Guidance on recording medications prescribed by other parties on GP clinical systems

Background

Medications may be prescribed and/or supplied directly to the patient by other parties outside of the GP practice. Typically, these include specialist medicines prescribed by secondary or tertiary care only, including RED medicines such as biologics (e.g., etanercept, adalimumab) or medicines used in addiction/alcohol services. These items may be dispensed via a hospital pharmacy department, community pharmacies via FP10HPs issued by a hospital or via homecare arrangements (prescribed by the hospital and delivered directly to the patient).

This poses a challenge to 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 medication history to hospitals/units on admission (medicines reconciliation), maintaining up to date summary care record.
- Recognising any adverse events associated with the non-practice medication and taking appropriate actions.

Examples of patient safety incidents where a medication was initiated by a prescriber outside primary care include,
- Tacrolimus interacting with certain antibiotics and resulting in hospital admissions,
- Depot antipsychotic injections or clozapine prescribed by a mental health Trust that were not recorded on the GP clinical system.

It is of paramount importance that GP practices have a record of these medications on their clinical system for safety and governance purposes, but do not inadvertently issue prescriptions for them.

This guidance aims to provide advice on how medications not prescribed in GP Practice 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.

INSTRUCTIONS FOR ADDING NON-PRACTICE DRUGS TO GP CLINICAL SYSTEMS:

On SystmOne we recommend you record the medication as 'Other Medication'. By recording as 'Other medication' this allows these medications to be merged into care home visits print outs and also the medications will be visible in the Summary Care Record.

Points to note when adding as 'other medication':

- 'Other medication' is not always easily visible on the medication's screens. If you chose to 'Hide This' section showing 'Other Medication', when you click to view it again it does not always expand properly to allow visibility again without dragging the blue bar up the screen.
- Items added as 'other medication' are not always easily identified by a clinical report.
- 'Other medication' may not merge into referral letters and letters and clinicians should check that they have been added if appropriate.
- The medication will only be displayed on the Summary Care Record for 12 months from the date of issue and will need to be re-added if appropriate after this time.

Record as 'Record other medication'

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

Process:

1. Use read code **XaIng** (hospital prescription) to document that the patient has a hospital prescription.

2. Go to '**Medication'** on the Clinical Tree – right click and select **'? Record Other Medication'**
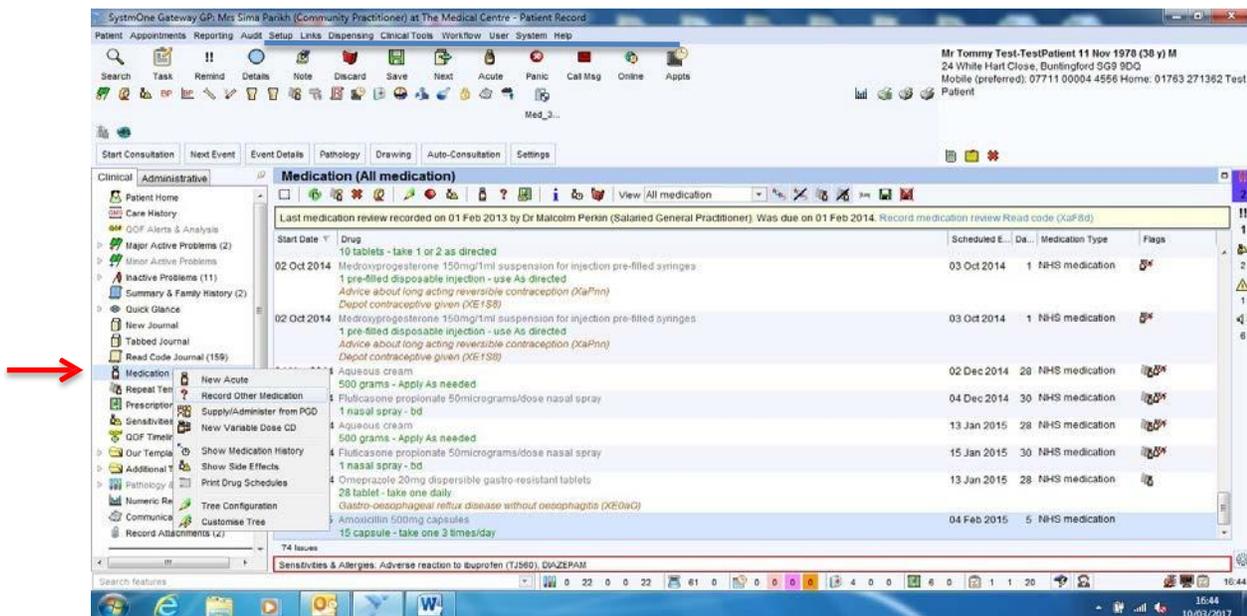
3. A new prescribing screen window, **'Select Drug or Appliance'**, will open.

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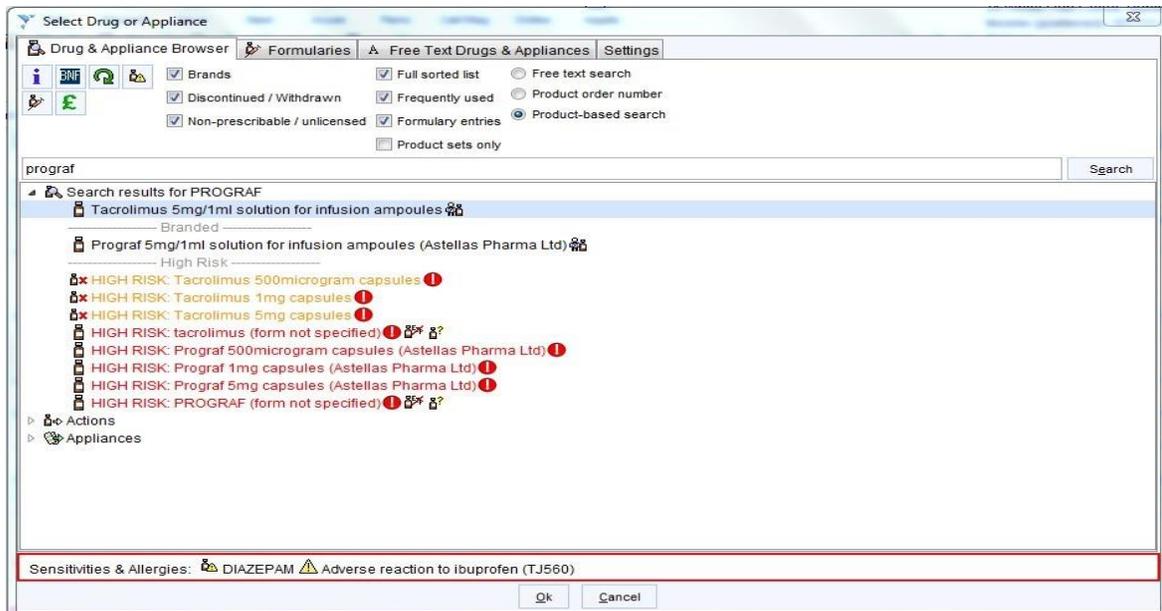
5. A new window, **'Record Other Medication',** will open.

6. Under '**Medication Source'** select '**Hospital Medication'** Complete the details of the drug.

7. In the '**dose'** field enter relevant text e.g. 'HOSPITAL SUPPLIED – NOT TO BE PRESCRIBED BY GP' or 'PRESCRIBED BY HPFT– NOT GP'. ***This information is essential to warn the patient / dispensing pharmacist in the event a prescription is issued by mistake.***

8. In the **'quantity'** field enter zero. If this is not possible enter the lowest possible quantity e.g., 1 tablet / 1ml.

9. In the '**Script notes'** enter details of who is responsible for prescribing e.g., hospital and consultant.

10. **Administrative notes** can also be used to record details such as per clinic letter including date of clinic letter.

11. Click on **'OK'** and **'Save Patient.**

12. The medication will be recorded under current medication.

13. The medication **will not** be on the patient's repeat template but will appear at the bottom of the repeat template screen as shown below. Click *"Click here to view 1 'other' medication"* to display details of the medication.

14. When required (for example when conducting an annual review) clicking on the box view 1'other' medication (as shown below) would show the medication that was prescribed by other parties (Not primary care staff).

15. If there are a lot of Repeat Templates this window may be hidden in which case, click on pale yellow banner at the bottom of the screen where it says **Click here to view 1 other medication**

16. It may be necessary to **resize** the **Repeat Template** window to see the details of **Other Medication** by dragging the lower edge of the Template Details upwards**:**
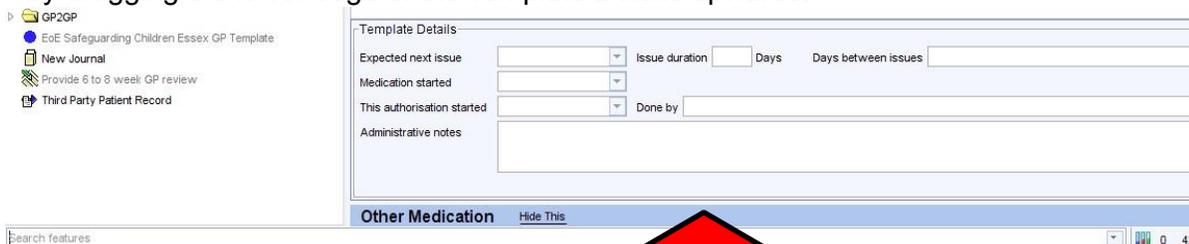
Drag upwards to reveal

EMIS Web

Record as 'Hospital only' medication

The EMIS Web clinical system has the facility to record non-practice medication prescribed elsewhere (not by the GP) on the patient's clinical record using the 'Hospital (No Print)' function.
- 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.
- Unfortunately, however, this function still allows the prescriber to print off a prescription and does not prevent the inadvertent issuing of a prescription however the system does alert the prescriber with a warning appearing in the **'Approve and Complete'** print box stating it was **'Issued by hospital'**. This warning can however be overridden **therefore, it is <u>essential</u> that the dosage field contains information regarding where the medication is to be supplied from and that it should not be issued by the GP.**
- It is advised that a medication summary is printed off and sent to the hospital following an admission or used for a home visit, since this will include the non-practice medication. However, the non-practice medication will not be displayed in a separate section but will be displayed according to whether it is a repeat or acute. This can be done by selecting summary from the patient record and then selecting print and then brief summary from the drop-down menu.

Process:

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.
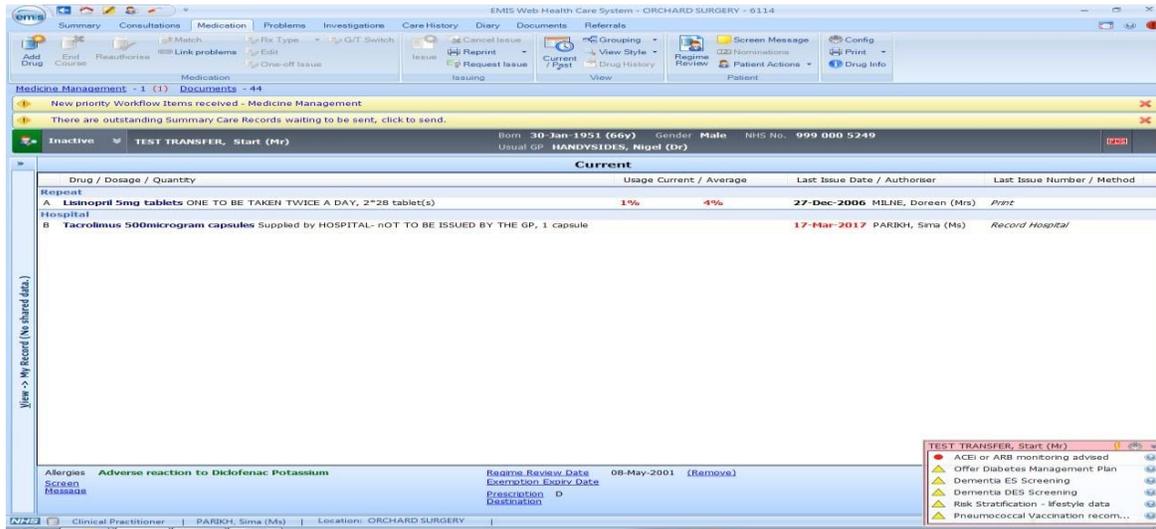
6. If the GP inadvertently tries to issue the non-practice drug, a warning will appear in the **'Approve and Complete'** print box stating it was **'Issued by hospital'**. This warning can be overridden and thus there is still the potential risk to issue this prescription in error. Therefore, it is essential that the information statement regarding the non-practice supply is added to the dosage field.

7. The non-practice medication will <u>not</u> 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. However, this also poses a risk in that repeat slips are commonly used for medicines reconciliation when patients are admitted into hospital. Therefore, this does not provide information on the non-practice medication that the patient is also taking.

References

- Recording Hospital/ Other Medications -Ardens 2021 Recording Hospital / Other Medications : Ardens SystmOne

- Recording medicines prescribed elsewhere into the GP Practice Record – NHS England Last edited: 12 February 2024 Recording medicines prescribed elsewhere into the GP practice record - NHS Digital

- Rotherham CCG Recording Non-Practice (e.g Hospital Only) medicines on GP Clinical Systems -July 2020 CCG-Recording-Non-Practice-Drugs-Final-1.pdf (yourhealthrotherham.co.uk)

- Surry Heartlands Health and Care Partnership –Advice on Recording Medicines Prescribed by Teams Other than the Primary Care Team on General Practice Clinical System August 2023 https://surreyccg.res-systems.net/PAD//Content/Documents/2/Advice%20on%20recording%20medicines%20prescribed%20by%20teams%20other%20than%20the%20Primary%20Care%20Team%20on%20General%20Practice%20systemUpdate%20Nov%202023.pdf

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