Cambridgeshire NHS
Primary Care Trust

Community Pharmacy Prescription Interventions Audit
Summary of Results of Re-audit, March 2008

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Introduction

One of the main roles of the community pharmacist is the error free dispensing of prescription medication. The pharmacist is the last line of defence in prescribing, dispensing and advising on administration of the medication process and can take a holistic view of patient care. As part of this role, pharmacists may have to amend, review or follow-up a prescription and the new pharmacy contract requires pharmacists to record details of any significant interventions they carry out.

Pharmacies are required to participate in a PCT determined audit each financial year. Prescription intervention was targeted for the PCT audit for 2007/08 as this was an area highlighted for improvement in last year's contract monitoring visits.

A baseline prescription intervention audit was carried out by community pharmacists in Autumn 2007 to determine the volume and severity of interventions made, and to agree standards for the process of making an intervention. The recommendations from the audit are given in appendix 4.

The re-audit was carried out in March 2008. This reviewed compliance with the agreed standards and highlighted any improvement in the processes used by the community pharmacists for making prescription intervention.

Aims and Objectives of the re-audit

Aim

To improve the quality and level of prescription interventions recorded by pharmacists

Objectives

- To ensure all community pharmacists have appropriate processes for recording prescription interventions
- To ensure all community pharmacists are recording the prescription interventions they make

Standards of re-audit

1. All pharmacists will have SOPs or other guidance for prescription interventions
2. All pharmacies will have systems to encourage all staff to raise queries about prescriptions
3. The details recorded for each intervention meets the RPS recommendations (date and time, patient id, relevant clinician, medical condition, name of person making intervention, reason for concern, summary of intervention)

The audit recommended a further standard that all prescriptions interventions that meet the RPS recommendations are recorded (clinically significance, provide opportunity for learning etc). This standard cannot be easily measured because

1. the appropriateness of an intervention and whether it should be recorded is subjective and dependent on the experience and qualifications of the person making the intervention
2. it is very difficult to collect data about interventions that should but have not been recorded

However, pharmacists were asked if the intervention recorded did fit into any of the RPS categories.

Methodology

The audit was planned in two stages; a baseline audit to identify current practice and to agree standards for prescription interventions, and a re-audit to determine compliance with agreed standards.

The re-audit was carried out in March 2008 using two forms to collect data covering:

1. The processes for prescription intervention in the pharmacy (appendix 2). One form to be completed by each pharmacy
2. Prescription interventions (appendix 3). Pharmacists were asked to choose a 7-day period in March 2008 and complete a data collection form for each intervention made by the pharmacy team during this period. A minimum of 5 forms was required so if these had not been completed within the week, the pharmacy was required to continue data collection until 5 forms had been completed.

The data collected for each prescription intervention was altered slightly to ensure the re-audit standards were measured. The reasons for an intervention were expanded based on baseline audit results.

Results

The results of the re-audit are summarised below. Further details of results are given in appendix 1.

74 out of 89 pharmacies (83%) had returned data as at 21 May 2008, a similar response rate as for the initial audit.

Prescription Intervention Processes

69 (78%) of pharmacies returned information about their prescription intervention processes. Of these, 67 (97%) had some form of guidance covering recording of prescription interventions, with 54 (78%) having SOPs.

65 (94%) gave details of their processes to encourage staff to raise queries about interventions. This was mainly through the inclusion of processes in guidance and individual discussion with staff.

Many pharmacies used more than one method to record prescription interventions, with only three saying they did not record prescription interventions at all.

There were several examples of good practice in prescription intervention recording. These included details of systems set up for recording interventions such as use of the notes facility on the computer system and a folder of intervention records. A list of these good practice points is given in appendix 5.

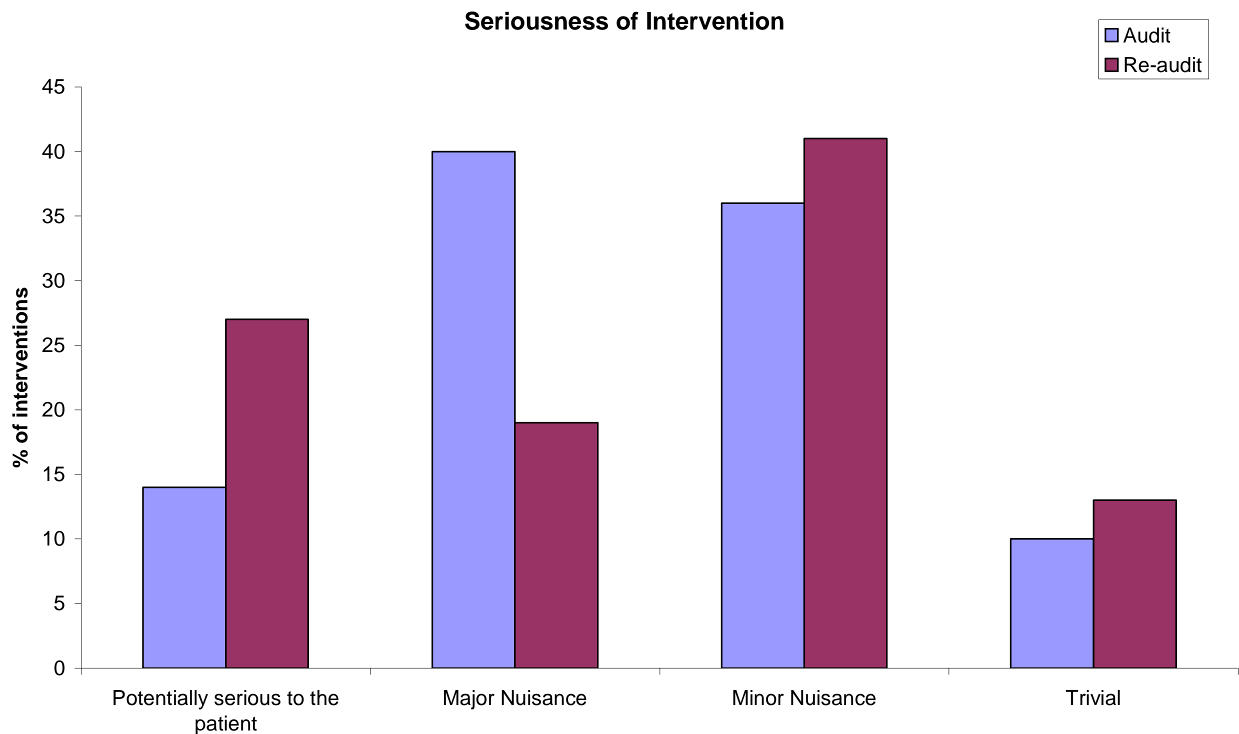
The main ideas given to improve prescription intervention covered recording systems such as a simple electronic system linked to the PMR which already has patient details, or a paper recording form prompting for the required fields. Many pharmacies said the main barrier to recording was time. Details of ideas for improvement are given in appendix 6.

Details of Prescription Interventions

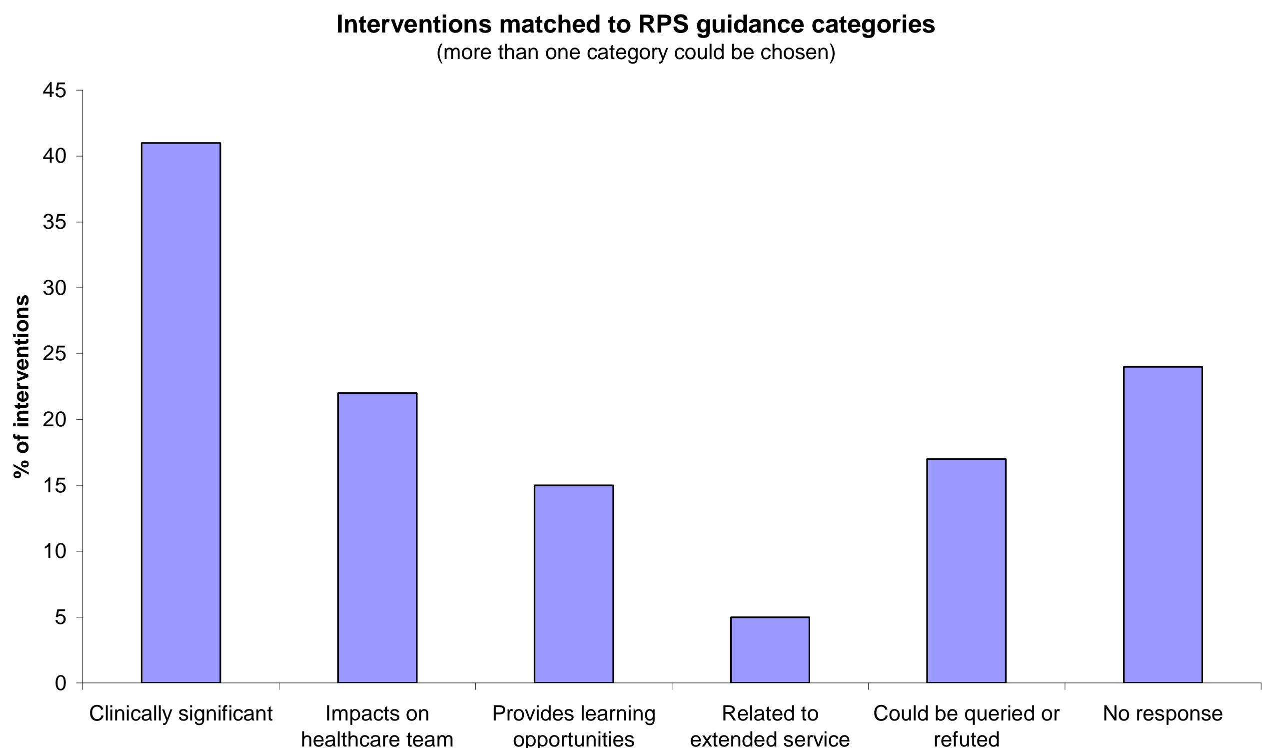
As noted in the audit, the number of prescription interventions varied between pharmacy, with 35 (47%) recording five interventions and 8 (10%) recording more than ten. The median number of forms returned was six.

The list of reasons for interventions had been extended for the re-audit to cover the areas highlighted in the audit. Missing signature remained the most frequent reason for the intervention, with queries about dose and availability of drug also noted by several pharmacies. There were 87 (13%) interventions made for reasons not given on the data collection form. Both the audit and re-audit have highlighted the significant range of issues where prescription interventions are made.

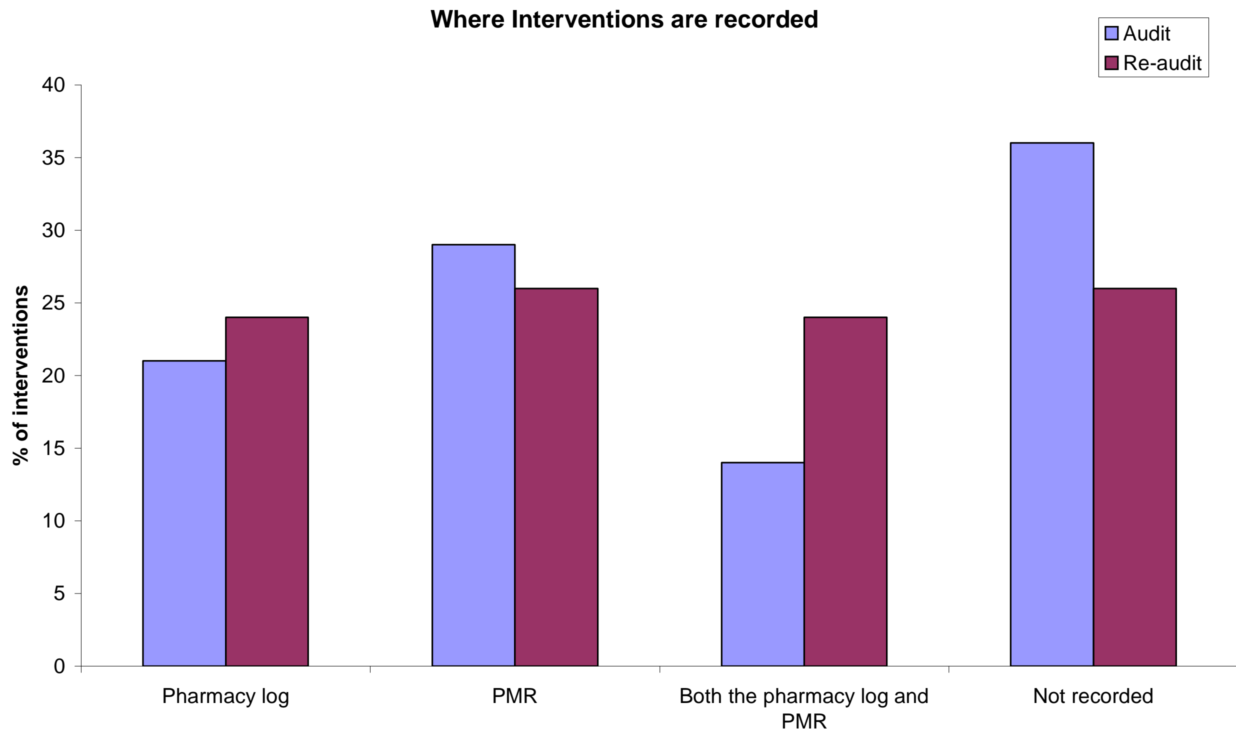
The type of intervention recorded was slightly different from the audit, with more serious interventions and less that were a major nuisance.



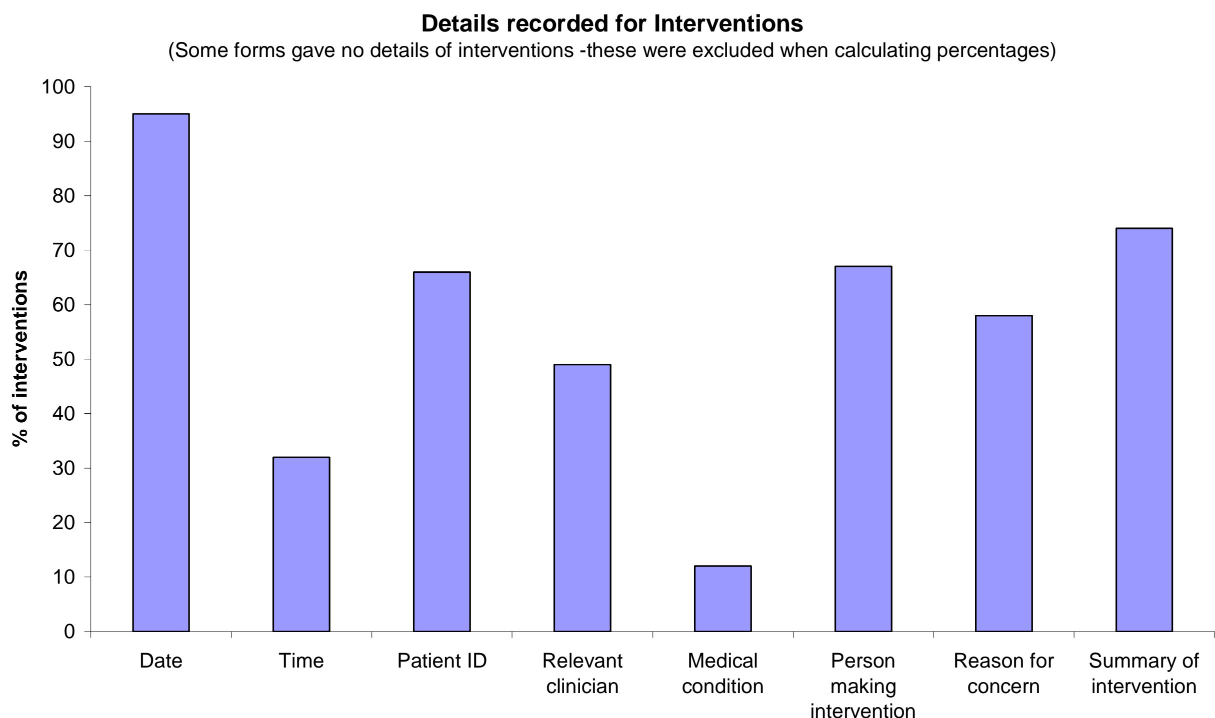
214 (41%) interventions were clinically significant, based on the RPS guidance categories. 126 (24%) of the interventions did not match any of the categories.



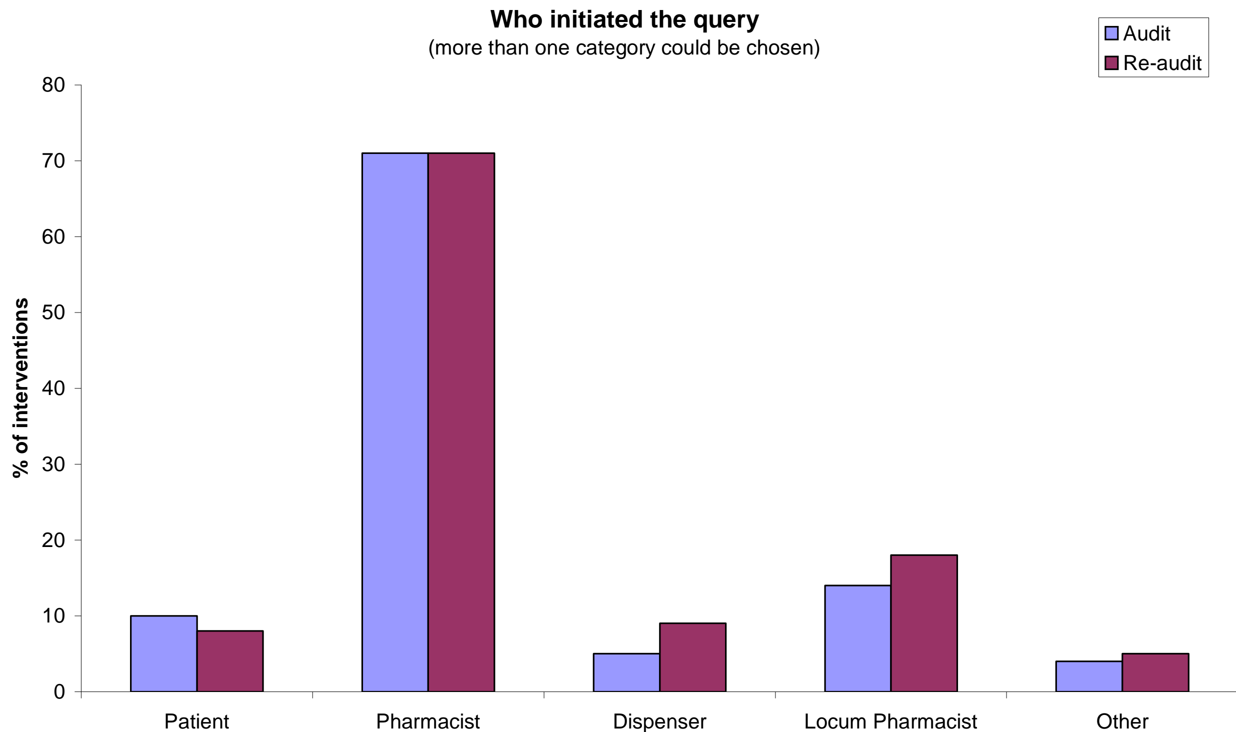
The percentage of interventions not recorded had fallen but still accounted for over a quarter of interventions.



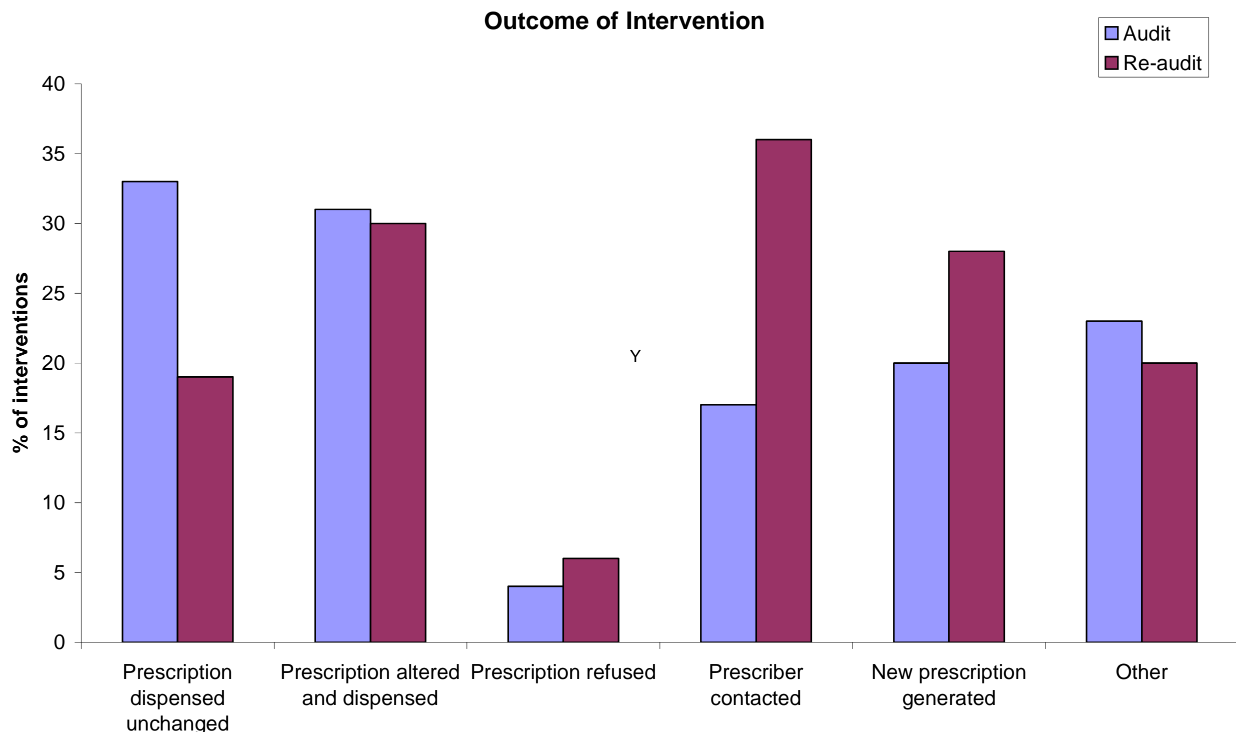
No information was given about the details recorded for the intervention on 151 (28%) forms. Where data was supplied, the majority of interventions had the date, patient ID, person making intervention, reason for concern and summary of intervention recorded. Medical condition was only recorded in 44 (12%) interventions.



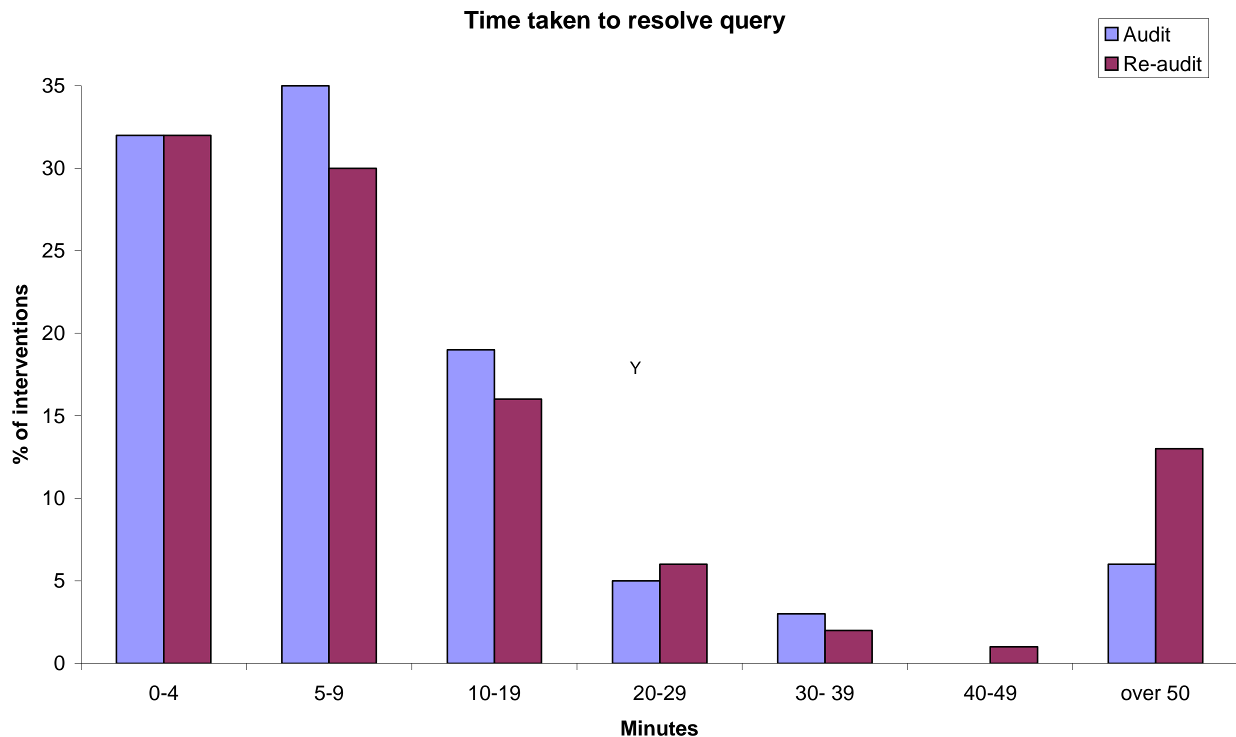
As in the audit, 71% of queries about the prescription were made by a pharmacist with dispensers also involved in a significant number of interventions.



Fewer prescriptions were dispensed unchanged in the re-audit, with an increase in the percentage where the prescriber was contacted and/or a new prescription was generated.



The time taken to resolve the query for the re-audit was similar to that for the audit, although the percentage of interventions taking over 50 minutes had increased. This may



reflect the slight increase of serious interventions.

Several pharmacists said there was learning from the intervention. This included the importance of checking prescriptions are relevant for the age of the patient, extra precautions when changing dose and highlighting interactions and specials to prescribers. A list of the learning is given in appendix 7.

Compliance with standards

97% of pharmacists had SOPs or other guidance for prescription interventions.

All pharmacies had systems to encourage all staff to raise queries about prescriptions.

72% of interventions had some of the RPS recommended details recorded. 61% of these had date, patient ID and person making intervention together with reason for concern and/or summary of intervention. 2 interventions had all 8 of the recommended details recorded.

Summary

- Community pharmacists have a major role to play in the error free dispensing of prescription medication. As part of this role, pharmacists may have to amend, review or follow-up a prescription and the new pharmacy contract requires pharmacists to record details of any significant interventions they carry out.
- The RPS guidance of prescription interventions states the importance of recording details of interventions carried out to improve patient safety and ensure lessons are learnt.
- The PCT community pharmacy audit for 2007/08 focused on prescription interventions. A baseline audit was carried out in October 2007 to establish standards for prescription intervention, with the re-audit based on these standards taking place in March 2008.
- 84% of pharmacies completed the audit and re-audit, with information about 845 interventions collected for the audit and 530 for the re-audit.
- Of the pharmacies that completed the re-audit, 97% had guidance on prescription interventions, and 94% had processes to encourage staff to record interventions.
- The pharmacies felt the best way to improve recording of prescription interventions was to have good templates in place to support recording, either electronic or paper based.
- Pharmacies were asked to classify interventions by their seriousness, based on definitions from the RPS. For the re-audit, 27% of interventions were classified as potentially serious to the patient, 19% as a major nuisance to pharmacist, prescriber and patient, 41% as a minor nuisance and 13% as trivial. The number of less severe interventions had increased suggesting pharmacies had widened the range of interventions recorded following the audit.
- There was a fall in the percentage of interventions not recorded between the audit and re-audit (36% to 26%). However, this is still a significant number not being recorded. It is very important that interventions are recorded to ensure an audit trail is available and lessons are learnt to improve patient safety.
- The reasons given for the interventions were varied and covered all areas of prescribing including missing information, ambiguous or questionable requirements and possible interactions or ADRs. The varied reasons given illustrate the vital role of the pharmacists in the quality assurance of the prescribing and dispensing process.
- No information was given about the details recorded for the intervention on 28% forms. Where data was supplied, the majority of interventions did record at least date, patient ID and person making intervention together with reason for concern and/or summary of intervention.
- The pharmacist was the most likely person in the pharmacy to spot a problem with a prescription. The patient also played an significant role. It is important that all staff in the pharmacy are aware of the process for interventions and feel able to query a prescription if they have a concern.
- Resolving queries with prescriptions can take a significant amount of work for pharmacists. 35% of queries required the pharmacist to contact the prescriber and for 28% a new prescription needed to be generated. Only 19% were dispensed unaltered. 13% of queries took over 50 minutes to resolve.

- Learning from interventions included the importance of checking prescriptions with patients, particularly for new patients or those who had difficulty with compliance. The pharmacists also highlighted issues with prescriptions for children and where different or unusual quantities were prescribed. The role of the pharmacist in highlighting concerns to prescribers was emphasised in the learning.
- The audit showed that the process for dealing with prescription queries and making interventions is a vital part of the prescribing and dispensing process. The robustness of recording interventions varied between pharmacies, with a simple electronic or paper system playing a major part in supporting the recording process.

Recommendations

1. Any pharmacies who do not have processes and guidance to support recording of interventions should establish these. The PCT can provide support for any pharmacies that require this.
2. Pharmacists should encourage all staff to record interventions, promoting recording using the benefits set out by the RPS.
3. Pharmacies should give details of their systems for recording prescription interventions to all staff, including locums, when they start work at the pharmacy, and have details of the processes easily available for reference when needed.
4. Pharmacies should review their systems to ensure what they have in place for recording prescription interventions is easy to use by all pharmacy staff. Systems should prompt the reporter for all the information required, as suggested by the RPS.
5. Pharmacists should regularly review the prescription interventions recorded to ensure trends are identified and learning shared.

Appendix 1 – Detailed Results

A. Processes to support prescription intervention

1. **Guidance about recording prescription interventions**

SOP	54	78%
Other guidance	12	17%
No guidance	2	3%
Other	4	6%

* seven pharmacies had more than one form of guidance

2. **Processes to encourage all staff (including locums) to raise queries about interventions**

Details in SOP/Other guidance	51	74%
Discussed at meetings	16	23%
Raised at induction	13	19%
Discussed individually	36	52%
Other	4	6%

* more than one process used in 36 pharmacies

3. **Method of recording prescription interventions**

PMR	59	86%
Pharmacy log	36	52%
Not recorded	3	4%
Other	12	17%

* more than one method of recording used in 41 pharmacies

B. Details of prescription interventions

Interventions recorded by Pharmacies

No of interventions	No of pharmacies	
5	35	47%
6	15	20%
7	13	18%
8 – 10	4	5%
11 – 13	4	5%
14 or more	4	5%

Max	37
Median	6

1. **What was the reason(s) for the intervention?**

(more than one option could be chosen)

	No of interventions	
Advice inappropriate/not understood	16	2%
Appliance insufficient/wrong information	6	1%
Direction given daily instead of weekly	6	1%
Direction incorrect	22	3%
Directions omitted/not clear	11	2%
Dose omitted/not clear	16	2%
Dose query	38	6%
Drug ADVR to drug prescribed	8	1%
Drug discontinued	14	2%
Drug form incorrect/not clear	28	4%
Drug inappropriate	14	2%
Drug incorrect/not clear	12	2%
Drug name spelt wrong/name change	4	1%
Drug necessary trade name not stated	0	0%
Drug prescriber not appropriate	4	1%
Drug unavailable	54	8%
Drug interaction	32	5%
Drugs of same class prescribed together	8	1%
Drugs repeat missed from script	21	3%
Drug not permitted on FP10	5	1%
Pack discontinued	9	1%
Pack size wrong	12	2%
Quantity wrong/inappropriate/omitted	30	5%
Script CD did not meet legal requirement	23	4%
Script changes not initialled	6	1%
Script child age missing	4	1%
Script prescriber details missing	4	1%
Script prescriber signature missing	112	17%
Script duplicated	5	1%
Script printed with detail missing	5	1%
Script patient details missing/incorrect	5	1%
Script prescriber intentions unclear	9	1%
Strength incorrect	13	2%
Strength omitted/unclear	5	1%
Other (please specify)	87	13%

2. **Type of intervention**

	No of interventions		% from Oct 07
Potentially serious to the patient	141	27%	14%
Major Nuisance	96	19%	40%
Minor Nuisance	213	41%	36%
Trivial	65	13%	10%

3. Interventions matching RPS guidance categories

(more than one option could be chosen)

	No of interventions	
Clinically significant	215	41%
Impacts on healthcare team	117	22%
Provides learning opportunities	80	15%
Related to extended service	25	5%
Could be queried or refuted	88	17%
Not given	126	24%

4. Where was the intervention recorded?

	No of interventions		% from Oct 07
Pharmacy log	118	24%	21%
PMR	130	26%	29%
Both the pharmacy log and PMR	116	24%	14%
Not recorded	129	26%	36%

5. Were the following details recorded for the intervention?

No information about details recorded given for 151 interventions

Percentages based on 381 forms where details were recorded

	No of interventions	
Date	366	96%
Time	122	32%
Patient ID	253	66%
Relevant clinician	186	49%
Medical condition	44	12%
Person making intervention	257	67%
Reason for concern	222	58%
Summary of intervention	283	74%

6. Who, within the pharmacy initiated the query?

(more than one option could be chosen)

	No of interventions		% from Oct 07
Patient	41	8%	10%
Pharmacist	367	71%	71%
Locum pharmacist	49	9%	5%
Dispenser	92	18%	14%
Counter assistant	6	1%	0%
Other member of staff	3	1%	0%
PMR system	6	1%	1%
MUR	1	0%	0%
Other	9	2%	3%

7. Please explain the outcome of your intervention?
(more than one option could be chosen)

	No of interventions		% from Oct 07
Prescription dispensed unchanged	93	19%	33%
Prescription altered and dispensed	146	30%	31%
Prescription refused	29	6%	4%
Prescriber contacted	175	36%	17%
New prescription generated	136	28%	20%
Risk/ near miss form generated	1	0%	0%
Other	98	20%	23%

8. Please give the approximate length of time (in minutes) that was taken to resolve the query

Mins	No of interventions		% from Oct 07
0-4	163	32%	32%
5-9	154	30%	35%
10-19	80	16%	19%
20-29	32	6%	5%
30-39	12	2%	3%
40-49	7	1%	0%
over 50	66	13%	6%

Appendix 2 – Data collection form 1

Form 1 Prescriptions Interventions Re-Audit Data Collection

Please complete this form **once only** and return with the intervention forms.

Forms are to be returned to the following address by **14th April, 2008**. Sue Nellis, Clinical Audit Facilitator, Nightingale Court, Ida Darwin, Fulbourn, CB21 5EE, or by email sue.nellis@cambridgeshirepct.nhs.uk

Name of Pharmacy …………………………………… Date form completed. ……………….

1. Does the pharmacy have guidance about recording prescription interventions?

   SOP ☐ Other guidance ☐ No guidance ☐

   Other ☐ Please specify ……………………………………………………………….

2. How does the pharmacy encourage all staff (including locums) to raise queries about interventions? (Please tick all that apply)

   Details in SOP / Other guidance ☐ Discussed at meetings ☐

   Raised at induction ☐ Discussed individually ☐

   Other ☐ Please specify ……………………………………………………………….

3. What process does the pharmacy use to record prescription interventions?

   (Please tick all that apply)

   PMR ☐ Pharmacy log ☐ Not recorded ☐

   Other ☐ Please specify ……………………………………………………………….

4. Does the pharmacy have examples of good practice in its prescription intervention recording?

…………………………………………………………………………………………………

…………………………………………………………………………………………………

5. What would help the pharmacy improve its prescription intervention recording?

…………………………………………………………………………………………………

…………………………………………………………………………………………………

Appendix 3 – Data collection form 2

Form 2 Prescriptions Interventions Re-Audit Data Collection

The re-audit should be completed during March 2008. Please choose a 7-day period in March and complete data collection form 2 for each intervention made by the pharmacy team during this period. If less than 5 forms have been completed in this period, please continue until you have at least 5 forms.

There should be a minimum of 5 forms, collected over at least one week.

Forms are to be returned to the following address by **14th April, 2008**. Sue Nellis, Clinical Audit Facilitator, Nightingale Court, Ida Darwin, Fulbourn, CB21 5EE, or by email sue.nellis@cambridgeshirepct.nhs.uk

Name of Pharmacy .... Date form completed. ....

6. What was the reason(s) for the intervention? (please tick as many as appropriate)

Advice inappropriate/not understood ☐ 1
Appliance insufficient / wrong information ☐ 2
Direction given daily instead of weekly ☐ 3
Direction incorrect ☐ 4
Directions omitted/not clear ☐ 5
Dose omitted/not clear ☐ 6
Dose query ☐ 7
Drug ADVR to drug prescribed ☐ 8
Drug discontinued ☐ 9
Drug form incorrect / not clear ☐ 10
Drug inappropriate ☐ 11
Drug incorrect/not clear ☐ 12
Drug name spelt wrong/name change ☐ 13
Drug necessary trade name not stated ☐ 14
Drug prescriber not appropriate ☐ 15
Drug unavailable ☐ 16
Drugs interaction ☐ 17
Drugs of same class prescribed together ☐ 18
Drugs repeat missed from script ☐ 19
Drug not permitted on FP10 ☐ 20
Pack discontinued ☐ 21
Pack size wrong ☐ 22
Quantity wrong/inappropriate/omitted ☐ 23
Script CD did not meet legal requirement ☐ 24
Script changes not initialled ☐ 25
Script child age missing ☐ 26
Script prescriber details missing ☐ 27
Script prescriber signature missing ☐ 28
Script duplicated ☐ 29
Script printed with detail missing ☐ 30
Script patient details missing/incorrect ☐ 31
Script prescriber intentions unclear ☐ 32
Strength incorrect ☐ 33
Strength omitted/unclear ☐ 34
Other (please specify) ☐ 35

....

.... **PTO**

7. Please indicate the potential seriousness of the problem

Potentially serious to the patient ☐ Major Nuisance ☐
Minor Nuisance ☐ Trivial ☐

8. Did the intervention fit the RPS guidance categories (Please tick all that apply)

Clinically significant ☐ Impacts on healthcare team ☐
Provides learning opportunities ☐ Related to extended service ☐
Could be queried or refuted ☐

9. Where was the intervention recorded?

Pharmacy log ☐ PMR ☐ Both the pharmacy log and PMR ☐ Not recorded ☐

10. Were the following details recorded for the intervention? (Please tick all that were recorded)

Date ☐ Time ☐ Patient ID ☐
Relevant clinician ☐ Medical Condition ☐ Person making intervention ☐
Reason for concern ☐ Summary of intervention ☐

11. Who, within the pharmacy initiated the query?

Patient ☐ Pharmacist ☐ Dispenser ☐
Locum Pharmacist ☐ Counter assistant ☐ Other member of staff ☐
MUR ☐ PMR system ☐
Other ☐ Please specify……………………………..………

12. Please explain the outcome of your intervention? (Please tick as many as appropriate)

Prescription dispensed unchanged ☐ Prescription altered and dispensed ☐
Prescription refused ☐ Prescriber contacted ☐
New prescription generated ☐ Risk / near miss form generated ☐
Other ☐ Please specify……………………………..

13. Please give the approximate length of time (in minutes) that was taken to resolve the query.

0-4 ☐ 5-9 ☐ 10-19 ☐ 20-29 ☐ 30- 39 ☐ 40-49 ☐ over 50 ☐

14. Was there any learning from this intervention for the pharmacy team? Yes ☐ No ☐

If **yes**, please give details……………………………………………………………………..

…………………………………………………………………………………………………

Appendix 4 – Recommendations from Audit

1. Ensure the pharmacy has an up-to-date SOP giving details of the interventions to be recorded, the details required, where to record the intervention, how to disseminate any learning, and any reporting requirements for serious prescription issues (eg NPSA).
2. Ensure all staff are aware of the SOP and feel able to raise queries about prescriptions if they have concerns.
3. Record those interventions highlighted in the guidance from the RPS:
   - Interventions that are of clinical significance ie could be regarded as having a direct impact on patient care
   - Interventions that provide learning opportunities to improve overall standards of care
   - Interventions that could potentially be queried or refuted would be appropriate to be recorded for future reference if the patient / patient representative queried or disagreed with the intervention
   - If the intervention affects or impacts on another member of the healthcare team – referral or refusal of disclosure
   - If the intervention relates to an extended service that the pharmacist is being paid for and is contracted to provide
   - It may also be necessary to record all interventions over fixed periods of time on a regular basis (point prevalence studies) to establish workload trends, or patterns of medication related problems
4. Maintain records of interventions to include the detail as recommended by the RPS:
   - Identification of patient / person involved, where possible or a brief description of the patient/ person ie Name & address of patient / person if available, NHS number if available
   - Name of regular GP and / or practice or hospital consultant
   - Medical conditions
   - Date of intervention
   - Time of intervention
   - Name of person who made the intervention / gave the advice
   - Patient condition or concern
   - Summary of intervention including outcomes or proposed courses of action
   - Names and roles of other people involved in intervention / contacted
   - Sources of information used
5. Review interventions annually to look for trends and review learning for the interventions. Use the learning to improve process for managing prescription interventions
6. Consider if software can be used to support the recording interventions.
7. Re-audit the prescription intervention process in March 2008 by reviewing the SOP for each pharmacy.

Appendix 5 – Examples of good practice in recording of prescription interventions

- 24 recorded interventions have been recorded in the computer system during period 01/01/08 to 12/03/08 all against specific scripts.
- A patient on warfarin tablets was put on amiodonone by hospital prescriber. Surgery contacted and GP acknowledged potential interaction and necessity for additional blood tests (INR).
- As demonstrated at contract monitoring visit we have records available.
- Dear Dr Book, prescription intervention/referral book plus patient history
- Easy to follow tick box system which can be accessed via PMR.
- Examples contained in intervention file.
- Folder available with record of prescription interventions recorded in Pharmacy.
- Folder maintained with completed intervention and referral forms.
- Interactions are flagged by clinically checking the script and discussing first with patients if necessary GPs and then recording.
- Many good examples in our log book.
- On PMR and patient note.
- Pharmacist always evaluates interventions recorded.
- Prescription intervention report forms. RPS Guidance April 2006.
- Records are kept on all the patients PMR under notes - this is dated and records the name of the user entering the note.
- Regular locum is an advocate for intervention recording.
- Try to always give suitable comments to give details of intervention and of experiences learnt for future use.
- We have been opened for less than a year, so not yet but I am sure we will have one for next data collection (Dr self-prescribing over £200 worth of medication on FP10 - is that a good example?)
- We have file divided into sections relating to contract where intervention forms are kept.

Appendix 6 – Ideas for improvement in recording of prescription interventions

- A better system on our PMR.
- Alert form freely available.
- At present I don't know.
- Carrying out the last audit was helpful in highlighting need to record interventions.
- Currently have enough info, SOP for prescription intervention.
- Discuss at meeting with locum pharmacists and other support staff.
- Doctors and staff at surgery given training on script legalities (I.e. signed/unsigned script).
- Easier access to PMR.
- Effective time management, so that the excuse of 'not enough time' is used. It needs to become part of the job, not just an occasional extra.
- Encouraging all locums to record interventions.
- Feel that paperwork gives us the opportunity to explain discussion with Dr and ??????
- Finding time to record the intervention is the biggest problem and when is an intervention worth recording?
- Guidance from PCT as to exactly what they require to be recorded for use in PCT visits.
- Guidelines on examples of 'significant' interventions. Making it a simpler process.
- Has been a time factor in past. This audit has been useful as a reminder and motivation for dispensary team.
- Have a separate log book at the counter for interventions to be recorded at the initial transaction of the script, as counter staff are not able to log on to PMR. Therefore, some interventions are not being recorded.
- Having an intervention recording facility available on the PMR. Company does not currently have this.
- Having more staff time.
- Having one system = combination of PMR and pharmacy log linked to surgeries via internet so phone calls to a surgery (with interventions) about e.g. amended scripts wouldn't be necessary any more.
- If the intervention could be recorded in a separate section on our computer records.
- In branch training.
- Less details to record to make the process easier and faster.
- Less paperwork.
- More direct contact with prescribing doctors directly to understand and resolve issues rather than via third party, e.g. receptionists where emphasis on issues may differ.
- More staff.
- More time or a quicker method of recording interventions.

- More time, SOP guidance.
- Motivation of staff to complete interventions on computer system (incentives for completion).
- Need more space on computer PMR record system.
- Nothing
- Nothing - New PMR system has already helped.
- Now we have up to date IT systems in place so it is the best now - can't improve any more.
- Only record significant interventions at present, must get all staff into the habit of recording all interventions as standard.
- PCT guidance/protocol of type of interaction, to keep record of.
- Practice, Practice
- Simpler electronic recording on PMR system, that is more easily retrievable after records made.
- Simplified method.
- SOP (to have an SOP)
- Standard way to present paper copies and access to PMR copies.
- Summarised intervention recording form.
- Team members prompting each other to remind to record intervention.
- Template attachments to save time.
- Time normally is the major issue because situations crop up in the busiest moments.
- Time?
- Time?
- When it has more employed pharmacists rather than locums which is soon.

Appendix 7 – Learning from prescription interventions

- A dialogue with patient can highlight the need of the customer and shows that sometimes the pharmacist is in a position to help with patient's query.
- Age of patient is relevant to what is prescribed.
- All prescriptions under 16 need age.
- All scripts need to be checked to see if they are valid.
- All scripts, especially CDs should be checked for signatures on collection from surgery. (This case wasn't noted for 24 hours after receipt.)
- Alternate to discontinued medication.
- Always check interaction with all medication the patient's on, use PMR and BNF/Stockley.
- Always check previous dispensed items especially specials manufacturing with new prescription.
- Always check that 2 drugs of same class not on prescription.
- Always check with certain ointments whether it is being used inside the nose and if preparation is suitable.
- Always confirm if new meds supplied by locum who may not know all patient's details (both locum doctor or locum pharmacist).
- Both cod liver oil and evening primrose oil has an effect on certain conditions
- Cannot dispense the script for one month old baby without checking with the doctor.
- CD instalments - check dose and no of instalments = total quantity.
- CD Regulations apply.
- CD scripts must not be written with dosage instructions as directed.
- Certain medicine should prescribe branded name.
- Change of pack size of locoten vioform for future Px.
- Check before taking the prescription.
- Check carefully the dosage for antibiotics.
- Check date on CD script for in date.
- Check drug availability.
- Check EPS script details carefully.
- Check it carefully before taking the prescription into the pharmacy (dispensary)
- Check PMR records before dispensing and contact the patient (or prescriber) if any queries.
- Check with patient all items ordered dispensed.
- Check with patient if he has understood how to use the device.
- Clinical assessment of Px.
- Could the prescribers be contacted by the drug companies in the event when they are not capable of manufacturing drugs. (List attached showing all UCB stock which has been referred back to GP.)
- Diabetic on nicotine patches suffering low blood sugar readings - referred to diabetic nurse.

- Different strength buprenorphine patches release over different time periods and so not interchangeable.
- Discussed different inhaler forms/devices with dispensing team.
- Dispensing assistant, use BNF, find alternative products.
- Doctor was unaware it was a special and unlicensed. She was grateful for us telling her the problem and cost, and we advised her to always phone us before prescribing a special, so we can help/advise on cost and availability, so not to inconvenience patient/ourselves.
- Doctors have different decisions about prescribing aspirin and NSAIDs to different patients, so check individually.
- Dose of hydroxyzine able to be used safely higher than pharmacy team were aware of.
- Doses appropriate for young children need care.
- Double check prescription for CD before they are gong to be dispensed.
- Drs are not allowed to self prescribe on FP10.
- Drug Has been discontinued.
- Elvavex hosiery is only charged at 1 charge per pair not 2 charges per pair as is the case with elastic hosiery.
- Ensure all details of interventions for methadone are recorded on PMR so other staff can access details when needed.
- Ensure patient informed of deadlines when issuing owing for CD.
- EPS checking.
- Faxed Brookfields to ask them to add day of week to script.
- Finding alternative product.
- Finding alternatives for out of stock medicines.
- Handwritten and not legible. Several persons had to 'read' before preparation was obvious.
- Handwritten scripts - no detail of tabs/caps or form. May worry patient.
- Healthcare assistant collecting scripts from GP surgery should check if they are signed by GP before collecting them.
- Hospital prescription. Dose incorrectly written and needed to be confirmed.
- Hospital prescriptions do not give much thought at times as to how much time is taken up - the handwriting is so poor.
- How to ascertain which women of child bearing age are breast-feeding mothers without upsetting them. Counter assistant may have large role to play.
- If Amoxicillin given with Methotrexate, contact prescriber since prescriber asked for patient to come to surgery for blood monitoring tests.
- If an item is not available then contact GP immediately - don't wait for person to come and pick up repeat script.
- Importance of CD been written correctly.
- Importance of communication with prescriber in these events.
- Importance of OTC/ADR.
- Importance of PMR repeats.
- Importance of printing interaction labels.

- Importance of WWHAM questions where selling items OTC. ADR to drugs.
- Important to try and identify those patients with reading difficulties.
- Legality of prescriptions.
- Long term manufacturer's problem - contacted wholesaler.
- MDS patients discharged from hospital should be given discharge summaries for local pharmacy filling meds as well as GP and community nurse team. As NEC.
- Mixed 10 and 20 now unavailable. Some dispensary staff were not aware of this at the time.
- Must know black listed items.
- Need to check details on EPS scripts.
- Need to check patient understands how to operate BP monitor when selling it.
- Need to fax with alternative for GP to consider.
- Need to perform extra precautions while changing dosage and dose.
- Need to perform extra precautions while changing the dose.
- Need to perform extra precautions while changing the dose.
- Need to refer to reference books, e.g. BNF. Dose of erythromycin 250 mg tablets was written as take on daily. After contacting prescriber he changed to one four times a day.
- Need to ring NPH Information dept. to confirm item N/A on NAS.
- Need to scrutinise prescriptions thoroughly so that patients are not at risk.
- Not all GPs following methotrexate audit guidelines still. Faxed GP with recommendations.
- Not all script for injections for personal administration are for dispensing by us.
- Not appropriate or cost-effective to supply 30 pack on script for 28.
- Not to use metronidazole whilst pregnant. Prescriber's discretion on breast feeding individuals.
- Note different GP practices may have different procedures for unlicensed medicine prescribing so contact for each individual will be necessary.
- Nurse cannot write private scripts (always check with local GPs).
- Observation - script dispensed and supplied on day before dosage change. Need to inform patient.
- Park mixtard 30 disc but there is another make available.
- Patient told Betnesol drops o/s but was unable to get from another pharmacy. FP10 should have been offered to be taken elsewhere.
- Patient's scenario activated need to understand warfarin dosages.
- PCT cost reduction scheme.
- Pharmacists need time for 'clinical check' of prescription (r/w BNF)
- Pharmacy team learned that GHC is more effective with first 24 hours after intercourse.
- Potentially serious interactions.
- Prescriptions to be valid must be signed.
- Px was from surgery whose policy is not to post Px for CD. Pharmacist had to personally collect amended Px which was a major inconvenience. Incorrect Px must not be dispensed in future.

- Recorded in dear Dr. Book.
- Repeatable prescriptions not always appropriate if patient's medication changes regularly.
- Resources available to check status of drugs, medicines.
- Resources to check drug status. Use of BNF to look for equivalents.
- Right prescription forms used.
- Sandoz and Actavis manufacture lactose free Citalopram.
- Saturday - Both items for 10 month old child (eyes). Tried several pharmacies, none bothered to ring prescriber and sort alternative for patient.
- Some interactions of clinical significance.
- That there is not a licensed UK product for ciprofloxacin ear drops. Either use eye drops if GP allow or order from imported wholesales. PPA will pay for either.
- The hospital prescribed 4-5 caps. Four times per day of Loperamide 2 mg caps.
- There is not always an exact chemical/drug alternative for every product.
- This interaction not generated by GP systems.
- To always check doses on the PMR warning.
- To check doses, Aciluvin tabs. Prescribed 7 tabs and dose take five daily, not one to be taken five times a day. Patient could have taken all five together.
- To check if script is signed on reception from patient.
- To contact prescriber instead of dispensing 2 x 500 g supps for the patient.
- To double check oral CD prescriptions meet legal requirements.
- To pay more attention to inhalers and inhaler devices.
- To take extra care with alendronic acid prescriptions.
- Use of progesterone (oral or vaginal/rectal).
- Use of SSRI, anti-depressants in teenagers can trigger suicidal behaviours.
- Vigilance with labelling and warnings of interactions on computer.
- Why not soluble tablet which is 1/3 cost price.
- With patients known to have problematical prescriptions, double check as handed in to reduce waiting time and inconvenience.