AUTUMN 2005
HOSPITAL PHARMACIST EDITION

INSIGHT

the magazine of the pharmacists' defence association

# PDA LAUNCHES HOSPITAL PHARMACIST MEMBERSHIP

## Hospital pharmacists now 'on-board'…

10,000 community and primary care pharmacists enjoy the benefits and peace of mind that membership of the Pharmacists' Defence Association bestows. From October 2005 the PDA extends its services so that hospital pharmacists can now also join

**Welcome to the first issue of the hospital edition of *Insight* – the magazine of the Pharmacists' Defence Association.**

The PDA has gone from strength to strength since it was founded in 2003 and has been able to help many members with their legal, ethical and employment problems. However, until now, membership of the PDA was only available predominantly to pharmacists in the community and primary care sectors.

**In brief, the aims of the PDA are:**

- Supporting pharmacists in their legal, ethical and employment needs
- Providing insurance cover to safeguard and defend pharmacists' reputations throughout their professional lives
- Seeking to influence the professional, ethical and employment agendas to support members
- Leading and supporting initiatives designed to improve the knowledge and skills of pharmacists in managing risk and safe practices, so improving patient care
- Working with like-minded organisations to improve the membership benefits to individual pharmacists

### Notable achievements of the PDA:

**2004:**

- Supported pharmacists in more than 700 incidents
- More than £150,000 claimed on behalf of PDA members who had been treated harshly or illegally by employers
- Dealt with more than 150 cases of potential claims for compensation
- Sponsored an annual conference for pre-registration students in October

**2005:**

- Held the first annual PDA conference in February
- Published Violence in Pharmacy resource pack in March
- Held a conference for primary care pharmacists in April
- Produced locum "contract for services" in June
- Sleeping rights gained for pharmacists who undertake emergency duties and the publication of pharmacist contract of employment guide in July

The reputation that the PDA has established in its two years of existence has not gone unnoticed by pharmacists working in the hospital sector, many of whom approached the PDA to ask why they could not also join the organisation and receive the benefits enjoyed by colleagues in the community and primary care branches of the profession. Because of these requests, the PDA decided to open membership to those pharmacists working in hospitals. Originally, the PDA hoped to work with the Guild of Healthcare Pharmacists in putting together a package for hospital pharmacists but unfortunately, many months of discussion came to nothing.

In today's world, people are becoming ever-more litigious and it is important that pharmacists have the backing of an organisation that has their interests at heart. Undoubtedly, the PDA fits the bill.

**Now that it has extended its services to include hospital pharmacists, the PDA is in a very strong position to defend the reputation of pharmacists, whatever their chosen branch of the profession.**

## inside this issue...

# Membership fee discounts for participation in CPD

A significant aspect of the work of the PDA is the defence of pharmacists whenever disaster strikes

## RISK MANAGEMENT

Despite the above statement, the PDA prefers to work with its members to try and prevent errors from occurring in the first place and this is done through a wide range of risk management activities.

One such important risk management activity is encouraging pharmacists to participate in continuing professional development and also in recognising that further qualifications will inevitably reduce risks in practice.

At the interface between defence and prevention lies one additional aspect which helps PDA to defend its members and this is when PDA uses participation in CPD to mitigate the consequences of an incident with the authorities.

**This is particularly important when pharmacists:**

- Face professional sanctions from the RPSGB.
- Have to attend an inquest into how an error occurred and who was to blame

When pharmacists are interviewed following an incident, PDA always ensures that if mitigating factors are available, then they are put forward to support them. Participation in CPD plays a powerful role in this defence as it can show that while pharmacists may have made a human error inadvertently, or simply had a bad day at work – they are, for all intents and purposes, otherwise thoroughly consummate professionals. Moreover, if it can be shown that others involved in the incident were not acting professionally, eg, doctors, nurses or even trust management – then this helps in extricating pharmacists from the firing line.

## CPD INCENTIVES OFFERED

To support this concept, the PDA offers membership fee discounts to members who participate in CPD and who can declare that they are involved in one or more of the following range of activities:

- Pharmacists who currently are studying for or in the past three years have successfully completed: a diploma in clinical pharmacy, a specialist services pharmacy course, an MSc in clinical pharmacy or prescribing science or an MBA or equivalent
- Pharmacists who are members or associates of the College of Pharmacy Practice
- Pharmacists who in the past year have attended more than 30 hours of formal training provided by any national pharmacy organisation or which has been accredited by the College of Pharmacy Practice

further qualifications will inevitably reduce risks in practice

**PDA Advice:**
The PDA is aware that CPD is already an important part of the culture of working as a hospital pharmacist, but to those pharmacists who are not yet engaged in this important aspect of professional life, we urge them to embrace CPD as soon as possible.

# Writing and signing patient group directions now automatically covered

Patient group directions (PGDs) are now quite widespread in hospitals

…However, a small group of pharmacists, usually those in the more senior positions, are also involved in the design and signing off of the PGDs under which many of their colleagues ultimately work.

When the PGDs' design and sign-off activity first came into operation just a few years ago, the practice caused a considerable amount of worry to insurance underwriters. Although it only involved a relatively small number of senior pharmacists, it was a practice which the underwriters considered to be leading edge and consequently more risk-prone than established hospital pharmacy activities.

Consequently, the insurance underwriters only offered insurance cover for the writing and signing off of PGDs on condition that those involved took out a more expensive specialist insurance policy.

However, during the recent discussions with underwriters about the launch of PDA for hospital pharmacists, the PDA managed to persuade the underwriters to soften their stance on this issue and bring the design and signing off of PGDs under the scope of standard cover.

**As a result of this, from 1 October 2005, which is the date PDA membership was opened up to all hospital pharmacists, the writing and signing off of PGDs is now fully covered for all full PDA members and there is no longer any need to upgrade the cover by taking out a specialist policy.**

don't forget to visit the website: **www.the-pda.org** for news, downloads and much more…



# Pharmacist in maternity rights quandary

In a recent incident, a member turned to the PDA for support in what she considered to be a maternity rights issue

Although this particular case involved a primary care pharmacist, nevertheless the case is relevant to pharmacists, particularly locums in the hospital sector. Having worked for the same Scottish health board (the Scottish equivalent of an English primary care trust) for several years as a sessional practice-based pharmacist, she decided after some considerable persuasion by the health board to take up employed status. Some months later, she discovered that she had become pregnant and so she notified the health board in accordance with its maternity policy. She then received a letter which indicated that the health board considered that she was not entitled to any maternity benefits from them because she had only been employed by them for a short period and therefore did not qualify for the full maternity rights (six months' full salary).

> **"…the health board conceded the point albeit on a "without prejudice" one-off basis and awarded the PDA member an entitlement to full maternity pay."**

It was the view of the PDA lawyers, however, that although the employer may indeed have started to deduct tax and national insurance from her only a few months earlier, her 'employment' with the health board had in reality commenced several years earlier when she had first commenced her sessional duties.

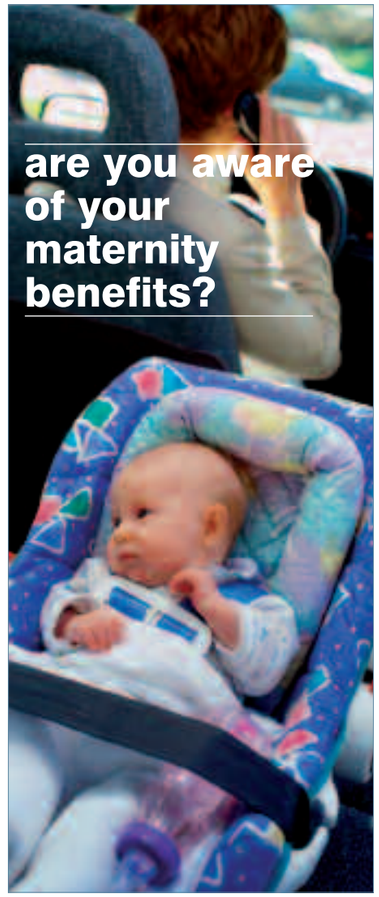
The reasoning behind this view was that her initial sessional duties had commenced only after she had been interviewed and appointed by health board staff and had undergone an initial induction which was also undertaken by all health board staff. During the years that followed she developed a regular pattern of work based predominantly in the same surgeries and her ongoing training, supervision, support and effectively, direction were all provided by the health board. When it came to rates of pay, she did not negotiate her salary (as a truly self-employed individual would have done); her rate of pay was dictated by the employer and handed down to her as a fait accompli. It was felt by PDA employment experts that despite the fact that her contract said that she was a self-employed individual, the reality of the situation was that the relationship that she had with the health board was one that strongly resembled an employment contract.

The PDA wrote to the health board to set out its view and to suggest that her maternity pay be adjusted accordingly. However, the health board initially refused to do this. Subsequently, the PDA wrote again making it clear that it was not intending to pursue the employer for several years' worth of backdated wide-ranging employment benefits - it merely wanted to secure a more beneficial treatment of its member's maternity benefits. However, the PDA made it clear that should this go to an employment tribunal (ET), both the PDA and the health board would not be able to control the extent to which the tribunal would want to examine the issues; it would be likely that the issue of backdating the full range of benefits would emerge.

Consequently, the health board conceded the point albeit on a "without prejudice" one-off basis and awarded the PDA member an entitlement to full maternity pay.

Because ultimately, this issue was not settled by an ET it does not provide a solid "legal test case" precedent. However, the incident provides a useful risk management case study for all pharmacists who may have crossed over from being locums to an employed post, doing the same job. The case is also useful for those senior pharmacists in management who may be responsible for determining the practical operational relationship between the hospital and its locums.

The Inland Revenue rules on what constitutes employment and what constitutes self-employment are contained in the Inland Revenue publication IR55.



# The Insight Interview ...Mark Koziol

If there is one phrase to describe **Mark Koziol,** director of the PDA, it is "a man with a passion". In this interview conducted by **Diane Langleben,** editor of the hospital edition of Insight, she finds out more about Mark and what led him on his chosen path

**DL:** ***Tell me about your early beginnings in pharmacy.***

**MK:** I graduated from Aston University in 1983 and then did my pre-registration year with Boots the Chemists in Wolverhampton. In 1986 I left Boots abruptly because although my career was doing well, I witnessed the axing of many Boots's territorial general managers (TGMs) in what has since become known as "the night of the long knives". We were told that this was because of problems with share values and that the loss of the TGM posts would be good for us junior managers because we would all be sucked up into the management vacuum that had been created. However, I concluded that even though this may be the case, I could not devote myself to an employer whom I believed had treated loyal employees badly. I served my notice period and became a locum. I realised that a first-class locum service was needed and I established PPLS, the locum agency, in 1986.

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**DL:** ***Tell me something about your time as director of a locum agency***

**MK:** This was really the role that gave me the passion to set up the PDA, although perhaps I did not realise it at the time. Over the 17 years of being director of PPLS, I saw many things that made me angry. I guess the most important lesson I learned was that although employee pharmacists (who now made up the majority of the register) allowed the employers to collectively define the way the profession is to be run and remunerated, they (the employees) would always end up with a very small slice of the cake in terms of remuneration and say in the profession. Over time, this would be hugely detrimental to them.

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**DL:** ***What led to your involvement with PIA and then the PDA?***

**MK:** Shortly after setting up the locum agency, it became clear that pharmacists needed to carry their own personal indemnity insurance. They were facing risks constantly and were vulnerable to all sorts of claims and penalties. I initially turned to the NPA to ask that they set up such a scheme, but they could not do this because their role was to look after the interests of employers.

This was the impetus for the establishment of the Pharmacy Insurance Agency in 1990. Soon the PIA had more individual scheme members than any other insurer in pharmacy. During the decade that followed, the hundreds of incidents and cases handled made it clear that pharmacists not only needed insurance; they also needed someone to champion the cause of individual pharmacists. This led to the creation of the Pharmacists' Defence Association. In 2003, I left both PPLS and the PIA to concentrate on my new role as director of the PDA.

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**DL:** ***You were at one time a member of the RPSGB council. What were the highlights for you?***

**MK:** Seeing Hemant Patel being elected as president of RPSGB in 1998. He was truly a caring leader, concerned about all pharmacists. In particular, he cared about the weakest members of the profession and those that could least take care of themselves; his views were very similar to mine. I am delighted that he has been re-elected.

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**DL:** ***You opposed the Society's modernisation plans. Can you tell me why?***

**MK:** Firstly, I am never opposed to modernisation – so let us be clear, what I was against were the plans that had been laid by a small but powerful group of senior council members, staff and others to secure a Charter which clearly would have been disastrous for the profession and, in particular, for all its members. Despite a clear message from the membership that they did not like their proposals, the council simply ignored those views. This was not only undemocratic, but was an effrontery to the common decent standards to be expected of a professional association. Thankfully, due to the Herculean efforts of many pharmacists, the now discredited Charter was stopped and all of the council members responsible for it have stood down or have been swept from office.

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**DL:** ***You are the project manager of the YPG Pharmacy Project. What does that involve?***

**MK:** The Young Pharmacists' Group intends to set up its own "practice laboratory" pharmacy. As an honorary life member of the YPG I was asked if I would consider organising the venture, on the basis that the group had no funds because it is a voluntary organisation. You could say that this is a bit of a tall order, for as well as finding and setting up the pharmacy, I would also have to raise all the funds!
To date, I have secured £135,000 worth of donations and pledges – with more funding on its way. I am hoping that we will see our flagship pharmacy open in 2006.

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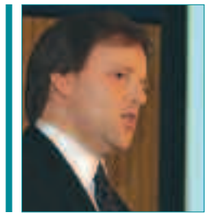
**DL:** ***You have now opened up the services of the PDA to hospital pharmacists. Why were they not included from day one?***

**MK:** We did not provide PDA membership services to hospital pharmacists from the beginning because we actually wanted to work with the Guild of Healthcare Pharmacists. We have our strong points and we felt they had theirs; together we could have provided a highly beneficial service for all hospital pharmacists. We spent one year trying to secure the date of an initial meeting with them and since it was held, we have waited a further year for a response from their executive who have still not responded. We are not prepared to wait any longer and so now the train has left the station and they are not on it. We believe that the arrangements we have put in place mean that the PDA provides by far the best, most comprehensive and most cost-effective defence association for hospital pharmacists. Furthermore, we are committed to ongoing enhancements to our service which will be led by membership requirements.



My big hope for the profession in 10 year's time is that pharmacists will come much closer to the patient by getting more intimately involved with the consequences of their actions.

Mark Koziol. PDA Director.

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**DL:** ***Surely the Guild of Healthcare Pharmacists has the welfare of pharmacists at heart?***

**MK:** I do not doubt that the officers of the Guild are well-meaning individuals. However, like many organisations in pharmacy, they are volunteers with other full-time jobs – able to meet up on a handful of occasions per year. There is a limit as to what they can do. They place great store in what they think that their parent union, Amicus, can do for Guild members. However, many hospital pharmacists who have spoken to us feel that the "big union" may not really have much time for the Guild because it has relatively few members compared with some of their other membership groupings that have hundreds of thousands of members. Moreover, some hospital pharmacists have concerns that the union may not have the necessary pharmacy expertise in adequate supply. By contrast, we have an office staffed with eight full-time members of staff of whom four are pharmacists and two are legally qualified, and we expect to be employing even more before the end of the year. Beyond that, we have instant access to the 16 members of the PDA advisory board. Most of these are senior pharmacists and lawyers, and a good proportion of them are experienced hospital pharmacists.

From our existing membership of more than 10,000, we handle as many as six serious incidents a day from our members. We would question whether the Guild would be able to provide such a service for their members.

**DL:** ***Mark, it is clear that you are a man with a passion, not only for the profession of pharmacy, but also for the rights of individual pharmacist employees. If you could gaze into a crystal ball, what would be your hopes for the profession in the next 10 years?***

**MK:** A major motivation behind setting up the PDA was to ensure that the voice of individual pharmacists would be heard. My time on the council of the RPSGB showed me that too many decisions on the future of our profession are made by the large employers and the NHS. Little or no notice is taken of the little guy, the individual pharmacist, because more often than not, his (or her) voice is simply not spoken in a way and in a place that can make a difference. I passionately believe that the PDA can change this. Through our constant discussions with PDA members, for example, our focus groups, conferences, and on-line surveys, we can, and do, develop proposals which are favourable to individual pharmacists and I believe that we will have a big impact over the course of the next decade.

My big hope for the profession in 10 year's time is that pharmacists will come much closer to the patient by getting more intimately involved with the consequences of their actions. Be these rewarding consequences – in having enhanced remuneration and professional reward when things are done well, or be these challenging consequences – such as taking personal responsibility and ownership of situations when things have gone wrong.

The reason why I passionately believe in these principles is that the further the pharmacist is removed from the consequences of his or her actions by large employer organisations or companies with shareholders, the worse it is for the profession in terms of job satisfaction and reward, and the worse it is for patients in terms of their safety and care.

For example, I would like to see pharmacist-led clinics in which the pharmacist has contracted to run the clinic. This is totally different to the pharmacist simply operating the clinic as an employee; moreover, it would provide a profoundly more rewarding role. I would like to see pharmacy being as influential on the NHS as the nursing profession. We need to get our voice across in the same way in the hospital sector; we can do this by concentrating on articulating the benefits pharmacists bring to patients.

don't forget to visit the website: www.the-pda.org for conference news, publications and more…

# DO I NEED MY OWN INDEPENDENT PROFESSIONAL INDEMNITY INSURANCE?

Approximately half of all hospital pharmacists do not carry their own PI insurance. In this case study, **Dr Gordon Appelbe** – co-author of Dale and Appelbe's Pharmacy Law and Ethics explains why it is so important for them to reconsider

**One of the reasons why many hospital pharmacists do not take out their own PI insurance is that they have been led to believe that the insurance cover provided by the hospital – known as the clinical negligence scheme for trusts (CNST) will be sufficient. Although a significant proportion of pharmacists believe this to be a fallacious argument, many others are confused. This case study clearly explains the issues involved.**

## THE CASE STUDY

*A child died from an overdose of tablets. The tablets had been supplied to one of his parents by the pharmacy department at the time the parent was discharged from hospital. The doctor had properly and lawfully prescribed the medicine. The child was found dead at home with an empty bottle of tablets that was not child- resistant.*

*The parents' evidence was that the tablet container had not been supplied with a childproof lock. The hospital trust's policy was that all tablets dispensed should be in child-resistant containers. The pharmacist maintained that as far as he was aware, the medicine had been dispensed in a child-resistant container. The pharmacy operates a checking technician system - and it is not entirely certain whether the pharmacist or the technician performed the final check.*

*There is a suggestion from one of the pharmacy technicians that the pharmacy department did not always comply with the trust's child-resistant container policy, and that the trust knew this. The inquest into the death is due to commence and the trust has suspended the pharmacist pending the outcome of the inquest and an inquiry into disciplinary proceedings. The trust has also informed the RPSGB, who intends to launch an inquiry. The pharmacist has received a letter from the RPSGB informing him that an inspector would like to interview him in connection with the incident. The parents have commenced civil proceedings for recovery of compensation from the trust.*

*The manager of the trust is of the view that this is a sensitive case that should be settled as quickly as possible. The local press telephones the pharmacist repeatedly to seek his comments on the case.*

This case is about alleged negligence and the resulting professional, administrative and civil proceedings. It concerns the role carried out by the pharmacist in protecting patients when dispensing medicines. In negligence cases one has to consider whether the individual has a duty of care to protect patients and/or individual members of the public; whether there has been a breach of that duty; and whether damage has resulted.

In this particular case it is argued that a number of different people all have their respective duty of care; those duties have been breached and damage caused: that is, the death of a child has occurred. The persons involved who would be responsible and carry the liabilities include the technician, the pharmacist and the hospital trust. Potentially, the parents could also be held responsible, but on different facts: of not safeguarding the medication in their care. However, this article deals only with the aspect of childproof closures not being used.

**A whole series of consequences can arise as a result of the facts as set out above. These can include:**

1. An inquest
2. The pharmacist's suspension, potential disciplinary proceedings, and dismissal by the trust
3. A proposed interview between the pharmacist and the Society's inspector. In addition, further regulatory proceedings by the RPSGB which could lead to the pharmacist being struck off the Register
4. Criminal proceedings and/or civil proceedings leading to financial compensation
5. The way that the pharmacist handles the press and the trust's relationship with the press, both of which can lead to loss of reputations

## THE TECHNICIAN

In any of the proceedings under 1-5 above, the primary person responsible could be the technician if he dispensed the medicine. However, it would be unlikely for any action to be taken against the technician alone as he/she would normally be acting under the supervision of the pharmacist. However the technician could be joined in any action together with the trust and the pharmacist.

## THE HOSPITAL TRUST

The trust would be liable for the vicarious activities of its servants, in this case the pharmacist and technician, and would therefore be liable in a case of negligence brought in the civil courts. It is clear that the trust has a policy that all tablets dispensed should be in child-resistant containers and this it would argue at any proceedings. However, it has been claimed that this policy was not always followed; only evidence can establish the facts.

The manager of the trust appears to accept, probably without accepting liability, that the case is politically and publicly sensitive, is likely to cause press comment, and he is therefore prepared to settle. The trust, however, does have insurance cover under the CNST and any claim in negligence would be settled by the CNST Litigation Authority, which is a government agency. Under such insurance, any cost incurred by the trust, eg, at the inquest or elsewhere, would be covered by the CNST provided the trust has notified the authority before it accepts liability or made any payment. The trust also has a right to argue contributory negligence against the pharmacist and/or technician if its policies have been deliberately broken.

## THE HOSPITAL PHARMACIST

In the worst case scenario, the hospital pharmacist could carry the bulk of the responsibility.

**Consequently, there are a number of important considerations that the hospital pharmacist would need to consider:**

**A)** Whether the trust was aware that its child-resistant container policy was not always complied with is a matter of fact and evidence. Pharmacists should bear in mind that at the inquest to establish the facts it is usual for all the parties to be represented and this necessitates representation for the pharmacist. The CNST scheme does not pay for pharmacist representation before inquests; the scheme only covers the trust itself

**B)** Similarly, the CNST scheme does not cover the cost of representation of pharmacists before any internal hospital procedures whether they include clinical and professional mistakes or employment issues

**C)** The CNST scheme does not cover pharmacists in civil actions for negligence even though the negligence has occurred within an NHS hospital, the CNST scheme covers the Trust. Furthermore, as stated above, the trust, if sued, also has a right to argue contributory negligence against the pharmacist if its policies have been deliberately broken. Moreover there are certain strict conditions that apply to the cover provided by CNST, the protection is NOT provided in a range of circumstances

**D)** The CNST scheme does not cover pharmacists in relation to regulatory matters within the profession. It is noted that the RPSGB has been informed and has initiated an inquiry

One must bear in mind not only the facts of the case but the provisions of the Society's code of ethics which states that all solid dose and all oral and external liquid preparations must be dispensed in child-resistant containers. There are some exceptions to this regulation but do not apply in this case study.

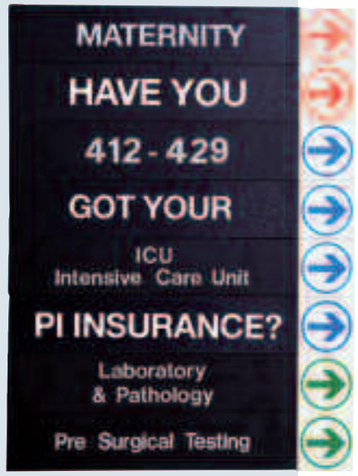
The first step is that the Society's inspector will wish to conduct a formal interview with the pharmacist. The pharmacist will need to take advice as to what he/she should do and whether or not he/she should have a legal advisor to sit with him/her when such an interview takes place. The interview is usually a taped one and the tape can later be used by the Society. The inspector then compiles a report for the Infringements Committee of the Society which usually asks for any comment from the pharmacist on the inspector's report. The pharmacist should take legal advice as the response will be critically important as it is then considered by the Infringements Committee before it makes a decision. The decision can be one of no action (unlikely), a reprimand, or a reference to the disciplinary committee - the Statutory Committee. If the pharmacist is called before the Statutory Committee, then further legal advice must be taken and legal representation arranged as the Statutory Committee is independent of the Society and may well call its own independent enquiry.

## SUMMARY

In the case in question, not all the facts are clear and there are disputes between the various parties. For instance, the trust insists it has a clear policy to use childproof containers. However, this has been challenged and it is alleged that the pharmacy department did not always follow the policy. The pharmacist maintained that a childproof container had been used but this was challenged by the parent. It would be essential for legal advice to be sought to assist with the defence of the pharmacist. The trust could have a problem in that it too could become a defendant.

RPSGB in its code of ethics insists that all pharmacists in all activities they undertake are covered by PI arrangements. However, there is a huge difference between PI that can simply compensate a patient and/or defend the interests of the employer (the trust), and that which is independent of the employer, which is specifically designed to protect the pharmacist.

All hospital pharmacists should have the kind of PI insurance cover which is not only able to fund a claim for compensation, but which also provides legal and other advice at all levels including preliminary inquiries such as inquests, civil and court cases, and ultimately Statutory Committee hearings. Adequate legal advice at an early stage of proceedings is essential and in the majority of cases can be most beneficial including occasions when charges are dropped. Hospital pharmacists should seek professional indemnity from an organisation that is not linked to an employer or the CNST in any way, and one which can cover all their activities with independent representation. One of the many benefits of membership of the Pharmacists' Defence Association is the independent provision of PI and legal defence costs insurance. Furthermore, there are other membership benefits which would be highly beneficial in the scenario described above. It can be seen that membership of the PDA would benefit hospital pharmacists whether at an inquest or internal hospital inquiry, in professional and employment matters, in civil, criminal and disciplinary issues, and with dealing with the press.




> **Hospital pharmacists should seek professional indemnity from an organisation that is not linked to an employer or the CNST in any way.**

|advisory**board**member|

**Gordon Applebe is a member of the PDA advisory board.**
Find out more about him and his skills and expertise in the article on pages 8-9.

# Getting to know the PDA*...

The PDA is managed by an office-based team, many of whom are pharmacists. In addition, it has put in place a carefully selected group who make up the advisory board. Here we introduce the individuals involved.

## THE OFFICE-BASED TEAM

**The day-to-day running of the PDA operates from their main offices in Birmingham. It was set up to be run for pharmacists by pharmacists.**

The office team comprises:

### Mark Koziol MRPharmS

Mark is Director of the Association and his main responsibilities are:

- **Determining the strategic direction of PDA**
- **Marketing the PDA to external organisations**
- **Facilitating the influence that the PDA has in government and professional circles**

### John Murphy MRPharmS

John is General Manager of the PDA and he:

- **Determines its strategic direction.**
- **Manages the office operations**
- **Develops the range of services provided to members**

### Mark Pitt MRPharmS

Mark is Membership Services Manager and he is responsible for:

- **Developing and maintaining communications with PDA members via the website and publications**
- **Responding to the needs of members.**

### Katherine Minchin

Katherine is senior administrator of the PDA. She is the first point of contact when members have requests and queries, and will be able to redirect them to the most appropriate member of the team.

### June Cluley

June is the administrator who oversees the issue of insurance documentation and ensures that the renewal procedures are handled efficiently.

### Claire Arthurs BA GDL LPC - Legal Advisor

Claire-Elaine has recently joined the team at PDA to provide in house legal support. She is the first point of contact for member's legal problems and is involved in managing issues we are assisting members with. She is also working on projects to assist in the further development of the PDA.

### Graham Southall Edwards MA (law), LLM, MRPharmS

Graham's first degree was in pharmacy and after registration with RPSGB his various roles included that of locum and he is familiar with the problems encountered by locum pharmacists. Graham then qualified as a barrister and has been involved in highly contentious 'tort' and contract court battles. His areas of speciality include law of contract (including employment), tort (including negligence), EU law, company law, credit and insolvency. He has considerable experience and expertise in advising pharmacists facing criminal and Statutory Committee enquiries.

## THE ADVISORY BOARD

**The PDA enjoys a close relationship with the advisory board on an ad hoc basis. The expertise that the members bring to the board gives the PDA access to a wide range of skills as and when required. These skills include: legal advice; mentoring services; answering members' questions at the on-line PDA advice centre (www.the-pda.org); assisting with the provision of courses and conferences; co-ordinating research; generating written articles and case studies for the advice centre and PDA publications; helping to develop PDA policy; providing a direct consultancy service for members.**

The advisory board comprises:

### Gordon Appelbe

*LLB, PhD, FRPharmS*

Gordon is a specialist in pharmacy law and ethics, and RPSGB regulatory and inspectorate matters. He has been involved in drafting pharmacy legislation in six countries and currently provides advice to the Medicines and Healthcare products Regulatory Agency. He has been an advisor to the Pharmacy Insurance Agency since 1993 and has extensive experience of advising pharmacists who are subject to an RPSGB or police investigation.

### Elizabeth Doran

*MRPharmS*

Elizabeth was the president of the British Pharmaceutical Students' Association for 2003-2004. She qualified in 2003 and now works as a resident pharmacist at the Northern General Hospital in Sheffield where she is undertaking a diploma in clinical pharmacy.

### John Farwell

*FRPharmS*

John has undertaken work assignments for many NHS trusts as an independent pharmaceutical consultant. Before this, he has been, among other posts, chief pharmacist for several hospitals.

### Richard Flynn

*MRPharmS*

Richard is an experienced community pharmacy manager whose strengths lie in encouraging best practice in relation to pharmacists and the issues that they face. This is achieved through coaching, motivating and encouraging others. As a skilled manager, Richard is passionate about facilitating good employer/employee communication and promoting employment best practice.

### Bob Gartside

*FRPharmS*

Bob is an experienced community pharmacist both as a proprietor and a locum. He was the original chairman of EPIC (Employee Pharmacists in the Community) which was established in 1995 (and disbanded soon thereafter) and he knows what makes an organisation work or fail. He is also an expert on pharmacy in Wales; he has been on the Welsh executive of the RPSGB for many years and a member of numerous Welsh government working parties. He has a special interest in repeat dispensing and medicines management.

### Duncan Jenkins

*PhD, MRPharmS*

Duncan is involved in the development, implementation, and evaluation of medicines management systems, drug administration errors and prescribing measures. He sits on the Medicines Management Services Collaborative panel as expert advisor and is public relations officer for the Primary Care Pharmacists Association. He currently works as a specialist in pharmaceutical public health for a public health network which spans two primary care trusts as well as being managing director of MORPh Consultancy.

### John Jolley

*FIQA, FRPharmS*

John is knowledgeable in corporate governance issues and has an Institute of Directors' certificate in corporate direction. He is a fellow of the Institute of Quality Assurance and this enables him to undertake corporate audits on companies' quality management systems. John is registered as a qualified person in the pharmaceutical industry and is also an assessor for persons seeking registration with the RPSGB. He is experienced in medication reviews and trained to carry out clinical reviews of the elderly in line with National Service Frameworks.

### Jahn Dad Khan

*ACPP, MRPharmS*

Jahn's expertise lies in all types of audits and is a community pharmacy audit facilitator. He writes exclusively about clinical governance issues in relation to pharmacy – a subject he knows at first hand as a Commission for Health Improvement reviewer. He is a trained continuing professional development facilitator and an author involved in pharmacist prescribing matters.

### Diane Langleben

*MRPharmS*

Diane spent 15 years working as a hospital pharmacist before switching direction and becoming editor of Hospital Pharmacy. She now works as a freelance writer on pharmaceutical matters and is editor of the PDA's Insight magazine for hospital pharmacists.

### Alan Nathan

*FRPharmS*

Alan has recently retired as a lecturer in pharmacy at King's College in London. Experienced in pharmacy law and ethics, Alan is a former chairman of the RPSGB's law and ethics committee. Alan is now involved in the PDA research programme.

### Shenaz Patel

*MRPharmS*

Shenaz is experienced in recruitment, training and development, disciplinary and some employment law at operational level. Shenaz can also advise on contract acquisitions and employment protection. She is currently working as a community locum pharmacist

### Mark Provost

*MRPharmS*

Mark is an expert IT developer and advises PDA on the development and management of the PDA website. Additionally he assists in the design, implementation and maintenece of the PDA's internal IT infrastructure. He also develops innovative uses of technology for the PDA.

### Paul Taylor

*LLB(Hons)*

Paul is the lawyer who acted in the peppermint water gross negligence manslaughter case representing the pre-reg. He has advised in many subsequent gross negligence manslaughter investigations throughout the country in a pharmacy, care home and hospital context; he represents pharmacists in disciplinary proceedings before the statutory committee of the RPSGB.

### Joy Wingfield

*MPhil, LLM, FRPharmS*

Joy is an expert in the application of law and ethics to pharmacy practice, particularly in a community pharmacy environment. Joy's extensive background within the RPSGB at a senior level gives her an in-depth understanding of disciplinary and enforcement processes at the RPSGB. Joy is currently chair (professor) at Nottingham School of Pharmacy. As joint author of Dale and Applebe's Pharmacy Law and Ethics, Joy is widely respected for her approach to risk management and the resolution of ethical dilemmas.

### Virginia Wykes

*MRPharmS*

Virginia has a background in pharmacist training and education with a particular interest in tutoring and training pre-registration students, as well as the assessment process. She now works freelance on projects related to the education and development of pharmacists and other health care professionals.

*Sorry, we don't have pictures for everyone!

# LOCUM PHARMACIST AWARDED HOLIDAY PAY BY EMPLOYMENT TRIBUNAL

**After working six years for the same employer, a self-employed locum pharmacist and PDA member was summarily asked to terminate his sessions by the engager.**

The locum turned to the PDA for support who felt that because the locum had served this particular employer for such a long period of time, he had begun to accrue certain benefits; in particular, he had accrued holiday pay entitlements. Consequently, PDA lawyers presented this case to an employment tribunal (ET).

The tribunal found that while the locum's self-employed status was not in question, his status should be classified as a 'worker'. They decided that he was entitled to certain benefits, which included some holiday pay for the previous year. Consequently, the locum was awarded £700 in compensation by the tribunal chairman.

There were extenuating circumstances around this ruling because the locum had worked full-time, exclusively for the same employer for a number of years, and had taken on responsibilities that would normally be carried out by an employee as opposed to a self-employed locum.

This case could have implications for many hundreds of locums who are working long-term in the hospital sector and who may be oblivious of the fact that they are entitled to certain employee-style benefits. Currently, the PDA is analysing the ET decision in detail to see exactly under what circumstances such benefits would be the case. The PDA hopes to be in a position to issue comprehensive guidance to locums by the end of the year.

**Commenting on the ruling, the locum said:**

*"Going to an employment tribunal was a daunting experience and it was shocking to see that the employer had retained two lawyers. It is at times like this that one realises how invaluable PDA membership truly is, for without the support of PDA, it is highly unlikely that I would ever have been able to take this matter further."*

During 2004, the PDA successfully secured more than £150,000 in compensation on behalf of PDA members who had been treated harshly or illegally by employers.





# LACK OF SLEEP AFFECTS PHARMACIST PERFORMANCE

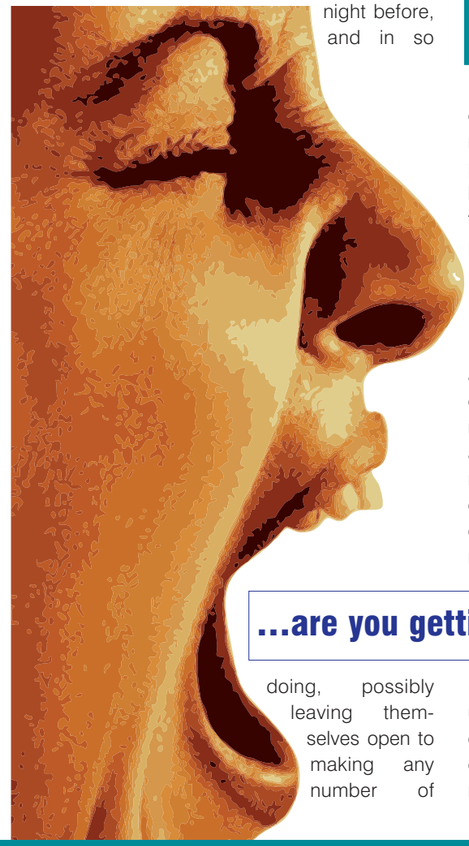
## by Elizabeth Doran, resident pharmacist

Working in a hospital can be challenging enough; but what happens when pharmacists have to work a full day after a night of interruptions during on-call duty?

**This article describes the risks involved and how the PDA has helped one hospital to put in place a system that is safer for patients and pharmacists alike.**

Working in a hospital can be challenging enough on a day-to-day basis without having to take into account the added pressures of working after a night of interruptions. Yet this is the scenario that many of us face when our duties include participating in an on-call service. Be it emergency duty cover or a full residency, many pharmacists working in secondary care are exposed to the dangers of working a full day shift after having been on call the night before, and in so doing, possibly leaving themselves open to making any number of errors, serious or otherwise.

There has been little public debate about the safety of pharmacists having a busy night on call and then doing a standard shift the following day. How safe can it be for pharmacists to work when their night has been interrupted repeatedly? In a profession where much of the work involves the checking of others and where decisions and advice directly affect the care of patients who are often seriously ill, the idea of a half-asleep pharmacist on the wards is disturbing. Currently, there is no definitive ruling that determines how much sleep a pharmacist is entitled to during on-call duty, but surely having a member of staff functioning on only a few hours of sleep presents a danger. This issue needs to be addressed in order to protect both patients and the staff themselves.



### ...are you getting enough sleep?

In my hospital, after consultation with the Pharmacists' Defence Association, we have adopted a system currently used by long-distance lorry drivers to ensure that they are not driving for long periods without an appropriate rest. We abide by a 'four hour rule' whereby if our sleep is interrupted and causes us to have less than four hours of continuous sleep overnight, we take the requisite amount of time off work the following morning to allow us to have this uninterrupted period. So for example, if the on-call duty starts at midnight and we are called out at 2am and again at 5am, we will not have had four hours without interruptions. Under the new system, now in place, we do not go into work the next morning until we have had the opportunity for the required four hours' rest. In this way, we can prevent a pharmacist from working when over-tired and potentially, minimise any errors on their behalf.

This is something that could be adopted in all hospitals to ensure that the on-call pharmacist is not exposed to long periods of work without an appropriate amount of rest. From experience, the occasions when the pharmacist is called out enough times overnight to break a four-hour period are infrequent, even within a large teaching hospital, and so any effect on the following day's rota is minimal. It is entirely possible that those pharmacists working as part of an emergency duty rota will never have to take advantage of such a system, but having such an arrangement in place is surely a wise risk management strategy.


|advisoryboardmember|
Elizabethz Doran is a member of the PDA advisory board. You can find out more about the PDA Advisory Board in the article on pages 8-9

# GUILD MISLEADS MEMBERS

A copy of the recent correspondence file between the Guild of Healthcare Pharmacists and the Pharmacy Insurance Agency – the insurer that arranges cover on behalf of all PDA members indicates that all is not well

The file which has been passed to PDA for information purposes by the PIA indicates that in the past few months, the Guild have allowed an article to be published in one of its communications with its members which PIA alleges is highly misleading and even Amicus the parent union of the Guild has written to PIA and has accepted that it could be misleading.

## MISLEADING ARTICLE IN NEWSLETTER

The newsletter which bears the name of Martin Pratt, who is the Guild Communications and Recruitment Officer contains a feature which is entitled: "Aren't you a member of the Guild – professional indemnity insurance INCLUDED"

**The offending article states;**

*"Guild membership will give cover for professional indemnity insurance purposes when an individual is employed by an NHS employer or is working as a locum for the NHS.' and goes on to explain that the cover is comprehensive and is cheaper in many respects to private professional indemnity Insurance".*

Following on from this newsletter which was transmitted electronically, the PIA received calls from PIA-insured hospital pharmacists who were not members of the Guild. They were keen to learn how this 'Guild insurance' offer compared with that provided by PIA. What were the limits of cover, did it provide cover in the event that work was being done off the NHS premises, did it provide cover for odd day locum work? Who was underwriting it, and most importantly of all – was the protection provided independent of the employer?

The PIA felt that the article could be misleading to Hospital Pharmacists in relation to their PI insurance

**"Upon investigation, the PIA could not find any evidence of any insurance scheme, or policy, being provided to pharmacists by the Guild."**

Upon investigation, the PIA could not find any evidence of the Guilds registration with the Financial Services Authority to provide insurance – which is a minimum legal requirement. Neither could they find any evidence of any evidence of an insurance scheme or policy being provided to pharmacists by the Guild.

Ultimately, the PIA concluded that although the newsletter gave the impression that membership of the Guild bestows a PI insurance benefit to its members, the Guild's 'so called' insurance was nothing more than the NHS clinical negligence scheme for trusts (CNST) which is the very basic cover provided to all NHS employees by their employer – the NHS, whether they are members of the Guild or not or even whether they are pharmacists or not. It is known that the reason why approximately 50 per cent of all hospital pharmacists carry their own independent PI insurance is because they are concerned that in the event that something goes wrong, the NHS clinical negligence scheme is not specifically designed to look after the interests of pharmacists, but is more generally concerned with looking after the interests of the trust. Furthermore, any serious incident in a hospital may not just involve the need to settle a claim for compensation, it will almost certainly involve other issues. These may include coroners inquests, RPSGB investigations, employment disciplinary proceedings or even criminal prosecutions. The CNST scheme provides no protection in these areas. Furthermore, there are concerns that in some cases the trust itself could even be a co-defendant. Additionally, hospital pharmacists need to understand that there are strict conditions under which the CNST will operate, outside of which it will not. Consequently, the CNST scheme does not provide comprehensive cover as described in the Guild newsletter; the cover provided is more a conditional understanding between the NHS and its employees.

## A COMPLAINT IS SENT TO THE GUILD EXECUTIVE

The PIA therefore felt that this article could be capable of misleading hospital pharmacists in relation to their PI insurance, so it wrote to both Martin Pratt and to senior colleagues on the Guild executive and bearing in mind the seriousness of the situation, the PIA asked the Guild to issue a clarification statement to its members within seven days of the receipt of the letter.

## MANY WEEKS OF DELAY

In the weeks that followed, the correspondence file shows that neither the Guild officers, nor Amicus seemed able to deal properly with this matter. Some of the officers simply claimed that all correspondence should be forwarded to Amicus the union and not to them direct – and subsequently, no response from Amicus was received.

The PIA then sent a second letter to all parties, this time giving the Guild officers and Amicus a new deadline to issue a clarification statement, otherwise they would be forced to consider referring the matter further.

The second deadline passed and still there was no response from either the Guild officers or Amicus. The PIA then offered a third and final deadline.

## FINALLY A RESPONSE…

This time a letter did arrive from Amicus, the contents of which were surprising. They were surprising because Amicus was supposed to be defending the Guild executive. However, it appeared to distance itself from the Guild executive by stating that Amicus had not seen the Guild publication prior to circulation.

**Moreover, it stated;**

*"I agree that the text you refer to contained within a newsletter issued by the [Guild] contains a statement that could be misleading."*

The Amicus response did not satisfactorily deal with the PIA's request to issue an immediate alert and a correction to Guild members. The response just stated that the guidance to Guild members would be reviewed.

This time PIA wrote to Amicus expressing its concerns that almost two months had gone by and there appeared to be no urgency either by the Guild executive, nor Amicus to deal with an issue of public interest or retract the misleading statements made to Guild members. Six weeks later, a brief letter arrived from Amicus explaining that the person dealing with this matter had gone on leave until the end of August and would not be dealing with this until she returned.

At the date of going to press on the 21 September 2005 no response has been received either from the Guild executive, or from Amicus.

Although the PIA would not reveal what it had done in light of the refusal by the guild Executive to act, the PDA understands that referrals to the regulatory authorities have been made.

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**This statement was received from the PIA;**

**This episode poses important questions about the actions of the Guild executive and also about the relationship between the Guild and Amicus the union. Furthermore, six months after Guild members were sent a misleading newsletter, about which serious complaints were made, there appears to have been no attempt made by the Guild executive to warn members that a mistake had been made.**

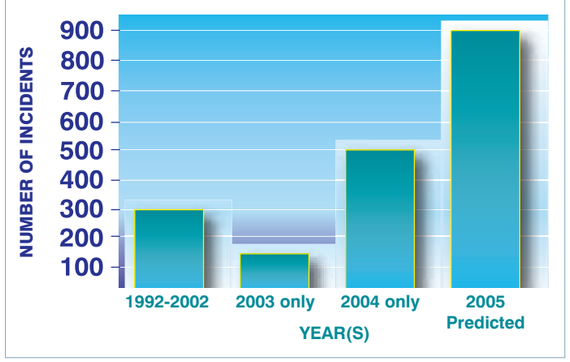
# PERFORMANCE OF THE PDA

The PDA was launched in September 2003 and in the first 18 months has attracted a membership of more than 10,000. This is more than any other defence association in pharmacy

The PDA exists because of the growing recognition that pharmacist are becoming more vulnerable to the consequences of their involvement in any incident we categorised under the banner of the 'Big 5' – as an analysis of the trend of all incidents reported over the years will show.

Although it is to be expected that the number of incidents will grow with the increase in the size of membership, a more alarming statistic is the ratio between incidents and membership numbers.

**Fig. 1** Graph showing the escalation in incidents involving pharmacists




- Ratio of incidents to membership 1992 – 2002: 1 in 166
- Ratio of incidents to membership 2004: 1 in 17.

### Over a fifth of our membership sought support in 2004

The PDA responds to these incidents offering support, advice and where necessary taking legal action, on a day-to-day basis. In addition, the PDA works proactively on behalf of its members, by providing risk management advice and education through web-site articles, publications, seminars and conferences. It also involves itself in lobbying on the national stage to ensure that the voice of the individual pharmacist is articulated and their interests represented.

## REACTING TO THE BIG 5

### 1.Civil Claims

***More than 140 cases dealt with in the first 18 months***

A fifth of the incidents reported have the potential to escalate to a civil claim for compensation as a result of negligence. The PDA has played a significant role in coaching its members in how to handle complaints which reduces the risk of them escalating to a claim.

The PDA's policy has been to settle any claim for negligence in as swift and amicable way as possible, in the interests of both the patient and the member. What we have refused to do is to pay out on claims that in our view are inflated, unreasonable or bordering on the fraudulent, in the interests of protecting the employers' brand at the expense of the reputation of the PDA's member.

In handling these claims, we have also held employers to account so that we can ascertain that the negligence has been partly or wholly due to them. There is now a growing trend, however, that some employers, through their insurers, are requiring their employees to settle negligence claims so that the error can be attributed to them (the employees).

### 2. Professional Disciplinary Action

***More than 60 cases dealt with in the first 18 months***

The Society's approach to regulation has resulted in ever-increasing activity in this arena.

Their disciplinary protocols allow no room for discretion among its inspectorate and if any complaint is received, it is obliged to investigate. More often than not by using formal police and criminal evidence standards (PACE). This is a harrowing experience for pharmacists.

**The PDA provides members with support on a number of levels**

- Advice on how to avoid a complaint reaching the Society
- Advice on how they should deal with an informal approach from the RPSGB inspector and their rights
- An experienced member of the advisory board to accompany and represent them in a formal interview with the Inspector under PACE guidelines in serious cases
- Assisting with written responses to the Infringements Committee.
- Legal representation at Statutory Committee hearings

More recently, PCTs are becoming involved in dealing with complaints, which has inevitably involved the PDA.

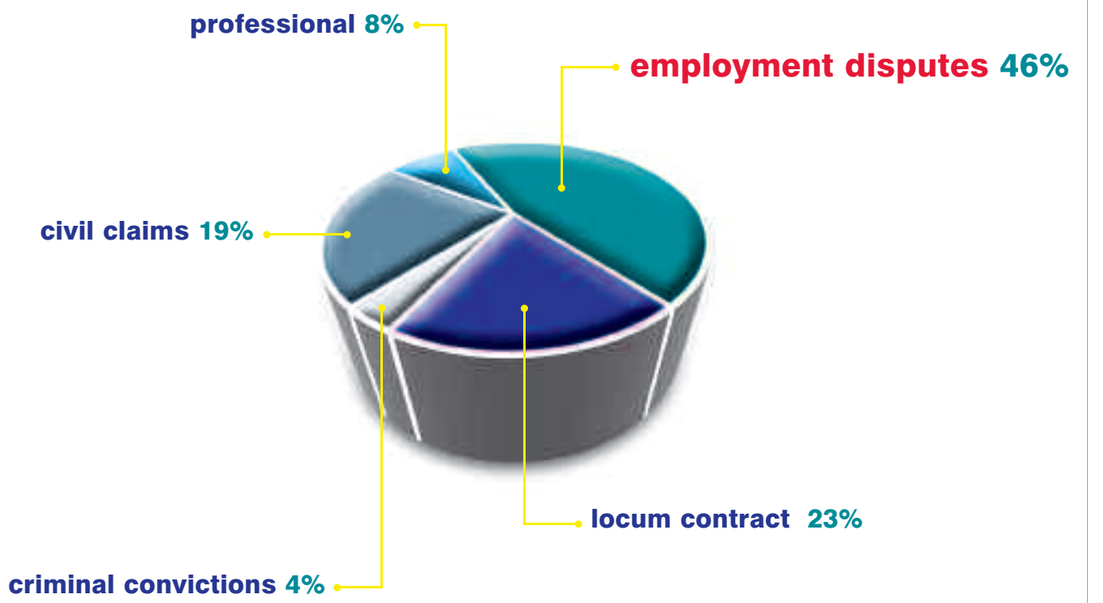
Regrettably some errors lead to the death of a patient; consequently PDA representatives have handled coroner inquests on behalf of members over the past year.

### 3. Employment Disputes

***More than 350 cases dealt with in the first 18 months***

Nearly half of the disputes dealt with by the PDA have been employment related. This is as a consequence of the fact that 90 per cent of pharmacists are employed or self-employed and for the first time, there is an organisation that has the individual's interests at heart – something that the employers have not been used to, and don't like.

**Fig. 2** Chart showing the appropriate split of the types of incidents dealt with by the PDA since September 2003.




During the period under report, £150,000 worth of compensation was claimed from employers on behalf of employees who had been treated unfairly or illegally. The PDA has dealt with lawyers acting on behalf of employers or the NPA – the organisation that represents the interests of employers.

### 4. Locum Dispute Service

***More than 100 cases dealt with in the last 12 months***

A further £25,000 was secured on behalf of locums who had previously been unable to secure their pay from employers. This service was not introduced until June 2004 and had a significant impact on many employers and self-employed locums alike, neither of whom appeared to understand their rights under contract law.

As a consequence the PDA has developed its own 'Contract for Services' to reduce the locum's vulnerability to breach of contract by employers, and to strengthen an employer's position if the reverse proves to be true.

### 5. Criminal Prosecutions

***More than 30 cases dealt with in the first 18 months***

The major area of activity has revolved around pharmacists who have unwittingly, contravened the Misuse of Drugs Act. The PDA continues to caution pharmacists that, regardless of intent, small misdemeanours will be treated as criminal offences under this Act by the authorities.

The PDA has also lobbied hard against the RPSGB's draconian measures in making it a requirement to declare any caution or conviction (how ever minor it may be eg, a speeding ticket) as a pre-requisite to remaining on the register.

## PROACTIVE AGENDA

### Risk management

By examining incidents that have already occurred the PDA has shared the learning with the wider membership in developing the risk management agenda. The PDA briefings are risk management tools which are available to any pharmacist who feels they may benefit. In addition, the PDA website www.the-pda.org which contains an interactive advice service has had almost 8,500 unique individual visitors who between them have visited the extensive PDA site on almost 52,000 occasions in the first year.

The PDA hold regular conferences to explore the issues of the day affecting PDA members.

### Lobbying activity

The PDA has undertaken several large-scale surveys and has worked with research establishments to provide supportive data. The concerns of individual pharmacists are being identified and articulated through conferences and meetings with officials of the RPSGB, NPA, PSNC, NPSA and BPSA, and written submissions to the DOH, CRHP, CCA and on the Shipman enquiry.

**The three areas of particular concern have been:**

- Staffing levels in the pharmacy
- Working hours
- Violence in pharmacy for which a policy and resource pack is available to all pharmacists on request

### Remember…

**The PDA is run by pharmacists for pharmacists. We continue to add relevant services and skilled people to meet the needs of our membership. We have doubled our staffing in the office and made strategic additions to our Advisory Board since September 2003.**

**We are geared up more than ever to achieve our overriding aim which is to is to defend the reputation of the individual pharmacist.**

# MEDICATION REVIEWS ARE YOUR FAULT

## ...THINK ABOUT IT

If something went wrong and a patient was harmed because of the work of a hospital pharmacist who would be blamed?

## who's defending your reputation?

In many respects, hospital pharmacy has led the "new roles" revolution, developing and pioneering many new and exciting pharmacy activities. These roles provide much opportunity and professional satisfaction, but they also bring with them additional risks for pharmacists.

In the event that something goes wrong, the issue may involve several health care practitioners: the prescriber, nurse, technician and even the trust management. All of these fellow practitioners are almost certainly members of their own defence association and the trust can rely on defence through the clinical negligence scheme for trusts (CNST). In any subsequent inquiry they will have their interests well represented – but will you?

We provide our members with the safeguard of up to £4,000,000 worth of professional indemnity, legal - professional support and representation in the event that an error leads to the harm of a patient.

You are aware of the principles of risk management, so why not risk manage your own reputation?

**You might call it looking after your interests; we would have to agree.**

**That's why more than 10,000 pharmacists are already members of the PDA. Are you one of them?**

- Robust legal support provided in dispute situations
- Specialists experienced in hospital pharmacy issues
- On-line advice centre to support your practice
- Professional indemnity insurance

## Find out how membership can benefit you:

Visit our website: www.the-pda.org

Call us: 0121 694 7000

| defending your reputation |

pda
the pharmacists' defence association