

Repeat prescription recording in general practice

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ANY MAJOR PROBLEM WITH REPEAT PRESCRIPTIONS began in 1948 when it ceased to be possible to include instructions for repetition on the prescription form introduced for National Health Service patients. Since then the problem has continued to grow. This is partially due to an increase in the number of drugs available, but mainly due to the ageing general population.¶

In our seaside retirement area practice the volume of work arising from repeat prescriptions is specially noticeable with roughly one third of the practice over 65. Figure 1 shows the increasing proportion of patients on long-term medication in older age groups, resulting in 27 per cent of our practice being on long-term medication *excluding* oral contraceptives. In day-to-day terms an average of 20 prescriptions per doctor per day for these patients is a good reason to look at the system of issuing of repeat prescriptions.

Recording methods

Methods of recording issue of prescriptions in general practice appear to fall into three main groups. First, no record at all may be kept. Secondly, a note of prescriptions issued may be made on the clinical record continuation card alongside the consultation record, or interspersed between clinical notes where no consultation took place. Thirdly, repeat prescriptions may be recorded on a small card carried by the patient.^{1 2} This may be combined with a record in the patient's notes.

About the first method (or lack thereof) little need be said, except that an accurate record of all prescriptions issued is most useful for checking whether the tablets are being taken as prescribed. In the case of overdose this record could be of vital importance.

The second method is the most convenient for recording the issue of single courses of drugs, but if repeat prescriptions for regular long-term medications are recorded along with clinical records on the continuation card they tend to swamp the clinical notes. Also this method means either writing the prescription in full on the continuation card each time of issue—wasteful of both time and space—or else using contractions, which, often combined with poor handwriting, tend to lead to errors. *Is the hypertensive on Dec 10 on Declinax 10 mg or Decaserpyl 10 mg?* The asthmatic on Thean will not thank you if you read this as Theom—short for Theominal.

The third method, which solves some of the problems of repeat prescription recording, is to issue small repeat prescription cards to selected patients on long-term medication. These cards generally measure about 10 cm × 12 cm (5 in × 6 in) so that they can easily be carried in the patient's wallet or handbag when folded. The outside usually bears the doctor's name, possibly the surgery office hours during which prescriptions may be collected, and room for the patient's name and address. On the inner left hand page is a list of prescriptions, and the right hand page is date stamped when a prescription is issued.

Using this system the practice secretary may copy out the prescriptions from the card ready

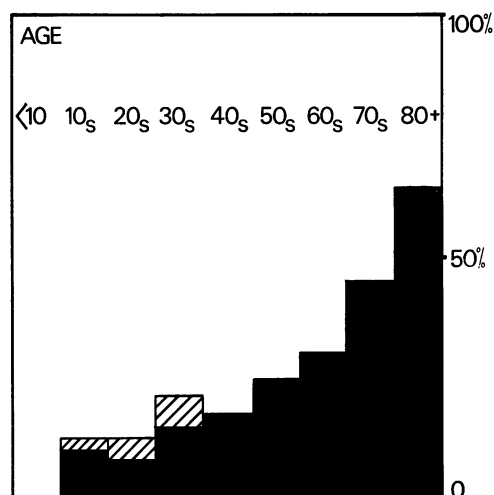


Figure 1
Proportion of patients in 10 per cent sample of practice on long-term medication shown by age group. Hatched portions represent patients on oral contraceptives

for signature after checking by the doctor. The card may also be helpful to other doctors attended by the patient; however, this advantage is probably more theoretical than real as the card is often kept 'in a safe place' at home. Dates of prescription issue can easily be checked with this card, but it may get lost, and the possibility of fraud then arises if a duplicate is issued.

These cards also tend to become tattered, specially those carried around by the patient, as they are encouraged to do, and this leads to loss of legibility.

FEMALE		Surname	Forenames
		Mrs Smith	Joan
Address			
50 Mainborough			
National Health Service Number		Date of Birth	
ABCD-98-7		22 AP 05	
DATE	★	CLINICAL NOTES	
MONTHLY	B	Digoxin 0.25mg tabs 10.m. (30)	
MONTHLY	C	Neonaclex-K tabs 10.m. (30)	
1/2 YEARLY	D	Neocytamen '1000' inj. (6)	
3 Monthly Appoint.			
1	30/3/70	BC	12
2	28.4.70	(A) BCD	13
3	30/5/70	BC	14
4	1/7/70	BC	15
5	24.7.70	(A) BC	16
6	22.8.70	(A) B ^{to} C ^{to}	17
7	5.10.70	(A) BC	18
8	3/11/70	BCD	19
9	8/12/70	BC	20
10			21

★ This column has been provided for doctors to enter A, V or C at their discretion.
(113611) Dd. 561893 2/750M 2/69 Hw. Form EC8

Figure 2
Example of the repeat prescription record card in use

The principal disadvantage of this system is that no record of issue of repeat prescriptions exists in the patient's record envelope. It was mainly to overcome this problem that in March 1970 we introduced into our practice a repeat prescription record card filed in the patient's record envelope.

Repeat prescription record card

As can be seen from figure 2 this card is modified from an EC7/8 continuation card. Although this means another card in the record envelope it is a considerable saving of space over recording of individual prescription issues in the continuation notes, as each repeat prescription record card should normally last about five years.

For ease of withdrawal without removing clinical record cards it is normally filed as the first item in the record envelope. It is further marked by a coloured adhesive tape tag slightly projecting from top centre. Although white as the RCGP approved tag colour for long-term medication might seem appropriate for the marker tag it is not sufficiently distinctive in practice. We use yellow Sellotape X. Where the RCGP colour tagging scheme is used this colour will also be used for tagging epileptic's cards. If, however, the disease index colour tag is placed on the outside of the record envelope no difficulty should ensue. The usual identification data are entered at the top of the card. It is helpful to precede the surname with the designation, *eg*, Mr, Miss, Mrs.

Items to be repeated are listed in the upper part of the 'clinical notes' column, printed clearly as they are to be copied onto the prescription form. Each item is identified by a code letter in the '★' column. (To avoid possible confusion with surgery attendances 'A' is not used.) The frequency at which an item may be prescribed is shown in the 'date' column. Most commonly this is 'MONTHLY', where the drug is to be taken regularly, or 'MONTHLY PSUS' where the dose may be decreased at the patient's discretion, but other frequencies may be used.

The lower part of the card, and similarly the back, is further subdivided into columns as shown. The frequency of doctor review is indicated in the first space. In the example shown in figure 2 this is '3 monthly appt', meaning that only two repeat prescriptions would be issued without the patient being seen again by the doctor.

The card in use

When a patient requests a prescription repeat the receptionist follows a standard procedure:

1. Withdraw record envelope from file.
2. Take repeat prescription record card from envelope.
3. Check that items requested are due without surgery attendance. (If the patient has come in person to request the prescription he is now told when it should be available; normally after morning surgery.)
4. Enter patient's name and address on prescription form. Copy prescription for item(s) requested from repeat prescription record card and date prescription form.
5. Enter date and code letters of item(s) prescribed on repeat prescription record card.
6. Pass patient's envelope with repeat prescription record card and completed prescription form to doctor for signature.

Before signing the doctor should check that the prescribed items are in fact due, that the prescription form has been filled in correctly, and that the prescription record card has been filled in correctly.

Given that one can rarely know for certain that drugs prescribed have been taken, the ease of checking on dates of prescription issue gives a ready check on the patient's drug taking. Any discrepancies noted can be ringed in red so that special attention is paid to the dates of subsequent prescription requests.

When items on the repeat prescription card are requested at a surgery or home consultation, the doctor records the issue on the repeat prescription card with the addition of the symbol A or V in the '★' column. It is to avoid possible confusion here that the letter 'A' is best not used as a code letter.

If the number of tablets or capsules prescribed differs from that listed at the top of the repeat prescription record card, this can be shown on the record of issue by a small number after the code letter, viz, B¹⁵ C³⁰ D E.

Repeat prescription issue systems have frequently been criticised for putting too much responsibility on the receptionist. We feel that using this system the responsibility is squarely on the doctor's shoulders, and further, that the patient is safeguarded to a greater extent than he is when no system is in use.

REFERENCES

1. Stevenson, J. S. K. (1967). *British Medical Journal*, 2, 827.
 2. Stevenson, J. S. K. (1967). *British Medical Journal*, 3, 312.
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PERSONAL EXPERIENCE: EDUCATION

The family doctor internship

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THERE ARE FEW MORE EXCITING developments in the field of medical education than the provision of initial and continuing education schemes for general practice.

Although the trainee—general-practitioner education scheme has been in existence since 1948¹, it was not until 1964 that the present facilities were clearly recommended by the Royal College of General Practitioners². These were later developed in detail in a booklet entitled 'Special Vocational Training for General Practice' published by the College³ and substantially supported by the Royal Commission on Medical Education in 1968. It was reference to this booklet which first set me upon a positive course of training for general practice after graduation. In essence it suggested that three years after graduation should be spent in 'suitable' hospital appointments, in which a variety of subjects are covered in a series of six-month and three-month appointments, followed by a further year in orientating to general practice as a trainee.

Summary of hospital posts most suitable for the future general practitioners³:

- (1) General medicine—six months (possibly with a further six months at a later stage)
- (2) General surgery with casualty experience—six months
- (3) Obstetrics, with gynaecology—six months
- (4) Paediatric medicine, including outpatient experience—at least three, preferably six months
- (5) Psychological medicine, especially outpatient experience—at least three, preferably six months

The following subjects are suitable for shorter or combined appointments:

- (6) Dermatology
- (7) ENT
- (8) Ophthalmology
- (9) Geriatric medicine
- (10) Physical medicine and rheumatology.

Table I lists the relevant clinical disciplines (inasmuch as it is possible to separate them), and compares the percentage of time spent training in each subject before and after graduation, with the respective percentages of the main groups of disease as seen by the general practitioner^{4 5}.

The Birmingham Regional Hospital Board operates an optional two-year training scheme for general practice, the first year being a 'family doctor internship' at SHO grade based at a general hospital in the region, and the second year an orientation course as trainee. The aim of this paper is to record my experiences as a family doctor intern in the South Birmingham Group of Hospitals, spent chiefly at Selly Oak Hospital, from February 1970 to January 1971.

First a few general comments. The intern's initial task is to select a provisional programme, suggesting the length of time he would like to spend in each department, while the chairman of