



CommunityPharmacist

March 2005



New guidance on MAR charts

The Royal Pharmaceutical Society has issued new guidance on the provision of medication administration record (MAR) charts. This has been produced in conjunction with a number of expert pharmacists and with input from the National Pharmaceutical Association.

The guidance highlights the point that MAR charts, although not an integral element of the supply of medicines to care homes, are an important source of information for care workers. Care workers often depend on the content and accuracy of MAR charts for the administration of medicines. As formal records of medicine administration MAR charts are considered official documents and have been used as evidence in court cases.

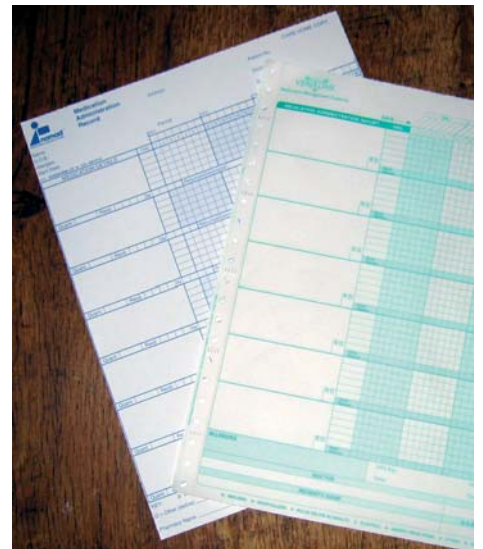
The main source of information for producing the MAR chart is the prescription and there must be consistency between the details on the chart (ie, the product, strength, dose and frequency) and the label attached to the dispensed item. There are a range of good practice recommendations, including the need to have a communication system in place between the prescriber, care worker and pharmacist to capture changes in prescribing and to manage appropriately medicines used on a "when necessary" basis.

MAR charts should be produced at the same time as dispensing and updated monthly. Where more than one chart is issued, they should be numbered sequentially and it is recommended that they should also be linked (eg, stapled). Separate charts are recommended for items of a limited duration (eg, antibiotics) but, if possible, these should be attached to patients' other chart(s).

It is important to remember that a MAR chart once received by a health and social care service becomes the responsibility of that organisation, which may add non-prescribed items that the client chooses to take, for example, herbal and homoeopathic remedies.

Supplying blank MAR charts to a care home or children's service is encouraged so that care workers can prepare a handwritten chart for new clients who are admitted with a supply of medicines so that the same administration record system can be used.

Some care homes ask pharmacies to supply duplicate labels when dispensing. However, in June 2002, the Council decided to recommend that pharmacists do not supply additional labels to attach to MAR charts already in use because they have no way of guaran-



teeing that they will applied to the appropriate chart or that they are not removed at a later date.

For a full version of the guidance visit the practice guidance section on the Society's website (www.rpsgb.org)

Dear Reader

Here is the new-style CPG newsletter. The Community Pharmacy Group committee was delighted when the Council decided to restore support for the newsletter and more so when *The Pharmaceutical Journal* agreed to accommodate us.

Ask any practising community pharmacist "what's new" and the immediate response is "the contract", followed closely by "the fallout from Shipman". Looking at the contract, the priority must be to ensure effective communication with primary care trusts. However, little has been said about implementation. For example, under current employment law, it is difficult for employers to overturn existing work practices and rewrite job descriptions unless employees are in agreement. Fortunately, we have an enormous reservoir of goodwill and loyalty in our staff.

The Shipman case will change the way we practise. There will be more bureaucracy in record keeping, running balances, new registers and identity checks. But forewarned is forearmed so watch the pharmaceutical press and archive the cuttings.

Thank you, the members, for your continuing support. Rest assured that the CPG committee is here to feed the above concerns, and more, straight into Lambeth.

Jeremy Clitherow

CPG chairman

FOREWORD

Framework for pharmacists with special interests

At a recent conference organised by the *Health Service Journal*, David Colin-Thomé (National Clinical Director for Primary Care) announced that the Department of Health will shortly be looking to develop the framework for pharmacists with special interest positions.

The purpose of developing practitioners with special interests is to improve access to services and bring more secondary care procedures into primary care settings. Clearly, pharmacists have an important role in delivering this agenda. Frameworks have already been developed for health care professionals, such as GPs and nurses.

The Royal Pharmaceutical Society is aware that some primary care trusts have already started to develop positions for community and primary care pharmacists and is interested in hearing from pharmacists working in these positions or developing these roles, especially if this involves dermatology.

Please send comments to Sue Kilby, head of practice (e-mail Sue.Kilby@rpsgb.org)



MEETINGS

Supplementary prescribers review and reflection day

Date: 11 April

Venue: Royal Pharmaceutical Society, Lambeth

Contact: Angela.Canning@rpsgb.org

If you are a supplementary prescriber, this day is for you. The Society wants to hear from pharmacist supplementary prescribers about their key challenges and benefits of prescribing. We would also like to find out what still needs to be done, especially with independent prescribing just round the corner.

While most of the day will involve workshops there will be presentations from Clive Jackson, Gill Hawksworth, Gul Root, Karen Acott, Helen Williams and Mahesh Sodha. The meeting outcomes will be used to inform the supplementary prescribing agenda so if you have completed the prescribing course we are keen to hear from you.

Interested in animals?

Have you ever wondered how many of your customers have pets? The Pet Health Council estimates that half of all UK households own one. There are 7.5 million cats and 6.1 million dogs in the UK so this means that a lot of people going into pharmacies could seek your advice on their pet's health care.

If this is an area that interests you but you do not know how to get involved, come to the annual veterinary pharmacy conference on Sunday 24 July at the Whitehouse Hotel in Telford, Shropshire. This year's conference, "Paws for thought" is aimed at people who want to find out about veterinary pharmacy. Community pharmacists who specialise in this area will be telling you how to get started and what the benefits are.

There will be a presentation from Stephen Dean, chief executive of the Veterinary Medicines Directorate, explaining the changes to the new veterinary legislation and what it will mean for pharmacy. Dr Dean is also a vet and he will be giving advice on how to work at a local level with vets.

While the main conference is on Sunday, if you want to come to Telford for the weekend, there will be a dinner on Saturday night where you can meet veterinary pharmacy group members and build up a network of contacts who will only be too willing to help and advise you on your journey into veterinary pharmacy.

For details of the conference or veterinary pharmacy contact Lorraine.Fearon@rpsgb.org (tel 020 7572 2409)

POM-to-Ps: what should be switched first?



The Royal Pharmaceutical Society is reviewing its approach to POM-to-P switches. It is high on the Government's agenda to increase access to medicines and to encourage self-care. Mechanisms to ensure medicines are considered from a safety and efficacy perspective before being moved from POM to P exist, but should other factors be taken into consideration and, if so, what are these other factors?

What is happening now

The Society has generally supported all the products that have been put forward for switching. This support was given based on confidence that switches would enable pharmacists to use their skills and knowledge to manage symptoms or requests made by the public more effectively. However, there is now a whole range of options for supply of medicines to the public, including patient group directives, minor ailment schemes, supplementary prescribing and, it is hoped, in the near future, independent prescribing. With these options available, is moving products from POM to P necessarily the right approach?

Where priorities should lie

For many prescribed therapy areas there are clear evidence-based guidelines. However, this is not necessarily the case for conditions managed over the counter. Should the Society review areas that are commonly managed by pharmacy using evidence-based guidelines? It could be argued that it is in conditions for which appropriate products are not available that the Society should prioritise and advocate switching.

We know that people often go into a pharmacy thinking that they have a particular condition when in fact their symptoms are common to many other illnesses. For example, someone might go to a pharmacy to purchase a cough medicine when in fact they have asthma. The pharmacist then has to refer the patient to his or her GP for treatment. So

should pharmacy be looking to obtain P products for conditions where we currently have to refer patients to GPs?

Should the Medicines and Healthcare products Regulatory Agency take account of whether or not there is a clear public health need? Community pharmacy already plays an important role in identifying conditions that are often undiagnosed in the population, such as hypertension. The step up from this would be to be able to treat these conditions in the pharmacy. There would, of course, need to be clear guidelines for the management of these conditions and good communication with the rest of the health care team.

Some people have conditions that are chronic but which are characterised by relapses and remissions. They know what they need to treat their condition and, often, it is important to start treatment quickly to minimise flare ups. Examples of this are skin conditions, such as eczema and psoriasis. More products in these areas could be ideal candidates for switching.

Equally important to which products should be switched is how they are switched. For some products, especially those being used to treat clinical areas new to community pharmacy (eg, asthma and hypertension), perhaps there should be an intermediate step before the product becomes a P medicine. This could be a patient group direction. An intermediate step would allow training and protocols to be piloted and information on customer and pharmacy acceptability could be gained before reclassification was attempted.

The training that is required and how this is provided is another issue the Society is looking at. This is likely to vary according to the product being switched and it is unlikely that one option will fit all.

Your view

If you have any comments or thoughts on the above please send them to Sadia.Khan@rpsgb.org

How one PCT is progressing the new contract

Michael Beaman, chief pharmacist for the North Hertfordshire and Stevenage Primary Care Trust has done a vast amount for the profession. His Barnet High Street Health Campaign Scheme in the 1980s was one of the first projects to give credit to community pharmacists for providing health promotion messages and this later became a requirement of the community pharmacy contract. Mike spoke to Robert Clayton of the practice division

How do you see the new contract for community pharmacy developing? We are fortunate that primary care trusts are enthusiastic to deliver the new contract and regard it as a golden opportunity to put community pharmacy at the forefront of creating a new health care system that is proactive and educational. However, the ability to implement the contract will vary throughout the country, depending on the level of pharmacy staff and relevant expertise within PCTs. My PCT is fortunate to have a comprehensive team of players. My team consists of another health care worker, a pharmacist recently recruited from the community and me.

In some areas, however, responsibility for the implementation of the contract has been given to PCT prescribing advisers. This is not always appropriate because for some, their remit has only involved them with GP prescribing. In addition, the fact that there are over 300 PCTs nationwide means that the ability to network across such a large number of trusts is not as easy as it was with health authorities.

How are you dealing with these sorts of communication difficulties? North Hertfordshire and Stevenage, and Welwyn and Hatfield

PCTs are working together. We are also running pharmacy development groups. These meet every four months and all community pharmacists can attend. We are especially keen to reach out to locum pharmacists. The meetings are sponsored by the PCTs and hosted by their support staff. Meetings normally follow the same format: a business section and an educational section with a guest speaker followed by a question and answer session. Of course, the new contract has been a hot topic at recent meetings.

Do you envisage problems in delivering the new contract? Hertfordshire's PCTs have a joint steering group and it is confident that essential services will be in place by 1 April. However, the delivery of advanced and enhanced services requires co-ordination and planning with GPs and other health workers. We want to implement diagnostic testing across Hertfordshire and discussions are being held with local surgeries to determine the unmet need in providing these services.

Enhanced services provide another set of problems. There is the potential for direct competition with GPs because there is only one pot of money. There needs to be a strategy within the PCT to identify where and by

whom these services will be provided. Community pharmacies already have a proven track record in smoking cessation and providing services for drug misusers. In addition, giving lifestyle advice is not an area that GPs have shown a great deal of interest in. Potentially this advice could be supported by diagnostic testing. It is important that these services are planned and co-ordinated by the PCTs across all health providers. Pharmacists should be aware that some PCTs might have additional funding streams. Implementing the new contract will be a challenge.

Are there any areas of the community pharmacy agenda that concern you? I am concerned about the change of the control of entry requirements that come into force next month. If there were a substantial increase in the number of pharmacies offering a 24-hour service, this could destabilise the pharmacy workforce by taking pharmacists away from already established premises. This could lead to an overall shortage of pharmacists in the short term. Although it is encouraging that there are several new schools of pharmacy coming on stream in September, there could be a national shortage of pharmacists for at least the next five years.

Practice committee looks at work pressures in community pharmacy

The work pressures facing community pharmacists were discussed at a recent CPG committee meeting. These included:

- A constantly rising workload, with no time for breaks
- Poor staffing levels and concerns about the quality of support staff
- Increasing bureaucracy and management tasks
- Evenings spent delivering medicines to house-bound patients, catching up on paperwork and attending training courses
- Needs to meet new contract requirements (but is it unclear what these are)
- An uncertain future due to threats of new pharmacies opening in competition

Staffing levels can be an especially difficult issue for locums who are not used to a pharmacy. There may be inadequate staffing levels to begin with or staff can be suddenly directed to other shops in a chain. With the range of new services that pharmacy is taking

on, it is even more important to have the right skill mix available in pharmacies.

The requirement to have standard operating procedures (SOPs) in place has been a recent pressure. It was agreed that SOPs are important but it was also recognised that their introduction can cause problems. For independent pharmacies, the major problem is the time required to produce them. Pharmacists working in multiples may have SOPs that are generic for the company but these can still need adapting to local circumstances.

Locums pharmacists face problems in ensuring that SOPs relate to what happens in practice, and some reported problems finding them. SOPs need to be reviewed on a regular basis.

The new contract for England and Wales is causing concern because of uncertainty over what it will mean and how it will be implemented. For example, where should consultation areas be positioned and what is actually required? If a primary care trust or local health board decides to commission a

diagnostic testing service, the consultation area will, at least, need a sink. But how can we be sure that what is required now will meet future needs? No one wants to invest in something that will need replacing later.

A deep concern of the Society's Practice Committee is that if pharmacists are working under too much pressure, it could affect patient care. Equally important is the adverse effects this might have on individual pharmacists. The Practice Committee has established a group to look at work pressures in community pharmacy now and in the longer term. The group will also look at what the Society can do to address these problems. Solutions might include work on skill mix, increased automation of dispensing, reviewing individual pharmacists, superintendents and corporate responsibilities, and making it easier for pharmacists to report their concerns.

The CPG is actively contributing to this work. Comments can be sent to Robert.Clayton@rpsgb.org



The CPG committee welcomes your input



Left to right: Gerald Zeidman, Caryl Kelly, Vanessa Taylor, Jeremy Clitherow, Mike King, Davan Eustace, John Hind and Sue Kilby

Ever wondered what the Community Pharmacy Group is and what it can do for you? Now is your chance to find out. The CPG was set up in 1994 to:

- Advance community pharmacy practice
- Promote the application of pharmaceutical knowledge and skills in community pharmacy practice
- Represent the views of group members to the Council on policies for development, on the committee's initiative, through the practice division
- Represent the views of group members to the relevant Council committee on implementation of policy, on the committee's initiative, through the Council committee's secretary
- Provide advice, on request, to the Council, its committees and its working groups on any aspect of community pharmacy practice

The CPG committee has nine elected members. The committee meets three times a year at the Society's headquarters to discuss policies and strategies that are likely to impact on community pharmacists and their staff. Comments on the topics discussed at committee meetings are passed on to the various committees within Lambeth. This means policy makers get an idea of how their decisions will be viewed by pharmacists working at dispensary benches and medicine counters throughout the country. Some of the topics discussed at recent meetings include:

The new contract The CPG committee has been looking at the practical implications of the new contract for community pharma-

cists in terms of accreditation, resource, training and capacity. Comments have been passed on to the appropriate Society committees to ensure that decisions are not taken without considering what will happen at grass roots.

Public health strategy The public health strategy for pharmacy 2005–15 and the various service developments that this might entail is a current hot topic. Discussions have included aspects such as pharmaceutical needs assessment, chronic disease management, smoking cessation, obesity, sexual health, mental health, veterinary products, language barriers and issues around the provision of information to family members of patients with inheritable conditions. Trying to emphasise the contribution that community pharmacists can have on the nation's health is one of the committee's aims.

Extended hours services The implications for community pharmacists of the extended- or out-of-hours services are widespread and can be a great opportunity but the CPG is trying to ensure that they do not become a massive burden. Suggestions and comments on the services have been passed on to decision makers within Lambeth.

Work pressures Many of the initiatives that community pharmacists are getting involved in mean an increase in paperwork. The committee members all have experience of working within busy community pharmacies and are pointing out the pressures that such impositions can cause in a day-to-day situation. Inadequate staffing levels are another source of concern. Lobbying the Society to insist on adequate staffing as a professional re-

quirement on the grounds of patient safety is another of the committee's aims (see pC3).

Community pharmacists comprise the largest proportion of the membership of the Society. It is important to make sure that our voice is heard in the corridors and meeting rooms where decisions are made. To be able to do this effectively, we need your input. We want communication from you, our colleagues, on how you manage the demands of your everyday situations. Pharmacists may not like the concept but, in the current political climate generated across the river from Lambeth High Street, documented examples of both the good and bad aspects of practice are essential to enable us to change the minds of civil servants in Whitehall. The CPG committee values your thoughts and ideas — whether they be critical or complimentary. You can contact the committee through Angela.Canning@rpsgb.org

Resources for the new pharmacy contract

- The Centre for Pharmacy Postgraduate Education is holding summer workshops to support pharmacists in implementing the new contract. Contact Jennifer@cppe.man.ac.uk
- The National Pharmaceutical Association has materials to help pharmacies meet new contract requirements. For example, the document "Implementing a community pharmacy strategy — a practical toolkit for primary care organisations in England" can be accessed at www.npa.co.uk