Information leaflet for patients of Fairfield Park Health Centre regarding changes to prescriptions

On Thursday 24th March 2016, the Practice had a meeting with GPs, Nurses, Managers, Reception and Administration staff to look at our prescribing processes. The purpose of this meeting was to enable us to understand how the whole system works, to identify areas where problems or errors may occur, to standardise our procedures and to improve the processes. In order to conduct a full review we used a process mapping method. This is where we map out all stages of the process from when the prescription request is received to the point where it is dispensed by the Pharmacy. The benefits of using this method is that everybody acquires an understanding of the whole process, not just the part in which they are actively involved, it identifies areas where there may be different processes used by different people, and easily identifies where problems may arise. We also used information from patient complaints and significant adverse events* regarding prescriptions to help to understand where errors can occur.

We receive requests for prescriptions from a variety of sources:

- Written requests hand delivered to the Practice by the patient or carer
- Written requests received via post from the patient or carer
- Written requests hand delivered to the Practice from Pharmacies on behalf of the patient
- Written requests received via fax from Pharmacies on behalf of the patient
- Electronic requests from Patients
- Acute prescriptions issued by GPs and Nurses during consultations

Different processes are used to issue and authorise these prescriptions, depending on a number of factors, e.g. where the request has originated, whether or not the requested medication is listed in the patient's repeat medications, whether the repeat medication has been reviewed and authorised by a prescribing clinician within the last 6 months etc.

We also identified that it is often difficult to establish an audit trail for paper prescriptions, i.e. we can identify whether or not it has been printed off but may not be able to identify whether or not it has been authorised and/or signed by a GP (or which GP it has been given to for authorisation). We identified a number of potential areas where errors may occur, for instance:

- Where Receptionists are unable to print off some medications, e.g. if they need to be reviewed, a card is included with a note to highlight to the GP that an addition is required to the medications printed on the prescription. These can sometimes be separated from the prescription, or overlooked.
- Prescriptions filed for collection by patients at reception can sometimes accidentally be given to the wrong patient, e.g. patients with similar names, which could be a serious breach of confidentiality.

- There have been occasions when patients have lost their paper prescriptions outside the Practice. Again, this is a possible confidentiality issue as well as causing delays for the patients.
- Sometimes, when a patient has queried where their prescription is, it is not always easy to identify where it is in our system.
- Paper prescriptions can sometimes be misplaced, lost, misfiled etc. This can lead to potential complications for patients who may miss, or be delayed in receiving, their medication.

After extensive discussion with the whole team we agreed that it would be simpler, safer and more efficient if we standardised our procedures more so that there are not multiple options for processing prescriptions. We also agreed that it is essential to have a clear audit trail so that we can identify exactly where a prescription is in the process, who has done what with it and when so that we can identify and address any problems, delays etc. promptly and accurately. The electronic processing of prescriptions is the only reliable process we have available to us that meets all of these criteria. Consequently, we decided that we would initiate a process whereby, from a specified date, we would cease to issue paper prescriptions and would send all prescriptions electronically, directly to the Pharmacy of the patient's choice. In order to allow us sufficient time to inform our patients, and for them to nominate a preferred Pharmacy, we agreed to begin implementing this new process form 1st June 2016.

Where a patient has not notified us of which Pharmacy they wish their prescriptions to be sent to, we agreed to nominate the Well Pharmacy in Claremont Terrace as the default Pharmacy until such time as the patient notifies us of an alternative preferred Pharmacy (this decision was based purely on convenience for the patient as this is the closest Pharmacy to the Practice). A number of local Pharmacies also provide a repeat ordering and/or home delivery service so patients who are less mobile or housebound could nominate one of these Pharmacies.

Ideally, it would be best if patients could be encouraged to register for, and use, the online appointment booking and prescription requesting service. However, it was recognised that many patients may not be able, or would prefer not, to use this service so it was agreed to continue to offer patients the same options as currently used for requesting repeat prescriptions.

*Definition of significant adverse events

An incident, arising from normal practice, processes and/or procedures, which has, or could have, led to a significant adverse outcome for patients, staff, or the general public. All significant adverse events should be reported and investigated and discussed at a whole team meeting to determine the root causes of the incident and to identify actions to reduce the likelihood of recurrence of the incident.