PHARMACISTS' AMENDMENTS TO PRESCRIPTIONS

April 2017

Version 2.5

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1. Introduction

Prescriptions issued by doctors and other independent prescribers are sometimes deficient in terms of timing, frequency, accuracy of transcription, reconciliation with previous medication or pharmaceutical aspects such as formulation. Where prescribers are present on the ward, these issues are dealt with face to face, but where the prescriber is unavailable it is appropriate for pharmacists to be able to amend these prescriptions while adhering to the original prescribing intentions. The alternative, leaving written messages for prescribers, is less reliable and can introduce delay.

2. Purpose of this Policy

To allow suitably experienced pharmacists to optimise prescriptions, and to ensure that any amendments to prescriptions by RCHT pharmacists are made in accordance with procedures approved by the Medication Practice Committee.

3. Scope

This document lists the occasions when an authorised pharmacist may amend or add to a prescription, originally prescribed electronically within RCHT, and the action which may be taken.

4. Definitions/Glossary

Aria	electronic prescribing system used for chemotherapy
BNF	British National Formulary
EPMA	Electronic Prescribing and Medicines Administration
GLF	General Level Framework, assessed by Education & Training Lead pharmacist
JAC	Software used at RCHT to provide EPMA
MedRec	Medicines Reconciliation
RCHT	Royal Cornwall Hospitals Trust
SPC	Summary of Product Characteristics

5. Ownership and Responsibilities

This procedure is intended to avoid the delay and uncertainty caused when pharmacists leave messages asking prescribers to amend electronic prescriptions. Pharmacists will still take opportunities to educate prescribers in good prescribing, either face to face or by example. This policy will not be used when seriously deficient prescribing needs to be discussed with the prescriber.

6. Standards and Practice

6.1. The following section lists the occasions when a pharmacist may amend a prescription, originally written electronically by a prescriber within RCHT, and the action which may be taken.

6.2. Times of administration

- When any medicine requiring evenly spaced dosing is prescribed at the recommended frequency but the timings selected are inappropriate a

pharmacist may modify the electronic prescription, choosing timings most appropriate for spaced dosing but may not alter the frequency of dosing.

- When two medicines which interact physically in the stomach are prescribed at the same time a pharmacist may modify the prescription choosing timings which separate the times of administration but will not alter frequency of dosing.

- When a medicine normally given at night (e.g. sedative antidepressant, older statin-type lipid lowering agents, quinine for cramps, once daily stimulant laxative) is prescribed in the morning and reference to the notes and/or patient indicates no reason for dosing in the morning a pharmacist may modify the prescription choosing night time dosing.

- When any medicine which requires timing in relation to mealtimes (eg antidiabetics, iron salts, phosphate binders) are prescribed at times which do not correspond to mealtimes a pharmacist may modify the prescription choosing timings appropriate for dosing at mealtimes but will not alter the frequency of dosing

6.3. Discrepancies on clerking or transcribing

- When an inadvertent change has been made to the frequency or to the dose of a patient's regular medication and the frequency or dose of the medication can be positively confirmed and there is no evidence in the notes that the change was intentional a pharmacist may modify or, if necessary, discontinue and represcribe the patient's usual frequency, dose or route.

- When a medicine that has been discontinued by the patient's GP has been inadvertently prescribed on admission and there is no evidence in the notes that the change was intentional a pharmacist may discontinue the prescription on confirmation with the prescriber. In exceptional circumstances, where the continuation of the medicine may cause patient harm and a prescriber cannot be contacted, a pharmacist may discontinue the medicine. A record of this must be made in the patient notes.

- When a continuing medication on admission appears to have been inadvertently omitted the pharmacist should consult the patient notes for possible reasons. If eye drops, inhalers, nasal sprays or topical medicines have been omitted without reason, the pharmacist may add these to the current electronic prescription. If a significant systemic medication has been omitted, this should be referred to the clinical team. However, if the medication is unrelated to the cause of admission and the clinical team are unavailable, the pharmacist may add it to the current electronic prescription and make an entry in the patient notes.

6.4. Frequency of administration

- When a therapeutic antibiotic is prescribed at a frequency other than as recommended in the BNF or SPC (allowing for renal or hepatic function) a pharmacist may modify the prescription with the correct frequency.

- When an "PRN" medication is prescribed with an inappropriate, frequency a pharmacist may modify the prescription in line with BNF or SPC recommendations.

6.5. Formulary substitution

For any pair of medicines specifically sanctioned by the Medication Practice Committee a pharmacist may discontinue a prescription and add a new prescription for the appropriate substituted medicine in accordance with any rules or conditions imposed by the Medication Practice Committee. Generally this can be done without the need to contact the prescriber but check the relevant entry in the switch appendix on the requirements.

6.5.1 The list of medicines deemed non-formulary and for which a switch to a formulary choice is considered acceptable is on the documents library as a separate Appendix. If a patient is admitted with a sufficient supply of their own non-formulary medicine, then there is no need to switch.

6.5.2 EPMA will highlight these medicines with (NF – SWITCH OPPORTUNITY) after the drug name or a drug note.

6.5.3 During the medicines reconciliation process there may be an opportunity to switch from the non-formulary drug to the formulary choice.

6.5.4 Outside of medicines reconciliation, the process by which such a switch occurs would generally involve the pharmacy being notified at the point of an order being placed for the non-formulary drug (e-nonstock order). The clinical checker would bleep the relevant clinical pharmacist to then advise the patient of the proposed switch and to alter the prescription to the formulary choice on EPMA.

6.5.5 The usual requirements under 6.11 (Process of prescription amendment) would apply.

6.6. Change of formulation

When a patient's needs require a change of formulation, for example a different type of inhaler, a soluble tablet, or liquid medications a pharmacist may discontinue and re-prescribe the prescription with the most appropriate formulation at an equivalent dose, altering the route as necessary.

6.7. Verbal authorisation

When a pharmacist has agreed with a prescriber that an amendment needs to be made and the prescriber is not available to make the change in a timely manner, a pharmacist may make the necessary amendment by discontinuing and/or writing a new prescription.

6.8. Inappropriate drug file selection

When a prescriber has chosen an inappropriate drug file for the dose to be given the pharmacist may discontinue the prescription and re-prescribe the drug. Examples of this include, but are not limited to:

- A prescription for a liquid when a liquid is not required
- A small dose which is cannot be given from the high strength tablet that has been prescribed
- A large dose that would require the administration of several tablets where a higher preparation is available

6.9. Transcribing items from the chemotherapy program (Aria)

When a supportive therapy (i.e. not chemotherapy) is prescribed on the chemotherapy prescribing system and is at risk of being missed by nursing staff a pharmacist may transcribe this onto the JAC EPMA system. They should add a note saying 'As on Aria' to this drug.

6.10. Electronic Prescribing Transcription

During the period where electronic prescribing is being deployed there will be instances of situations where patients move to EPMA wards from non-EPMA wards and vice versa. Normally the transcription from paper to EPMA (and the reverse) will be carried out by doctors. However, if a doctor is not available to carry out the transcription the ward pharmacist can undertake this function.

6.11. Process of prescription amendment

In all cases when a pharmacist is not certain of the prescriber's intentions, the prescriber will be contacted and any changes made by verbal authorisation. When a prescription needs to be amended, it will be done as follows:

- Amendments should be made by modifying the existing prescription where possible.

- If the original prescription needs to be discontinued, the appropriate reason should be entered in the drop-down box

Whenever a pharmacist amends a prescription on JAC it will appear that they have prescribed it. It is therefore necessary to record in the system why the change has been made. This should be done by adding a note that is suppressed whenever any change to a prescription is made, detailing the change and the reason for making it. Additionally, an intervention code should also be recorded in accordance with the Recording Pharmacist Interventions and Communicating Clinical Issues in JAC EPMA Procedure.

7. Dissemination and Implementation

Only pharmacists with the necessary qualifications and experience, and authorisation from the Head of Clinical Pharmacy Services, will be permitted to amend prescriptions in the way described above. The required qualifications and experience required to use this policy are listed below

8. Necessary qualifications and experience

Qualifications	*Minimum experience*	*Sections authorised*
Newly qualified starting clinical work	Completion of clinical training pack (TR044) and satisfactory GLF assessment	Timings, formulary switches, file selection (6.2, 6.5, 6.8)
	Additional 3 months' clinical experience	As above + frequencies, verbal authorisation (+ 6.4, 6.7)
	Further 3 months' clinical	As above + MedRec

	experience	discrepancies, formulation changes, Aria and EPMA transcribing (+ 6.3, 6.6, 6.9, 6.10)
Clinically experienced but new to RCHT	Completion of clinical training pack (TR044) 3 months at RCHT regular ward visiting commitment	All sections as above

9. Monitoring compliance and effectiveness

Element to be monitored	Uptake of amendment policy by pharmacists DATIX reports where policy implicated
Lead	John Glinn, Head of Clinical Pharmacy Services
Tool	JAC EPMA software; DATIX system
Frequency	Annual, in line with annual appraisal
Reporting arrangements	Uptake part of appraisal/PDR DATIX via Medication Safety Group
Acting on recommendations and Lead(s)	Either individually during appraisal, or more generally (and anonymously) via peer group meetings
Change in practice and lessons to be shared	Learning from any reported incidents fed back to pharmacists and prescribers via minuted, regular meetings

10. Updating and review

Policy will be reviewed by August 2019

11. Equality and Diversity

11.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

11.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1 Governance Information

Document Title	Pharmacists' amendments to prescriptions					
Date Issued/Approved:	March 2016					
Date Valid From:	April 2017					
Date for Review:	No later than April 2020					
Directorate / Department responsible (author/owner):	Sally Miles, Head of Clinical Pharmacy Services, Pharmacy Department					
Contact details:	01872 252590					
Brief summary of contents	Process by which suitably trained and authorised pharmacists can amend prescriptions					
Suggested Keywords:	Pharmacists, Prescriptions, Electronic Prescribing					
Target Audience	RCHT	CFT	KCCG			
	✓					
Executive Director responsible for Policy:	Medical Director					
Date revised:	August 2016					
This document replaces (exact title of previous version):	Pharmacists' amendments to prescriptions					
Approval route (names of committees)/consultation:	Medication Practice Committee					
Divisional Manager confirming approval processes	, Divisional Director CSSC					
Name and Post Title of additional signatories	, Divisional Governance Lead					
Signature of Executive Director giving approval	{Original Copy Signed}					
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	✓	Intranet Only			
Document Library Folder/Sub Folder	Clinical / Pharmacy					
Links to key external standards	None					
Related Documents:	• Appendix 1. Formulary switches • Medicines Code Of Practice - Prescribing,					

	Dispensing and Administration of Clinical Trials Medicines Policy • Injectable Medicines Policy (incorporating SOP for Prescribing, Preparing and Administering Injectable Medicines in Clinical Areas • The Medicines Policy: Chapter 2 - Standards Of Practice - Prescribing
Training Need Identified?	Yes

Version Control Table

Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
Jun 10	2010 – 1.00	First edition as a Trust policy	John Pickup, Trust Medication Safety Lead
Jun 10	2010 - Final	Minor changes before approval	John Pickup, Trust Medication Safety Lead
Jul 13	V2.1	Amended existing policy to apply also to electronic prescriptions	John Glinn, Head of Clinical Pharmacy Services
Jan 15	V2.2	Approved amendments to necessary qualifications and experience	John Glinn, Head of Clinical Pharmacy Services
Mar 16	V2.3	Amendment of text relating to formulary switches	Mike Wilcock, Head of Prescribing Support Unit
Aug 16	V2.4	Additional medicines included in Appendix	Mike Wilcock, Head of Prescribing Support Unit
Apr17	V2.5	Additional medicines included in Appendix	Mike Wilcock, Head of Prescribing Support Unit

Appendix 2 Equality Impact Assessment Screening Form

Name of service, strategy, policy or project (hereafter referred to as *policy)* to be assessed: Pharmacists' amendments to prescriptions	
Directorate and service area: Pharmacy/Clinical Areas	Is this a new or existing Procedure? Existing, revised
Name of individual completing assessment: John Glinn	Telephone: 2590
1. Policy Aim	To ensure all electronic prescribing is of the highest standard
2. Policy Objectives	To authorise pharmacists to optimise prescriptions where appropriate
3. Policy – intended Outcomes	Deficient or ambiguous prescribing is dealt with promptly within the competency of staff
1. How will you measure the outcome?	Process and activities are logged on JAC prescribing software
5. Who is intended to benefit from the Policy?	Patients and staff
6a. Is consultation required with the workforce, equality groups, local interest groups etc. around this policy? b. If yes, have these groups been consulted? c. Please list any groups who have been consulted about this procedure.	No

7. The Impact
Please complete the following table.

Are there concerns that the policy **could** have differential impact on:

Equality Strands:	Yes	No	Rationale for Assessment / Existing Evidence
Age		✓	
Sex (male, female, trans-gender / gender reassignment)		✓	
Race / Ethnic communities /groups		✓	
Disability - Learning disability, physical disability, sensory impairment and mental health problems		✓	

Religion / other beliefs		✓	
Marriage and civil partnership		✓	
Pregnancy and maternity		✓	
Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian		✓	

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked "Yes" in any column above and
- No consultation or evidence of there being consultation- this excludes any *policies* which have been identified as not requiring consultation**. or**
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended.	**Yes**	**No** ✓

9. If you are not recommending a Full Impact assessment please explain why.

No potential for differential impact identified

Signature of policy developer / lead manager / director	Date of completion and submission

Names and signatures of members carrying out the Screening Assessment	1. John Glinn 2.	

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust's web site.

Signed _____

Date _____

Appendix 3 Formulary switches.
The purpose of this Appendix is to detail the agreed formulary switches. The process for implementing these switches is described in the policy – Pharmacists' amendments to prescriptions.

There are two distinct categories of switches: where the hospital doctor needs to be informed that the switch is planned (currently only required in the one instance highlighted), and where the hospital doctor does not need to be informed.

In those instances of switching oral medication, if a patient is admitted with a sufficient supply of their own non-formulary medicine, then there is no need to switch

Non-formulary item	**Formulary choice**
Inhaler switch considerations: • what other inhaler devices is the patient using as some patients may get confused if the switch causes them to be on >1 different inhaler device • has the patient tried the proposed device previously and not got on with it • inhaler technique training is necessary • ensure this switch appears as a discharge medication review note for GP and regular community pharmacy (for follow up MUR/NMS at community pharmacy)	
Seretide Evohaler 250 (in COPD as unlicensed indication or in asthma) Two puffs twice daily ⇒ This switch provides a slightly lower dose of inhaled steroid on Fostair. **Hence CHECK WITH the doctor prior to switch**	Fostair 200/6 MDI (in COPD as unlicensed indication or in asthma) Two puffs twice daily.
Seretide Evohaler 250mcg (in asthma) Two puffs twice daily ⇒ Both are categorised as high dose inhaled steroids in BTS Asthma Guidelines 2016	Fostair 200/6 MDI Two puffs twice daily
Seretide Evohaler 125mcg (in asthma) Two puffs twice daily ⇒	Fostair 100/6 MDI Two puffs twice daily
Seretide 500 Accuhaler (in COPD) One puff twice daily ⇒	Fostair 200/6 Nexthaler Two puffs twice daily
Symbicort Turbohaler 200/6mcg (in COPD or in asthma) Two puffs twice daily ⇒	DuoResp 160/4.5 Spiromax Two puffs twice daily
Symbicort Turbohaler 400/12 (in COPD) One puff twice daily ⇒	DuoResp 320/9 Spiromax One puff twice daily
Symbicort Turbohaler 400/12 (in asthma) Two puffs twice daily ⇒	DuoResp 320/9 Spiromax Two puffs twice daily
Spiriva Handihaler (tiotropium) (in COPD) One puff once a day ⇒	Braltus (tiotropium) inhalation powder One puff once a day

Non-formulary item	Formulary choice
Aspirin EC 75mg ⇒ Aspirin EC 300mg ⇒	aspirin dispersible 75mg aspirin soluble 300mg
Prednisolone 5mg soluble – switch to prednisolone 5mg standard tablet as 5mg strength is a relatively small tablet and does not present a problem in swallowing for the majority of patients. The plain tablets disperse in water to make a fine suspension (unlicensed use). Exceptions to this switch include when the soluble version is required for a fine-bore enteral feeding tubes. Prednisolone 5mg EC - switch to prednisolone 5mg standard tablet as there is no substantial evidence that enteric coating reduce the risk of peptic ulceration caused by prednisolone. In addition, from the limited available data, it would appear that EC tablets may be associated with less predictable absorption.	
Calcium and vitamin D choices – RCH stock only Adcal D3 chewable tablet and Calforvit D3 powder sachet as routine calcium and vitamin D products. BUT see exclusion below. Exclusion - Calcichew 500mg chewable tablets contain only 500mg calcium and are **NOT** included in this switch policy. Calcichew, as advised by the Renal Team, is used in patients with renal impairment as a phosphate binder. Renal patients on any Calcichew product should **NOT** have their therapy switched.	
Accrete D3 tablet calcium 600mg/ vitamin D3 10mcg (400 units) One tablet taken twice a day ⇒ Adcal-D3 300 mg caplet calcium 300mg / vitamin D3 5mcg (200 units) Two caplets taken twice a day ⇒ Calceos chewable tablet calcium 500mg/ vitamin D3 10mcg (400 units) One tablet twice a day ⇒ Calcichew-D3 calcium 1000mg / vitamin D3 20mcg (800 units) One chewable tablet taken daily ⇒ Calcichew-D3 calcium 500mg / vitamin D3 5mcg (200 units) One chewable tablet taken two or three times a day ⇒ Calcichew-D3 Forte calcium 500mg/ vitamin D3 10mcg (400 units) One chewable tablet taken twice a day ⇒ Calcichew D3 caplet calcium 500mg/ vitamin D3 10mcg (400 units) One caplet twice a day ⇒ Natecal D3 tablet calcium 600mg/vitamin D3 (10mcg) 400 units One chewable tablet taken twice a day ⇒	Adcal-D3 chewable tablet containing calcium 600mg and 10mcg vitamin D3 (400 units) One tablet twice a day
Adcal-D3 Dissolve calcium 600mg/vitamin D3 (10mcg) 400 units One effervescent tablet taken twice a day ⇒ Cacit D3 500mg calcium/vitamin 440 units Two sachets a day ⇒	If a dissolvable product is required Calfovit D3 powder in sachet containing calcium 1200mg / vitamin D3 20mcg (800 units) One sachet daily
Watch out for Kalcipos-D 500 mg/ 800 IU chewable tablets which has a lower dose (one tablet daily) of calcium.	

Vitamin D choices – the non- formulary products commonly prescribed in primary care are in the left hand column, though this list is not comprehensive. Those in the right hand column are similar formulary choices	
Stexerol-D3 1,000 units tablet (formulary choice will provide slightly less units) ⇒	Fultium D3 capsule 20mcg vitamin D3 (800 units colecalciferol)
Any other product containing 20mcg vitamin D3 (800 units colecalciferol) ⇒	Desunin tablet 20mcg vitamin D3 (800 units colecalciferol) Does not contain gelatin, peanut oil or soya. May be acceptable to vegetarians
Any other product containing 80mcg vitamin D3 (3200 units colecalciferol) ⇒	Fultium D3 capsule 80mcg vitamin D3 (3200 units colecalciferol).
Hux D3 20,000 units colecalciferol ⇒ Check if using and needing vegetarian capsule in which case Fultium not suitable Stexerol-D3 25,000 units tablets (formulary choice will provide slightly less units) ⇒	Fultium D3 capsule 500 mcg vitamin D3 (20,000 units colecalciferol)
	InVita D3 oral solution 625 mcg vitamin D3 (25,000 units colecalciferol) per 1ml unit amp oral solution

(MPC April 2017)