diabetes
- Thyroid disorders
- Chronic musculoskeletal conditions
- Hormone Replacement Therapy
- Endocrine disorders
- Long term neurological conditions

**N.B.** CDs cannot be issued on Repeat Dispensing

b) Colostomy & surgical appliances (rubber items tend to deteriorate)

Up to 3 months' supply should be met by issuing separate prescriptions for one month at a time. Recommended quantities can be found under Stoma Prescribing Guidelines on the Colostomy Association website. [13]

c) For the oral contraceptive pill, prescriptions should normally be for 3 to 6 months' supply

d) Original Pack (OP) Dispensing: Please **avoid** using the term OP in order to prevent confusion with the term Patient Packs.

Examples of conditions where **no more than** one month's supply should be prescribed:

- Controlled Drugs – see below
- Psychotropic Drugs
- Most Initial Prescriptions

Prepayment certificates are the most economical way of paying for prescriptions when more than one regular prescription item is required each month. Prepayment certificates are available at <http://www.nhsbsa.nhs.uk/healthcosts/2131.aspx> .

## **10. REPEAT PRESCRIBING AND REPEAT DISPENSING**

### **10.1 Repeat Prescribing**

EPS enables prescribers - such as GPs and practice nurses - to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. [14]

The prescriber is responsible for any prescription they authorise for electronic transfer or sign, including repeat prescriptions for medicines initiated by colleagues, and so should make sure that any repeat prescription authorise or sign is safe and appropriate.

Agree with the patient how their condition will be managed, including the reason and date of review. Inform them what to do if they suffer side effects or adverse reactions or stop taking their medicines before the review date. Make clear records of this discussion and reason for repeat prescribing.

Secure procedures must be in place for prescribing with repeats and generating repeat prescriptions. Ensure that:

- The right patient is issued with the correct prescription
- The correct dose is prescribed, particularly for patients whose dose varies during the course of their treatment
- The patient's condition is monitored, taking account of medicine usage and effects.
- Only staff who are competent to do so prepare repeat prescriptions for authorisation.
- Patients who need further examination or assessment are reviewed by an appropriate health professional.
- Monitoring whether the medicine is still safe and necessary for the patient.

No regulation of repeat prescribing can prove effective unless all members of practice staff are aware of the importance of a review regime, and the reason for it. A method of limiting the number of prescriptions the computer will issue without further authorisation should be used. Patients should be given ample warning of when a review will be necessary, to avoid inconvenience.

Automatic generation of prescriptions should be avoided

In addition practices should review their management of repeat prescribing with regard to:

- Volume of drugs prescribed particularly if prescribed on a 'prn' basis
- Duration of prescription cycle
- Relevance of repeat prescribing – is the medication regime stable
- Relevance of original pack size – does it match to the quantity required
- Non-equivalence of quantities of different drugs prescribed on the same FP10 to cover the same period of time
- Frequency of patient review
- Method of ensuring regular review

- Practice staff familiarity with the review requirements
- Ensuring all members of staff are fully aware of the repeat prescribing system and their responsibilities.

To avoid misunderstandings and improve compliance, it may be valuable to issue written guidance on these issues to all members of staff. This may also be helpful in explaining any changes of policy to patients. [14]

Careful audit of prescriptions issued to care homes can show substantial savings of prescribing costs when repeat prescriptions are tailored to the same time cycle, ideally 28 days. Special care needs to be taken with amounts for those medicines which are to be taken when required i.e. “prn”.

NB repeat prescription requests should be instigated by the person in charge of the home or their deputy, not the community pharmacist.

Prescribing with repeats (repeat dispensing) may reduce the need for repeat prescribing. [3]

## **10.2 Prescribing with Repeats or Repeat Dispensing**

Repeat dispensing [15] is the process by which patients can obtain supplies of their repeat medicines over a defined period of time, without the need to contact their GP practice on each occasion a new supply is required. People with chronic conditions that are likely to remain stable for the duration of the repeatable prescription are most likely to benefit from repeat dispensing services. The decision whether to use a repeat dispensing service is a matter for the prescriber's clinical judgement and mutual agreement between the prescriber, the patient and, ideally, the pharmacist.

The potential benefits include:

- Greater choice for patients who require repeat prescriptions for the medicines they need
- Reduced workload for GP practices
- More efficient use of practice staff time
- More opportunities for early interventions to identify medicines-related problems through improved patient contact
- Fewer prescriptions for medicines no longer needed
- Greater involvement and better use of the skills of community pharmacists.

Repeat dispensing will not be suitable for all patients, nor is it an overnight ‘quick fix’ for longstanding supply problems. It requires commitment and support from all those involved to realise all of the potential benefits.

Under the repeat dispensing system, the prescriber produces a master 'repeatable' prescription on a standard FP10 prescription form for the patient's repeat medicines. This is annotated to distinguish it from a standard prescription form and also gives details of how many instalments the prescription contains.

A series of accompanying 'batch issues', one for each time the prescription is to be dispensed, is supplied at the same time (these are also printed on FP10 forms). These enable the pharmacist to continue to dispense the medicines by instalments for the duration of the original repeatable prescription. This can be up to 12 months and each accompanying batch issue is annotated with the number of the batch. This is done by overwriting the prescriber signature box on each batch issue form with text, for example, 'Repeat dispensing: 6 of 12'. The date on which the repeats were authorised is printed on all the batch issues.

The repeatable prescription contains all the usual details i.e. name and address of patient, age, date of birth, prescriber details, signature and date. The prescriber is required to specify the number of repeats or 'issues' they wish to permit from this prescription and, if appropriate, the dispensing interval can be stipulated (for example weekly, monthly, quarterly). The repeatable prescription cannot be hand-written.

The prescriber signs the original repeatable prescription form as this is the legal prescription (as defined by the Medicines Act 1968) needed by the pharmacist at each dispensing episode. A batch issue is printed for each instalment that a repeat supply is to be made. The batch issues are not signed by the prescriber as they are not legal prescriptions but are used solely for reimbursement purposes.

The patient nominates the pharmacy to provide the service and presents the repeatable prescription at that pharmacy for dispensing in the usual way. [15]

### **10.3 Medication Review**

Medication Review is an important part of repeat prescribing. It is defined as a structured, critical examination of a patient's medicines with the objective of reaching an agreement with the patient about treatment, optimising the impact of medicines, minimising the number of medication-related problems and reducing waste. [16]

At each review it should be confirmed that the patient is taking their medicines as directed and that the medicines are needed, effective and tolerated, especially after a hospital stay or home visit. Consider poor compliance leading to inadequate therapy or adverse effects.

Concordance agreement with the patient is important. If it is identified that a patient is not taking, and has made an informed choice not to take a medicine, it should be removed from the patient's medication list, fully documented and where necessary exception reported (for

QOF). This saves waste and reduces risks related to inappropriate medication administration if patient goes to hospital.

#### **10.4 Medicines Use Reviews**

MURs, offered by community pharmacists were introduced in April 2005, with changes made in 2011 and further minor amendments in 2012. [17]

The purpose of the MUR service is to improve the patient's experience of taking their medications, maximise the benefits and reduce wastage.

This is achieved by establishing the patient's actual use and experience of taking their medicines, assisting in cases of poor or ineffective use, and working with the patient to resolve any problems, (such as side effects) that may impact on effective use. In an MUR, the pharmacist will consider all the medicines the patient is taking, including those which aren't prescribed. MURs are not clinical medication reviews as community pharmacists do not have access to patients' medical records.

Since 1 October 2011 contractors have been expected to perform at least 50% of MURs on patients in one (or more) of three national target groups. The target groups are:

- patients taking a high risk medicine(s) (on a national list)
- patients recently discharged from hospital who had changes made to their medicine(s) while they were in hospital
- Patients with respiratory disease.

MURs can still be carried out on patients who are not within the target groups.

Outside the target groups, pharmacists are expected to select patients who will benefit from the MUR service. All patients who receive an MUR should experience the same level of service regardless of their condition.

MURs cannot be claimed for under QOF. The information gathered may contribute towards a clinical review by a member of the practice. MUR documentation coming into the GP practice should be assessed so that issues raised can be addressed before scanning it onto the patient records

#### **10.5 Emergency supplies and Retrospective Prescriptions**

No prescription only medicines or appliances should be supplied to a patient without an authorised prescription.

However the Human Medicines Regulations 2012 allow exemptions from the Prescription Only requirements for emergency supplies to be made by a person lawfully conducting a retail pharmacy business at the request of either the prescriber or the patient so long as certain qualifying criteria are met – see current version of the BNF.

When making a decision whether to provide an emergency supply or not, the Royal Pharmaceutical Society's guidelines state that the pharmacist should consider the medical consequences of not supplying a medicine in an emergency; and if the pharmacist is unable to make an emergency supply of a medicine the pharmacist should advise the patient how to obtain essential medical care.

Retrospective prescriptions will only be issued by the prescriber in an emergency situation at the request of the patient/patient's carer or clinical specialist as described above.

Dispensing appliance contractors and pharmacy contractors should not request retrospective prescriptions for items already supplied, that are outside the emergency supply qualifying criteria. Such requests may be refused by the prescriber.

## **11. CONTROLLED DRUGS**

### **11.1 Controlled Drug Prescription Requirements**

It is unlawful for a practitioner to issue, or a pharmacist to dispense, any prescription for a Schedule 2 or 3 Controlled Drug (except temazepam) unless it meets ALL the required Regulations (see current version of the BNF). The prescription must include details required as for general prescription writing, but the following are additional legal requirements.

- FORM of Preparation, for example, tablet or capsules
- NAME of preparation
- STRENGTH of Preparation (where necessary)
- DOSE – vague terms such as a prn, mdu, sos, etc., are NOT acceptable as doses. ONE as directed is acceptable.
- TOTAL QUANTITY in both WORDS and FIGURES. N.B. The number of days' supply is NOT acceptable unless the dose happens to be one daily.
- It is strongly recommended by the Department of Health that the quantity of Schedule 2, 3 and 4 Controlled Drugs prescribed should not exceed 30 days' supply. Pharmacists may legally dispense a quantity greater than 30 days. The prescriber will need to be able to justify a supply of more than 30 days on the basis of clinical need and this should be recorded on the patient's notes.
- SIGNED by the PRESCRIBER IN OWN HANDWRITING.
- The DATE can be stamped or computer generated.
- Prescribers must use FP10 MDA prescriptions to order the supply of Methadone etc. for daily instalments. FP10MDA prescriptions must not be used for single amounts. It must have BOTH the dose AND the instalment amount, the total quantity, the amount of instalments and the intervals to be observed.

- PRIVATE PRESCRIPTIONS for schedule 2 and 3 CDs (including temazepam and midazolam) must be written on specially designated forms FP10PCD. The prescription must specify *the prescriber's identification number and address*.
- A PRESCRIPTION for a controlled drug in schedules 2, 3 or 4 (including temazepam and midazolam) is only valid for 28 days from the date stated thereon.
- No repeats are allowed.
- DENTAL PRESCRIPTIONS must include the words “for dental treatment only”
- Pharmacists can amend the prescription if it specifies the total quantity only in words or in figures or if it contains minor typographical errors, as long as they are indelible and clearly attributable to the pharmacist.

All practitioners working with controlled drugs (CDs) must comply, and keep up to date with current legislation. The BNF has a helpful chapter on Controlled Drugs and drug dependence:

### **11.2 Safety in prescribing controlled drugs**

When prescribing, in anything other than acute emergencies, any recent opioid dose should be confirmed. If a dose increase is intended, it should be safe for the patient. Prescribers should ensure that they are familiar with the characteristics of the opioid and follow their local policy.

Any concerns, errors or discrepancies concerning controlled drugs should be reported to the Accountable Officer for Controlled Drugs.

Prescribers must take all reasonable steps to ensure that medicines liable to substance misuse are not being diverted by monitoring the time interval between prescription requests.

Healthcare professionals who are involved with or prescribe for substance misuse and dependence services should have the necessary training and competences to carry out the service.

National Patient Safety Agency in Rapid Response Report 005 [18] recommends:

“When prescribing, dispensing or administering these medicines the healthcare practitioner or their clinical supervisor should:

- Confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient.
- Ensure where a dose increase is intended, that the calculated dose is safe for the patient.

- Check the usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose, and common side effects of that medicine and formulation.”

## **12. PRESCRIBING FOR CHILDREN**

Children are different from adults in relation to their response to medication. Special care is needed in the neonatal period. Prescribing decisions must take into account the child’s age, weight and development stage. For detailed advice, consult the current version of the BNF for Children:

Medicines licensed for use in children in the specific age range and for specific disease must always be used if available. However, many drugs are not licensed for use in children. Thus the informed use of unlicensed medicines or of medicines for off-label use is often unavoidable. All such use must be well documented in the patient’s medical records. (See Section 8 Unlicensed Medicines and Medicines Off-label.)

### **12.1 Prescriptions for Children**

The consequences of errors in prescribing can be more serious in children than in adults. A common source of error is the misplacement of decimal points in dose calculations. Decimal points should be avoided where possible e.g. 500mg not 0.5g; “micrograms”, “nanograms” and “units” should not be shortened and strengths of liquids should be clearly stated. All dose calculations must be double checked to ensure accuracy. Prescribers must refer to the most current version of the BNF for children for general guidance.

### **12.2 Adverse Drug Reactions in Children**

As children may be more susceptible to the toxic effects of some medicines, reporting of adverse reactions, no matter how minor, in children under 18 years, is strongly encouraged through the Yellow Card Scheme even if the black triangle for intensive monitoring has been removed. This includes unlicensed medicines and licensed medicines used off label. See the most current version of the BNF for children chapter on adverse reactions to drugs.

The Yellow Card reporting site can be found at <http://yellowcard.mhra.gov.uk/> or yellow cards which are found at the back of the BNF can be sent to **FREEPOST YELLOW CARD** (no other details required)

MHRA 24-hour Freephone advice and information on adverse drug reactions **0800 731 6789**

### **12.3 Gillick competence and Fraser Guidelines**

The age at which children are ready to take care of, and be responsible for their own medicines varies. Health professionals must assess, with parents and children the appropriate time to

make this transition. The courts have determined that children can be legally competent if they have “sufficient understanding and intelligence to enable them to understand fully what is proposed”. This concept is known as Gillick Competence [19]. Any assessment of such competency must be fully documented in the patient’s medical records. Fraser guidelines [20] apply to contraceptive products only.

### **13. PRESCRIBING IN THE ELDERLY**

Elderly patients often receive multiple drugs for co-morbidities. This greatly increases the risk of drug interactions as well as adverse reactions, and may affect compliance. The balance of benefit and harm of some medicines may be altered in the elderly e.g. increased falls risk. Therefore, elderly patients’ medicines must be reviewed regularly and medicines which are not of benefit should be stopped. Non-pharmacological measures, where they may be appropriate, should be considered.

In some cases prophylactic drugs are inappropriate if they are likely to complicate existing treatment or introduce unnecessary side effects however elderly patients should not be denied medicines which may help them e.g. anticoagulants, statins, osteoporosis drugs.

### **14. PRESCRIBING IN PALLIATIVE CARE**

Palliative care is the active total care of patients whose disease is not responsive to curative treatment. Careful assessment of symptoms and needs of the patient should be undertaken by a multidisciplinary team. Guidance on prescribing is available in the most current version of the BNF, via hospice teams and in local guidelines.

Although drugs can usually be administered by mouth to control the symptoms of advanced cancer, the parenteral route may sometimes be necessary.

#### **14.1 Syringe Drivers**

Incorrect use of syringe drivers is a common cause of drug errors. Staff using them must be adequately trained and different rate settings should be clearly identified and differentiated.

In December 2010, the NPSA issued a Rapid Response Alert [21] stating that ambulatory syringe drivers and pumps used in healthcare should have rate settings in millilitres (ml) to minimise the risk of error.

Prescribers must be aware of the suitability and compatibility of medicines intended for use within syringe drivers. Provided that there is evidence of compatibility, selected injections can be mixed in syringe drivers. Not all types of medication can be used in subcutaneous infusion. In particular, chlorpromazine, prochlorperazine, and diazepam are contraindicated as they cause skin reactions at the injection site; to a lesser extent cyclizine and levomeprozine also sometimes cause local irritation

Subcutaneous infusion solution should be monitored regularly to check for precipitation or discolouration and to ensure the infusion is running at the correct rate.

## **15. PRESCRIBING MEDICINES TO PEOPLE WHO LACK CAPACITY TO CONSENT**

When patients lack the mental capacity to consent to treatment, medication may still be prescribed and administered to them, provided the principles of the Mental Capacity Act 2005 are followed. Staff should also be guided by their local policy.

For full details refer to the following source documents:

- The Mental Capacity Act 2005
- The Mental Capacity Act: Code of Practice 2007

In summary:

- The person's capacity to consent to the treatment must be formally assessed according to the process prescribed in Section 2 and 3 of the Mental Capacity Act 2005, for which more detailed guidance is provided in Chapter 4 of the Mental Capacity Act Code of Practice (Department of Constitutional Affairs 2007).
- When an adult lacks the mental capacity to give or withhold consent to treatment, no one else can give consent on their behalf other than an attorney under the Lasting Power of Attorney (LPA) or a deputy appointed by the Court of Protection, where the decision is within the scope of their authority.
- If the person lacks capacity to consent, and in the absence of an attorney or deputy with relevant authority, the treatment can still be given, provided it is in the patient's "best interests". The process of determining best interests must be carried out in accordance with Section 4 of the Mental Capacity Act 2005, for which more detailed guidance is provided in Chapter 5 of the Mental Capacity Act Code of Practice (DCA 2007).
- The process of assessing capacity and determining best interests must be documented in the clinical records.
- Staff should be aware that the Mental Capacity Act 2005 includes provision for adults, who have the capacity to do so, to make advance decisions to refuse specified treatment for a time in the future when they lack capacity to consent to it. Provided it can be established that an advance decision is valid and applicable, it has the same effect as a decision made by a person with capacity, and healthcare professionals must respect this decision. Further guidance on this is available in Chapter 9 of the Mental Capacity Act Code of Practice and in the best practice guidance "Advance Decisions to Refuse Treatment: A Guide for the Health and Social Care Professionals"

(NHS End of Life Care Programme & the National Council for Palliative Care 2008).  
[22]

The GMC consent guidance [23] summarises 'Making decisions when a patient lacks capacity' as follows:

In making decisions about the treatment and care of patients who lack capacity, you must:

- a. make the care of your patient your first concern
- b. treat patients as individuals and respect their dignity
- c. support and encourage patients to be involved, as far as they want to and are able, in decisions about their treatment and care
- d. Treat patients with respect and not discriminate against them.

You must also consider:

- a. whether the patient's lack of capacity is temporary or permanent
- b. which options for treatment would provide overall clinical benefit for the patient
- c. which option, including the option not to treat, would be least restrictive of the patient's future choices
- d. any evidence of the patient's previously expressed preferences, such as an advance statement or decision
- e. the views of anyone the patient asks you to consult, or who has legal authority to make a decision on their behalf, (holders of lasting powers of attorney and court-appointed deputies) or has been appointed to represent them (Independent Mental Capacity Advocates)
- f. the views of people close to the patient on the patient's preferences, feelings, beliefs and values, and whether they consider the proposed treatment to be in the patient's best interests
- g. What you and the rest of the healthcare team know about the patient's wishes, feelings, beliefs and values.

## **16. PRESCRIBING NEW DRUGS and VACCINES - BLACK TRIANGLE DRUGS**

New drugs are intensively monitored to ensure that any new safety hazards are identified promptly. The Commission on Human Medicines (CHM) and the MHRA encourages the reporting of all suspected reactions to newer drugs and vaccines (including those to be considered not serious), which are denoted by an inverted Black Triangle symbol (▼). This symbol appears next to the name of a relevant product in the BNF, BNF for Children, MIMs, ABPI advertising material and the MHRA Drug Safety Updates. The list of these drugs is

updated monthly on the MHRA website. Reporting of adverse reactions is done using the Yellow Card Scheme. Report forms can be found in the BNF, MIMs or online.

These drugs should be used with caution and alternative drugs with a more established safety profile should be considered first line.

## **17. ADVERSE REACTIONS**

### **17.1 Adverse Drug Reactions**

An adverse drug reaction (ADR) is an unwanted or harmful reaction which occurs after administration of a drug or drugs and is suspected or known to be due to the drug(s). Adverse drug reactions are frequently serious enough to result in admission to hospital. It is well recognised that adverse drug reactions place a significant burden on the health service.

Studies performed in an attempt to quantify this have shown adverse drug reactions account for 1 in 16 hospital admissions, and for 4% of hospital bed capacity.

ADRs themselves are also thought to occur in 10-20% of hospital in-patients, and one study found that over 2% of patients admitted with an adverse drug reaction died, approximately 0.15% of all patients admitted.

It is clear that adverse drug reactions adversely affect patients' quality of life and can also cause patients to lose confidence in the healthcare system. There is a significant impact through increase costs of patient care and the potential to lengthen hospital stays. Adverse drug reactions may also mimic disease, resulting in unnecessary investigations and delays in treatment. [24]

For new drugs (denoted by ▼) ALL adverse reactions should be reported. For established drugs and vaccines (including over-the-counter and herbal medicines), report all suspected adverse reactions that you consider to be SERIOUS. They should be reported even if the effect is well recognised.

Serious reactions are those which are;

- fatal
- life-threatening
- disabling
- incapacitating
- have resulted in, or prolonged, hospitalisation
- medically significant
- congenital abnormalities

See also the current version of the BNF

## **17.2 Adverse reactions to medical devices**

Definitions of adverse reactions to medical devices and reporting details can be found on the MHRA website.

## **18. PRESCRIBING OF HIGH RISK MEDICINES**

### **18.1 Prescribing of Insulin**

Errors in the administration of insulin are common. To address this, the National Patient Safety Agency (NPSA) has produced two patient safety alerts:

1. NPSA/2010/RRR013 [25] all regular and single insulin (bolus) doses should be measured and administered using an insulin syringe or commercial insulin pen device. Intravenous syringes must never be used for insulin administration.

The term 'units' should be used in all contexts. Abbreviations, such as 'U' or 'IU' must never be used.

2. NPSA/2011/PSA003 [26] When prescribing insulin the NPSA recommends:
  - Offering the use of an insulin passport to record information on the insulin products they use;
  - Provide a patient information booklet which describes known error-prone situations and actions that may cause harm and enforce the benefits of using the insulin passport to minimise these risks
  - Record the patient's decision of whether or not to use the passport offered to them (the patient's passport status) in medical notes.
  - Assist patients in completion of therapy details in the insulin passport, specifically in how to describe their insulin products so that there is no ambiguity in what they are using
  - Instruct patients to present their insulin passport when visiting all healthcare professionals.

More details can be found at <https://www.cas.dh.gov.uk/SearchAlerts.aspx>

## 18.2 Prescribing Of Low Molecular Weight Heparin (LMWH)

The dose of LMWH depends on the patient's current weight, renal function and its clinical indication. Overdosing increase the risk of bleeding and under dosing increases the risk of a further thromboembolic event. The NPSA (NPSA/2010/RRR014) [27] recommends:

1. A patient's weight is used as the basis for calculating the required treatment dose of LMWH. The weight must be accurately recorded in kilograms (kg) on the inpatient medication chart (when in use) and clinical record. Patients should be weighed at the start of therapy and, where applicable, during treatment.
2. Renal function is considered when prescribing treatment doses of LMWHs. The renal function test should not delay initiation of the first dose but every effort must be made to base subsequent dosing on these results.
3. Dose calculation tools are available for a range of body weights, specific clinical indications and LMWH products, and that consideration is given to rationalising the range of LMWH products used in the organisation.
4. Essential information such as dose, weight, renal function, indication and duration of treatment is communicated at transfers of care (e.g. by discharge letters) and used to ensure that future doses are safe.
5. Dosing checks based on patient information are made by healthcare professionals who review, dispense or administer LMWHs when this information is readily available to them.
6. System improvements should be demonstrated through the collection and review of data, such as incident reports, clinical pharmacy interventions, audit or other relevant outcome measures.

An additional Patient Safety Alert was circulated in January 2015. [28] The alert related to harm from using Low Molecular Weight Heparins when contraindicated. The report highlighted that although there are important benefits from the use of LMWHs, there are various contraindications when their use can cause harm or death:

**It is therefore vital to assess each patient individually as to whether the benefits of using LMWHs outweigh the risks.**

It is apparent from medication safety incidents reported to the National Reporting and Learning System (NRLS) that there have been missed opportunities to appropriately risk assess all patients for pharmacological or clinical contraindications.

More details can be found at <https://www.cas.dh.gov.uk/SearchAlerts.aspx>

### **18.3 Prescribing of Lithium**

Some patients taking lithium have been harmed because they have not had their dosage adjusted based on recommended regular blood tests. If patients are not informed of the known side effects or symptoms of toxicity, they cannot manage their lithium therapy safely.

Regular blood tests are important, linked to adjust of dose as necessary. Clinically significant alterations in lithium blood levels occur with commonly prescribed and over-the counter medicines. The blood level of lithium is dependent on kidney function and lithium has the potential to interfere with kidney (renal) and thyroid functions. The NPSA (NPSA/2009/PSA005) [29] recommends:

1. Patients prescribed lithium are monitored in accordance with NICE guidance;
2. There are reliable systems to ensure blood test results are communicated between laboratories and primary care and specialist prescribers.
3. At the start of lithium therapy and throughout their treatment patients receive appropriate on-going verbal and written information and a record book to track lithium blood levels and relevant clinical tests\*;
4. Prescribers and community pharmacists check that blood tests are monitored regularly and that it is safe to issue a repeat prescription and/or dispense the prescribed lithium;
5. Systems are in place to identify and deal with medicines that might adversely interact with lithium therapy.

\* The NPSA has developed a patient information booklet, lithium alert card and record book for tracking blood tests. Resources are available from specialist services or Primary Care Support Services.

### **18.4 Prescribing of Methotrexate**

Oral methotrexate is a safe and effective medication if taken at the right dose and with appropriate monitoring. However, very occasionally problems with taking the medication can cause serious harm and even death. Two thirds of all incidents result from the wrong dose being prescribed and a fifth are linked to poor monitoring. The NPSA produced advice in 2004 "Towards the safer use of oral methotrexate" and then a Patient Safety Alert in 2006 [30]:

1. Information on the risks and benefits of oral methotrexate should be given to the patient. Confirmation of the patient's understanding and consent should be sought, baseline tests conducted, monitoring schedule explained, and patient-held monitoring booklet issued.

2. For NHS organisations with Shared Care Guidelines, the following issues should be addressed:
  - clarity of prescribing and monitoring responsibilities;
  - how often blood tests will be conducted and in which location;
  - which clinician will be responsible for receipt and review of the results;
  - who will communicate any necessary dosage changes to the patient and the GP;
  - who will record test results on the patient-held monitoring booklet.
3. NHS organisations without Shared Care Guidelines must make similar appropriate arrangements. The BSR has published guidelines on the monitoring of disease modifying drugs, including oral methotrexate, which may be a useful source of information.
4. All prescribers must avoid the use of 'as directed' in prescribing – a specific dose must be applied to each prescription. Bear in mind that patients often understand their dose by the number of tablets they take rather than 'mg'. The required quantity and frequency of dose should be regularly discussed with the patient.
5. Repeat prescriptions should be retained separately for prescriber review prior to authorising. It may help to change the printer driver software so that it shades the prescription signature space on FP10/WP10 to alert the prescriber to this high-risk drug. Be aware of patients who attend with symptoms such as breathlessness, dry persistent cough, vomiting or diarrhoea, as these can be signs of oral methotrexate toxicity or intolerance.
6. Handwritten prescriptions and discharge summary information must be complete, legible and include the form, strength, dose and directions in full.
7. Consideration needs to be given to the duration of supply and frequency of issue of repeat prescriptions for methotrexate. Ideally patients should not be given more than a four week supply
8. A check should be carried out to ensure necessary monitoring is conducted prior to issuing or re-authorising repeat prescriptions.

More details can be found at <https://www.cas.dh.gov.uk/SearchAlerts.aspx>

### **18.5 Prescribing of Warfarin**

Anticoagulants are one of the classes of medicines most frequently identified as causing preventable harms and admissions to hospitals. Managing the risks associated with

anticoagulants can reduce the chance of patients being harmed in the future. The NPSA issued a Safety Alert NPSA/2007/17 [31] and gave the following advice to GPs.

1. Ensure that before issuing a repeat prescription for anticoagulant medication, check that the patient's INR is being monitored regularly and that it is at a safe level for the repeat prescription to be issued. The easiest way to do this is to ask to see the patient-held INR record, which may be in the form of a single printed sheet, a small booklet or another format used locally.
2. Ensure that if a patient who is already on oral anticoagulants is co-prescribed one or more clinically significant interacting medicines, that arrangements are made for additional INR blood tests, and that the anticoagulant clinic is made aware that an interacting medicine has been prescribed. The patient may be empowered to ensure this happens in appropriate cases
3. Ensure that doses are expressed in mg and not in number of tablets.
4. Review and, where necessary, update any sections of clinical procedures and protocols that relate to parts of the anticoagulant care pathway for which they or their staff take responsibility.
5. Ensure that all dose changes, originated by the surgery, for patients in care homes are confirmed in writing.
6. Ensure that patients on anticoagulant therapy have received appropriate verbal and written information at the start of their therapy, and when necessary throughout their treatment. In practice, this means making sure that patients have received a 'yellow book' and ensuring that they (or their carers) fully understand its contents.
7. Participate in an annual audit of anticoagulant services.

More details can be found at <https://www.cas.dh.gov.uk/SearchAlerts.aspx>

## **19. PRIVATE PRESCRIBING**

The 2009 department of health document 'Guidance on NHS patients who wish to pay for additional private care' and the NHS constitution define situations in which patients can access additional private care alongside their NHS care. In summary, any additional private care must be delivered separately from NHS care (with some exceptions – see '[Guidance on NHS patients who wish to pay for additional private care](#)') but can be delivered alongside NHS care. Patients also have the choice of switching from private care to NHS care at any time during their treatment.

If a patient has been seen privately by a specialist and is given a private prescription but then requests that the medicine is supplied on an FP10 or a private specialist requests an NHS GP directly, the following should be considered:

1. If an NHS GP receives communication from a private specialist recommending a medicine that is suitable to be prescribed in primary care, then it may be appropriate for a prescription to be issued on an FP10, but only if:
  - a. the GP agrees with the advice,
  - b. the medicine to be prescribed is commissioned by the CCG.
    - i. If the medicine requested is not commissioned by the CCG a suitable therapeutic alternative that is commissioned should be offered.
2. If a GP receives communication from a private consultation recommending a medicine that is not suitable to be prescribed in primary care, then it would not be appropriate for a prescription to be issued on an FP10 and the patient should be informed of this as soon as practicably possible. Alternatively, the GP should:
  - a. obtain a full communication from the private consultant, and
  - b. complete a referral to an appropriate NHS specialist for the patient to receive appropriate NHS care.

If a patient is being seen as an NHS patient in a private facility, they should be provided with NHS prescriptions by the clinician responsible for their care. The patient should be referred back to the provider to be issued an NHS prescription.

### **19.1 Transfer of care between NHS and private providers**

Transferring between private and NHS care should be carried out in a way which avoids putting patients at any unnecessary risk. The NHS and the private provider (which may be an NHS organisation) should work collaboratively to put in place protocols to ensure effective risk management, timely sharing of information, continuity of care and coordination between NHS and private care at all times.

If different clinicians are involved in each element of care, these protocols should include arrangements for the safe and effective handover of the patient between the clinician in charge of the NHS care, and the clinician in charge of the private care.

**It must always be clear which clinician and which organisation are responsible for the assessment of the patient, the delivery of any care and the delivery of any follow-up care.**

## 19.2 Private Prescriptions for NHS Patients

GPs should provide their NHS patients with any medication available to NHS patients deemed clinically appropriate on an NHS FP10 prescription. GPs may not issue private prescriptions alongside or as an alternative to FP10s.

However, GPs may write private prescriptions for patients for drugs not available through the Drug Tariff. However, GPs may not charge their registered patients for providing such a prescription. The only occasions when a doctor may charge for a private prescription are:

1. For drugs which are being issued solely in anticipation of the onset of an ailment while outside the UK, but for which the patient does not require treatment when the medicine is prescribed.
2. For drugs issued for the prevention of malaria.

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## **20. PATIENT GROUP DIRECTIONS (PGDs) and PATIENT SPECIFIC DIRECTIONS**

### **20.1 Patient Group Directions**

PGDs provide a legal framework that allows some registered health professionals to supply and/ or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a prescriber. [33] However, supplying and/or administering medicines under PGDs should be reserved for situations in which this offers an advantage for patient care, without compromising patient safety. Defined in Health Service Circular (HSC 2000/026) [34] as:

'Written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment'

Each PGD has a named lead author who has responsibility for developing a PGD, supported by a locally determined multidisciplinary PGD working group. This includes a doctor (or dentist), pharmacist and representative of any other professional group(s) using the PGD. PGDs must be authorised only by an appropriate authorising body in line with legislation.

Legislation requires that PGDs must be signed by a doctor or dentist, a pharmacist and must also be signed on behalf of the authorising body, as set out in the legislation. In the NHS in England, the following organisations are authorising bodies:

- CCGs
- Local authorities
- NHS trusts or NHS foundation trusts
- Special health authorities
- The NHS Commissioning Board

A lead person with responsibility for managing the use of PGDs should be nominated within each GP practice and other clinical areas.

For each PGD, the commissioning and provider organisation(s) should collaborate to firmly establish local governance arrangements with clear lines of responsibility and accountability.

Health professionals supplying or administering medicines according to PGDs must sign and retain a copy of the PGD as a legal document.

Lead persons must ensure that wherever a service is provided which depends upon a PGD:

- On-going training is provided

- Staff required to supply or administer medicines according to a PGD are adequately trained and competent
- Records of signed copies are retained as legal documents
- New/Agency/Locum staff are trained to use PGDs
- Audit is carried out to ensure that PGDs are being used correctly

Appropriate records must be kept as specified within the individual PGD.

Appropriate organisational records are to be maintained, stored securely and archived, in line with relevant legislation and the Department of Health's code of practice on records management.

All current immunisation and vaccine PGDs that have been approved for use across Lancashire can be found on the LMMG website: <http://www.lancsmmg.nhs.uk/pgds/>

## **20.2. PATIENT SPECIFIC DIRECTIONS**

A Patient Specific Direction (PSD) is the traditional written instruction, authorised by a doctor, dentist, or non-medical prescriber (hereafter referred to as “the prescriber” unless stated otherwise) for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis. This instruction may be in writing and signed or in an electronic format instruction for the practice nurse or other competently trained health care professional to administer the medicine. The instruction may be for example:

- primary care: a prescription or simple written or electronic instruction in the patient's notes
- secondary care: instructions on a patient's ward drug chart

In practice, we know that a PSD is commonly referred to as a prescription by those who write and follow them because this indicates that it is written by a prescriber.

A PSD, signed by a qualified, registered prescriber, at a minimum should specify:

- Name of patient and/or other individual patient identifiers
- Name, form and strength of medicine (generic or brand name where appropriate)
- Route of administration
- Dose
- Frequency
- Start and finish dates.
- Signature of prescriber.

As a PSD is individually tailored to the needs of a single patient, more information may be required to enable safe supply and/or administration of some medicines and to manage identified risks such as drug interactions or contraindications.

PSD do not limit those who can supply or administer the medicine. For example, a suitably trained health care assistant can do so, even though they cannot work under a PGD.

PSDs are often used in relation to the administration of vaccinations for named patients as well as some depot medications and vitamin B12

Where a Patient Specific Direction exists, there is no need for a Patient Group Direction (PGD). [35]

## **21. TRAVEL ABROAD**

Under NHS legislation, the NHS ceases to have responsibility for people when they leave the UK. However, to ensure good patient care the following guidance is offered. People travelling within Europe should be advised to apply for a free European Health Insurance Card (EHIC), which offers access to reduced-cost medical treatment. This is available from the NHS Business Services Authority. Everyone should also obtain adequate holiday insurance cover.

GPs are not responsible for prescribing items required for conditions which may arise while travelling e.g. travel sickness and diarrhoea. Patients should be advised to purchase these items locally prior to travel. Advice is available from community pharmacists if required. For conditions unresponsive to self-medication the patient should normally seek medical attention abroad.

To ensure continuity of care for patients on a stable medication regime, it is reasonable to provide a routine repeat prescription (usually one and no more than three months), to enable the patient to find a doctor who can continue their care in the country to which they are travelling. GPs could be in breach of the Terms of Service if they issue an NHS prescription to cover an extended absence from the country (after three months, a patient would have to re-register as their name should be removed from their list). The NHS normally will not pay for any treatment or services for patients no longer resident in the UK. This includes people who are in receipt of UK state retirement pension.

Where a patient requires a prescription for larger supplies of his/her medication because of a longer stay abroad, the patient can be given a private prescription to cover the additional period of absence; however the Doctor is clinically responsible for prescribing, and for longer periods this may be clinically inappropriate, as they are not able to monitor and care for patients.

Emergency travel kits are available in two forms. The “basic kit” contains items such as disposable needles and syringes, IV cannulae, sutures and dressings. The “POM” kit contains additional items such as plasma substitutes and medicines. A private prescription is required for the latter. The kits, or a list of suppliers, are available through travel clinics or community pharmacies. Neither kit is available under the NHS.

Patients entering or leaving the UK for 3 months or more with personal medication containing a controlled drug must get a licence. Online applications must be made on the Home Office website [36] at least 10 working days before travel date. Applications from overseas could take longer. Travel arrangements should not be made until the licence has been received.

Patients entering or leaving the UK for less than 3 months do not need a licence but should have a letter from their doctor with the following information.

- Patient’s name
- Patient’s travel itinerary
- a list of prescribed controlled drugs being carried
- dosages and total amounts for each drug

This letter may have to be shown when going through customs.

### **21.1 Immunisation for holiday & business travel abroad**

Guidance for GPs on risk assessment for travellers and appropriate advice can be found on the website of the National Travel Health Network and Centre (NHS):

<http://www.uclh.nhs.uk/ourservices/servicea-z/htd/nathnac/Pages/Home.aspx>

NHS England [38] advise that prescribers in primary care should **not** initiate the following vaccines exclusively for the purposes of travel for any NHS patient. These vaccines should **continue to be recommended** for travel but the individual traveller will need to bear the cost of the vaccination. These vaccines are:

- Hepatitis B
- Japanese Encephalitis
- Meningitis ACWY
- Yellow Fever
- Tick-borne encephalitis
- Rabies
- BCG

The following vaccines may still be administered on the NHS exclusively for the purposes of travel, if clinically appropriate, pending any future review:

- Cholera
- Diphtheria/Tetanus/Polio
- Hepatitis A
- Typhoid

## **21.2 Malaria prophylaxis**

Public Health England has issued guidance for malaria prevention in travellers from the UK. [37] The guidance document can be found via the following:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/461295/2015\\_09.16\\_ACMP\\_guidelines\\_FINAL.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461295/2015_09.16_ACMP_guidelines_FINAL.pdf)

Medicines for the prevention of malaria are available from community pharmacies, GPs and Travel Health clinics. Some must be prescribed on a private prescription.

Medicines for the prevention of malaria (except for Malarone®, mefloquine and doxycycline) are available for purchase “over the counter” at community pharmacies. Malarone®,

mefloquine and doxycycline are prescription only medicines and should be prescribed on private prescription.

Local community pharmacies have access to up to date advice about appropriate prophylactic regimens and can advise travellers accordingly (MIMS has updated antimalarial travel charts).

Patients should be advised to purchase sufficient prophylactic medicines to cover the period of their travel. It is recommended that treatment commences one week before arriving in the risk area (two to three weeks for mefloquine) so that if adverse events occur there will be time to switch to an alternative before departure. Treatment should continue for at least four weeks on return. Malarone® and doxycycline are exceptions being started 1-2 days before travel and Malarone® stopped one week after leaving the risk area<sup>(11)</sup>

The importance of permethrin impregnated mosquito nets, mats and vaporised insecticides, insect repellents containing 20-50% DEET applied to the skin of adults and children over 2 months of age, long sleeves and trousers worn after dusk to protect against being bitten should be stressed as no chemoprophylactic regimen can be considered 100% effective.

Remember the Health Protection Agency's (HPA) four steps to prevent suffering from malaria in UK travellers: [37]

ABCD of malaria prevention

**A**wareness of risk

**B**ite prevention

**C**hemoprophylaxis

Prompt **D**iagnosis and treatment

## **22. PRESCRIBING OF BORDERLINE SUBSTANCES**

The BNF states that in certain conditions some foods (and toilet preparations) have characteristics of drugs and the Advisory Committee on Borderline Substances (ACBS) advises as to the circumstances in which such substances may be regarded as drugs. GPs are reminded that the ACBS recommends products on the basis that they may be regarded as drugs for the management of specified conditions. Doctors should satisfy themselves that the products can safely be prescribed, that patients are adequately monitored and that, where necessary, expert hospital supervision is available.

A complete list of conditions can be found in the BNF or Drug Tariff.

Standard food related ACBS indications

- Disease related malnutrition

- Pre-operative preparation of malnourished patients
- Intractable malabsorption
- Short- bowel syndrome
- Dysphagia
- Following total gastrectomy
- Proven inflammatory bowel disease
- Bowel fistula

There are several areas where prescriptions for dietary products do not comply with the above recommendations and the responsibility lies with individual GPs who may use their judgement to make exceptions to the above recommendations. This may occur following recommendations from a dietician or for a medical condition requiring nutritional support for a defined period of time. An example of the latter would be a patient having had maxillo-facial surgery, being discharged from hospital with a wired jaw and requiring nutritional support for 6 – 8 weeks post-operation. Such a patient would be unlikely to receive adequate nutrition from a manageable volume of liquidised foodstuffs.

Skin conditions for which ACBS products can be prescribed

- Birthmarks
- Dermatitis, eczema, pruritis
- Dermatitis herpetiformis
- Disfiguring skin lesions
- Disinfectant (antiseptics)
- Dry mouth (xerostomia)
- Photodermatoses (skin protection in)

## **23. VITAMINS, MINERALS, SUPPLEMENTS, HERBAL AND HOMEOPATHIC MEDICINES WITHOUT A PRODUCT LICENCE**

Most food supplements (such as herbal medicines, various vitamins and minerals) do not have a product licence (UK marketing authorisation). Products that do not have a product licence have not undergone the strict criteria laid down by the regulatory authorities to confirm the safety, quality and efficacy of these products. They are often not manufactured to the same high pharmaceutical standards used for licensed medicines to ensure consistency in formulation and potency.

Patients may of course purchase these medicines to take as a complementary form of therapy, but should in all cases discuss the use of them with their GP or pharmacist. The latter will try to advise whether they are likely to interact with their usual medication or concurrent disease states, although this information is not always available as these supplements have not undergone the usual tests that conventional medicines are required to go through. Examples include:

Antioxidants for Age-Related Macular Degeneration eg ICAPS<sup>®</sup>, Ocuvit<sup>®</sup>

Cod Liver Oil

Co-Enzyme Q10<sup>®</sup>

Glucosamine

Herbal Medicines eg Ginko Biloba, St John's Wort.

A position statement is available for use across Lancashire, informing prescribers about when it would be appropriate to prescribe these products.

#### **24. PERSONALLY ADMINISTERED ITEMS**

Items that **can** be claimed as personally administered include: [38]

- Vaccines, anaesthetics and injections;
- Intrauterine contraceptive devices (including drug releasing IUCDs, contraceptive caps and diaphragms);
- Pessaries which are appliances;
- Sutures (including skin closure strips) – for emergency wounds etc.

Items that **cannot** be claimed as personally administered include dressings used in minor surgery, hormonal implants, nebulas, catheters, clinical reagents etc.

Note:

- Implanon/Nexplanon cannot be claimed as a personally administered item (since an implant, rather than injection).  
An FP10 prescription should be provided. A prescription charge is not payable since it is a contraceptive.
- Goserelin (even though an implant) can be claimed as personally administered item, as can leuprorelin and triptorelin.  
An FP10 prescription should be provided.
- High volume vaccines (e.g. influenza, typhoid, hepatitis A, hepatitis B, pneumococcal, meningococcal) can be claimed for on the form FP34PD  
These items, personally administered do not attract a prescription charge.

For other items an FP10 prescription needs to be submitted. A prescription charge would be payable (unless the patient is exempt).

## **25. DOCTORS PRESCRIBING FOR THEMSELVES OR THEIR FAMILIES**

It is poor practice for doctors and their families to be registered at the doctor's own practice. Unless there are exceptional circumstances, doctors and their families should register with a GP outside the family. Doctors who believe they and/or their family cannot avoid being registered at their own practice should contact their Responsible Officer.

Doctors (or any other prescribers) should not prescribe for themselves or their family. Prescribers must not treat themselves or family members other than in an emergency, or other exceptional circumstances (which should be discussed with the prescribers Responsible Officer). GMC Good practice in prescribing and managing medicines and devices [3] provides further useful advice

## **26. PRESCRIBING FOR VISITORS FROM OVERSEAS**

The National Health Service (Charges to Overseas Visitors) Regulations 2015 (the Charging Regulations) came into force on 6th April 2015 and apply to all courses of treatment commenced on or after that date. The Regulations were subsequently been amended, and the changes came into effect on 1st February 2016. [39] In summary:

The following services are free at the point of use for all patients. A charge cannot be made or recovered from any overseas visitor for:

1. Accident and emergency (A&E) services, this includes all A&E services provided at an NHS hospital, e.g. those provided at an accident & emergency department, walk-in centre or urgent healthcare centre. This does not include those emergency services provided after the overseas visitor has been accepted as an inpatient, or at a follow-up outpatient appointment, for which charges must be levied unless the overseas visitor is exempt from charge in their own right;
2. Services provided outside an NHS hospital, unless the staff providing the services are employed by, or working under the direction of, an NHS hospital;
3. Family planning services (does not include termination of pregnancy);
4. Diagnosis and treatment of specified infectious diseases;
5. Diagnosis and treatment of sexually transmitted infections;
6. Treatment required for a physical or mental condition caused by:
  - a. torture;
  - b. female genital mutilation;
  - c. domestic violence; or

d. sexual violence,

Except where the overseas visitor has travelled to the UK for the purpose of seeking that treatment. [39]

The following categories of overseas visitor are exempt from charge: [39]

1. Those who have paid the health surcharge or are covered by transitional arrangements;
2. Those with an enforceable EU right to free healthcare;
3. Vulnerable patients and those detained;
4. UK Government employees and war pensioners;
5. Those covered by reciprocal healthcare agreements, other international obligations and employees on UK-registered ships.

Full details of those that are eligible to receive treatment or liable to pay for it can be found via the following:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/496951/Overseas\\_visitor\\_hospital\\_charging\\_accs.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/496951/Overseas_visitor_hospital_charging_accs.pdf)

## **27. SECURITY OF PRESCRIPTION FORMS AND CONTROLLED STATIONERY**

### **27.1 Background**

With several million blank prescriptions in circulation the potential for theft is a real possibility. The councils of the British Medical Association and the Royal Pharmaceutical Society have issued a joint statement on the security and validity of prescriptions. In particular prescriptions should:

- Not be left unattended at reception desks;
- Not be left in a car where they may be visible;
- When not in use, be kept in a locked drawer within the surgery and at home

### **27.2 General Advice**

Organisations should maintain clear and unambiguous records on prescription stationery and stock received and distributed preferably using a computer system to aid reconciliation and audit

FP10s or the equivalent non-medical prescribers FP10 forms e.g. FP10 CN should only be held by registered qualified / accredited practitioners who have been issued with them, and who are responsible for their security. Stock order forms, requisition books (stock or non-stock)

or prescription cards must also be treated as controlled stationery and kept in a secure area when not in use i.e. in a locked cupboard / drawer within a locked room.

Doctors and surgery stamps should be kept in a separate, equally secure location to prescription forms.

It is important to record delivered and stored prescription stock. Two members of staff should always be in attendance when a delivery arrives, one of whom should always remain with the delivery vehicle. The delivery should be thoroughly checked against the order and delivery note and only be signed for if the packaging is sealed and unbroken

Recording requirements for prescription forms and other medicine order forms should include:

- Date of delivery
- Name of person accepting delivery
- Number of forms received (and serial numbers if applicable)
- Storage site
- Date of issue
- Name & signature of person to whom it was issued
- Name & signature of person issuing
- Number issued
- Serial numbers of forms issued if applicable
- Details of the prescriber

Records of serial numbers received and issued should be retained for at least three years.

### **27.3 Storage of Prescription forms**

- Minimal stocks should be kept to reduce theft potential and keep stocks up to date.
- Prescribers are responsible for any forms they have and they should be locked away when not in use.
- Prescribers should ensure that forms are never left unattended and unauthorised staff or patients should never be allowed into secure areas where forms are stored.
- Supplies of forms should never be left in e.g. care homes for GP or locum visits.
- The prescription pad must only be produced when needed and must never be left unattended. When out visiting, prescribers must keep prescription pads with them out of sight; they must never be left in the car.

## **27.4 Use of Prescription Forms**

- Prescribers should keep records of the first and last serial numbers of prescription forms issued to them, plus the number of the first remaining form on the current pad at the end of each session or day.
- Completed prescriptions should be locked away until issued to the patient and security checks put in place to ensure the form is being issued to the patient or an authorised person on their behalf.
- Computerised prescription forms should also be kept secure in printers in a locked room and patients should not be left unattended where they are in use. When ordering new printers consideration should be given to ordering a tray to secure the forms or locating the printer in a secure part of the building.
- Blank prescription should never be pre-signed
- Duplicate prescriptions should be securely destroyed (e.g. by shredding) before being put into confidential waste, with appropriate records kept
- Spoiled in error prescriptions should be securely destroyed as above.
- Personalised forms which are no longer in use should be securely destroyed (e.g. by shredding) before being put into confidential waste, with appropriate records kept. The person who destroys the forms should make a record of the serial number of the forms destroyed. Best practice would be to retain these prescription forms for local auditing purposes for a short period prior to destruction. The destruction of the forms should be witnessed by another member of staff. Records of forms destroyed should be kept for at least 18 months.
- All personalised unused prescription forms relating to these prescribers should be recovered and securely destroyed (e.g. by shredding) before being put into confidential waste, with appropriate records kept. The person who destroys the forms should make a record of the serial number of the forms destroyed. The person responsible for the recovery and destruction of forms should be in a position of suitable seniority. The destruction of the forms should be witnessed by another member of staff. Records of forms destroyed should be kept for at least 18 months.

## **27.5 Action in case of Lost or Stolen Prescription Forms**

If missing prescriptions forms cannot be accounted for, the matter should be reported to the designated person with overall responsibility for prescription forms at the health body, the accountable officer for CDs and the police as required.

The LSMS should also be notified using the Missing/lost/stolen NHS prescription form(s) notification form found at annex B in the NHS Protect Security of prescription forms guidance. See annex A for the Missing/lost/stolen prescription form flowchart which outlines actions to be taken by staff in the event of an incident. [40]

The prescriber should be instructed to write and sign all prescription forms in a particular colour for a period of two months. The health body should inform all pharmacies in the area and adjacent areas of the name and address of the prescriber concerned, the approximate number of prescription forms missing or stolen, serial numbers (if known) and the period for which the prescriber will write in a specific colour. [40]

If a patient claims to have lost their prescription, practices may consider asking the patient for a police incident number to ensure that this is legitimate before issuing a replacement script.

## **28. FURTHER INFORMATION ON MEDICINES**

Contact your CCG Prescribing/Medicines Optimisation Lead or Practice Pharmacist  
or

Contact North West Medicines Information, 70 Pembroke Place, Liverpool; Tel 0151 794 8113; or email [nwmedinfo@nhs.net](mailto:nwmedinfo@nhs.net)

## 28.1 Useful Websites

### NHS Lancashire CCG Websites

1. [NHS East Lancashire CCG](#)
2. [NHS Chorley and South Ribble CCG](#)
3. [NHS Fylde and Wyre CCG](#)
4. [NHS Greater Preston CCG](#)
5. [NHS Lancashire North CCG](#)
6. [NHS West Lancashire CCG](#)
7. [NHS Blackpool CCG](#)
8. [NHS Blackburn with Darwen CCG](#)

Controlled Drug Accountable Officer (CDAO):

**Until January 2017:** NHS England, North (Lancashire & Greater Manchester) is responsible for the appointment of Accountable Officers for Controlled Drugs. The Accountable Officer for Controlled Drugs within the Lancashire area is currently Karen O'Brien. All incidents and concerns involving controlled drugs including destruction should be reported using the web based controlled drug reporting tool: [www.cdreporting.co.uk](http://www.cdreporting.co.uk).

**After January 2017:** NHS England, North (Lancashire) will be responsible for the appointment of Accountable Officers for Controlled Drugs within Lancashire. Further information can be obtained from: <https://www.england.nhs.uk/north/>

### Other Websites

1. [National Institute for Health and Care Excellence](#)
2. [The Medical Royal Colleges](#)
3. [Lancashire Medicines Management Group](#)
4. [Medicines and Healthcare products Regulatory Agency \(MHRA\)](#)
5. [NHS Central Alert System](#)
6. [NICE Evidence Search](#)
7. [NICE Medicines and Prescribing Centre](#)
8. [Electronic Medicines Compendium](#)
9. [British National Formulary \(BNF\)](#)
10. [British National Formulary for Children \(BNFC\)](#)
11. [Scottish Medicines Consortium \(SMC\)](#)
12. [Department of Health](#)
13. [All Wales Medicines Strategy Group](#)
14. [Midlands Therapeutic and Review Advisory Committee MTRAC](#)
15. [The Drug Tariff](#)
16. [The Human Medicines Regulations 2012](#)
17. [Mental Capacity Act 2005](#)
18. [Mental Capacity Act 2005: Code of Practice 2007](#)
19. [Commission on Human Medicines](#)
20. [MIMS](#)
21. [ABPI \(The Association of the British Pharmaceutical Industry\)](#)
22. [MRHA Drug Safety Updates](#)
23. [MRHA Yellow Card Scheme](#)
24. [NHS Business Services Authority](#)
25. [NaTHNaC Yellow Book](#)
26. [National Travel Health Network and Centre website](#)
27. [Prescription prepayment certificates](#)
28. [MHRA Serious and Severe Adverse Drug Reactions](#)

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## APPENDIX 1

### BEST PRACTICE GUIDANCE FOR PRESCRIPTION FORM SECURITY

1. **Develop a prescription security awareness culture.** Many health care staff, including doctors, nurses and other health professionals, are not aware of the potential dangers, cost implications and significant losses to the NHS that can arise from poor prescription form administration and security. Prescription forms in the wrong hands are blank cheques with an extremely high street value. A dedicated programme of education and awareness should be prepared and made available to all concerned, including prescribers of private prescriptions.

2. **All organisations should ensure that robust policies and procedures are in place to manage the effective security of prescription forms at a local level.** The security of prescription forms extends from the printing stage to the point of being handed to a legitimate patient. However, responsibility and ownership of the security function transfers with the forms. National standards should be followed and procedures and processes developed and introduced locally.

3. **All organisations should designate a member of staff to accept overall responsibility for overseeing the whole process involved – from the ordering, receipt, storage and transfer to the access to and overall security of prescriptions.** This person should be able to ensure appropriate security measures are implemented and maintained and they should undertake regular inspections of prescription administration and security. They should also complete regular stock checks.

4. **Orders received by NHS England area teams from GP practices should be checked against prescribers' current details and status and verified against the order.** All organisations should keep a full list of all of the prescribers employed by them and the items they can prescribe. Copies of prescribers' signatures should be held by the employing or contracting authority and individual prescribers should be willing to provide specimen signatures to pharmacists.

5. **Deliveries of prescription forms from the prescription form suppliers to NHS England area teams (or designated agency) must be thoroughly checked against delivery notes.** Two members of staff should always be in attendance when a delivery arrives, one of whom should always remain with the delivery vehicle. The delivery should be checked against the order and delivery note and only be signed for if the packaging is sealed and unbroken.

6. **Prescriptions must be transferred to a secure store immediately.** Best practice is for batches never to be left unattended and appropriate paperwork always to be checked.

7. **Irregularities at delivery stage must be reported immediately.** Any irregularities at delivery stage must be reported to the designated person through the local incident reporting system. The CDAO and LSMS and/or LCFS or nominated equivalents should be notified. In such circumstances, the delivery driver should be asked to remain on-site while the prescription form supplier is contacted to check the details of the delivery.

8. **Where loss or theft is suspected, the police should be informed immediately.** It may be necessary to circulate details via a fraud notice/security alert and for arrangements to be made for the prescriber in question to take agreed action in the 36 way subsequent forms are completed for the near future. The police controlled drugs liaison officer (CDLO) should also be notified.

9. **Two staff from the organisation should be in attendance when batches are being prepared for transfer to GP practices.** It is important that the established security measures are consistently adhered to.

10. **Delivery within NHS England and other organisations (e.g. to GP practices, nurse/pharmacist prescribers) should be by internal courier and only handed over against when signed for.**

11. **All organisations should adopt and implement similar security policies and procedures to those used by NHS England.** This is especially important in relation to the receipt and storage of prescription forms which should, as far as possible, always be done away from public/patient view.

**12. Prescribers who work in teams, e.g. nurses and health visitors, should restrict access to spare prescription pads to prescribing clinicians only.**

**13. Personalised prescription forms which are no longer in use should be securely destroyed, e.g. by shredding before putting into confidential waste.** The person who destroys the forms should make a record of the serial number of the forms destroyed. Ideally, the destruction of the forms should be witnessed by another member of staff.

**14. Patients, temporary staff and visitors should never be left alone with prescription forms or allowed into secure areas where forms are stored.**

**15. Frontline mobile staff should be warned of the potential dangers associated with carrying/leaving prescription forms in vehicles.** Mobile staff that carry prescription forms in the course of their duties should keep the forms secure. They should ideally keep forms on their person at all times or, if they must leave items in their vehicle, they should ensure that they are out of sight. Prescription pads should not be left in vehicles overnight.

**16. Spoiled or cancelled prescription forms should be retained for audit purposes.**

**17. Professional advice on general security management matters may be sought from the LSMS.** The LSMS is trained and accredited in the management of security within the NHS. Further information can be found at: [www.nhsbsa.nhs.uk/Protect.aspx](http://www.nhsbsa.nhs.uk/Protect.aspx)

**This guidance does not override the individual responsibility of health professionals to make decisions in exercising their clinical judgement in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer. For full prescribing information please refer to the BNF and SPC**