Pharmacy News

Christmas Edition —

Volume 7, No.

December 2018

Please Circulate to All Staff

Inside this issue:

Guidance for Nicotine Replacement Products

Community pharmacy staff are reminded that where patients have been referred by stop smoking service to community pharmacy to access either nicotine replacement products or varenicline then patient details should be recorded on the PCR and the supply can be made as long as the community pharmacist feels the supply is appropriate. A supply can be made even if the patient will continue to receive stop smoking support from one of the stop smoking team.

MDS Box Supply

Patient's receiving an MDS box from community pharmacies should be supplied on a weekly basis. Only in extenuating circumstances and with agreement from a multi-professional team review should patients receive all four boxes as a single collection. This process is in place to ensure patient safety.

Controlled Drug Errors

As well as following normal company processes for errors in community Pharmacy, errors involving controlled drugs should be reported to the controlled drug accountable officer. Forth Valley Controlled Drug Accountable Officer is Scott Mitchell, Director of Pharmacy. A template for reporting Controlled Drug Incidents is available on the Forth Valley Community Pharmacy Website along with contact details for submission.

Pharmacy Resources

In the last twelve months the community pharmacy development team have invested in additional resources for community pharmacies. These resources are designed to increase patient information and awareness of community pharmacy services. They provide tools for pharmacists and pharmacy support staff to enable easier delivery of services and better communication between patients, GP practice and community pharmacy. Resources you have received in the past 12 months include:

- Business card patient information on the self management of conjunctivitis
- Duplicate SBAR pads to allow quicker accessibly of this tool to communicate with GP practice
- Business card patient information on who can be treated for UTI and who may have to see their GP

These resources have been supplied at some cost due to specific requests and to enable pharmacies to deliver the services more effectively.

Please ensure when you receive resources that you use them effectively within the pharmacy. If you have not received any of the resources above and and/or wish additional supplies please email the community pharmacy development team at: FV-UHB.communitypharmacysupport@nhs.net

Naloxone Provision over the Festive Period

Naloxone is a potentially life-saving medicine when used in opiate overdose. A focus on overdose awareness and naloxone provision should be undertaken by services at this period of high risk. Pharmacies currently participating in the Take Home Naloxone Program should continue to supply, raise awareness of overdose risk and document these in the patient's Care Record in the PCR.

Additional counselling for these patients should be to check the patients awareness of:

* Signs and symptoms of suspected overdose e.g pinpoint pupils, breathing problems, blue lips, no response
* Knows how and when to administer naloxone
* Knows to always call 999
* Knows naloxone is short acting and effects will wear off after 20-30 minutes
* Knows the importance of staying with the person until help arrives

Transdermal Fentanyl Patches: life-threatening and fatal opioid toxicity from accidental exposure, particularly in children

The MHRA recently highlighted the risks associated with transdermal Fentanyl following continued reports of unintentional opioid toxicity and overdose due to accidental exposure to Fentanyl patches. Clear information should be provided to patients and caregivers about how to minimise the risk of accidental exposure and the importance of appropriate disposal of patches.

Advice for healthcare professionals:

Always fully inform patients and their caregivers about directions for safe use for fentanyl patches, including the importance of:

- not exceeding the prescribed dose
- following the correct frequency of patch application, avoiding touching the adhesive side of patches, and washing hands after application
- not cutting patches and avoiding exposure of patches to heat including via hot water (bath, shower)
- ensuring that old patches are removed before applying a new one
- following instructions for safe storage and properly disposing of used patches or those which are not needed

Ensure that patients and caregivers are aware of the signs and symptoms of fentanyl overdose (see link below) and advise them to seek medical attention immediately (by dialling 999 and requesting an ambulance) if overdose is suspected

In patients who experience serious adverse events, remove patches immediately and monitor for up to 24 hours after patch removal

Report any cases of accidental exposure where harm has occurred or suspected side effects via the Yellow Card Scheme

Further information available at:

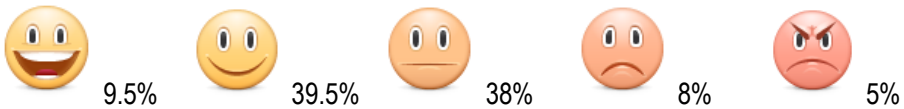
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/747591/PDF-Oct-2018-DSU-FINAL.pdf

Pharmacy Support Staff – Community Pharmacy Services

PLT Training November 2018

On the 13th November the community pharmacy development team held a protected learning time event for pharmacy support staff on the delivery of community pharmacy services. Below is a summary of what was covered and effective the pharmacy support teams thought workshops were.

Before the training event what was your knowledge of pharmacy first and how confident were you to triage patients?



9.5% 39.5% 38% 8% 5%

After the training have you learnt anything about pharmacy first and do you feel more confident to triage patients?

63% 27% 10%

Nobody left the training feeling only semi or not at all confident in their knowledge of pharmacy first and their confidence to triage patients. Ideally all community pharmacy staff should feel extremely confident to triage patients to avoid easily identified inappropriate patients from impacting on pharmacist's time.

Before the training event what was your knowledge of the MAS formulary and how confident were you suggesting a formulary product to patients

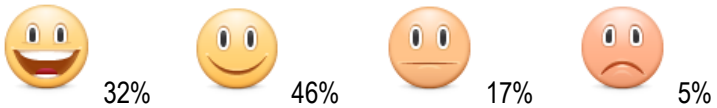
16% 49% 26% 6% 3%

After the training event what was your knowledge of the MAS formulary and how confident were you suggesting a formulary product to patients

71% 21% 8%

This workshop was popular with the pharmacy support staff who were interested in their formulary compliance performance and showed enthusiasm to make improvements, this would help Forth Valley maximise efficient prescribing and allow pharmacist to concentrate on alternative priorities.

Before the training event how confident were you to consult with patients?



32% 46% 17% 5%

After the training event how confident are you to consult with patients?

59% 28% 13%

After training in almost 90% of support staff stated they were either extremely or very confident in their consultation skills. As front line, patient facing ideally all pharmacy support staff should be extremely confident to consult with patients.

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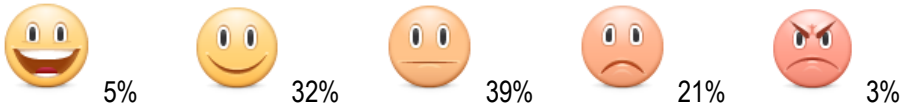
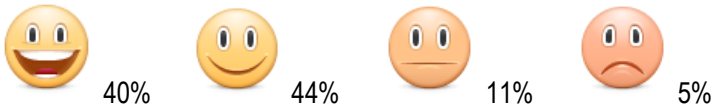
Before the training event how proactive in providing the OST bundle of care were you?

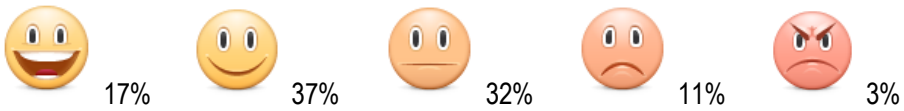


After the training event how confident do you feel to contribute more to the OST bundle of care?



Providing the OST care bundle appeared to be the pharmacy service that support staffs were least proactive in providing. Confidence to become more proactive in the provision of the OST care bundle rose considerably after training with a combined 84% of staff saying they would feel extremely confident or very confident to contribute more to this service. Past audits of the provision of this care bundle in community pharmacy have been disappointing and it has been identified that this is an area that pharmacy support staff can aid in the standardisation and quality of this service deliver, results from the training workshop would support this.

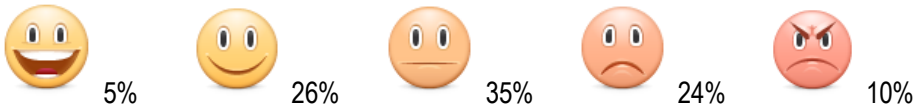
Before the training how confident were you suggesting NRT products to patients?



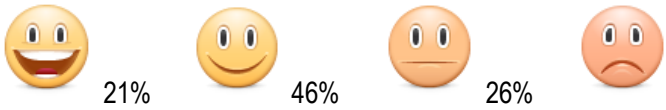
After the training do you feel confident to suggest NRT products to patients?

As one of the longest running services provided by community pharmacy it was unsurprising that this was a service that a combined 54% of support staff felt extremely confident or very confident to deliver. After training this figure climbed to 86%. The community pharmacy development team see this service being run almost exclusively by pharmacy support staff (with the exception of Varenicline prescribing).

Before the training to day what was your knowledge of and how confident were you to deal with MCR Rx



After today's training how is your knowledge of MCR Rx's and your confidence to deal with them?



This service provided the highest percentage of staff who felt only semi confident or not at all confident at a combined total of 34%. At the end of training this service also provided the highest percentage of staff who felt only confident or semi confident to deliver this service, this was reflected in the answers given when attendees were asked what additional training they would like to see provided.

Overall confidence in knowledge and ability to deliver the community pharmacy services climbed after the training workshops. Asked what additional training support staff would like to see the community pharmacy support team deliver the majority of responses requested more frequent training overall to keep staff updated with fresh knowledge of the services and changes. Following requests for more frequent training events CMS came out as the most requested subject for further training followed by CPD. There was one request for more IT training and a further request for additional OST training.

Merry Christmas!