Improving the safety and quality of the GP practice repeat prescribing process

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Introduction

Repeat prescribing systems in general practice are recognised as an important area of risk and cause of medicines related safety incidents. The GMC Practice study recommends that strategies for reducing the prevalence of errors should include improving safety of systems in general practice. Repeat prescribing systems also represent an important cause of medicines waste.

Our work aimed to improve the safety and quality of the repeat prescribing process and reduce associated waste.

What did we do?

We developed a set of good practice repeat prescribing standards. These were evidence based and refined by a GP and practice pharmacist consensus group.

A key contentious standard was “non-clinical practice staff are not able to add new medications, or change repeat medicines (e.g. change in dose, formulation), with the exception of appliances, to the patients repeat prescribing list, even if the patient has had it before”.

Our Prescribing incentive scheme required practices to:

- Demonstrate Practice Repeat Prescribing Policy to meet agreed Surrey Downs CCG repeat prescribing policy standards, including the medicines reconciliation process

The practice pharmacist process mapped and reviewed the prescribing processes in all 33 practices in Surrey Downs. They worked collaboratively with their practice to facilitate improvements where needed.

What did we find?

- There was a wide variation in the quality of prescribing processes between practices
- Some practice processes contained significant risks such as allowing non-clinical staff to add and make amendments to patients’ medicines
- Following support from the practice pharmacist 31 practices (out of 33) met our good practice repeat prescribing standards.
- CCG growth in prescription items reduced

Next steps

The standards are being implemented in two local CCGs, and have been presented to the NHS England Primary Care Patient Safety Expert Group.