

Guidelines on the recording of non GP prescribed medications on GP clinical systems

Background

There are a number of medications which are prescribed and/or supplied directly to patients by other parties outside of the GP practice. Typically these include specialist drugs prescribed by secondary care only e.g. RED drugs, addiction/alcohol services, clozapine or dementia drugs. There are also financial implications for CCGs since some specialised treatments are commissioned by and hence the financial responsibility of NHS England. If such a drug is prescribed by the GP, then this would be an additional cost and a financial risk to the CCG.

This poses a challenge in Primary Care to ensure that all clinical staff are aware of the patient's current medication prescribed elsewhere when:-

- making clinical decisions.
- avoiding interactions or other risks when new medication is prescribed.
- providing a comprehensive drug history to hospitals/units on admission (medicines reconciliation).
- recognising any adverse events associated with the non GP medication and taking appropriate actions.

There have been recent patient safety incidents due to this issue. It is therefore of paramount importance that GP practices have a record of these medications on their clinical system for governance purposes but do not inadvertently issue prescriptions for them.

This guidance aims to provide advice on how non-practice medications can be recorded in the patient's clinical records on each of the GP clinical systems (depending on the functionality) and highlights the associated advantages and limitations/risks. Unfortunately, currently none of the clinical systems have a robust and fully appropriate functionality in place.

SystemOne

The SystemOne clinical system has the facility to record non-practice medication prescribed elsewhere (not within the GP Practice) on the patient's clinical record.

Advantages

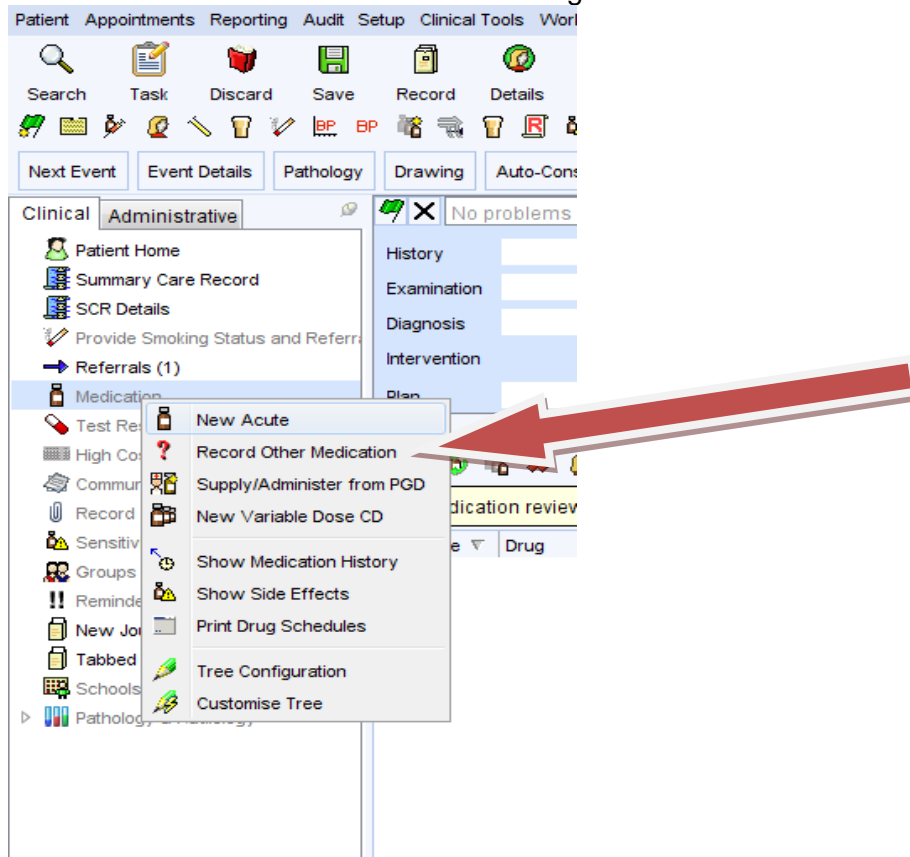
- The system will flag up potential interactions when a drug treatment is subsequently prescribed that interacts with the non-practice medication. Please note that interactions with patient's current medication will not be highlighted at the point of recording the non Practice medication but may be flagged when other medicines are prescribed later.
- The prescription **cannot** be inadvertently issued when recorded in this way.
- The non GP medication will not be printed on the right-hand side of the repeat prescription ensuring that the patient will not be able to order a repeat prescription for this non-practice medication from their repeat slip.

Disadvantages

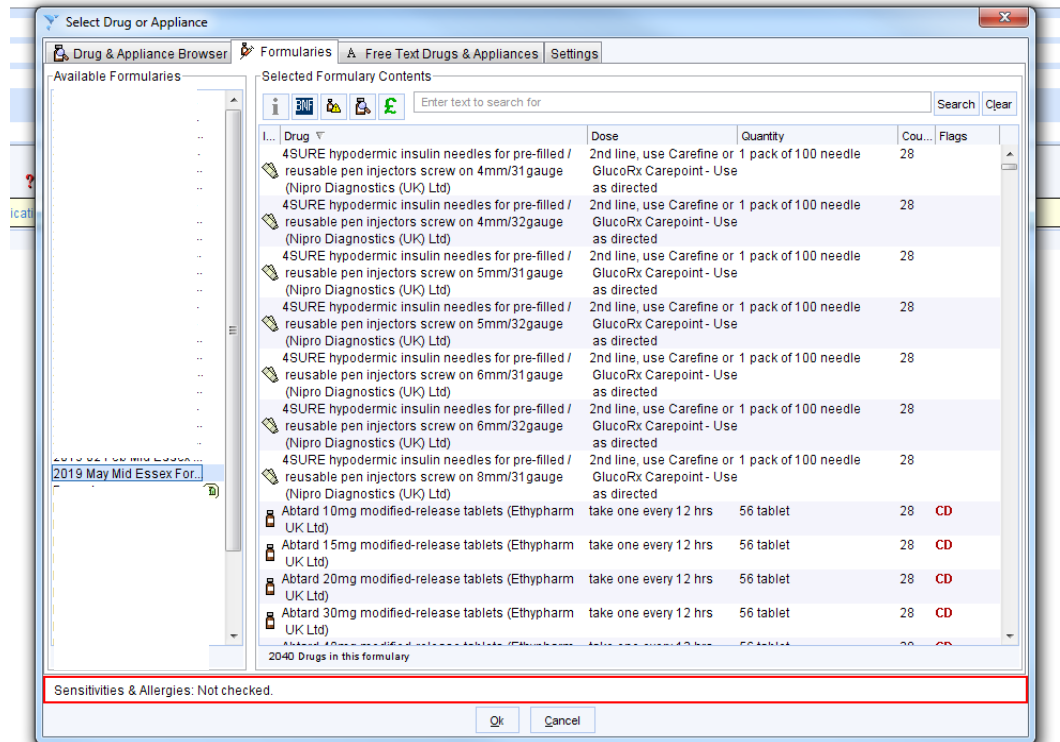
- Repeat slips are commonly used for medicines reconciliation when patients are admitted into hospital. As non-practice medication does not show on the slip it poses a risk that the hospital will be unaware of other medications the patient may be taking. This risk can be minimised by printing off the Summary Care Record. The non-practice medication will be displayed in a separate '**Current acute medication**' section after the '**Current repeat templates**' section and will be flagged with '**H**' for hospital ie non-practice supply

Procedure

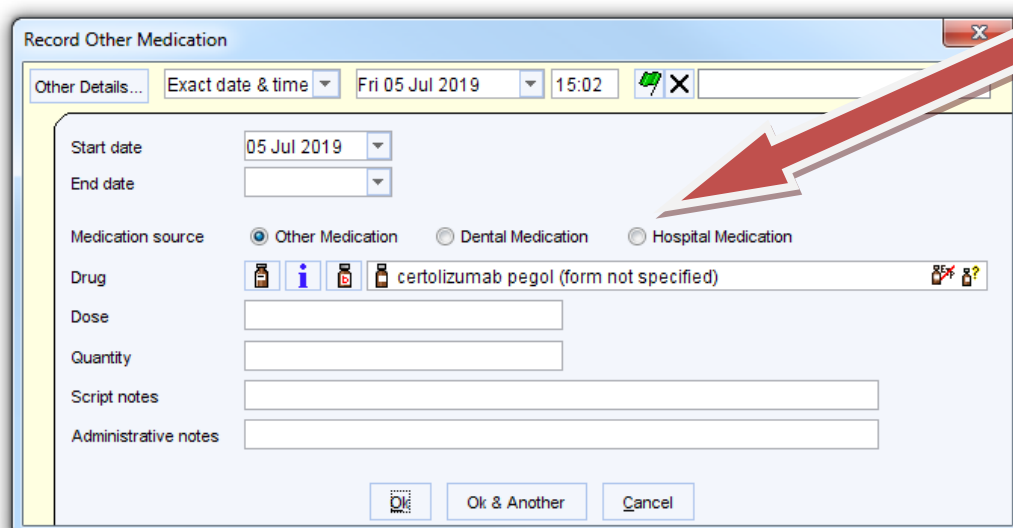
1. Go to '**Medication**' on Clinical Tree – right click and select '**Record Other Medication**'



2. A new prescribing screen window, 'Select Drug or Appliance', will open



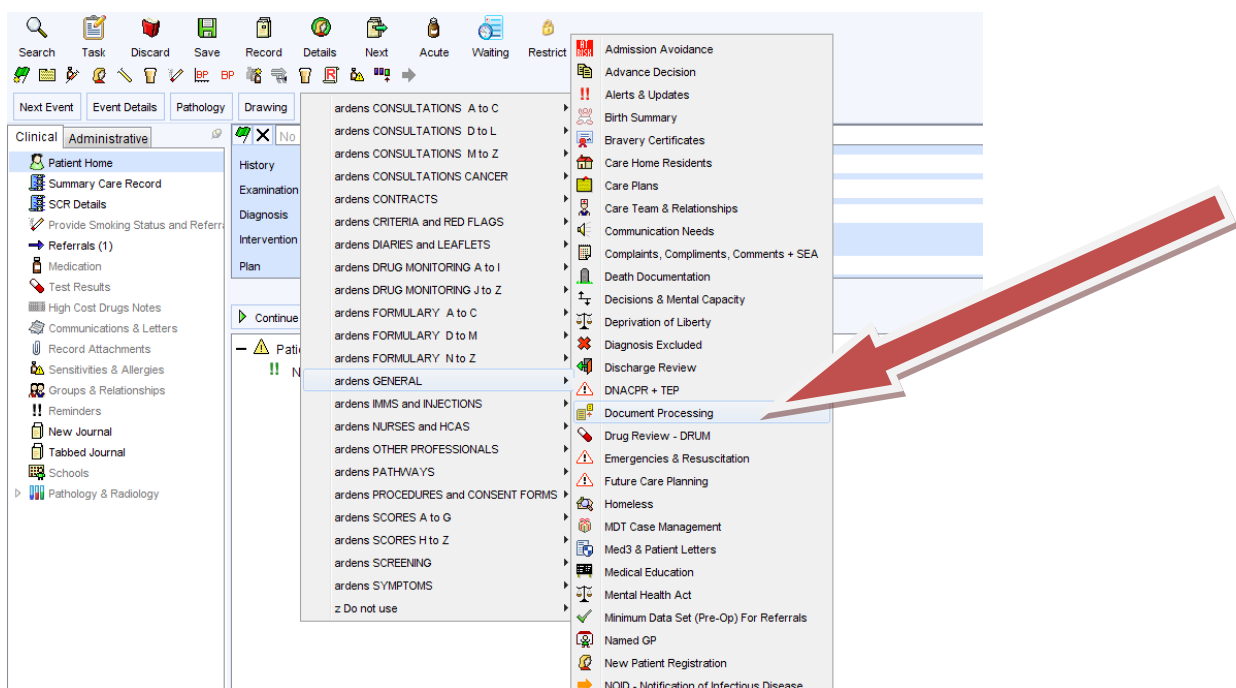
3. Search for the medication and select the appropriate drug
4. A new window, 'Record Other Medication', will open



5. Under 'Medication Source' select 'Hospital Medication' or one of the other options if that is more appropriate.

6. Complete details of the drug, i.e. Dose, Frequency and Quantity given.
7. You may wish to add notes such as 'HOSPITAL SUPPLIED – NOT TO BE PRESCRIBED BY GP' in the script note section as these are visible on the prescription while administrative notes aren't.
8. Click "OK".
9. Add the snomed code 394995008 or the read code Xalng with any comments you wish to add to the patient notes.
10. Save the patient record.

You may find it helpful to use ARDENS templates if reconciling medication – the following template – Document Processing - can help (see also Transfer of Care SOP – MECCG)



EMIS web

The EMIS Web clinical system has the facility to record non-practice medication prescribed elsewhere (not the GP) on the patient's clinical record using the 'Hospital (No Print)' function.

Advantages

- This will enable the non-practice drug to be placed in a different 'Hospital' section of the medication screen separate to the other regular medication prescribed by the GP.
- The system will flag up potential drug interactions for subsequently prescribed drugs when non-practice medication is recorded in this way.
- When '**Acute**' Rx type is selected, the non-practice medication will not be printed on the right-hand side of the repeat prescription ensuring the patient will not be able to order a repeat prescription from their repeat slip.

Disadvantages

- This function still allows the prescriber to print off a prescription and does not prevent the inadvertent issuing of a prescription. Therefore it is essential that dosage field contains the information regarding where the medication is to be supplied from and that it should not be issued by the GP, e.g. "HOSPITAL PRESCRIBING ONLY-DO NOT ISSUE"
- When '**Repeat**' Rx type is selected, the non-practice medication will be printed on the right-hand side of the repeat prescription. This may be helpful for medicines reconciliation but poses the risk of the drug being inadvertently ordered.
- Repeat slips are commonly used for medicines reconciliation when patients are admitted into hospital. Where non-practice medication is not shown on the slip it poses a risk that the hospital will be unaware of other medications the patient may be taking. This risk can be minimised by printing off the Summary Care Record or medication summary. Non-practice medication is not displayed in a separate section but will be displayed according whether it is a repeat or acute.

Procedure

1. Open '**Medication**' tab.
2. Select '**Add Drug**' icon and enter drug details.
3. Complete the other required details of the non-practice drug:
 - '**Dose**': SUPPLIED BY HOSPITAL – NOT TO BE ISSUED BY GP
 - '**Quantity**': *Enter lowest possible quantity possible e.g. 1 tablet or 1ml*
 - '**Rx Types**': Select '**Acute**' or '**Repeat**'
4. Select '**Issue**'. This will open another window. Go to the '**Change All**' tab and select '**Hospital (No Print)**' from the drop down menu.
5. Then click on '**Approve and complete**'. The non-practice drug will now be displayed in a different section of the medication screen to the other GP prescribed medications.

6. If the GP inadvertently tries to issue the non-practice drug, a warning will appear in the **'Approve and Complete'** print box stating it was **'Issued by hospital'**. This warning can be overridden and therefore there is still the potential risk to issue this prescription in error. Therefore it is essential that the information statement regarding the non-practice supply is added to the dosage field.
7. Add the snomed code 394995008 or the read code 8B2D with any comments you wish to add to the patient notes.
8. Save the patient record.

Vision

The INPS Vision clinical system has the facility to record medication prescribed elsewhere (not the GP) on the patient's clinical record.

Advantages

- The system will flag up potential drug interactions.
- The prescription cannot be inadvertently issued when recorded in this way.
- The non GP medication is not printed on the right-side of the repeat prescription ensuring the patient cannot order a repeat prescription from their repeat slip.
- The non GP medication will not be routinely displayed on the '**Repeats**' screen. The '**inactive filter**' will need to be turned off to show the non-practice medication – refer to points 7 and 8 below.

Disadvantages

- Repeat slips are commonly used for medicines reconciliation when patients are admitted into hospital. Where non-practice medication is not shown on the slip it poses a risk that the hospital will be unaware of other medications the patient may be taking. This risk can be minimised by printing off the Summary Care Record or medication summary.

Procedure

1. Open '**Therapy**' tab and add repeat item.
2. Go to the '**Source of Drug**' field and click on for the drop down menu and select '**By Hospital**'
3. Enter the drug name and in the drug '**Dosage**' field indicate the source of supply of the non-practice drug. E.g. 'HOSPITAL SUPPLIED – NOT TO BE PRESCRIBED BY GP' or PRESCRIBED BY HPFT DEMENTIA CLINIC – NOT TO BE ISSUED BY THE GP
4. A value must be entered in the '**Repeats**' field to save the record. Enter '1' since a prescription cannot be issued when the '**By Hospital**' option has been selected.
5. You will notice that the prescriber box is now inactive. Click '**OK**'.
6. The entry is given bowtie icon and stored under the inactive repeats and cannot be printed.
7. The default setting is to filter inactive items not to show and so non-practice items will not be routinely shown on the '**Repeats**' screen. The clinical system will still flag up potential interactions even though the item cannot be seen on this screen.
8. To see non-practice items, the filter will need to be switched off.
9. Add the snomed code 394995008 or the read code 8B2D with any comments you wish to add to the patient notes.
10. Save the patient record.

Useful Links / Resources / References

- [Transfer of Care Standard Operating Procedure](#) – MECCG General Prescribing Guidance, Jan 2019
- [Transfer of Care Webkit](#) – PresQIPP
- [Medicines optimization: the safe and effective use of medicines to enable the best possible outcomes](#) – NICE, March 2015
- [Transition between inpatient hospital settings and community or care home settings for adults with social care needs](#) – NICE, December 2015
- [Keeping patients safe when they transfer between care providers – getting the medicines right](#) – Royal Pharmaceutical Society, July 2012
- [Emergency and acute medical care in over 16s: statement 4](#) – NICE, September 2018

Title	Guidelines on the recording of non GP prescribed medications on GP clinical systems
Document reference	RecordingNonGPMedsGUI201907V2.0FINAL
Author	Mid Essex CCG Medicines Optimisation Team
Reference:	Adapted with kind permission from Herts Valley CCG guideline “Guidance on recording non-practice medications prescribed by other parties (not the GP) on GP clinical systems” issued May 2014
Approved by	Virtual approval – Medicines Optimisation Group
Date approved	July 2019
Next review date	July 2022

Previous version	Key Changes
N/A	New document
February 2015	Minor format edit; addition of screenshots; inclusion of ARDENS & references