Children Collecting Medicines From A Pharmacy

Recently an adverse incident occurred where incorrect medication was handed out to a child who had presented with a prescription to a pharmacy.

Occasionally, pharmacists are asked to supply medicines that have been dispensed against a prescription to a child (the medicine could either be for the child, or the child is collecting on behalf of another person such as a parent). The decision on whether to supply dispensed medicines to a child needs to be taken on an individual basis, considering individual circumstances. The pharmacy's standard operating procedure (SOP) for dealing with supply of dispensed medicines should cover the arrangements for supplying medicines to a child.

The following factors should be considered when deciding to supply a dispensed medication to a child:

- **Knowledge of the child**: Is the child known to the pharmacy? What information is known?
- **Maturity of the child**: Are there any concerns about the child delivering the medicines? Is the pharmacist satisfied that the child is capable and competent to understand the importance of the medicines that they are collecting. The *PSNI Professional Standards and Guidance for Patient Consent* provides guidance on capacity and how to assess. If the medicine is prescribed for the child, and the child is competent, then patient confidentiality principles apply, see PSNI Professional Standards and Guidance for Patient Confidentiality: www.psni.org.uk/about/code-of-ethics-and-standards/.
- **Nature of the medicine(s) supplied**: What are the medicines being collected? Is there any potential for misuse? Is there a risk that the child will misuse or tamper with the medicine?
- **Prior arrangement**: Does the child regularly collect medicines from the pharmacy? Is the collection by the child pre-arranged by the patient, e.g. an advance phone call by the patient or a letter of explanation?
- **Reason for collection**: Is there a reason why the child is collecting the medicine in the circumstances? For example, collection is on behalf of a patient who has mobility problems; or the child is expected to self-medicate, e.g. with an inhaler; or the child / young person is a carer for the patient.
- **Counselling**: Does the patient, who the medication is for, require counselling? How will this be given? If the patient is the child, are they able to understand?

Action for community pharmacists

Community pharmacists should ensure that SOPs are in place for dealing with supply of medicines dispensed against a prescription to child. Pharmacists should be able to justify any decision to supply dispensed medicine(s) to a child and, if appropriate, make a record of the decision in the patient medication record (PMR).

This newsletter has been produced for community pharmacists and pharmacy staff by the Regional Pharmacy and Medicines Management Team. If you have any queries or require further information on the contents of this newsletter, please contact one of the Pharmacy Advisors in your local HSCB office:

Belfast Office: 028 9536 3926 South Eastern Office: 028 9536 1461 Southern Office: 028 9536 2104
Northern Office: 028 9536 2845 Western Office: 028 9536 1008

Pharmacy Regional Newsletter

HSC Health and Social Care Board

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In This Issue

Omeprazole Suspension — Consider Alternatives

If omeprazole suspension is prescribed, it has to be ordered as an unlicensed 'special' preparation. Costs can vary greatly — invoices to BSO for omeprazole 10mg/5ml oral suspension range from £23 to £1664. Last year, unlicensed 'specials' of omeprazole, lansoprazole and ranitidine cost the NHS in Northern Ireland over £1,000,000.

The sodium bicarbonate in the suspension gives it an unpleasant taste and a high sodium content.

So what are the alternatives?

- Licensed omeprazole and lansoprazole orodispersible tablets are available, and are often a more suitable product for most patients who cannot swallow solid dosage forms (both children and adults).
- Royal Belfast Hospital for Sick Children (RBHSC) and the Royal Jubilee Maternity Service (RJMS) neonatal unit are moving to use lansoprazole orodispersible tablets as their preferred option.
- Lansoprazole orodispersible tablets are preferred over omeprazole suspension for a number of reasons, including bioavailability issues with omeprazole suspension, problems with enteral feeding tube blockage with omeprazole, and cost.

Action for community pharmacists

- Consider informing the prescriber of the cost of omeprazole suspension compared to orodispersible tablets.
- If the suspension continues to be prescribed, consider checking alternative suppliers for cost-effective prices. For further information on 'specials', visit the 'Specials' section of the NI Formulary website http://niformulary.hscni.net
- Further information on the use of antisecretory agents in infants is available in the *Medicines Management Newsletter Supplement: Omeprazole / Lansoprazole / Ranitidine in Infants* in the Prescribing Newsletters section of the NI Formulary website (updated Feb 2017).

Reporting Suspected Prescription Fraud in Community Pharmacy

One of the more common fraud methods likely to be employed within a community pharmacy is **altered prescriptions.**

Examples of prescription fraud reported to HSCB

A genuine prescription was issued at an out of hours surgery for 9 diazepam. This was altered to 90 and presented to the pharmacy.

The pharmacy spotted and reported the fraud, and a new prescription was issued. However, unfortunately the original was shredded, so there was loss of evidence for the police.

A prescription was stolen from an unused printer stored in a GP surgery and a practice stamp was taken from the reception area of the same practice.

The resulting forged prescription was presented to community pharmacy, but the stamp remains unrecovered.

A prescription pad used for hand writing prescriptions was taken from the reception area of a GP practice.

Subsequently two forged prescriptions were presented in two local community pharmacies.

Action for community pharmacists

If fraud is suspected,

- Take steps to delay filling the prescription to allow time to check with the prescriber
- Take a photocopy / scan of the prescription in case the person demands it back and you need to return it to avoid confrontation
- Report all confirmed instances of alterations of prescriptions to the PSNI (police) on 101 as they are criminal offences whether medication was obtained or not
- Contact Counter Fraud and Probity Services (CFPS) during working hours to discuss your concerns and report the matter, if appropriate
- Keep the original prescription for the PSNI or CFPS as it will be required for any future prosecution
- Retain any CCTV footage that may have recorded the incident

Further guidance on the reporting, recording and investigation of fraudulent medication reports (FMRs) for community pharmacists is available on the website at:

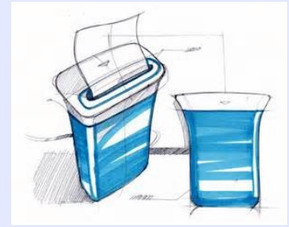
http://www.hscbusiness.hscni.net/services/2798.htm

Did you know there is a reward for reporting prescription fraud ?

Disposal of Sensitive Personal Data

The Data Protection Act 1998 sets out the requirements for processing personal data. Sensitive personal data includes information on a living individual's physical or mental health. Principle 7 of the Act states: *Personal data shall be secure, protected against unlawful or unauthorised processing and against accidental loss, destruction or damage to personal data.*

A recent incident reported to HSCB involved accidental loss of personal data from a community pharmacy



Non-confidential waste was found to contain sensitive personal data including:

- Right hand side of prescriptions
- Dispensing labels with the associated bag label
- Pharmacy owing slips

The pharmacy had a SOP for the management of confidential waste but the items were accidentally placed in the incorrect bin which was located next to the confidential waste bin.

Learning from the incident included:

- Confidential and non-confidential bins are now physically separated by being kept in two different rooms
- Different coloured bin liners are used to alert the pharmacy staff when disposing of waste.

Robust information security arrangements should be in place in community pharmacies, including procedures for disposal of sensitive personal data. It would be good practice to include steps to review if the procedures are actually working in practice, e.g. checks to be made periodically on waste.

Pharmacists are reminded that all reasonable steps should be taken to protect and secure personal information in their care. Failure to do so has the potential to lead to investigation by the Information Commissioners Office and could result in significant financial penalties.

Policies should include steps on what to do if there has been a data breach in the pharmacy, e.g. the pharmacist / contractor should:

- Consider informing the patients affected. Name, Address, GP and prescribed medication could be potentially harmful if they fell into the wrong hands, e.g. if someone knew that a patient was being prescribed drugs with the potential for misuse, or if the medication is for a sensitive condition.
- Consider whether you need to report the incident to the Information Commissioners Office. Guidance is available from the Information Commissioner's Office and HSCB Information Governance Team can also provide advice (contact details in the links provided).

Resources

HSCB leaflets on Information Security and Data Protection are available from the BSO website http://www.hscbusiness.hscni.net/services/2449.htm.

The Information Commissioner's Office website has a number of useful resources. https://ico.org.uk/for-organisations/health/

Action for community pharmacists

Community pharmacists are advised to review their procedures for disposal of sensitive personal data and ensure all staff and locums are made fully aware of the requirements.