NHS
Luton
Clinical Commissioning Group

SAFETY CONCERNS RELATING TO COMMUNITY PHARMACY REPEAT ORDERING OF PRESCRIPTIONS

Richard A Jones
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This paper highlights patient safety and quality issues associated with community pharmacy repeat ordering service.

Definitions

Community Pharmacy Repeat Prescription Ordering Service where the community pharmacy orders a patient's medicine from their GP surgery. Community pharmacy ordered repeat prescriptions can be divided into two main types;

Automatically Ordered Repeats Service that is ordered by community pharmacy without timely prompt from patient or carer (7-10 days before prescription needed).

Patient Requested Repeat Service that is where any repeat ordered by community pharmacy is at the timely request of patient or carer (7-10days before prescription needed).

Problems identified

An audit carried out by Medicines Optimisation between October 2013 and January 2014 on repeat medicines showed significant safety and waste issues (approximate £2M to £3M per annum). The audit showed that the great majority of safety and waste issues are associated with pharmacies operating automatically repeat ordering services.

Patient safety issues resulting from automatic ordering:

Discontinued medicines

Patients frequently have their medicines stopped and new medicines prescribed. These changes may occur in primary or secondary care settings. There is currently no system in place to inform pharmacies of any changes that have been made to patients' medicines. This has resulted in inappropriate requests from pharmacies. Where these medicines have been prescribed there have been several instances where the patient has been at serious risk of a major adverse event. This may occur where a new medicine may have an interaction with a discontinued medicine or where a new medicine might be similar in action to a discontinued medicine and where the combination of the 2 medicines results in toxicity.

Examples:

- 30 items ordered by pharmacy of which only 13 were appropriate orders. The order included medicines that had been discontinued in 2009 and also included 4 calcium channel blockers 3 of which had been discontinued.
- Two cases where 3 medicines ordered for thinning the blood that should not be taken together (dabigatran, rivaroxiban and clopidogrel & aspirin, clopidogrel and dabigatran). The first error was discovered at the Luton & Dunstable Hospital. The second error was noticed by family of the patient. Both errors put the patients at significant risk of death through a major bleed.

- Pharmacy ordered 2 strong opioids for a patient (Morphine Sulphate MR and Fentanyl patches). If the patient had taken these they might have gone into a coma and possible death. This prescription was not issued to the patient.
- Patient ordered 2 diuretics where one had been discontinued (Furosemide 40mg & Furosemide 20mg). This patient had a history of falls that may have been exacerbated because of low blood pressure through volume depletion and subsequent reduction in blood pressure.
- 2 statins ordered for a patient putting patient at risk of statin induced adverse event e.g. myalgia.

Compliance

One of the checks on whether a patient is taking their medicines as prescribed is from the patients' medication record held by their GP practice. If a patient is only ordering enough medicine to last 6- months of the year then this will be a strong indication that the patient is at best 50% compliant. However this non-compliance will be masked where a pharmacy automatically orders for a patient. A key finding from a recent national review conducted by the Royal College of Physicians (May 2014) into asthma related deaths 'Why asthma still kills' states that there was evidence of widespread underuse of preventer medication. Overall compliance with preventer inhaled corticosteroid (ICS) was poor, with low repeat prescription fill rates. The recommendation from the report was that non-adherence to preventer inhaled corticosteroids should be continually monitored.

Stockpiling

The over-ordering of patients' medicines results in stock piles of medicines in patients' houses. This can present in increased risk to others where medicines are not able to be contained in safe medicine cupboards and might be more readily accessible to children. Excess medicines may be diverted to other persons known to the patient and having similar long term condition. If this medication is stopped there is a signficant amount of wastage. Additionally there are environmental issues as the medicines will need to be disposed of eventually.

Examples:

- 4 years of insulin discovered by community service nurse. The patient had had their insulin ordered too frequently by their pharmacy..
- Pharmacy ordering 45 days' supply of insulin on a weekly basis
- 3 years supply of insulin ordered for a patient in 3 months
- Patient storing excess insulin in her freezer and defrosting when needed. Freezing should be avoided as will adversely affect the integrity of the medicine

Out-of-date medicines

Medicines generally have an expiry date of 2 years or less when dispensed to a patient. Excess medicines will eventually go out of date. A patient may not necessarily notice a medicine is date expired and might continue taking a medicine that has lost some of its potency.

GP surgery responsibilities

There are systems in place in GP practices to manage repeat prescribing processes and these processes generally could be improved. However there is some expectation that repeat medicine orders made by community pharmacy should be appropriate. In most instances the practice would need to contact the patient to verify the need for the medicine as a patient may have misplaced or lost their medicines, there might have been changes made in hospital that had yet to be communicated to the GP practice. Increases in practice and GP workload through processing and checking the appropriateness of a prescription request would mean essentially less time to provide clinical input for patients.

Mitigation

A communication is being circulated to GP practices and Community Pharmacies highlighting the current issues relating to repeat medicines and advising better practice.

Medicines Optimisation team are currently working closely with GP practices to observe and monitor current repeat prescribing practice and help improve practice.

An engagement exercise is in progress involving several focus groups and other stakeholders to discuss issues and options.

A paper exploring various options to reduce inappropriate ordering of medicines is being presented to the July 17th Clinical Commissioning Committee. These options will include the following but may include other options identified in current stakeholder engagement.

- **Option 1:** Do nothing.

- **Option 2:** Stop the community pharmacy repeat prescription ordering service in its current format. This means that pharmacies would not be able to order medicines for the majority of patients. This option would include detailed focus on vulnerable patients and how funds may be diverted to improve the management of these patients and additionally how funds may support the education of carers providing services to these patients.

- **Option 3:** Stop automatically ordered repeat service, which do not require input from the patient or carer, and allow only patient requested repeat service, where there is direct input from the patient or carer (in a timely fashion 7-10 days before the prescription is due) to say whether they need the prescription or not. This option would require assurance that robust auditable systems are put in place to ensure requests submitted are appropriate