PHARMACIST AMENDMENT OF PRESCRIBING REGIMENS AND COMPILING LISTS OF TAKE HOME MEDICATION POLICY AND PROCEDURE

Version: 3

Name and Designation of Policy Author(s) | Gareth Price, Deputy Director of Pharmacy – Clinical Services
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Approved By (Committee / Group) | Clinical Governance Programme Board
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Target Audience | All pharmacists and all trust staff involved in medicines
Links to Other Strategies, Policies, Procedures, etc | Trust Policy 045 – Medicines Management Policy (General)
Consultation, Communication and Implementation

<table>
<thead>
<tr>
<th>Consultation Required</th>
<th>Authorised By</th>
<th>Date Authorised</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Impact Assessment</td>
<td>Julie Orton</td>
<td>14th November 2008</td>
<td>Screened for relevance – full impact assessment not required.</td>
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<tr>
<td>Policy Group</td>
<td>Pippa Roberts</td>
<td>8th December 2008</td>
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<td>Other Stakeholders /</td>
<td>Richard Stevenson –</td>
<td>8th November 2008 -</td>
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<td>Groups Consulted as Part of</td>
<td>Staff Governor and</td>
<td>8th December 2008</td>
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<tr>
<td>Development</td>
<td>Debra King, Consultant Physician</td>
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<td>Trust Staff Consultation</td>
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<td>via Intranet</td>
<td>8th November 2008 - 8th December 2008</td>
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</tbody>
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Date notice posted in the Team Information Exchange (TIE) | October 2010 | Date notice posted on the intranet | September 2010 |

Describe the Implementation Plan for the Policy / Procedure (Considerations include; launch event, awareness sessions, communication / training via DMBs and other management structures, etc) | By Whom will this be Delivered? |
| This policy will become part of all new pharmacists’ induction process and an update session will be held for current pharmacists | Deputy Director of Pharmacy, Clinical Services |

Version History

<table>
<thead>
<tr>
<th>Date</th>
<th>Ver</th>
<th>Author Name and Designation</th>
<th>Summary of Main Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 07</td>
<td>1</td>
<td>Neil Caldwell, Assistant Director of Pharmacy, Clinical Services</td>
<td>Update to new Trust format, re-structure to improve clarity and inclusion of section on prescribing medication to take home.</td>
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<tr>
<td>Mar 10</td>
<td>2</td>
<td>Gareth Price, Deputy Director of Pharmacy – Clinical Services</td>
<td>Additional statement regarding competency assessment of pharmacists to work under the policy (section 3) – approved by CGPB 08.10.10. Further clarity provided relating to the application of policy in additional prescribing scenarios (section 7.3, 7.6, 8.3) - approved by CGPB – 08.10.10. Additional statement regarding pharmacist self-check of amendments in section 7, 8, 9 – approved by CGPB 21.01.11. Addition of section 8.8 – prescribing of skin cleanser – approved by CGPB 21.01.11.</td>
</tr>
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<td>Jan 11</td>
<td>3</td>
<td>Gareth Price, Deputy Director of Pharmacy – Clinical Services</td>
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</tr>
</tbody>
</table>
### Monitoring Compliance with the Policy

<table>
<thead>
<tr>
<th>Describe Key Performance Indicators (KPIs)</th>
<th>Target</th>
<th>How will the KPI be Monitored?</th>
<th>Which Committee will Monitor this KPI?</th>
<th>Frequency of Review</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amendments to prescriptions will be documented in the notes as described in this policy.</td>
<td>100%</td>
<td>Audit. A sample of pharmacist amendment of prescribing regimens will be undertaken in each clinical division.</td>
<td>Clinical Governance Programme Board</td>
<td>Annual</td>
<td>Deputy Director of Pharmacy – Clinical Services.</td>
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<tr>
<td>Amendments described in section 6 of this paper will be confirmed with the Independent Prescriber.</td>
<td>100%</td>
<td>Audit. A sample of pharmacist amendment of prescribing regimens will be undertaken in each clinical division.</td>
<td>Clinical Governance Programme Board</td>
<td>Annual</td>
<td>Deputy Director of Pharmacy – Clinical Services.</td>
</tr>
</tbody>
</table>

### Performance Management of the Policy

<table>
<thead>
<tr>
<th>Who is Responsible for Producing Action Plans if KPIs are Not Met?</th>
<th>Which Committee Will Monitor These Action Plans?</th>
<th>Frequency of Review (To be agreed by Committee)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deputy Director of Pharmacy, Clinical Services</td>
<td>Clinical Governance Programme Board</td>
<td>Annually as part of a medicines management annual report or more frequently if action dictates</td>
</tr>
</tbody>
</table>
## CONTENTS

<table>
<thead>
<tr>
<th>Content</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>2. Purpose</td>
<td>1</td>
</tr>
<tr>
<td>3. Scope</td>
<td>1</td>
</tr>
<tr>
<td>4. Definitions</td>
<td>1</td>
</tr>
<tr>
<td>5. Duties / Responsibilities</td>
<td>1</td>
</tr>
<tr>
<td>6. Policy Statement: The Amendment of Prescribing Regimens by Pharmacists</td>
<td>2</td>
</tr>
<tr>
<td>7. Amendment of prescribing regimens by pharmacists where contact with the prescriber is needed before a change is made.</td>
<td>2</td>
</tr>
<tr>
<td>7.1 Clarification of Drug History</td>
<td>3</td>
</tr>
<tr>
<td>7.2 Inhaler Devices</td>
<td>3</td>
</tr>
<tr>
<td>7.3 Altered Dosage Forms</td>
<td>3</td>
</tr>
<tr>
<td>7.4 Clarification of Free-Text Order Entry</td>
<td>3</td>
</tr>
<tr>
<td>7.5 Prescription Therapy That May Result in Significant Patient Harm</td>
<td>3</td>
</tr>
<tr>
<td>7.6 Change to IV Therapy</td>
<td>4</td>
</tr>
<tr>
<td>7.7 Ward Round Working</td>
<td>4</td>
</tr>
<tr>
<td>8. Amendment of prescribing regimens by pharmacists where contact with the prescriber is not needed before a change is made.</td>
<td>4</td>
</tr>
<tr>
<td>8.1 Incorrect Dosing Schedule</td>
<td>4</td>
</tr>
<tr>
<td>8.2 Obsolete Medicines</td>
<td>5</td>
</tr>
<tr>
<td>8.3 Medicine Devices and Formulations</td>
<td>5</td>
</tr>
<tr>
<td>8.4 Incorrect Dosage Forms</td>
<td>6</td>
</tr>
<tr>
<td>8.5 Clarification of Free-Text Order Entry</td>
<td>6</td>
</tr>
<tr>
<td>8.6 Duplicate Therapy</td>
<td>6</td>
</tr>
<tr>
<td>8.7 Miscellaneous Dose Changes</td>
<td>7</td>
</tr>
<tr>
<td>8.8 Addition of skin cleanser solution for patients with a MRSA z-alert on PCIS</td>
<td>7</td>
</tr>
<tr>
<td>9. Compiling a List of Medication to Take Home</td>
<td>7</td>
</tr>
</tbody>
</table>
1. Introduction
Pharmacists have a professional responsibility for the way that medicines are managed. They review prescriptions for patients, provide expertise and advise both healthcare professionals and patients about optimal, safe, effective, evidence-based and cost-effective use of medicines. They provide training for junior medical staff on safe, rational and effective prescribing and give individual feedback on safe prescribing practice.

An intervention audit in 2009, co-ordinated by Manchester University, and sponsored by the General Medical Council, examined prescribing errors at WUTH. On 7 separate days 1286 errors were identified: 429 were class as minor, 775 were significant, 68 were serious and 14 were potentially lethal (the classification of these errors was peer reviewed by an expert panel). Interventions by a pharmacist and discussion with the prescriber prevent significant patient morbidity, and supports a reduction in length of stay.

Pharmacists routinely review all prescriptions for patients and work in partnership with other health care professionals to ensure appropriate outcomes from drug treatment.

2. Purpose
The purpose of this policy is to provide guidance to pharmacists with respect to amending prescriptions at WUTH and compiling lists of take home medication. It also aims to clarify permitted practice for pharmacists to other healthcare professionals working in the Trust.

3. Scope
The policy applies to all pharmacists providing pharmaceutical care within WUTH who are involved in amending prescribing regimens and compiling lists of take home medication. Only those pharmacists who have been approved by the Director of Medicines Management, Clinical Director Pharmacy Services or Deputy Director of Pharmacy (Clinical / Operational Services), having passed a competency assessment, may amend prescriptions as indicated in this policy.

4. Definitions
- **Medicines Reconciliation** – the process of identifying what medicines a patient was taking before a change in healthcare setting, comparing those medicines to what has been prescribed on admission, investigating any unexplained variances and rectifying any unintentional differences.
- **Non-Medical Independent Prescriber** – a qualified and registered non-medical (nurse or pharmacist) prescriber who is able to prescribe medicines within their area of competence and recorded in their individual P-formulary.

5. Duties / Responsibilities
- **Clinical Director of Pharmacy, Director of Medicines Management**
The Clinical Director of Pharmacy, Director of Medicines Management is accountable to the Board of Directors for the systems and processes relating to the safe and secure handling of medicines.
• **Pharmacists**
Pharmacists must always act within their level of competence. They must understand the legal framework for medicines management and be clear about their professional responsibilities under current legislation whilst working to ensure the well-being and safety of patients and members of the public. Pharmacists must follow this policy when amending prescribing regimens for patients or compiling lists of take home medication.

• **Independent Prescribers (IPs)**
IPs must always act or advise within their level of competence.

### 6. Policy Statement: The Amendment of Prescribing Regimens by Pharmacists

At WUTH, pharmacists can make adjustments to drug therapy, provided that the change is discussed with a doctor and the discussion documented in the patient’s record. The record should include the name of the doctor who agreed the change, the name of the intervening pharmacist, the date and their bleep number. Usually this record will be made in the patient’s case notes, however, if the intervening pharmacist is working in the Pharmacy the prescriber may be asked to record the change in the medical noted and the pharmacist may record the in the change in pharmacy notes on PCIS.

In most instances the pharmacist will discuss with the doctor before a change to the prescription is made. This policy and procedure also details instances when a pharmacist can amend a prescribing regime without first making contact with the prescriber e.g. when additions are made to clarify a particular aspect of an individual patient’s medication regime rather than amend the medication prescribed.

Pharmacists can also compile a list of take home medication for patients in accordance with section 9 of this policy.

### 7. Amendment of prescribing regimens by pharmacists where contact with the prescriber is needed before a change is made.

In the majority of instances a doctor or other IP must be contacted before a change to the prescription can be made. In each case the pharmacist must undertake the following:

- The change must be made clearly to the electronic and / or paper prescription record, complying with the requirements specified for prescriptions in the Trust’s Medicines Management Policy (General).
- The pharmacist must perform a self-check of the prescription once the amendment has been made (or alternatively the prescription may be checked by another pharmacist or medical staff).
- The change to the prescription must be clearly documented in the patient’s record – as described in the Medicines Management Policy (General).
  a) If the patient’s medical notes are accessible to the pharmacist - the change must be documented by the pharmacist in the medical notes.
  b) If the patient’s medical notes are not accessible to the pharmacist, for example the requirement for a change is identified by a pharmacist working in the dispensary, the doctor or IP must be asked to record the change in the medical notes at their earliest convenience.
• Where appropriate, the change may be recorded in the pharmacy notes in PCIS in addition to the medical notes (eg to ensure clear communication to other pharmacy staff).

N.B. It is important to remember that if the change is made following approval from a non-medical independent prescriber then the prescriber must have the medicine which is being amended (stopped, started, dose change) in their personal formulary.

Examples of where discussion with an independent prescriber must take place prior to a change follow below:

7.1 Clarification of Drug History
During the medicines reconciliation process the pharmacist may identify that the initial prescription is ambiguous or incorrect. A pharmacist can remedy this in most instances by gaining clarity directly from the patient or GP regarding what medicines they were taking before admission. Examples include:
• Medication omitted from clerking in
• Medication prescribed on admission but not in the medication history

7.2 Inhaler Devices
A change to the inhaler device may be required following counselling and assessment by a pharmacist.

7.3 Altered Dosage Forms
Dosage forms of medicines may be incorrectly prescribed. Examples include:
• When a patient is 'nil by mouth', or is no longer nil by mouth – medicines may need to be changed from oral to parenteral or vice versa.
• The prescription may need to be amended to an unlicensed medicine to facilitate administration. For example, if an enteral tube has been inserted (or taken out) the formulation may be changed from tablet to an unlicensed liquid preparation, or to crushed tablets ('off-label' or unlicensed use of a medicine).
  i. In the case of an unlicensed product being used - the prescriber needs to be contacted prior to the change (and the change must be documented in medical notes) to ensure that the prescriber is aware of the implications of using an unlicensed medicine.
  ii. If the change involves the use of a licensed drug, but outside of its product license – the pharmacist can make the change without contacting the prescriber first if it does not involve a change in dose (see section 8.3).
• The prescribed dose form (eg modified release preparation) is ambiguous and needs clarification.

7.4 Clarification of Free-Text Order Entry
Medicines prescribed on PCIS by free-text order entry and not selected from the medicines index may be incomplete or incorrect. Often the dose, route of administration, dosage form or strength / concentration of solution is omitted from the prescription. If the prescriber’s intention is unclear the prescriber must be contacted before the prescription is amended.

7.5 Prescription Therapy That May Result in Significant Patient Harm
Very occasionally medicines are prescribed which, if administered to a patient, could cause fatality or significant harm. The pharmacist has a duty of care to protect the patient
from such events. For example, where a pharmacist considers that the prescribed therapy presents an immediate danger to a patient, for example penicillin prescribed to a patient who has previously suffered an anaphylactic reaction to penicillin, the pharmacist will liaise with nursing staff to ensure the drug is not given. The pharmacist should remove the order from the prescription. The pharmacist should attempt to contact the prescriber before this change is made, but if this is not possible attempts must then be made to contact the prescriber or medical team as soon as possible after making the change.

### 7.6 Change to IV Therapy

If the prescriber has specified the IV diluent and volume for an IV infusion which is not the recognised standard method of delivery – the prescriber should be contacted prior to changing the prescription to discuss and agree the changes. If no diluent or volume is specified and the requirements are uncertain (e.g., renal impairment) the prescriber must be contacted prior to the change to clarify.

### 7.7 Ward Round Working

Pharmacists work closely with the multidisciplinary teams and on a ward round can adjust, remove or add any drug on the instruction of the doctor. Either the doctor or the pharmacist should record the change in the medical notes.

### 8. Amendment of prescribing regimens by pharmacists where contact with the prescriber is not needed before a change is made.

In certain circumstances, the pharmacist can make a change to the prescription before they communicate the change to the prescriber. In these situations:

- The change must be made to the electronic and/or paper prescription by the pharmacist, complying with the requirements specified for prescriptions in the Trust Medicines Management Policy (General).
- The pharmacist must perform a self-check of the prescription once the amendment has been made (or alternatively the prescription may be checked by another pharmacist or medical staff).
- The prescriber should be contacted retrospectively for educational purposes (this may be in the form of 1:1 communication, or in the form of feedback during a ward round or training session).
- It is not necessary to document these changes in the patient’s medical notes. The pharmacist may make a record of the change in the pharmacist notes in PCIS, where appropriate, to inform colleagues and ensure continuity of care.

Examples where changes can be made without prior contact with the prescriber follow below:

#### 8.1 Incorrect Dosing Schedule

Medicines prescribed at inappropriate schedules in terms of patient preference, clinical efficacy, potential for drug interaction or medicines prescribed regularly which may be more appropriate on a PRN schedule. The pharmacist can amend schedules to improve efficacy, promote compliance or take account of patient preference. Examples include:

- Quinolone antibiotic prescribed at the same time as ferrous sulphate. These medicines interact with reduced absorption of the antibiotic so the times of administration need amendment.
- Metformin which is not prescribed at meal times (e.g.: 500mg TDS which schedules administration on PCIS at 1000, 1400 and 2200 hours) needs the times
of administration changing (i.e.: to 500mg TDS-AC which schedules medicines at breakfast, lunchtime and teatime).

- A bisphosphonate prescribed at a meal-time when it needs to be on an empty stomach.
- “Folic acid 5mg tab po stat,” with a free typed instruction, “and then weekly”. The prescriber’s intent is clear but PCIS would remove the prescription once the stat order was given. This needs amending by prescribing a weekly scheduled order.
- Changing the day of a weekly drug to correspond with the day the patient usually takes the medicine.
- Medicines prescribed "when required" where they are unlikely to be therapeutically effective unless given regularly. The pharmacist can make the change only for those medicines where there is a recognized standard dose. This situation only applies to:
  o Aciclovir cream PRN can be changed to five times a day
  o Nystatin oral solution PRN can be changed to QDS
  o Chloramphenicol eye drops PRN can be changed to QDS.

8.2 Obsolete Medicines
The pharmacist can discontinue obsolete medicines, such as “when required” medicines which are no longer clinically necessary and are not being administered, or those which have expired according to their intended duration and unnecessary “stat” doses. Examples include:

- A sodium chloride intravenous flush may be discontinued when the cannula has been removed, or intravenous therapy discontinued for patients with no venous access or where there is no need for continuation of therapy, such as “Ondansetron 4mg inj iv 6hrly prn n/v.”
- Some prescriptions are no longer indicated when they have passed the recommended duration of therapy, and they should be removed from the current drugs list on PCIS. On PCIS this means “discontinuing” it, when in reality it has already been discontinued, it is just “tidying up” the prescription. For example - patients may be transferred from CCU with a range of PRN orders to manage chest pain, some with duration of 3 days only.
- STAT doses of agents such as paracetamol where patients are prescribed a regular schedule of the drug as well which the nurse was able to administer at a suitable time without the need for the stat prescription. The stat dose should be removed to reduce the risk of incorrectly giving the stat dose in addition to the regular prescription.

8.3 Medicine Devices and Formulations
Pharmacists are able to add to the prescription to specify the appropriate device or formulation if this is not clear in the original prescription. Examples include:

- Inhaler formulations / devices are commonly not specified or incorrect. The pharmacist can amend an inhaler device to the usual device used by the patient. However, if the prescription is for one puff but the patient takes two puffs – to make this change would require a change in the prescribed dose and as such must be confirmed with the prescriber or medical team as in section 7.
- Incorrect insulin device prescribed - the pharmacist can amend or add an insulin device to the usual device used by the patient. The device is often not stated, namely 3ml cartridge, vial or disposable pen. This information is required to allow a prescription to be dispensed, and informs the GP on the discharge summary.
what device the patient uses. For example, “Novorapid inj sc tds,” may be amended to “Novorapid Flexpen inj sc, tds-ac – see chart.”

- The pharmacist can transcribe insulin or warfarin that has been written onto a paper insulin or anticoagulant chart alone onto PCIS (with the annotation “see chart” so clinicians are directed to the paper chart)
- The pharmacist can change the formulation of GTN to the formulation regularly used by the patient, provided this does not involve a dose change.
- The pharmacist can change the formulation of an oral medicine, when required, to facilitate administration when a patient has an enteral feeding tube inserted (or taken out), when this involves changing from a tablet to liquid formulation that does not require a change in dose. This only applies if a licensed medicine is available, unless the use of licensed drug outside its product license has been approved by the Trust via a clinical guideline. See section 7.3 if this scenario involves a change to a drug without a product license.
- If an IV infusion has been prescribed, but the diluent and volume has not been specified – the pharmacist can give clarity to the prescription by specifying the standard licensed diluent and volume to be used (or that specified in a Trust approved guideline). If there is any uncertainty about the diluent or volume to be used (e.g. due to renal impairment, or use outside the product license) the prescriber must be contacted prior to amending the prescription (see section 7.6).
- If a prescription for a child specifies a tablet formulation and the parent requests a liquid formulation because the child will not accept a tablet – the prescription can be amended by the pharmacist to a licensed (or Trust approved use of a drug outside of its license via clinical guideline) liquid alternative to facilitate concordance, provided this does not involve a dose change. If this amendment involves a dose change, or a change to a product without a license – the prescriber must be contacted first.

8.4 Incorrect Dosage Forms
Dosage forms of medicines may be incorrectly prescribed. For example, a patient may bring in their own modified release theophylline which is prescribed as Nuelin SA 200mg tab po nocte - but the preparation does not exist. The pharmacist can amend this to Uniphyllin 200mg tab po nocte provided it has been confirmed with the patient that this is what is regularly taken.

8.5 Clarification of Free-Text Order Entry
Medicines prescribed on PCIS by free-text order entry and not selected from the medicines index may be incomplete or incorrect – commonly omitting the generic drug name, dose, the route of administration, dosage form or strength / concentration of solution. The pharmacist may re-prescribe free text orders to complete or clarify missing or ambiguous data if the prescriber's intent is clear. Examples include:
- A patient may be prescribed, “Think and Easy prn.” The pharmacist can amend this to, “Thick and Easy, po prn add to feeds as directed by dietician.”
- A prescription for “Plavix 75mg mane” may be changed to “Clopidogrel 75mg tab po mane”.
- A prescription for “Amlodipine 10mg mane” may be changed to “Amlodipine 10mg tab po mane”.

8.6 Duplicate Therapy
Duplicate orders may result in overdose, so the pharmacist can amend and discontinue duplicate therapy to avoid overdose. Examples include:
• Patient prescribed a medicine both regularly and “when required” which may result in an overdose, or different formulations or routes of administration of the same medicine (paracetamol and co-codamol).

8.7 Miscellaneous Dose Changes
A range of prescriptions will require clarification to improve efficacy, reduce waste and enable a supply of medicine to be dispensed to the patient. Examples include:
• Pharmacist amending the prescription to illustrate a standard dose – such as eye drops to 1 drop, ear drops to 3 drops, or clarify the volume of mouthwash to be used. This does not need to be documented in the patient’s medical record.
• Availability of some medicines may be erratic, and in such cases the patient is best served by receiving the medicine which pharmacy has in stock. Where relative bioequivalence is accepted and approved by the Drugs and Therapeutics Committee Chair, the pharmacist can change prescriptions to enable a supply of a similar dose of medicine. Supplies of sodium bicarbonate switch between 600mg and 500mg depending on what is available from suppliers.

8.8 Addition of skin cleanser solution for patients with a MRSA z-alert on PCIS
All patients with a MRSA z-alert on PCIS should have a skin cleanser solution prescribed at the earliest opportunity. If a patient is found not to have a skin cleanser prescribed the pharmacist may add the appropriate skin cleanser to the prescription – accounting for patient allergies and in line with the Trust recommended 1st / 2nd choice agents.

9. Compiling a List of Medication to Take Home
A pharmacist must be authorised by the Clinical Director of Pharmacy, Director of Medicines Management to compile lists of take home medication.

Pharmacists will not compile a list of take home medication for a patient unless they have full knowledge of their requirements for medication.

Pharmacist compilation of lists of medication to take home will generally be done as part of the multidisciplinary team and usually within the ward round setting. The pharmacist must liaise with the patient, nursing staff and doctor or dentist, as appropriate to decide what is needed to take home. The doctor, dentist or non-medical independent prescriber must confirm either that everything is to continue or specify what amendments must be made to the in-patient prescription, such as a course length or discontinuation of therapy which is no longer necessary. If a non-medical prescriber is to confirm what is required to take home and what is to stop – all the medicines involved must be in their P-formulary. The pharmacist should document in the medical notes that the TTH has been compiled with the agreement of a named doctor, dentist or IP. The pharmacist must complete an unambiguous To Take Home requisition, with no duplicate orders. The pharmacist must perform a self-check once the TTH has been compiled (or alternatively the prescription may be checked by another pharmacist or medical staff).

A pharmacist may generate the necessary PCIS proforma for controlled drugs that are subject to the prescription requirements of the Misuse of Drugs Regulations 2001, as amended. The proforma must be authorised, signed and dated by a legitimate prescriber, before a supply will be dispensed.