Advice and FAQ for prescribing and non-prescribing pharmacists in primary care

Introduction

PDA members will know that a key condition for safe effective practice and satisfying GPhC and indemnity cover requirements is to work within your competency. This applies to all pharmacists wherever they work and equally to Independent Prescribers (IPs) and non-IPs.

Whilst the clinician ultimately signing a prescription is the individual who will carry the bulk of medicolegal responsibility should a patient be harmed by the medicine concerned due to an error or omission, any pharmacist must ensure that they are competent to undertake the activities they are involved in and that any advice they give or changes they make to patient records are safe and accurate.

Members are expected to make use of key guidance documents regarding prescribing practice and to reflect on their areas of practice, experience, and training regularly. Below are links to some key resources regarding prescribing:

1. https://www.pharmacyregulation.org/sites/default/files/document/in-practiceguidance-for-pharmacist-prescribers-february-2020.pdf
2. https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/Prescribing%20competency%20framework/prescribing-competency-framework.pdf?ver=2019-02-13-163215-030
3. https://www.pharmacyregulation.org/sites/default/files/document/high-level-principles-remote-prescribing-november-2019.pdf

The PDA has published a series of articles based upon Coroners' Regulation 28 Prevention of Future Deaths reports. In all cases, there were learning points for independent prescribers from all professions. You can find links to the articles below:

1. Coroner highlights the role of poor medicines review in death of patient
2. Coroner's Prevention Of Future Deaths Report - Adrenaline Auto Injectors
3. Reports to prevent Future Deaths with implications for pharmacists - poor record handling
4. Coroner highlights the importance of robust monitoring of patients taking hazardous medicines

Frequently asked questions (FAQs)
The following scenarios represent questions which are frequently asked by members to the PDA Advice Line and are designed as a first port of call, if you have a specific query which is not covered here, please contact the team for advice on 0121 694 7000

Working in general practice

	Query	Response
1.	**I am new to general practice, what are all the things I need to know to practice safely?**	General practice is a huge area with many different areas of work and an infinite number of ways to carry out tasks. As such, we cannot possibly tell you everything you need to know, however, there are some key principles which will hopefully set you on the right path: • Always work within your competency unless you are undertaking training directly supervised by a clinical supervisor. • Always consider test results where they may make a difference to the treatment under consideration. If there are no recent test results, you should consider whether it is safe to recommend or prescribe or whether you should refer to a GP. • Always consider **every** drug the patient is taking together with potential interactions, even if you are only being asked to advise on or prescribe one drug. • Never assume that another sector is 'taking care' of required tests – obtain confirmation. • Make clear and contemporaneous consultation records for all the patient related work which you do. Should something go wrong, these will be essential to show what you did and why you did it. GPhC guidance for prescribers is equally applicable to non-prescribing pharmacists in general practice, so we have summarised it here: When prescribing or providing pharmaceutical care within general practice, pharmacists should consider the following three areas: 1. Having all the necessary information to prescribe/advise safely 2. Prescribe/advise safely 3. Follow-up

2.	**Would a Clinical Pharmacist or Advanced Clinical Practitioner (ACP) Pharmacist be insured by the PDA to work in a GP Practice without the physical or telephone support of a GP present? Would the PDA provide insurance for a Clinical Pharmacist/ ACP Pharmacist to work alone under any conditions?**	Our entire GP practice-based programme/policies are based on the pharmacists working under a delegated framework. In such a scenario, the GP would still take some (considerable) responsibility for the work of a pharmacist and would have to demonstrate how they supervised the work of the pharmacist. The GP would have to show how this was given effect. In the event of a claim, the GP would therefore have to take some responsibility, if they erred in that supervisory role. If a pharmacist was working in a GP surgery with no GP present, it would be very difficult indeed to see how this supervision could be given effect – in particular in the event of the unexpected happening. In that sense, unless the pharmacist could demonstrate how the satisfactory level of supervision was being delivered by the GP; on a case-by-case basis, he/she would have fallen outside of the delegated framework within which our policies operate. In the above situation described of working without the GP available for support/supervision, should you refer patients without a GP present this would be considered a referral framework, because the GP would likely not be available to support you on the phone, moreover, it would be the case that the GP is absolutely not calling in routinely to check up on your work; and the resulting 'referral framework' is outside of our scheme parameters. Additionally, you would have to demonstrate that you had competency to be able to work either with or without the delegated levels of supervision and it is very likely that a pharmacist would not be able to deliver this level of certainty even with an ACP qualification in the absence of a GP being available for support. Our schemes therefore would not provide cover for a pharmacist working on their own in a referral capacity in a GP surgery. The pharmacist would have to be satisfied that there was a satisfactory supervisory regime (i.e. that they were working in a delegated capacity) and also that the appropriateness of their wider competency could be demonstrated when scrutinised.

3.	**I have been asked to implement a drug switching programme. Can I change patients'**	An IP qualification is not required to undertake switches or change patients' medicines, but any such exercise must be performed safely. We advise that any drug switches you make,

	medicines if I am not an IP?	should be done in accordance with safe practice ensuring that the switches are safe for the specific patient, that the switches have been authorised and confirmed with a prescriber, any monitoring requirements are managed appropriately for the switch to ensure patient safety, and that you are working within the boundaries of your clinical competence. Ideally, where these exercises are done as part of a CCG or PCN programme, there should be a standard operating procedure or similar, to ensure that all pharmacists taking part do so in a uniform manner. Finally, we would strongly advise that any changes to patient medication should be done with the knowledge and agreement of the patient.

4.	**I have recently started work as a Primary Care Network (PCN) pharmacist and I have been tasked with processing hospital correspondence via Docman as well as numerous other activities.** **The practice manager has said that I will be allocated 30 minutes daily to do this, but this is a large busy practice.** **I am worried that I won't be able to deal with all the correspondence within 30 minutes and may be performance managed as a result. What does the PDA advise?**	Since you are part of the PCN DES programme, you should have a senior Clinical Pharmacist and a CPPE Educational Supervisor as well as your GP clinical supervisor providing support. If you have not already had a meeting with your GP clinical supervisor, we would suggest that you ask to arrange one to sit down with them and discuss your responsibilities and current competencies. As you are new to general practice this should be taken into account when considering the time set aside for your tasks. At this early stage, it might also be a useful to set the parameters within which you will process the letters and those areas where you would be expected to refer to a GP for advice if necessary. In hospital, this activity (adding new drugs to a patient record based on information from hospital TTO or letter) would be regarded as transcribing (e.g., transferring prescribing information from one type of chart or information source to another) rather than prescribing. Whilst the concept of transcribing does not exist in primary care, it would seem sensible to look at having some sort of written agreement between you and your practices/federation about what types of discharge and OPD medication is appropriate for practice pharmacists to add or prescribe (when/if you do become a prescriber) and when it is agreed that they should be able to print off the prescription but leave it for the GP to sign. Any new arrangements should be added to the practice prescribing policy (or Federation template document if there is one).

5.	**Now that the law has been changed, is it okay for me to sign fit notes?**	Whilst this legislation is due to come into effect on 1 July 2022, any of the new healthcare professional groups listed must have completed mandatory training prior to starting to sign fit notes. The PDA would add that even after completing the mandatory training (once it is made available by the Department of Work and Pensions and Health Education England), pharmacists should not be signing fit notes where the required therapeutic, diagnostic or examination skills lie outside their competence. You can see our article on Fit Notes here: https://www.the-pda.org/regulations-passed-to-enable-pharmacists-and-other-healthcare-professionals-to-issue-fit-notes/

Non-IP practice pharmacy		
	Query	Response
1.	**I have been asked to oversee management of specialist shared-care drugs. I generate the repeat prescriptions ready for the GPs to sign.** **Due to the pandemic, we are not doing blood tests and I have some patients coming up for review who have not attended for their essential blood tests.** **Shall I just generate the prescriptions since we are not doing face to face appointments at the moment?**	The PDA advise against delaying or cancelling the requirement for blood results where specialist or high-risk drugs are involved unless this practice has been agreed across the local health economy with the endorsement of your local CCG and hospital laboratories. Whilst the clinician signing the prescription would carry ultimate medicolegal responsibility should a patient come to harm, you carry professional responsibility for the advice you provide, and you should ideally pass any such patients to the GP for a clinical decision unless it is based upon locally agreed guidelines for managing high-risk medicines during the pandemic. The Royal College of General Practitioners produced a guide for GPs on how to manage routine work during the pandemic which you may find useful. Any tests which could make a difference to treatment remain high priority: https://www.bma.org.uk/media/3654/bma-rcgpcovid-workload-prioritisation-nov-2020.pdf

2.	**What are my responsibilities when preparing**	As a professional medicines' expert, you should ensure that any activities you undertake are within your competency and ensure the safe

	prescription requests for GPs to sign?	treatment of the patient. As an example, if you are preparing a prescription for a GP to sign or passing prescriptions to be issued you should consider the following: • What are the common side effects of the medicine? • Are there any blood test results required to monitor safety – if so, are there recent results and are any of them out of range requiring possible adjustments to treatment? • Is the patient undergoing shared care with another healthcare provider increasing the risk? • Is the dose for the medicine you are adding within limits as per BNF guidelines and age appropriate for the patient? • Are there any hazardous interactions between the requested medicine and any other medicines which the patient takes? For example, if you pass a prescription for signing to a prescriber and the patient suffers harm because you failed to mention raised blood test results to anyone as you assumed someone else had acted, then you could be at risk of a compensation claim; similarly, should you fail to identify risks associated with drug interactions. The PDA has dealt with cases where both scenarios were involved. In those cases, patients came to harm, in one case catastrophic harm. When it comes to reviewing medicines for prescribing or issue, the PDA view is be that as a pharmacist you are expected to undertake the full range of responsibilities and considerations which are highlighted above.

3.	**Can I bring forward medication review dates to coincide with SMRs I am carrying out?**	If this activity is covered by a Standard Operating Procedure (SOP) or practice procedure which clearly sets out the parameters within which you are authorised to amend medication review dates and is approved by your clinical supervisor, then it is acceptable.

Repeat Prescribing		
	Query	Response
1.	**I am an independent prescriber. I have**	No clinician should be compelled to sign any prescriptions unless they feel clinically competent to do so.

	recently joined a GP practice. **I have been told that I do not work fast enough, and they want to monitor how quickly I can complete certain tasks which include signing repeat prescriptions. Can they do this?**	Unfortunately, the PDA sees numerous cases where pharmacists are pressurised to undertake prescribing which is outside their scope of practice and competency or where they are given insufficient time to complete this task safely. If pharmacists are taking on the routine signing of repeat prescription without the time or opportunity to check patient notes, your supervisor and you may need to consider: a. Whether this is prudent b. What value you are bringing to the process. If you cannot complete this activity with any greater scrutiny than the GPs you are replacing, then the system has not been improved in any material way. For the PDA, if pharmacists are routinely signing repeat prescriptions, they should be doing this with additional time which allows them to bring their unique pharmaceutical knowledge into play and therefore significantly improve patient safety and treatment.

2.	**As a new pharmacist prescriber to a GP practice, what advice would you give regarding signing of repeat prescriptions that the surgery expects of me?**	Pharmacists and GPs need to have a clear conversation about competence. The pharmacist prescriber must only work within their own competence and confidence and when they are new prescribers and (in many cases) new to general practice, this scope of competence may be quite limited. We advise that pharmacists should not be signing repeat prescriptions if they do not feel competent or confident to do so. For example, they may not feel confident to sign repeat prescriptions for patients they have never seen or for patients on medicines that are outside of their prescribing scope of practice. As education, training and experience increases, this will change. If pharmacists do not, initially, feel confident to sign repeats, it would be better for them to support practices by looking at their prescribing processes to identify ways to save GP time. Leading change such as electronic prescribing and repeat prescribing initiatives, as well as training for prescription clerks can all have significant impact. Pharmacists can answer medicines-related queries that arise when repeat prescriptions are issued, and this may save GP time and use a suitably qualified professional to

		meet patient need. No clinician can be compelled to prescribe in a therapeutic area in which they do not feel confident. t is neither safe nor sensible to expect them to start signing all repeat prescriptions at this stage. There is no fast track to prescribing – competence and confidence must grow through appropriate support and clinical supervision. As you continue to work within general practice, over time you are likely to be asked (and expected) to expand your areas of competence. This should be discussed and agreed with your clinical supervisor/GP Lead as part of your career development with appropriate training, mentoring, supervision, and support provided to help upskill you. For non-medical prescribers who have never used their IP qualification, it may be prudent to consider a period of shadowing followed by supervised prescribing until both parties are confident that the pharmacist is ready to prescribe unsupervised. The CPPE also provides a Return to Prescribing module for pharmacists undertaking the Primary Care Pharmacist Education Programme. https://www.cppe.ac.uk/career/return-prescribing

3.	**I receive District Nurse (DN) request forms (filled in by DNs after home visits) for a lot of dressings however often there is no indication on the record for why they are needed/requested - am I covered to issue these?**	The PDA would advise that you check if a diagnosis has been made for the condition. As is often the case, you would have to work collaboratively with Nurses/ Advanced Nurse Practitioners / District Nurses etc. You would need to assure yourself that the condition has been appropriately assessed, the dressings are appropriate in type and quantity for the condition and are in the locally approved dressing formulary, that there is a follow up if necessary, for the patient, and if you feel it is within your boundaries of clinical practice, that it would be safe to prescribe the dressings. You would also need to establish if this is a new condition or perhaps an ongoing condition which may have been diagnosed in the past. The GPhC guidance for pharmacist prescribers is quite clear: • Pharmacist prescribers must use their professional judgement, so that they act in the person's best interests and prescribe only the medicines they know to be safe and effective for the condition

		they are treating. • When prescribing, pharmacy professionals should consider the following three areas: 1. Having all the necessary information to prescribe safely 2. Prescribe safely 3. Follow-up Prescribing clinicians carry medicolegal responsibility for the prescriptions they sign. Should a patient suffer harm because of taking a prescribed medicine or using an appliance which was not appropriate, they may bring a claim for clinical negligence against the prescriber of that medicine. It is worth checking local practice regarding District Nursing teams – in some areas each team has at least one nurse prescriber so that they can organise their own team prescriptions.

4.	**Would a member (being an employee of the Federation) be covered if another non-medical prescriber issued and signed a prescription with the member's name on?**	The PDA recommends that if your name is attached to a prescription as the IP you would need to ensure that you are signing that prescription and no one else as it will be attached to your registration number. Should harm come to a patient because of an item prescribed under your name, any claims or investigations will revert to yourself as the name on the prescription. It is true that GPs in practice sign prescriptions with other GPs names on them, however as a nonmedical prescriber (NMPs), best practice is that you should be the only one signing your own prescriptions. Indeed, some CCG areas have nonmedical prescribing policies which expressly prohibit NMPs signing prescriptions for other NMPs.

5.	**Do you need to be a Pharmacist Independent Prescriber (PIP) to re-authorise prescriptions?**	We would advise that a PIP can authorise repeats and indicate the number of repeats allowed for medicines which they feel are within their competence. However, if pharmacists are undertaking this activity, then this should be in accordance with the practice/PCN Repeat Prescribing Policy. Where a policy currently states that only GPs can reauthorise repeat prescriptions, then this will need to be amended, updated and signed off in line with practice governance processes, if this is to be delegated to a suitably competent PIP. Non-prescribing Pharmacists need to agree their scope of activity and can make recommendations regarding those patients who they consider safe

		for the GP/Prescriber to re-authorise their medication. The onus is also on the GPs of the practice to ensure that those PIPs are competent to undertake the activities that are delegated to them. See guidance below from CQC and GMC. **1. CQC guidance on Pharmacists in general practice** GPs who delegate any part of their responsibilities or activities under the GMS contract to other healthcare professionals (HCPs), must have satisfied themselves that those HCPs are competent to undertake the activities. GPs will be expected to provide evidence of the competence of the pharmacist undertaking those activities during Care Quality Commission (CQC) assessments. 2. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/repeat-prescribing-and-prescribing-with-repeats You [General Practitioner] must be satisfied that procedures for prescribing with repeats and for generating repeat prescriptions are secure and that: • The right patient is issued with the correct prescription. • The correct dose is prescribed, particularly for patients whose dose varies during the course of treatment. • The patient's condition is monitored, taking account of medicine usage and effects. • Only staff who are competent to do so prepare repeat prescriptions for authorisation. • Patients who need further examination or assessment are reviewed by an appropriate healthcare professional. • Any changes to the patient's medicines are critically reviewed and quickly incorporated into their record.

'Minor ailment' clinics		
	Query	Response
1.	**I have worked in community pharmacy since registration two**	The PDA view is that there is no such thing as a 'minor ailment' in general practice unless and until a suitably qualified and experienced

	and a half years ago but recently obtained my IP qualification and have been offered a job working in a general practice providing walk-in clinics and telephone triage. **This sounds like a really great opportunity and starting with minor ailments sounds like a good introduction to general practice – which policy do I need?**	clinician has diagnosed it. If you are a recently qualified IP, do you have the experience and expertise to diagnose and treat the patients attending your clinic confidently and competently? Is that lump something benign or something more sinister? The PDA has seen several cases where members have made decisions and provided treatment with the best of intentions but based on mistaken diagnoses. We would advise any pharmacist wishing to embark on a career involving first contact treatment and diagnosis to undertake a full advanced clinical practice qualification to equip themselves with the required clinical and diagnostic skills.

2.	**Is it acceptable to prescribe repeated acute prescriptions containing OTC products for recurrent conditions such as cold sores, hay fever, allergy treatments and flare ups of irritable bowel syndrome if they have been prescribed successfully in the patient past medical history? Is it acceptable to prescribe medication for repeated acute conditions e.g. repeat for acyclovir cream for a recurrent cold sore which is an OTC prep? Are pharmacists covered for OTC preparations that would be prescribed in the**	If it is a **repeat** acute, practice policy/SOPs cover this activity and it is done within Boundaries of Clinical Practice Statement (BCPS) then this would be covered, since the diagnosis has already been made by another clinician. At this point, please check the practice's prescribing policy on prescribing of Medicines of Limited Clinical Value and medicines which should not routinely be prescribed in primary care. https://www.england.nhs.uk/medicines-2/itemswhich-should-not-be-routinely-prescribed/

	past and reissued again as an acute such as nsaid gel, cold sore treatment, hay fever preps, rhinitis, allergy treatments, flare up of Irritable Bowel Disease (IBS) (all prescribed successfully in past medical history).	

Online pharmacies and remote prescribing services		
	Query	Response
1.	**I have been working for an online pharmacy as an IP pharmacist for 4 months.** **There has been a complaint because I prescribed a medication which a patient requested, and they were harmed.** **I followed company policies, so I do I have anything to worry about?**	There have been a series of incidents involving online prescribing services and we would urge our members to consider whether what they are being asked to do is in line with required professional practice. On further investigation, it transpired that in this case, the company policy did not require GP confirmation regarding the POMs being requested OR any form of communication with the GP to advise them of the medicines which had been prescribed by the service (it was up to the patient to consent to the GP being contacted and they declined). In all the cases which we have spoken to PDA members about, the safeguards in place have been questionable. We suggest that anyone considering this area of work considers; • How does the scenario above correspond with good professional practice? How do you know that the person who has filled in the online form and ticked all the boxes is telling the truth about their age or any other question? • How does the company gather information from patients – is it via a telephone consultation or the filling in of an online form? • Is it possible for patients to game the system by filling in the form, be rejected and then change the relevant answers to ensure their request is accepted? As a healthcare professional, you should consider how the regulator would view matters if someone were harmed because of a prescription

		you issued in a situation like the one described?

2.	**Can Pharmacists Independent Prescribers sign private prescriptions?**	• Any qualified independent prescriber can sign private prescriptions – however, this must be for medicines which lie within the scope of their training and competence. We would advise pharmacists to review their boundaries of my clinical practice statement (BCPS). • From an indemnity point of view (and for the safety of patients) the PDA cannot provide cover for private prescribing services which lie out with current regulatory frameworks. • **In practice this means that prescribing for online organisations or services which are not registered with the following regulatory bodies will not be covered**: ○ General Pharmaceutical Council ○ Pharmaceutical Society of Northern Ireland ○ Care Quality Commission (CQC) registered service provider in England, ○ Regulation and Quality Improvement Authority (RQIA) in Northern Ireland, ○ Care Inspectorate in Scotland ○ or the Care and Social Services Inspectorate Wales (CSSIW). The PDA advises members that the GPhC or PSNI can still take regulatory action against PIPs working in unregulated services for breach of professional standards and that this may result in suspension from the register.

Private practice		
	Query	Response
1.	**I am an IP pharmacist and am considering setting up a private prescribing clinic in a rented room.** **Are there any legal issues I need to think about, and will I be covered by my indemnity?**	The PDA would not be able to cover this activity which would be regarded as a business venture. The PDA would also not indemnify any service which was not overseen by a national regulator. Consider the following precautions: • If any of the items you prescribe might interact with or have an impact on medicines provided by the patient's usual GP, then mechanisms for communication and sharing of relevant information must be in place. • You should be able to confirm whether any Prescription Only Medicine (POM)

		requested is part of the patient's usual medicine regime and you should let the GP know what you have prescribed. If a patient is resistant to this important safety measure, you should be extremely wary of prescribing.

Telephone consultations		
	Query	Response
1.	**Can I conduct telephone reviews / consultations in my GP Practice?**	Telephone and remote consultations can cover a wide variety of activities ranging from the routine to the highly complex. Telephoning a patient may be high risk or not depending on what you are doing and how you are doing it. If you are telephoning a patient to check on progress and see how they are getting on with their medicines, then this is a safety measure which might not occur in the absence of the practice pharmacist and is a positive intervention (unless of course you fail to check that biochemistry tests are up to date or fail to ask other pertinent questions to ascertain the safety of prescribing). If you are phoning a regular patient to carry out a pre-arranged consultation with them and have their clinical record and your own experience as a foundation for the consultation, then whilst far from ideal, this may well be considered preferential to not having any interaction with the patient at all. It would be like the activity in first scenario above, but with the bonus that you may know the patient. So, not a proper clinic consultation, but at least you can still check how they are getting on with their medicines and find out if they have any worries or concerns. If you are telephoning unfamiliar patients to carry out telephone triage, then this is a high-risk activity from an underwriting viewpoint since you cannot see the patient to gauge how they are, and you are likely to be making a new diagnosis at some point. How good are you at excluding red flags over the phone? Is it a feverish cold or is the patient in the early stages of sepsis? Are you going to organise a home visit or just tell them to take some paracetamol and plenty of fluids? These scenarios are ones which underwriters know are associated with more errors and claims – hence the higher risk classification.

		In summary, think about the types of patients you usually see in your clinics and take things from there. Do a pre-clinic risk assessment of the aspects which you could reasonably predict and mitigate (so, if they are due for a blood test and they are not going to get one, you can discuss with your GPs, agree how you will discuss this with the patient, or perhaps whether you will have 'special' clinics or send out a nurse to take the sample). If you think some of the patients are too complex to deal with over the phone, discuss with your GP Lead. Always ensure that your indemnity covers telephone/remote consultations and is at an appropriate level of cover for the types of telephonic interactions you are having with patients as stated above.