

Repeat prescribing audit

Introduction

It is estimated that about 70% of prescriptions are issued on a repeat basis, that is, issued to a patient on long-term therapy between review appointments without seeing a doctor. Systems and procedures for operating repeat prescription services vary greatly between different practices and even within practices for different patient groups or therapy groups. Often there is no standardisation within given areas.

Clearly this represents a high cost area of prescribing and can, without safeguards, cause strain on practices' drug budgets. Conversely, if managed properly, such systems can give savings of both financial and personnel resources, with long-term benefits to patient care and improved working relationships between healthcare professionals. It can also lead to an increased level of detection of adverse drug reactions, non-compliance by patients and possible drug-drug interactions.

Careful monitoring and management of repeat prescribing systems by the whole healthcare team can help this function operate smoothly to the benefit of both professional and patient.

Aspects for audit

1. Timeliness

A factor defining the efficiency of repeat prescribing systems is that it should enable any patient requiring repeat medication to obtain a prescription promptly – within 24 hours of requesting it. Evidence from a number of studies has shown that GPs agree that the period for processing requests should be 24 hours and that this is achievable. By conducting an audit of existing systems and their operation one can determine if this is being achieved in a practice. This clearly would ensure minimal inconvenience to patients.

2. Unwanted or returned medication

An indication of the effectiveness of repeat prescribing systems, and also of patient compliance, is the level of medicines unused or not accepted at the time of dispensing. Classic examples of this are where the asthma patient says: "I don't need the brown inhaler" or the elderly patient says: "Don't give me the painkillers - I've got plenty of them at home" and those sad occasions where relatives of deceased patients bring back carrier bags full of unused medicines. Many pharmacies now collect returned medicines for safe disposal, and they may be able to give the surgery feedback on such returns.

3. Clinical monitoring

Close monitoring of the prescriptions issued under such systems can lead to closer control of matters of clinical importance, for example the detection of unnecessarily high dosages or non-compliance by patients. Fewer errors would be made when generating repeat prescriptions and patients could expect a greater level of consistency.

4. Inequivalence

An aspect that could be tackled as a result of such an audit is that of inequivalence between the number of days' supply of different medicines issued at the same time. This can lead to stocks of unwanted, or "not yet needed" items in the home which could lead to problems such as out-of-date medicines being taken, or inadvertent doubling of doses. Addressing this issue could have a major role in preventing accidental poisoning.

5. Prescriptions with ambiguous or missing directions

Many elderly patients have difficulty remembering exactly how to take their medications. This is compounded when the patient is taking several medications. It is widely recognised that reinforcing verbal information with written information improves understanding.

The instructions on the label of the medicine bottle act as a daily reminder to the patient and will aid compliance. The absence of precise instructions on the prescription robs the patient of this daily reminder.

Ambiguous directions with no indication of dose or how often to take the medication can be similarly confusing.

An audit of prescriptions with missing or ambiguous directions will identify how big a problem this is and what the community pharmacist does to improve understanding.

6. Drugs liable to dependence or abuse

An area that could usefully be audited is the supply of medicines liable to abuse or liable to cause dependence. Benzodiazepines and opioid analgesics are often authorised for repeats and, despite accepted guidelines for their prescribing, can often be repeated for too long a period of time or at too great a frequency. Tighter control on the issue of such prescriptions and greater vigilance by all will help to reduce the incidence of abuse or dependence.

Benefits

Benefits for the patient

- fast, accurate and efficient system for repeat prescriptions
- prescriptions only issued for those items required
- potentially fewer trips to the surgery and the pharmacy
- improved understanding of medication

Benefits for healthcare professionals

- fewer errors, saving time in putting them right
- wider professional input from all professionals
- increased level of clinical input
- reduced level of wastage/hoarding of unwanted medicines with knock-on effects on drug budgets
- identification of over/under use of medications
- compliance with *Patients' Charter*/local targets

Criteria and standards

Criteria

The criteria used for the purposes of the audit can be based on local or national guidelines. They should be agreed by all participants and whilst they should allow prompt issue of prescriptions, they should not place

undue pressure on staff. Nor should they result in lack of control over the issue of prescriptions.

The criteria employed could be split into three distinct groups:

- functional -who does what, when, how, with what safeguards/checks and how long will it take
- administrative -what documentation will be provided to authorise repeats and to record the issue of repeats, inequivalence
- clinical - such as the reporting of possible ADR s or drug-drug interactions, monitoring of the patient's condition, medication reviews, compliance, missing or ambiguous directions

The criteria should be quite specific and should seek to engender a commitment from the team. For example a criterion statement of "all requests for repeat prescriptions will be processed promptly" is open to a range of interpretations, whereas "requests for repeat prescriptions will be processed within 24 hours of request" will represent a greater commitment to patient service.

It would be wise, when defining the criteria, to consider the practice policy on issuing repeat prescriptions for certain groups of medication, such as benzodiazepines or those medicines with a "prn" dosage. For example, should temazepam be allowed for repeats, and if so, for how many repeats between reviews? Should coproxamol "i-ii qds pm ; m.100" " be allowed to be repeated as frequently or more frequently than other items without a check on quantities held or on repeats already issued?

Standards

As with the criteria adopted, the standards should reflect national and local targets and accepted best practices. These standards should then be agreed by the team.

Data collection

Once the criteria and standards have been agreed, the team must devise a suitable means for collecting data in order to match performance with those standards. There will have to be two different forms in use, those for use by GPs and their surgery staff and those for use –at the

pharmacy. In both situations, someone must be given the responsibility for compiling the data in a summarised form for later analysis. Surgery staff could look at how quickly repeat requests are dealt with by logging in the time when a repeat request is received and the time the repeat prescription was available for collection. Other things that may be recorded include the time between requests for specified drugs (such as benzodiazepines, opioid analgesics), the frequency with which prescriptions for wrong items are issued, the frequency of handing-out errors (such as Mrs J Smith is given Mrs G Smith's prescription) and the number of requests received after the specified review date. All of these will require data collection forms which will be able to capture the information required to give a full picture of what is happening.

The pharmacy staff will have different information to record. For example, they will be better placed to spot an inequivalent number of days' supply on prescriptions or prescriptions with missing or ambiguous directions. They can also record instances where patients say they do not require certain items as they have been discontinued or because the patient already has a supply; or where non-compliance is suspected. Potential drug-drug interactions can be highlighted. The pharmacy can record instances of items being wrongly issued on repeat prescriptions. These should be reported as they come to light but should also be reported with all other summaries of information collected.

Below and over the page are examples of two data collection forms used in auditing inequivalence and ambiguous/missing directions.

Audit data collection sheet

Ambiguous/missing directions

Please record all prescriptions with ambiguous or missing directions and the action taken to clarify the prescription

The codes to use for the source of the information about dosage are as follows:

G	= GP	S	= Standard dose
R	= Receptionist	H	= Hospital
P	= Patient	N	= Not done
C	= Carer	PMR	= Patient medication record

Date	Name	Prescriber	Drug	Source	Time taken	Comments

Inequivalence

Please record all prescriptions with inequivalent quantities on them.

Date	Name	Prescriber	Items on prescription	Required by patient (Yes/No)

Duration of audit

The length of time for which the audit is conducted will depend on a number of factors (for instance: how many different areas are to be investigated, the workload of the surgery and pharmacy). If several aspects are to be reviewed, perhaps a short audit should be considered. If, on the other hand, just one area is to be considered, the audit could be carried out over a calendar month or more. The main thing to remember is that the audit should be both manageable and meaningful.

Analysis of the data

In order to analyse the data they must be carefully looked at to ensure that they are complete and have been correctly recorded. Any situations that may have arisen during the data collection that may have influenced the result, such as staff absence, must also be considered. Possible inconsistencies in data recording must be pinpointed and attempts must be made to identify and eliminate, or allow for, such inconsistencies.

Once the data have been scrutinised for accuracy, they must then be looked at to identify what they actually mean. Identifying trends is a good way to do

this. For instance, do fewer repeat requests get processed within 24 hours on a particular day of the week? This may point to a need for more reception staff at certain times.

The point of such analysis is to determine whether current performance is within the standards previously identified and to indicate areas where improvements need to be made. Once these improvements have been pinpointed, the team must put them into operation.

Making the change

The changes in operation must be agreed in full consultation with every member of the team before implementation. A timetable for change must be given, with target objectives set within the agreed timescale. It is important that any changes in operational practices that may have an effect on patient services should be communicated to the patient.

When to re-audit

Set a date after which changes may be expected to be evident, for example, one year later.