NHS
South Yorkshire
Integrated Care Board

Recording medication prescribed elsewhere on clinical practice systems

Summary of Purpose and Scope

This document provides standardised guidance for general practices in South Yorkshire ICB on how to safely and consistently record medication that is prescribed by non-GP practices (organisations other than the patient's registered GP practice) within GP clinical systems. Correct recording supports patient safety, medicines reconciliation, clinical decision-making, and the accuracy of the Summary Care Record (SCR).

This guidance applies to medications prescribed or supplied by secondary and tertiary care, independent and private providers, community pharmacy services, and other non-GP practices. It covers EMIS Web and SystmOne. Prescribing responsibility does not transfer unless formally agreed.

Why Recording Medication Prescribed Elsewhere Is Important

Recording medication prescribed elsewhere ensures that the patient's Summary Care Record (SCR) is accurate and up to date, supports safe and effective medicines reconciliation across care settings, enables clinical systems to trigger relevant drug–drug interaction alerts, and improves the quality and safety of referrals, transfers of care, and clinical decision-making.

Local patient safety incidents in South Yorkshire have demonstrated that omissions or unclear recording of medication prescribed by non-GP practices can contribute directly to patient harm, particularly during transitions of care such as hospital admission or discharge.

This guidance replaces previous local advice that recommended recording medicines prescribed elsewhere as repeat medications. That approach carried a recognised risk of inadvertent prescribing or re-issuing. The updated guidance reflects current best practice and system functionality to ensure medications prescribed elsewhere are visible for safety purposes without creating unintended prescribing or financial risks.

General Principles

• Medication prescribed elsewhere must not be issued or dispensed unless clinically and contractually appropriate.
• The prescribing source must be clearly documented.
• Sensitive medications should be recorded with appropriate consideration of patient privacy.
• When medication is stopped or changed, the GP record must be updated promptly.
• Medication prescribed elsewhere should be included in routine medication reviews.

NHS England Recording medicines prescribed elsewhere into the GP practice is found here.

Background

To support patient safety, it is important to have a consistent and reliable way of recording all medications a patient is receiving, regardless of which prescriber takes responsibility for its issue. The majority of medication prescribed to patients will usually be managed by the patient's general practice. However, a significant number of patients receive medication from other providers including:

- Specialist medication from secondary and tertiary care such as biologics, clozapine, immunosuppressants, steroid loading doses and antipsychotic depot injections.
- Titration or short courses of medicines suppllied from secondary and tertiary care such as steroids from respiratory clinics and venous thromboembolism prophylaxis post surgery.
- Medication from private weight management services such as GLP-1 receptor agonists.
- Medication from pharmacies including pharmacy first, pharmacy contraception service and over-the-counter medication.
- Medicines used in clinical trials.

Often these treatments remain the responsibility of the hospital or other non-GP practice based prescriber. This usually includes the on-going prescribing of a medication(s) e.g. red traffic light drugs. However, it is crucial that the patient's general practice is both aware of the status of the medication and is able to record its existence on the practice system. Recording medication the patient receives from other sources on the clinical systems ensures that they are included on the patient's summary care record (SCR) for other organisations, and when primary care make any referrals, letters or choose and book appointments, the hospital can be provided with a full and up to date list of a patient's current medications. It also ensures that drug interactions with medication prescribed elsewhere are highlighted to the prescriber when new drugs are added in primary care.

There are areas of concern related to recording medication that is prescribed by other providers on the practice clinical system;

- To avoid the risk of inadvertent issue of these drugs from the practice and to allow the clinical system to highlight any potentially harmful drug interactions with other medication that the patient is prescribed.
- To respect patient privacy when recording sensitive medication (e.g. HIV medication)

Note: A system interaction check between unlicensed drugs and other prescribed drugs cannot always be guaranteed.

Examples of where patient safety incidents have occurred in South Yorkshire that could have potentially been prevented if the patients SCR was up to date with records of prescribing from outside primary care include:

- A patient did not receive a newly initiated medication prescribed by the community team because it was not included on the patient's SCR at the time of hospital admission. The patient was unable to communicate, a medicines reconciliation in hospital was performed using the information on the SCR and consequently the medication was omitted from the inpatient prescription. The incident could have been prevented if the information in the community team's letter detailing the medication titration plan had been transcribed to the patient's medication record on the primary care clinical system.
- A patient receiving both IV and oral bisphosphonate treatments. The issue arose because the patient's IV infusion was not recorded in a way that would appear on the patient's SCR. One recommendation from the after action review was to request GP practices to record IV treatment on the medication section of a patient record.

Purpose

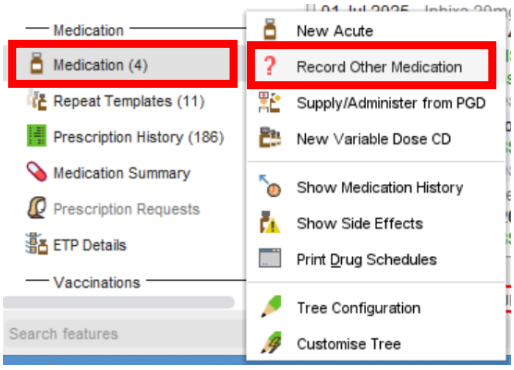
There are multiple ways of recording non-practice prescribed medication, each of which can give a different outcome on the clinical system. This document provides guidance for South Yorkshire ICB's preferred, standardised ways of recording medication prescribed elsewhere in the medication field on EmisWeb and SystmOne to help mitigate clinical safety and financial risks. For the alternative ways to record non-GP practice issued medication see - Recording medicines prescribed elsewhere into the GP practice record - NHS England Digital

NB:

- When a medication prescribed by another provider is discontinued or changed, the GP practice should have a procedure in place to remove/change the medication from the patients' record. Details of the discontinuation/change should also be recorded in the patients' notes.
- Medication prescribed elsewhere should also be reviewed as part of the medication review.

SystmOne

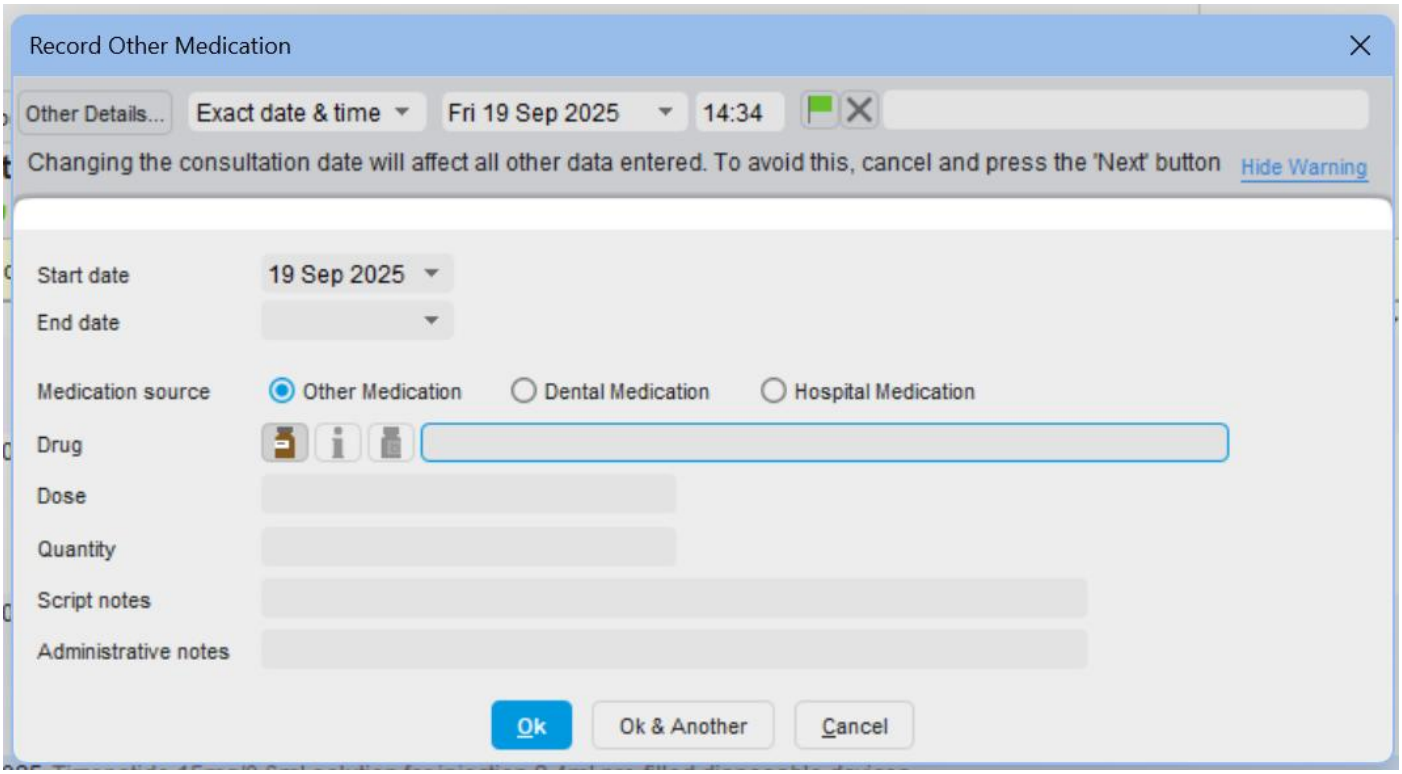
Right click on 'Medication' in the clinical tree and select 'Record Other Medication'



Complete the relevant detail in the 'Record Other Medication' window, inputting the drug and dose. The start date will automatically populate and can be altered.

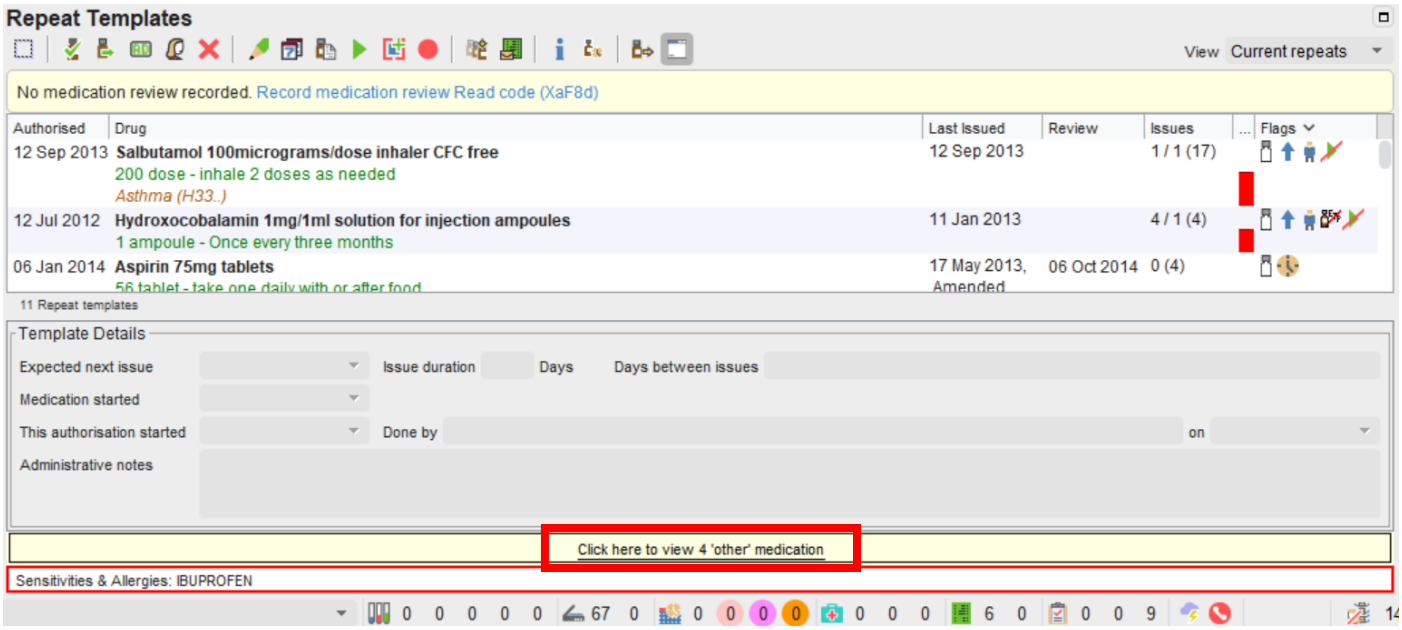
Note: medication which has been entered with an end date will not appear on this screen, the SCR or on referral letters, once that end date has passed - please take this into consideration for example with titration medicines where it is important they are still visible on the SCR.

In the dose box please record - DO NOT ISSUE / DISPENSE – OBTAINED FROM *INSERT PRESCRIBER* eg HOSPITAL/ PRIVATE WEIGHT MANAGEMENT SERVICE/VIA PHARMACY CONTRACEPTIVE SERVICE. Add any relevant details to the script notes section such as prescribing organisation, clinic and date e.g *as per later dated XXX from Sheffield Teaching Hospital Rheumatology Clinic.* Optionally the medication could be linked to an existing condition or a new condition could be coded. Then click OK.



The medication is now recorded in the patient's record and added to the Medication view and to a separate 'Other Medication' section at the foot of the Repeat Templates view.

On the repeats view you can see at the bottom 'Other Medication' and a link to 'Hide this'
If you have clicked on 'Hide this' you can see from the screenshot below that the medication can easily be overlooked. To restore the view click on 'Click here to view X 'other' medication'.



Stopping medication

If you need to stop a medication:

- Right-click on the hospital drug and select **Stop Medication**.
- When prompted, enter the reason and click **OK**.

If you are taking over prescribing:

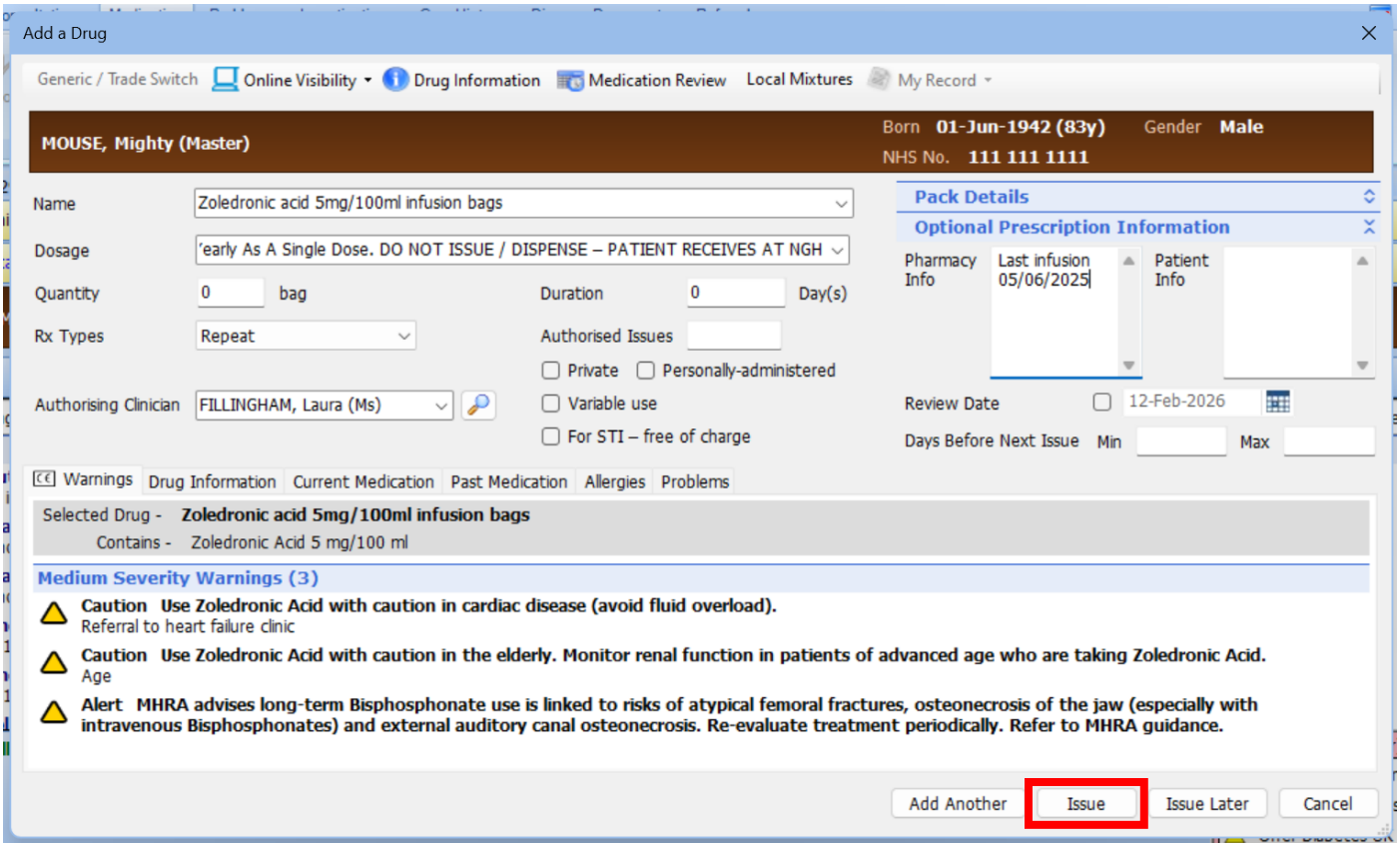
- Right-click on the hospital drug and select **Make Repeat**.
- Update the **dose, directions, and total quantity** as required.
- Add relevant comments (e.g. *'Shared care drug'*) in the administration notes.
- Then stop the original hospital drug listed in the **'Other Medication'** section by following the steps above.

EMIS Web

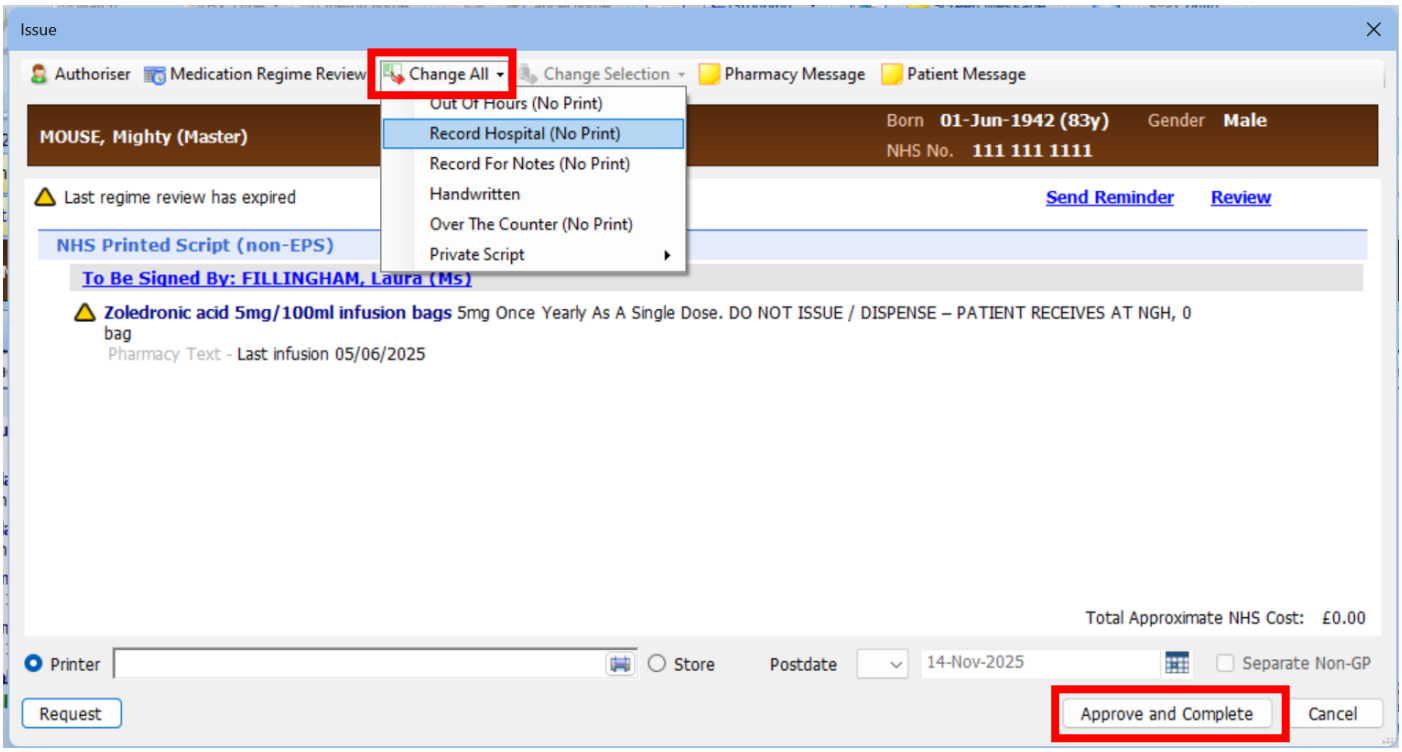
When in a patient record, enter the drug details as normal on the 'Add Drug' screen, in the dose box enter the dose and the wording DO NOT ISSUE / DISPENSE – OBTAINED FROM *INSERT PRESCRIBER* eg HOSPITAL/ PRIVATE WEIGHT MANAGEMENT SERVICE/VIA PHARMACY CONTRACEPTIVE SERVICE enter 0 in the quantity and duration, and ensure that either 'acute' or 'repeat' is selected as appropriate. Add any relevant details to the 'Optional Prescription Information' – 'Pharmacy Info' section such as prescribing organisation, clinic and date e.g *as per letter dated XXX from Sheffield Teaching Hospital Rheumatology Clinic* and click 'Issue'.

Note: clinical judgement needs to be applied to determine if a particular medication should be recorded as either an acute or repeat medication:

- *If the medication is entered onto the GP System as an 'Acute Medication', then this will be displayed on the SCR for 12 months from the date of issue.*
- *If the medication is entered onto the GP System as a 'Repeat Medication', then this will be displayed on the SCR until the medication is discontinued.*



The ‘Issue’ screen is then displayed. Select 'Change All' at the top of the screen and select the appropriate ‘X (No Print)’ option e.g 'Record Hospital (No Print)' or ‘Record For Notes (No Print)’. Next step is to select an authoriser. Once this has been done, follow the steps by clicking the ‘Approve and Complete’ button. Medications entered in this way will display on EMIS under Acute, Repeat or Hospital but will appear on the patient’s SCR under the medication 'type' heading ‘Repeat Prescribed Elsewhere’.



Stopping medication courses

If you need to end a medication course:

- Open the **Medication** screen.
- Select the required item(s) and click **End Course** on the ribbon.
- When prompted, enter the reason and click **OK**.

Clinical Trials

If a patient is taking part in a clinical trial:

- Licensed medicines (in DM+D):
  If the medicine is licensed and listed in the DM+D (Dictionary of Medicines and Devices), record it in the patient's record as above.
- Unlicensed medicines (not in DM+D):
  If the medicine is not licensed and isn't in DM+D, use the following SNOMED codes:
  - 713670002 *'Entered into clinical trial'* – add when the patient starts the trial
  - 443729008 *'Completed clinical trial'*– add when the patient finishes the trial

  Important:
  These codes do **not** trigger alerts for drug interactions. Recording them is good practice, but it will not prevent or highlight possible interactions between medicines. If there are any concerns about potential drug interactions, the team conducting the clinical trial should be contacted for advice.

References

1. EMIS Web – Recording over the counter medication in EMIS Web. Available at: https://www.emisnow.com/csm?id=kb_article_view&sys_kb_id=778473bcc3438e10beb93a0c05013186&table=kb_knowledge&searchTerm=recording%20medication [Accessed 12.09.2025]
2. EMIS Web – Prescription types and issue methods. Available at: https://www.emisnow.com/csm?id=kb_article_view&sys_kb_id=bf948f41fb8cbe90f614fd63aeefdc29&table=kb_knowledge&searchTerm=recording%20hospital%20medication [Accessed 12.09.2025]
3. NHS England Digital: Recording medicines prescribed elsewhere into the GP practice record. Available at: https://digital.nhs.uk/services/summary-care-records-scr/recording-medicines-prescribed-elsewhere-into-the-gp-practice-record [Accessed 25.09.2025]
4. Recording Hospital / Other Medications : Ardens SystmOne. Available at: https://support-s1.ardens.org.uk/support/solutions/articles/31000168602-recording-hospital-other-medications [Accessed 12.09.2025]

Version: v1.0
Approved by: IMOC July 2026
Review date: July 2031
Author: Laura Fillingham. Additional content, Greg Westley