Community Pharmacies

- All staff to review the SOP and sign. Out of date CDs to be labelled clearly 'out of date' and 'do not destroy'. CD cabinet to be checked regularly for any new out of dates and clearly organised. Patient returns to be destroyed as soon as possible and kept clearly separate. Staff are not to go in CD cabinet without pharmacist being aware of reason and should not open in relation to destruction. Review training of newer staff
- Importance of weekly balance checks and timely entries into CD register
- Ensure all appropriate staff members can perform balance checks and entries into the CD register so that good CD management and record keeping is maintained when there is no regular pharmacist
- Importance of pharmacy team being aware of instalment information for patients, having that information highlighted in event diaries and record cards
- Pharmacy learning and recommendation is to make sure that pharmacy staff are aware that third party collections for OST clients need to be first authorised by a substance misuse service prescriber
- Importance of always checking the patient's name and address prior to handing out the supply of any medicine but especially a supervised methadone supply
- Staff will be re-briefed to read SOPs in handing out Rx. Staff to ask for patient Identification - where the name and address is checked
- CD items are to be stored in transparent plastic bags so they can be seen before handing out
- To check the identity of the patient on each occasion against the prescription and labels no matter how well known
- Stock should not be placed on the checking bench. Pharmacist to review working methods - ensure checking and bagging process complete before breaking away to speak to a patient
- The pregabalin has now been moved to a separate shelf in the dispensary and a notice placed where it was located on the 'P' shelf advising operators of its location
- Importance of not overloading benches, if necessary, pause dispensing so checkers can catch up. Importance of having separate work areas for different activities e.g. checking, dispensing, delivery unpacking
- Importance of ensuring self-check is only done as a last resort and done following relevant SOP; importance of thorough accuracy checks throughout entire dispensing and checking process.
- Old prescription dispensed from – prescription changes to be communicated to locum pharmacists and for only one script to be active
- Must have separate checks by another colleague as well as the pharmacist. Must be dispensed either using the substance misuse module within the PMR software or entering in from the start - must not be labelled using 'repeat' facility. Pharmacist to change working methods and ensure prescription is fully read end to end each time an instalment is dispensed.
- Schedule 2 CDs had been transferred into the MDS room meds cupboard for storage/dispensing into dosette in error. CD register recording - in error schedule 2 CDs stock was found to be routinely being recorded as ‘transferred out to MDS’ in the register. Discussion helped to identify gaps in knowledge/ competencies. Staff now aware fully of CD storage requirements and recording in and out of the register.
- Out of date stock destroyed without an Authorised Witness and recorded in the patient returns book. Discussion helped to identify gaps in knowledge/ competencies. Staff aware of requirement for an authorised witness to be present and who to contact to request an Authorised Witness.
- Remain vigilant to the potential for fraudulent prescriptions, particularly private prescriptions which are not always on letterheaded paper. If fraudulent prescription presented, retain prescription, and advise patient to return after prescriber contacted - ask patient for contact number
- Importance of staying up to date and being made aware of all alerts and updates sent. Important that the teams are making locums aware