Medication Safety Series: MSS 26

Prescribing - Record Keeping & Communication Expectations

Tees, Esk and Wear Valleys NHS Foundation Trust

In November 2022, the Prescribing & Initiation of Treatment Procedure was updated following consultation to include 4 key standards for record keeping in relation to medicines prescribed [initiated], stopped or changed. The update was made to reflect learning from incidents. This was audited in 2023 (see right hand box).
The information should be recorded in the electronic patient record (EPR) and in communication to the patient's GP.

The recording & communication standards are – for all initiated, stopped or changed medication to include (prompts are available if recorded as a medication treatment note in Paris – the same will be available in Cito):

- ✓ Details of the medication prescribed
  - Including drug, indication, form, dose and quantity
- ✓ Rationale for the decision
  - Include key factors in decision making
- ✓ Patient information provided
  - Describe the level of shared decision making and note information provided to the patient / family / carer – include any significant discussion points
- ✓ Treatment plan
  - Describe plans for review, monitoring of effectiveness, physical health monitoring and planned next steps

For further details including a list of key aspects to consider before prescribing (described in section 3) and a guide to recording in the EPR (appendix 3) see the Prescribing and initiation of treatment procedure

Our comprehensive Medicines Optimisation – Interactive Guide (MOIG) will signpost you to all the information you need in relation to prescribing.
The Safe transfer of prescribing guidance indicates the "rules" of transferring prescribing to primary care. This should be read in conjunction with the Psychotropic Medication Monitoring Guide which describes the physical health tests required when taking medication.
The medicines adherence section of the MOIG links you to two other medication safety series documents; Medication adherence & Sources of prescribing information and information for patients
Our primary source of patient information leaflets is Choice & Medication. The MOIG also links you to a range of side effect rating scales.

In 88% (112/127) of cases the rationale for the decision to prescribe had been clearly recorded.

In 85% (108/127) of cases a Treatment Plan had been recorded.

Where a Treatment Plan had been recorded, it included:

Plans for review	82%
Next steps	88%

Details of the medication provided had been recorded:

Drug	98%
Indication	90%
Dose	97%
Quantity	93%

Details of the medication provided had NOT been recorded:

Form	47%

In 36% (46/127) of cases patient information had not been provided.

Where a Treatment Plan had been recorded, it did NOT include:

Monitoring of Effectiveness	30%
Physical Health Monitoring	32%

In 44% (48/108) of cases the details had not been recorded as part of a "Medication Treatment Plan" casenote. NOTE: Recommendation only.

The Medicines Reconciliation procedure focusses on in-patients but defines the need – in community settings – to establish current medications prescribed by the GP. Understanding this and ensuring the GP understands what we are prescribing. This reduces the risk of duplication and of unexpected interactions. CITO includes access to the Great North Care Record and the Yorkshire & Humber Care Record.
It may not always be possible to communicate small one-off supplies of "when required" medication in a timely manner, but this should always be done where supplies are more frequent.

Psychotropic medication initiation audit compliance captured between April and June 2023 (primarily community prescribing).

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