Health and Social Care Board

Directorate of Integrated Care
Health and Social Care Board
12-22 Linenhall Street
Belfast
BT2 8BS

Tel : 028 9536 3926
Fax : 028 9536 3126

Web Site:
www.hscboard.hscni.net

Sent via Email

To: All GP practices
All Community Pharmacies

16 July 2015

Dear Colleague

Re: Communication between GPs and Community Pharmacies about patient clinical concerns

Background:

A number of adverse incidents, some of them serious, have been reported to the HSCB where incorrect or inappropriate prescriptions were issued by GPs and subsequently dispensed by community pharmacies, with little or no follow-up with the prescriber. Examples of incidents which resulted in serious harm include:

- A patient received a sub-therapeutic dose of an immunosuppressant following a selection error from the drug dictionary on the clinical system by the GP. The community pharmacist assumed the dose was correct as the patient was under review by secondary care and therefore did not query the dose change with the GP, even though the patient had been taking a higher dose for a number of years.

- Patients received higher than the maximum dose of pregabalin over a period of time. The community pharmacists did not query the doses with the GP as they had been dispensed on a number of previous occasions and/or the pharmacist assumed they had been recommended by secondary care.

- Excessive prescribing of controlled drug medications by GP practices which were not adequately queried by community pharmacies; any

queries made were not recorded on the community pharmacy patient medication record (PMR).
- A patient was prescribed medicines intended for another patient as a result of two separate letters from secondary care being combined into one patient's prescription. Although the pharmacy did query the prescription with the practice, the query was dealt with by reception staff.

Guidance and recommended actions

1. Community Pharmacists:

As outlined in the Pharmaceutical Society of Northern Ireland's Professional Standards and Guidance for the Sale and Supply of Medicines[1], pharmacists must ensure that:

- a clinical assessment of every prescription is undertaken to determine the suitability of the medication, the appropriateness of the quantity and its dose frequency;

- Where appropriate, the pharmacist should consult with other agencies and signpost or refer patients to other health and social care professionals and/or relevant organisations;

- appropriate records of clinical interventions are maintained.

[1]http://www.psni.org.uk/wp-content/uploads/documents/313/standards_on_sale_and_supply_of_medicines.pdf

In line with this guidance, community pharmacists and their staff should note the following recommendations:

- If there is a concern that a prescription may not be appropriate, the pharmacist (not other dispensary staff) must speak **directly** to the prescriber (not reception staff) about this. Involvement of third parties such as dispensary/reception staff can lead to confusion with potentially serious consequences.

- Medication should only be dispensed if the pharmacist is satisfied that it is appropriate to do so.

- The local HSCB office should be contacted if the pharmacist continues to have concerns following discussion with the prescriber.

- Appropriate records of clinical interventions, including discussions with the prescriber, must be maintained by community pharmacists in their clinical records.

2. Prescribers

Prescribers should pay due regard to clinical/safety queries from pharmacists and where appropriate, consider amending prescribing accordingly. Recent advice from the GMC echoes this recommendation*: "When you are on duty you must be readily accessible to patients and colleagues seeking information, advice or support"* (http://www.gmc-uk.org/guidance/good_medical_practice.asp).

In line with this guidance, GPs and practice staff should note the following recommendations:

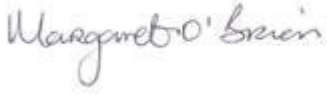
- Ensure that there is a process in place to allow community pharmacists to speak directly to a GP (or other prescriber if appropriate) when they have a clinical/safety query about a prescription.

- Changes to a patient's medication should be made by a GP or other prescriber. **Reception staff should not make changes to patients' medication.**

- Appropriate records of clinical interventions, including discussions with the community pharmacist, must be maintained by GPs in their clinical records.

If you have any queries about this, please contact your local Medical Adviser and/or Medicines Management Adviser.

Yours sincerely



Dr Margaret O'Brien
Assistant Director, DOIC
Head of GMS

Mr Joe Brogan
Assistant Director, DOIC
Head of Pharmacy and
Medicines Management