# Electronic Repeat Dispensing – eRD

## 'Myth Busters' – reducing barriers to implementation

Like any change to practice, it can be difficult to digest the implications in one go. Early experiences, and those of our colleagues, can influence how we feel about the change. Often, change generates a lot of questions about the new system. If these are not managed, barriers form.

Below we try to address some common questions/'myths' about eRD.

1

**It isn't safe to authorise up to a years' worth of prescriptions with no checks.**

There are checks built in to the eRD process. Community Pharmacists are contractually obliged to check with each patient, before handing out the medicine(s), that they are still clinically suitable and that the patient still requires them.

2

**eRD is very costly.**

This is not reflected in national data. We are able to look at the % increase in eRD vs the % increase in cost per item. A recent review, comparing the period Jan-Mar 2020 with Apr-Jun 2018, showed no appreciable correlation between the two*.

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**It is much harder to stop eRD medications.**

In reality, stopping medication when using eRD provides a robust audit trail. As we are implementing eRD with very stable patients, this should not prevent you from moving patients onto eRD. Prescribers have the option of cancelling one item or the whole prescription. Practices who use eRD with large numbers of patients say that cancellation is just a matter of a new process and, once comfortable with it, you will see a more robust audit trail.

View this training video for the cancellation process
https://learning.necsu.nhs.uk/nhs-digital-electronic-repeat-dispensing-elearning/

As with non eRD, once the prescription has already been dispensed, the pharmacy has to be contacted by email or telephone and advised not to hand the medicine to the patient.

4

**eRD increases medicines waste**

We currently have no reason to believe that eRD, when used as intended, increases medicines waste. It can allow for resource and supply planning. This should result in a reduction in wasted time and medicines rather than an increase.

It also presents an opportunity to review patient medication and potentially can reduce incidences of avoidable polypharmacy.

On reviewing the last three months of NHSBSA data for EPS non-dispensed (ND) items vs eRD ND items, we can see that there is a significant reduction in ND items when eRD has been used*.

5

**eRD increases polypharmacy.**

eRD, when used as intended and set-up correctly, provides an opportunity to reduce inappropriate polypharmacy.

Firstly, a patient's medication should be reviewed for suitability prior to setting-up as eRD. This naturally allows for a review of current medicines. Then, the annual medication review is built into the eRD cycle and enables the GP and patient to carry out a regular structured medication review.

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**You cannot put high-risk medicines on eRD**

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Lithium and Methotrexate are classified as high-risk medication and therefore need careful monitoring before prescriptions can be safely issued. However, we know from national eRD data that there are, in fact, thousands of patients on such medications whose repeats are managed using eRD.

The key points in considering adding a medication to eRD are;

- Is the patient stable on the medication?
- If applicable, is medication monitoring up to date?
- Does the patient have capacity to understand the new process for managing their medicine?
- Does the medication appear in the excluded list e.g. a CD? (see eRD Handbook p.8)

As this is a process consideration, it should not be affected by what medications they are but more by how they are managed by the prescriber and the patient.

If practices are going to prescribe high-risk medicines using eRD, they should have a clear standard operating procedure agreed with their local pharmacies. They should ensure that monitoring and medication reviews are built into the eRD pathway to ensure that prescriptions are issued **only** when monitoring indicates that it is safe to do so and that systems are in place to identify and address the issue where patients are not routinely accessing the monitoring that they should.

**eRD is not suitable for care homes**

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When used correctly, eRD may reduce the workload associated with prescriptions for care homes. It is important, before embarking on this, that practices **ensure that care home patients meet the criteria for eRD** (see p. 21 of eRD Handbook).

All care homes should receive prescriptions for a duration of 28 days. Seek advice from your practice pharmacist before issuing seven-day prescriptions for regular medicines for patients in care homes. If a seven-day prescription is appropriate, record the reason(s) for this in the patient's record for future reference.

Pharmacies will need enough information to dispense the medication for the care home and for any care staff to administer the medication appropriately. The use of 'as directed' instructions should be avoided.

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Before initiating any care home patients on eRD, it is important to ensure that the procedures in place for ordering medicines at the care home are agreed between the care home, the pharmacy and GP practice. Failure to set up a clear system that all parties sign up to will result in duplication of medicines and potential failure to order some medicines, which could have serious consequences for the care home resident.

Some care homes may have a homely medicines policy and this should be taken into consideration when deciding if 'when required' medicines need to be issued to individual patients. All 'when required' medicines should have the reason for their use stated on the instructions to guide those administering the medication.

**eRD cannot be used for anything but simple medicines regimes**

**8**

eRD can be used for more complex medication regimes, if the patient;

- Is stable on the medication
- Has capacity to understand the new process for managing their medicines
- Is not on any of the 'excluded' medication, such as CDs, and
- If appropriate monitoring is up to date.

For example, although warfarin is subject to monitoring and change, eRD can still be used.

- To accommodate possible dose changes, a separate warfarin prescription should be raised. This needs to be done in a similar way to creating a 'when required' batch by re-entering the patient record and creating a separate prescription with all the strengths that the patient might need (up to four) of warfarin listed. (Alternatively, separate, individual prescriptions for each strength can be generated.)
- The patient will need to let the pharmacy know which strengths of tablets they require after they have received their latest INR result and when they are running low on the required strength(s) of tablets.
- Patients will be required to show the result of their most recent INR test when requesting supplies of warfarin at the pharmacy. To ensure that the patient is attending for regular monitoring, the INR test presented should be no more than 3 months old.
- The pharmacist will issue the required strengths and mark the rest as 'Not Dispensed'. This will prevent stockpiles of warfarin building up at the patient's home, whilst allowing the patient and the surgery to realise the full benefits of the eRD service (see p. 19 of the Wessex handbook).

***NHSBSA reference data available on request**

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