CQC Guidance - Prescriptions in Dispensing Practices

CQC has been asked a question about dispensing practices where during a consultation, the GP sends a prescription to the dispensary for printing, which is then dispensed before it's signed. The following has been agreed with the Dispensing Doctors Association and the British Medical Association.

Although potentially this does not comply with regulations, sending a prescription to the dispensary electronically is in keeping with modern good practice. It's safe, liked by patients – and has the great advantage that we know that the prescription has been collected.

The prescriber takes responsibility for the medicine being provided to the patient. This function is provided in the consultation by the prescriber (as opposed to a dispenser) pressing the 'issue' button, much as letters can now be electronically 'signed'. All IT systems have an audit trail that records exactly when this took place. So in many ways this is more robust than a paper signature.

Background

Practices need to have robust systems in place to ensure that prescriptions are produced and signed in accordance with the current regulations.

Schedule 2 of the National Health Service (pharmaceutical) Regulation and the associated paragraph 39(3) of Schedule 6 to the GMS Regulations

In circumstances where paragraph 3 does not apply and subject to the following provisions of this Schedule, where a dispensing doctor is authorised or required by virtue of Part 5 of these Regulations to provide a drug or appliance to a person—

(a) he shall record an order for the provision of any drugs or appliances which are needed for the treatment of the patient on—

(i) a prescription form completed in accordance with the term of a contract which gives effect to paragraph 39(3) of Schedule 6 to the GMS Regulations or an equivalent provision applying in relation to that contract, or

(ii) if paragraph 39A(1) of Schedule 6 to the GMS Regulations applies, an electronic prescription form;

Schedule 2 of the National Health Service (pharmaceutical) Regulation 2005

(3) In issuing any such prescription form or repeatable prescription the prescriber shall himself sign the prescription form or repeatable prescription in ink with his initials, or forenames, and surname in his own handwriting and not by means of a stamp and shall so sign only after particulars of the order have been inserted in the prescription form or repeatable prescription, and —

(a) the prescription form or repeatable prescription shall not refer to any previous prescription form or repeatable prescription; and

(b) a separate prescription form or repeatable prescription shall be used for each patient, except where a bulk prescription is issued for a school or institution under paragraph 44.

Paragraph 39(3) of Schedule 6 to the GMS Regulations 2004

DDA guidance to its members is clear that prescriptions should be signed before they are dispensed. This has been included in their publications for the past four years.

Dispensing practices should be able to demonstrate that they are aware all prescriptions should be signed before being dispensed. If they do not sign prescriptions before they are dispensed they should be able to demonstrate that they have risk-assessed this and put a process in place that minimises risk.

Pragmatic approach

Acute/consultation prescriptions

Ideally prescriptions should be printed in the consultation room and signed at the time. If this is not the case, there needs to be a robust process in place to ensure that prescriptions are usually signed at the end of the same day. There should also be a robust system to verify the accuracy of the supply. This will be acceptable – even though it's not in strict compliance with the terms of the regulations. This would not apply to those prescriptions for Controlled Drugs that should be signed before being dispensed except in an emergency situation.

Repeat prescriptions

These should be signed before medicines or appliances are supplied to the patient – and ideally before the dispensing takes place. There needs to be a robust process around this. There may be occasions where this is not possible, but the procedure to follow for these occasions should be covered by the practice protocol. On these occasions there would also need to be a clear audit trail.