

To:
Community Pharmacies

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8th November 2019

Dear Colleague

Learning from Adverse Incidents:

Adherence to Requests for Dispensing in Instalments &

Communication of Instalment Dispensing Medication Changes

I write to request your consideration of processes associated with instalment dispensing following a series of adverse incidents.

1 Adherence to Request for Dispensing in Instalments

Two incidents have recently been reported where patients were admitted to hospital following self-administered overdoses of medication.

Both patients were in receipt of prescriptions which had been annotated by the GP to be **dispensed weekly**. However, in both incidents, the patients were supplied with four weeks' worth of medicines at the same time. These were packed into individual Monitored Dosage System (MDS) trays. The patients subsequently took more than the directed medication dose, resulting in overdose and hospital admission. Thankfully neither patient came to any long term harm.

In both incidents, there was non-adherence to the request to dispense in instalments and no justification to depart from this instruction.

2 Communication of Instalment Dispensing Medication Changes

The HS21 prescription form is the source document for community pharmacies to dispense medicines to patients, including those who have their medicines dispensed in instalments. However on occasion, issues can arise for instalment dispensing patients in the period between regular prescriptions being generated where there is a need to amend their medicines mid-cycle, for example a medication may be stopped, a new medication commenced or a dose changed.

Additionally, there may be a change in patient circumstance, such as hospital/nursing home admission or death. Previous letters to GP practices¹ and community pharmacists^{2 3} have highlighted the risks associated with the provision of medicines in instalments.

HSCB has been made aware of several adverse incidents relating to communication issues about such changes.

3 Recommendations

- Any proposed variation or changes to instalments supplied (e.g. additional supplies to facilitate holidays) must be discussed with the prescriber before implementation. The pharmacist should ensure they record the outcome of these discussions in their Patient Medication Record (PMR).
- Dispensing directions specified on the prescription **MUST** always be followed, including those relating to instalment dispensing, regardless of what type of packaging is used for the medicines e.g. original packs, skillets or MDS trays.
- GP practices and community pharmacies should have robust communication systems in place in relation to instalment dispensing prescriptions. To assist practitioners in areas where systems have not yet been implemented, a template instalment dispensing communication pro-forma has been developed (attached) which may be of benefit - this form is not intended to replace either the HS21 prescription form or systems which already exist and work well in local areas. GP practices have also been similarly advised to consider using where appropriate.

We appreciate and acknowledge the challenges faced in maintaining safe systems within dispensing and the contribution that pharmacy services make to maintaining safety. If you have any queries in relation to this correspondence, please don't hesitate to contact your local pharmacy adviser.

Yours sincerely,



Mr Joe Brogan
Assistant Director Integrated Care
Head of Pharmacy & Medicines Management

¹ <http://www.medicinesgovernance.hscni.net/wpfb-file/003-no3-risks-when-dispensing-medicines-into-monitored-dosage-systems-july-2010-41kb-pdf/>

² <http://www.medicinesgovernance.hscni.net/wpfb-file/risks-when-dispensing-medicines-into-monitored-dosage-systems-letter-to-cps-march-2010-pdf/>

³ <http://www.medicinesgovernance.hscni.net/wpfb-file/150720medicinessafetymatterscpvol3issue2-pdf/>