



# Pharmacy Regional Newsletter

May 2026

## The Drug and Appliance Testing Scheme

The Pharmaceutical Services Regulations (Northern Ireland) 1997, state that “The Department, after consultation with the Local Pharmaceutical Committee, shall prepare a scheme for testing the quality and amount of the drugs and appliances supplied and the accuracy of dispensing.”

Every community pharmacy in Northern Ireland is visited at least once every five years to have a drug and appliance test carried out. The visits, undertaken by a Pharmacy Adviser from the SPPG, Pharmacy and Medicines Management Team, are random and the pharmacies are not given any prior notice.

The test involves the checking of a prescription which is awaiting collection. All items on the prescription are checked for accurate labelling. The items dispensed are also checked for correct drug, strength, form, expiry date, quantity, container. A short report is completed at the visit and a copy provided to the pharmacy if any issues are identified.



A quarterly report on the drug and appliance testing is presented to the Pharmaceutical Committee of the BSO. In the case of an incorrect drug and appliance test, the Committee is provided with an anonymised report providing details of the incorrect test and decides what action to take, which may include a follow-up visit.

In the period 1<sup>st</sup> September 2021 – 12<sup>th</sup> March 2026 a total of 674 tests had been carried out on 1,291 individual items and resulted in no

incorrect test results. These results illustrate the high standard of prescription dispensing by pharmacy contractors throughout Northern Ireland.

## In this issue

- The Drug and Appliance Testing Scheme
- Suicide Prevention Strategy: Safe Medicines Disposal
- Supporting Patients Through Levemir<sup>®</sup> Withdrawals
- Pharmacy First Service for EHC: Referral into the service

## Suicide Prevention Strategy: Safe Medicines Disposal

[Protect Life 2](#) is a strategy for reducing suicides and self-harm in NI. It stresses the importance of services, communities, families and society working together to help prevent suicides.

Restricting access to the means of suicide, including medication, is a proven method of reducing suicide, particularly for people known to be self-harming or vulnerable to suicidal thoughts. Encouraging patients and / or their carers to return any unwanted medicines to their local community pharmacy for safe disposal, can help to:

- Reduce access to means of overdose
- Reduce accidental poisoning of children
- Prevent unused medicines entering the environment

A recent case in England, involving the tragic death of a 14-year-old child, highlights the importance of safe disposal and return of unwanted medicines from the home.

**Community pharmacists are asked to** encourage patients and/or their carers to return any unwanted medicines to their local community pharmacy for safe disposal. Further information on the safe collection and disposal of unwanted medicines in community pharmacy is available [here](#) and training for staff regarding self-harm and suicide at [Training | Minding Your Head](#).



# Supporting Patients Through Levemir® Withdrawals

Novo Nordisk is discontinuing Levemir® FlexPen® and Penfill®, by December 2026. Guidance on managing this insulin discontinuation is provided in MSNs [14 August 2025](#) and [15 April 2026](#).

It has been agreed that **all insulin switching in NI will be completed by Trust Diabetes Teams and must NOT be undertaken in Primary Care** – see [letter](#). Community pharmacists play a vital role during this transition due to their frequent patient contact and expertise in safe insulin use.

## 1. Identifying Patients Currently Prescribed Levemir®

Pharmacy teams should proactively identify patients on Levemir® and counsel them on key points:

- Levemir® is being discontinued **for commercial reasons**, not because of any safety concerns
- Patients will continue on their insulin until reviewed and switched by their Hospital Diabetes Team
- GPs will refer patients for a switching appointment if this has not already been arranged
- If unsure, patients should check with their GP whether a referral has been made

Patients should be signposted to the [Diabetes UK Levemir® update](#) for more information. Community pharmacists should make all dispensing staff aware.

## 2. Checking Accuracy of New Insulin Prescriptions

Pharmacists should provide key safety checks and confirm that:

- The insulin product and device prescribed are correct and clinically appropriate
- The correct disposable pen, cartridges, reusable pen, or needles are supplied
- The insulin is prescribed **by brand**, as required for all insulin products
- Directions are clear and appropriate
- Any concerns are clarified with the prescriber and all outcomes documented



## 3. Counselling and Device Training

Pharmacists should ensure that patients feel confident using their new insulin. This includes:

- Confirming the insulin name with the patient and showing them the device.
- Checking that they understand their dose and correct timing of administration.
- Demonstrating how to use the new pen or device.
- Providing Diabetes UK advice on:
  - ⇒ injection technique and safe handling
  - ⇒ site rotation to avoid lipohypertrophy
  - ⇒ using a new needle for every injection
  - ⇒ correct injection depth
  - ⇒ safe sharps disposal
  - ⇒ recognising and treating hypoglycaemia
  - ⇒ correct insulin storage, including in-use vs unopened pens
  - ⇒ signposting to [Diabetes UK's insulin](#) video resources for further support

## 4. Follow-Up and Monitoring

Patients may require closer blood glucose monitoring after switching. Encourage them to:

- Check their blood glucose more frequently during the initial period
- Report any significant patterns of hypo- or hyperglycaemia promptly to their Diabetes Team to support safe dose adjustment and titration

## 5. Reporting and Governance

Pharmacists should escalate concerns to the GP or Diabetes Team and report switching-related issues or supply concerns in line with local SPPG incident reporting procedures. Examples include:

- Receiving a different insulin than expected (e.g. Tresiba® instead of Lantus®)
- Unclear or incomplete directions
- Difficulty operating the new pen
- Missing pen needles or incompatible reusable pens

## Pharmacy First Service for EHC: Referral into the service



If a woman or young person presents in the pharmacy requesting to purchase oral Emergency Hormonal Contraception (EHC), she should be offered referral into the **Pharmacy First EHC Service** regardless of whether or not she requested a consultation via the service.

It is advantageous for women and young people to access EHC via the service rather than purchasing OTC, for a number of reasons.

The service provides:

- An opportunity for an in-depth confidential consultation with the pharmacist, in a private area of the pharmacy.
- The opportunity to discuss the risk of acquiring sexually transmitted infections (STIs) and how to obtain test kits, free of charge, if needed.
- The opportunity to discuss ongoing contraceptive need and to obtain a supply of bridging contraception (if appropriate).
- An opportunity to identify potential safeguarding issues, particularly in young or vulnerable women who may be at risk, and who may require referral to the local Trust [Gateway Service](#) or the Police Service NI.
- There may also be age restrictions on the sale of oral EHC based on the product licence, whereas girls as young as 13 years may receive a supply of oral EHC via the service.
- If a double dose of levonorgestrel is required, two tablets may be supplied off-licence as part of the service, this is not an option for an OTC sale.
- A second dose may be supplied if vomiting occurs within 3 hours of taking oral EHC.

To avail of the service, the woman or young person must be registered with a GP practice in NI. She is required to provide consent and her personal details will be recorded; she may not wish to provide this information and in that case may opt to purchase oral EHC instead.

If your pharmacy does not provide the Pharmacy First EHC service please signpost the woman or young person to the nearest pharmacy offering the service.

All documentation relating to the service is available [here](#).

**I DON'T WANT TO GET PREGNANT**

- ✓ **FREE** confidential and discreet service
- ✓ **FREE** supply of the morning after pill
- ✓ **Available up to 120 hours** after unprotected sex

**Available from your local community pharmacy**

This newsletter has been produced for community pharmacies by the DoH Strategic Planning and Performance Group Regional Pharmacy and Medicines Management Team. If you have any queries or require further information on the contents, please contact one of the [Pharmacy Advisers](#).

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