NHS
Barnsley
Clinical Commissioning Group

COMMUNITY PHARMACY

KEY DISPENSING GUIDELINES

Both healthcare professionals involved in a prescription (the dispenser and the prescriber) share responsibility for the safety of the medicine.

1. Patients (and/or their guardians or representatives) should always be counselled by a Pharmacist where they identify a new medication or change of dose of an existing medication has been prescribed.

2. The Pharmacist should satisfy themselves that the change is intended and appropriate.

3. The Pharmacist should satisfy themselves that the patient (and/or their guardians or representatives) understands how to correctly administer the medication and knows the correct dose/ volume of medication to be taken.

4. Where the change has been initiated in hospital and the Pharmacist has sight of a copy of the hospital letter or D1 discharge medication list, via Summary Care Record or other accepted route, then an additional check should be made against this.

5. Should the Pharmacist need to contact the prescriber/practice based pharmacist they should do so themselves.

6. The source of any confirmatory evidence should be made on the pharmacy Patient Medication Record (PMR) by the Pharmacist.

7. Any new medicines / changes to medication for children under the age of 12 should always be confirmed by a Pharmacist or an appropriately trained and accredited member of the Pharmacy staff.

8. Solid oral dosage form to liquid conversions should always be checked by a Pharmacist or an appropriately trained and accredited member of the Pharmacy staff.

    - Dosages on liquid medicines and injections need to specify ‘milligrams’ and volume, for example: Furosemide liquid 40mg/ 5ml [2.5ml (20mg) to be taken three times a day]
      Exceptions to this are laxatives, antacids and commonly prescribed antibiotics

9. Patients and/or their carer who have been issued with a MDS device.

- Patients and/or their carer should be advised on the safe and appropriate use of the device - including the potential risks to children as the MDS device is unlikely to be child resistant and may not be tamper evident. Where possible demonstrate to new patients or their carers how to use the monitored dosage system to ensure that they understand exactly how to use it

- The patient's practices needs to be informed if medicines are not being supplied to the patient in the original packs and a MDS is being used, this is particularly important if the clinician decides to alter the patient's medication

- Any issues identified in relation to non-compliance should be communicated with the practice i.e trays being returned to the pharmacy un-used.

- The duration and cycles of prescriptions should be based on the clinical needs of the patients

10. Communication between community pharmacies and practices

Both healthcare professionals involved in the prescription (the dispenser and the prescriber) share responsibility for the safety of the medicine.

Both practices and pharmacies should have systems in place to minimise barriers to communication regarding prescription queries, which includes:

- Clinical queries on prescriptions should be dealt with by a Pharmacist and clinician or practice based clinical pharmacist directly.

- Other pharmacy and surgery staff should not be involved in relaying clinical messages.

- The Community Pharmacist should be prepared to advise on possible solutions when calling to alert the prescribing clinician to a problem.

- The practice should advise the pharmacy of a realistic time for response, *i.e. end of clinic session, within nominated times, or within a couple of days.*

- If community pharmacies are getting a lot of similar enquires (for example supply issues) you may wish to agree a way forward with the GP practice to avoid repeated phone calls

(Note that clinical queries should not be considered as resolved unless a prescribing clinician or pharmacist has been involved/consulted)

Practices or community pharmacies wishing to facilitate or resolve problems around communication should contact the Medicines Management Team at the CCG.

11. Where the Pharmacist has sight of the hospital discharge letter or D1 discharge medication list, a check should be undertaken that medication changes have been made by a prescribing clinician.

12. Dispensing systems should ensure that no prescription can leave the Pharmacy unless it has been appropriately checked by a Pharmacist.

13. Managing patient expectations

    Pharmacies should aim to publicise that certain systems are in place in order to maximise patient safety (e.g. notice in waiting area, pharmacy counter, website, leaflet)

    Pharmacy staff should be trained on how to handle urgent requests/ demands from impatient patients- they should not feel pressured to make decisions which should be made by a Pharmacist.

If pharmacies choose not to do this they should:-

- Ensure that the dispensing standard operating procedure includes a method of alerting the Pharmacist of a change in medication.
- Where information is obtained by pharmacy staff, they are appropriately qualified (as defined within the Community Pharmacy SOP) and have acknowledgment of their responsibility.
- That information is presented to the Pharmacist in an appropriate manner for a clinical decision.
- The information is noted on the pharmacy patient medication record by the member of staff who obtained it.
- Particular care should be made when items are delivered to a patient's home.