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Prescribing Hints & Tips

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DIRECTION TO ADMINISTER FORMS (COMMUNITY NURSING FORMS) UPDATE:

Forms for nursing and residential home patients

Direction to Administer forms are commonly written for patients in residential homes. However, the practice varies for nursing homes, creating inconsistency in the process and on occasion, unnecessary delay in patient care.

It is now advised that a Direction to Administer form is written for ***both*** nursing and residential home patients as needed. Please kindly implement this practice going forward for safer, consistent and timely care for our patients.

Update to Allergy box

Previously, if a patient had no allergy recorded, then the allergy box in the forms remained blank.

The box in all DA forms will now prepopulate with "No known allergies recorded in medicines allergies section."

Please note that the responsibility for checking allergies recorded lies with both the prescriber and the nurse administering the medication as per their regulatory requirements.

Reminder – save forms as final

If forms are not saved as final, and open to edit, then…

- There is no audit trail of the first form when written as this will be overridden.
- It may have the GMC/registration number of the first prescriber and then the signature of the new prescriber leading to governance and safety issues.

Therefore, the governance policies for community nurses state that they must not administer from a form that is not 'saved as final' which can cause further delay to patient care. A new form needs to be written if any change is made to medication or dosing.

The written 'How to' guides for SystmOne practices and EMIS practices support with how to ensure the forms are saved as final.

Thank you for supporting us with the safe use of the Direction to Administer forms.

If you have any queries or concerns please contact us on nnicb-nn.medsman@nhs.net.

REPEAT PRESCRIBING PROCESS AND PATIENT SAFETY

A recent Regulation 28- Prevention of future death report explains how a prescribed prophylactic medicine was not monitored for repeat issues, the patient was left unprotected and later died from infection.

GP practices should have a robust repeat prescribing system in place to improve patient compliance and safety. The 'Repeat Prescribing Guide for GP Practices' is for practice staff involved in the repeat prescribing process and aims to ensure safeguards are in place to minimise errors and risks. The guidance suggests a '*recall system should also be in place for patients who are not ordering their medicines*' and '*any prescription not collected after one month should be highlighted to the prescriber. If it is determined that the prescription is to be destroyed, the prescription should be deleted from the issue record, and the reason documented in the patient records*.' Specific to the case above practices should also consider systems and/or alerts to identify those most at risk and highlight clinical indications for which a prophylactic medicines should be prescribed e.g. sickle cell disease, asplenia etc.

The Royal Pharmaceutical Society (RPS) and the Royal College of General Practitioners (RCGP) have developed a toolkit to help practices improve the consistency of repeat prescribing process.

APC AND INTERFACE UPDATE

The latest updates from APC can be found on their website here.

MAILING LIST

If you wish to be added or removed from the Prescribing Hints and Tips mailing list, please email e.moncrieff@nhs.net