Children collecting medicines from a Pharmacy

The Pharmacy Forum NI has recently produced guidance to community pharmacists concerning children collecting medicines from a community pharmacy[1]. For the purpose of this guidance the term "child" is defined as anyone aged less than 16 years. The pharmacist must decide on a case by case basis and under what circumstances it is appropriate to hand out medicines to a child. The pharmacy's standard operating procedure (SOP) for dealing with supply of dispensed medicines should cover the arrangements for supplying medicines to a child as well as complying with the PSNI professional standards of conduct[2].

Action

When making the decision regarding handing out medicines to a child the pharmacist should consider the following factors

- Their knowledge of the child e.g.; maturity, age, have they previously collected medicines
- Are the medicines for the child or for another individual?
- The nature of the medicines dispensed – is there a potential for misuse / abuse
- Is this a regular activity – has a prior arrangement for collection been put in place?
- Is there a reason why a child is collecting?
- Is patient counselling required and if so how can this be facilitated?
- Can identity be confirmed?– this is important if controlled drugs are being collected

It is also important to consider what procedure is required if it is deemed not appropriate for a child to collect medicines and the implications for the patient they are collecting on behalf of. A record should be kept of any issues and decisions made.

Pharmacists should also be cognisant of child protection and safeguarding[3] requirements and any matters of concern and/or emerging issues, in their local area in respect of the abuse of drugs.

Useful references

1. Pharmacy Forum NI Guidance – Children Collecting Medicines from a Pharmacy

https://www.pfni.org.uk/wp-content/uploads/2019/07/Pharmacy-Forum-NI-Guidance-Doc-Children-Collecting-Medicines-from-a-Pharmacy-June-2019.pdf

2. The Pharmaceutical Society NI (2016); "The Code: Professional Standards of Conduct Ethics and Performance for Pharmacies in Northern Ireland", http://www.psni.org.uk/wp-content/uploads/2012/09/22504-PSNI-Code-of-Practice-Book-final.pdf

3. Safeguarding Board for Northern Ireland; www.safeguardingni.org

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

Past and current editions of the PRN can be found in the Newsletters section of the Northern Ireland Formulary website http://niformulary.hscni.net/PrescribingNewsletters/Pages/default.aspx.

Pharmacy Regional Newsletter

HSC Health and Social Care Board

Volume 5 Issue 3
October 2019

Hypo awareness week

As part of Hypo Awareness week earlier this month, a short video on hypoglycaemia and a link to a patient information leaflet was shared to the public on the HSCB facebook page. This is still available at https://www.facebook.com/healthandsocialcareboard/videos/522468958297462 and may be of use to some of your patients.

Dispensing Owings & Beta-blockers

An incident occurred where a beta-blocker was inadvertently supplied to a patient as a result of a selection error when dispensing an 'owing'. The patient had been prescribed Captopril but received Carvedilol.

The pharmacy had a number of safeguards in place to reduce the occurrence of a beta-blocker dispensing incident:

- Beta blockers had been moved to a separate storage area
- Shelf edges had been clearly marked to highlight beta-blockers
- An alert had been added to the computer to highlight drugs which have the potential to be mis-selected
- Packaging had been considered when procuring beta-blockers to allow them to be distinguished easily.

However the contributory factor in this incident was that the process for dispensing 'owings' by-passed these safety measures; the recently delivered stock (incorrect item) was simply selected from the wholesaler delivery tote.

Action

- Pharmacists should review procedures to minimise the risk of selection errors when dispensing 'owings':
- It is important for an accuracy check for 'owings' to be performed using the original prescription.
- Consideration should be given to dispensing 'owings' from stock stored in the normal dispensary location rather than from delivery totes.

THIS BULLETIN SHOULD BE PLACED ON THE DOOR OF THE CD CABINET

Learning from Controlled Drug Dispensing Errors

A number of controlled drug (CD) dispensing errors have been reported to the HSCB. CDs come in various strengths and formulations and many incidents involve selection of the incorrect strength or formulation during the dispensing process which was not subsequently detected during the final accuracy check. In other incidents there was an inadequate clinical check. The following are examples of errors reported:

Prescribed	Dispensed	Specific contributory factors
MST® 10mg	MST® 100mg	**Similar strengths** – selection error not picked up in the final check
Butec® 10 patch	Butrans® 10 patch	**Similar names** - selection error not picked up in final check
Palexia® 50mg	Palexia SR® 50mg	**Inadequate clinical check** due to unfamiliarity with the different formulations of Palexia® (i.e. immediate release and prolonged release) and their respective dose regimens
Elvanse® Adult 30 mg	Elvanse® 30mg	**Inadequate clinical check** due to unfamiliarity with the different products (and licence) available for adults
Palexia SR® 50mg	Palexia SR® 100mg	**Dispensed from an incorrect label** which had been copied from the previous PMR. Dose change not picked up as part of clinical check
Methadone (oral substitution therapy): 45mg prescribed dose supplied even though the patient had not received their dose for 5 days.		**Inadequate clinical check**. (If a patient has missed 3 or more doses the prescription should be held until the patient has been reviewed*).
Longtec® and Shortec®: supplied 29 days after the prescription date and a second prescription supplied 5 days later.		Delay in collecting the prescription from the pharmacy meant the prescription became **invalid due to the date expiring**. This was not picked up at point of supply. The subsequent early prescription was not picked up during the clinical check.

Opioid Substitution Treatment:* ***Northern Ireland Supplementary Guidance For Community Pharmacists 2019*

http://www.hscbusiness.hscni.net/pdf/OST_NI%20Guidelines%20for%20Community%20Pharmacists_2019%202.pdf

The contributory factors and subsequent learning in many cases are similar. It is important to note that simple changes to storage, and extra vigilance during the dispensing and checking processes, can have a significant impact on reducing the risk of errors.

Contributory Factor	Learning identified
No second check	A second check should be carried out during the dispensing of all medicines, taking extra care with CDs
Selection errors due to similar names and strengths, or different formulations	**Keep CD cabinets tidy:** Separate different strengths and formulations where possible Keep stock levels to the minimum required - avoid overcrowding Take extra care when dispensing to select the correct product, strength and formulation as specified on the prescription.

THIS BULLETIN SHOULD BE PLACED ON THE DOOR OF THE CD CABINET

Contributory Factor	Learning identified
Inadequate clinical check	The clinical check should include a check for possible compliance issues, e.g. early/late prescriptions or gaps in treatment, and changes to medication e.g. strength/dose. If identified during the labelling/dispensing process these should be alerted to the pharmacist for action as appropriate. Staff should pay attention to previous CD register entries as this can also help to highlight possible compliance issues.
Lack of knowledge of the products available	Pharmacists should be familiar with the different CD product strengths and formulations and their recommended dose regimens.
Labelling/ copying from PMR	On each occasion, an entry should be created in the PMR and label generated in accordance with the current prescription details.
Medicines dispensed against the label	Medicines should always be dispensed against the prescription – not the label. Labels should be checked carefully against the prescription and dispensed product during the final accuracy check.
Inappropriate generic prescribing	Certain CDs should be prescribed by brand name to ensure the patient receives the same brand each time, e.g. buprenorphine and fentanyl patches, morphine and oxycodone products. (Refer to: http://niformulary.hscni.net/PrescribingNewsletters/generic/unsuitable/Pages/default.aspx) If these products are prescribed generically, the brand required should be confirmed with the patient/carer or prescriber (as appropriate). The GP practice should also be informed so that this can be rectified for future prescriptions.
Incorrect entry in the CD register	Entries should be made in the correct section (as per prescription) of the CD register at the time of handout to patient/carer. The running balance should also be recorded. It is good practice for a second person to check the register entry. Where there is a delay between receiving/dispensing the prescription and the supply, a check should be made when making the register entry that the prescription is still legally valid. Prescriptions for Schedule 2, 3 and 4 CDs are valid for 28 days from the prescription date (or a specified prescription start date). CD registers should be reconciled with CD cabinet stock on a regular basis (at least monthly) and a record made in the CD register.
Inadequate consultation with patient or carer	When handing out medication, the patient/carer's understanding of the medicine and dose they are expecting should be checked where possible. This will help verify the accuracy of the prescription and dispensed medication. If a small or unusual quantity of liquid preparation is required an appropriately sized oral syringe should also be provided.

Note: The HSCB AO must be informed of **all** incidents involving **any** Schedule 2-5 CD. The MRG pharmacy inspectors must be informed of any incident involving a schedule 2 or 3 CD, or if there is diversion or suspected diversion of any schedule 2-5 CD.