Repeat Prescribing Policy

MCNZ '**Make the care of patients your first concern**. You should only prescribe medicines or treatment when you have adequately assessed the patient's condition, and/or have adequate knowledge of the patient's condition and are therefore satisfied that the medicines or treatment are in the patient's best interests'

Relates to Prescribing Policy, Medication Reconciliation Policy, Prescribing of Harmful Drugs Policy,

Key stakeholders - Patients; Carers and Families; GP/NP and Nurse Prescribers; Nurses; Reception; Pharmacy

Key Principles

- ***quick yes, slow no (or soft no)*** we want it to be simple for patients to access repeat prescriptions, (reducing risk of interruption to important medication) maintaining an important narrative that we are an accessible and responsive service, here to help.
- ***repeat prescriptions are requests (not demands)*** it is our duty to prescribe where clinically appropriate safe, this policy should help guide this. We use clinical judgement to balance patient requests with best practice and standards of safe prescribing (remembering the duty and responsibility we carry as prescribers).
- ***we can manage expectations*** - clear communication with patients, amongst ourselves and in the medical record will help set shared expectations and keep this process as smooth as possible.

Key Values – **Best Practice, Clear Communication and Care with Compassion**

Repeat prescriptions will be processed and sent to pharmacy within business days (within 48hrs)
Urgent requests will be processed same or next business day (within 24hrs)

Patients are central to this process. Remember pressures on patients include financial, pressures of time, simply forgetting … they don't always come to us at their best. We can help manage the workflow by being consistent, clear and helpful. **Prescribers** in particular can please explain to patient when they next need to be seen, and document this in the clinical record.

Possible 4 outcomes from a repeat prescription request

- **Script generated for 3 months**
- **Script generated with instruction for patient action by time of next script**
- **Script generated for 1 month with instruction for pt action by time of next script**
- **Script declined with request for appointment**

Examples of types of action that might be required;

- **BP check / WT**
- **Bloods (draw up form)**
- **Consult required for next script (phone or in-person)**
- **Book for nurse Asthma, COPD, COCP, Heart or Diabetes review**

Request for repeat prescriptions may come;

- **via Reception / Nurse in-person or phone?**
- **via Reception email**
- **via Patient Portal**

Reception / Nurse – gather as much info as practically possible to help prescribers help the patient.

- Enquire of the patient, when did you last see the GP/NP? When did GP/NP say they would like to see you next? (phone or in-person)
- Encourage patients to detail which specific medications they are requesting. If the patient says 'same as last time', have there been any changes to medication in that time?
- Use your best judgement, if on balance you think the patient is likely to need review then book an appointment. If on discussion patient would prefer repeat prescription advise you will task the Prescriber team as below .

Reception / Nurse – create prescription request and allocate task to prescriber in Prescriber Tasks (if possible, to the Prescriber who saw them last) and add to appointment pad.

Prescriber – attend to script requests by the end of each am and pm surgery (reception are managing patients expectation of the 24/48 hr turnaround time). Same for scripts coming via Patient Portal.

- Open notes, check last consult. Is there any outstanding clinical instruction in last consult?
- Are relevant screening information / blood tests up to date?
- Are there any outstanding tasks or recalls that need attention?
- If script request arrived via Patient Portal please add to appt pad for reception to action and invoice

Prescriber – if in your clinical judgement you are satisfied prescription is appropriate please complete script as per best practice.

If Te Kauwhata Pharmacy annotate on pad 'scpt TKP'

If another Pharmacy send via NZePS and annotate on pad 'scpt sent'

- If screening such as BP or bloods or further action are also required please add instruction for action to notes and annotate pad.
- If you judge patient requires review before 3 months please do one month of meds with instruction for prescriber appt before next script – this allows time for the patient to book appt without stress or interruption to their medication.
- If on notes review action from last time has not been completed please issue one month of meds with clear instruction in notes **(make it bold)** on appt pad and task reception.
- If you deem it clinically unsafe please write clear instruction in notes **(make it bold)** advise reception on appt pad and via task that the patient must have clinical review.

Reception / Nurse – communicate to patient script completion, invoice and any clinical action if required**. Options include email, phone, text, patient portal, post-it on the script.** Tailor the means to the patient.

Rules of thumb

"If patient has not been seen for 6 months or requests more than 6 meds they will probably need prescriber review"

Levothyroxine – annual TSH/T4 and annual phone consult

Statin – primary prevention, check LDL near / at target, phone consult 1-2 years

NSAID – annual review discussion of harms, BP, renal blds

PPI – annual consult documenting ongoing indication and discussion to stop

Salbutamol – requires pause and consideration SMART in asthma / LAMA in COPD

Inhalers – annual Asthma / COPD review, more if exacerbations or if elevated ACT/CAT score

SSRI – long-term and stable, recommend consult 6-9 monthly, mental wellbeing and ongoing indication

Lithium – if stable 6 monthly bloods and consult, otherwise 3 monthly

BZD – if stable 6 monthly consult, documenting harms aim for reduction

Opiate – if stable 3 monthly consult, reviewing. If concern for monthly review.

DMARD – regular bloods, 3/6 monthly consult depending on shared care model

Hypertension – single / double agent, BP check every 6-9 months, is it to target? and annual CV bloods

IHD, stable – 6 monthly consult and annual CV bloods

CCF stable – 3-6 monthly consult

Diabetes – tablets recommend 3 monthly bloods and review, 6 monthly review if to target and stable

Diabetes – insulin recommend 3 monthly bloods and review, 6 monthly review if to target and stable

COCP – 6-12 monthly depending on risk, should have dedicated pill consult annually

POP – can have annual consult

Bisphosphonate – annual review and bloods

Polypharmacy – 6 or more meds recommend 3 monthly consult unless prescriber makes explicit otherwise

Patients clinically unstable – will often require monthly review until stable enough to return to 3/6 monthly prescribing