

■ MINOR AILMENT SERVICE

Envy of pharmacists outside Scotland

From Mr N. J. Wicks, MRPharmS

I had to respond to the recent letters about the Minor Ailment Service in Scotland. My experience of working in one of the busiest MAS pharmacies in our health board is completely different to that of Nadim Ali (*PJ*, March 8, p273) and David McNaughton (*PJ* 15 March 15, p307).

This service has given me room to spread my wings professionally as an NHS prescriber. It also provides an invaluable service to patients who wish to access the NHS for information and treatment of minor ailments.

I have never had patients come in with a medicines shopping list. What I have had is patients who have been registered at another pharmacy coming to us with misconceptions about what the service is about. On closer examination this has usually been due to a poor explanation by the other pharmacy when signing up the patient or, less commonly, a misunderstanding by the patient.

I think it does MAS a great injustice to focus on the occasional problem. In my experience across our group of 10 pharmacies the key to a successful MAS service is ensuring that patients understand what it is and what it is not.

It is also important to ensure that there are appropriate resources in the pharmacy to offer a good service. If these are in place then our experience would indicate little decline in over-the-counter

sales, the main reason being that those ineligible for MAS choose us and not the supermarket to purchase medicines because of the word of mouth about how we add value.

MAS is the envy of pharmacists outside Scotland and rightly so. It provides patients with a walk in NHS service in the heart of their community without the need for an appointment. How many others can boast that?

Noel Wicks
*Managing Director ACMS Ltd
Larbert, Stirlingshire*

All about patient care

From Mrs T. Orr, MRPharmS

I would like to point out a couple of facts that Nadim Ali (*PJ*, 8 March, p273) seems to have missed at the training days for the Minor Ailment Service. I was one of the community pharmacists involved in the pilot study in Ayrshire and I also gave the community pharmacist's perspective at the two NHS Education for Scotland training days at Stirling (which is now part of the NES implementation pack).

The aims of the MAS are well documented and I cannot believe that anyone could think it is an ineffective service unless they do not fully understand it. The people who will not fully understand the service are patients, and who could blame them? It is a service in its infancy so it is the pharmacist's responsibility to understand how it is meant to work and then communicate this to patients.

The two issues Mr Ali addresses in his letter are amply covered in the NES pack, and they are:

People are meant to be treated for a minor ailment that they are experiencing at that moment. It is not for stocking up their medicine cabinet "just in case". This scenario happened many times during the pilot and people soon got the message if pharmacists or their assistants take the time to explain how the system works.

These patients would previously have had to be referred to their GP, as they do not pay prescription charges, so a sale may not have happened anyway. This is not a service we give for free, unlike the countless delivery services and monitored dosage systems that pharmacists provide for little if no payment and in far greater numbers than treatments for minor ailments.

I urge Mr Ali to read the implementation pack and learn how to make the scheme work because at the end of the day it is all about patient care.

Toni Orr
Livingston, West Lothian

The service must be re-explained

From Miss C. N. Cormie, MRPharmS

Although it is encouraging to read recognition of Scotland's advances in community pharmacy, I disagree with the overall comment in Nadim Ali's letter (*PJ*, 8 March, p273).

Most customers I see present for the Minor Ailment Service the way it was intended: with the pharmacist making a recommendation based on an ailment that has been discussed with the customer. For the occasional customer who presents for "medicines on demand", the service must be re-explained. The analogy of a GP visit can be helpful: patients visit their GP with an ailment, not a demand; this service should be treated the same way.

I would also dispute the points about "little clinical intervention" and a reduction in over-the-counter sales. In my experience, having a greater opportunity to engage with customers through provision of MAS positively encourages clinical intervention. This varies from simple intervention such as recommending a customer buys a nit comb as the pack provided on

MAS does not contain one, to detailed interventions, for example, uncovering long periods of self-medication that has been masking serious underlying conditions. The former style of intervention has led to an overall increase in OTC sales in my store since MAS implementation. The latter style provides the patient with an appropriate referral and treatment, contributing to a multidisciplinary health service.

To conclude, I believe MAS has been highly beneficial to patients in Scotland, providing an excellent, well used service. My concern now is, what will happen when the Scottish Government scraps prescription charges in a few years time? Will all be eligible for MAS? Or only those currently exempt from prescription charges? Or, as would possibly be simpler, will the MAS be scrapped altogether?

Clair Cormie
Edinburgh

■ LOCUM RESPONSIBILITIES

Where do the boundaries lie?

From Mrs R. L. Prosser, MRPharmS

Working as a locum I have little control over staff training but I remain responsible for what goes on in the pharmacy. I have two situations I am concerned about, relating to staff competence and dispensary training requirements and the grandparent clause.

Recently I found myself in a pharmacy that had accepted a school pupil for work experience. I became unhappy to have him there as he was not even seriously considering pharmacy as a career choice.

As I understand it, putting stock on shelves is covered by the requirement for training or "grandparent clause" status. There is concern about confidentiality before allowing an untried stranger access to patient details.

In this case the individual was unable to convince me that I should trust him. I was unhappy to be put in this position, by the shop manager.

As a profession, it would be short-sighted to refuse to allow work experience placements. I would like an opinion as to what is an appropriate role for an inexperienced 15-year-old, in a pharmacy, staffed by locums and part-time staff members?

My second situation raises similar issues: when working in an

Letters are welcome from all readers. Letters for publication can be posted, faxed, or sent by e-mail to letters@pharmj.org.uk and should not normally be of more than 400 words and should cover one topic only. *The Journal* reserves the right to abridge letters and to edit them for clarity and style. Pharmacist and registered pharmacy technician correspondents should supply their membership numbers, and a contact telephone number should always be given.

All letters are considered on their merit and are accepted for publication on the understanding that they have not appeared anywhere, including electronic media, previously. If the issue is of such significance that the correspondent has simultaneously submitted the letter elsewhere, it is the responsibility of the correspondent to inform *The Journal* at the time. Further to a recommendation by the Journal Oversight Board (*PJ*, 1 March 2008, p244), pharmacists and pharmacy technicians whose names appear on the non-practising part of the relevant register are asked to make their status known.

Letters that are critical of individuals, organisations or companies may be sent to the person or body concerned so that they are given a simultaneous right of reply. In these instances, the authors' identities will not be disclosed until publication, and publication will usually be delayed.

Anonymity will only be accepted in exceptional circumstances. These circumstances will be at the discretion of the editor and the decision made in consultation with the correspondent.

independent pharmacy on a regular basis, I became aware that the member of staff I was working with had not completed any training course. I asked whether she had been signed off under the grandparent clause but she did not think so. I assess this woman as attentive to detail and good at her job. Where do I stand as a locum?

Rachel Prosser
Bradford

JANET FLINT, head of support staff regulation, Royal Pharmaceutical Society, replies: Staff training and team working is covered under principle 7 of the new Code of Ethics for Pharmacists and Pharmacy Technicians. Pharmacists and pharmacy technicians are accountable for any work done under their supervision and must ensure that any individuals to whom tasks are delegated have undertaken or are undertaking the training required for their duties.

The writer is correct that the Society's minimum training requirements apply equally to occasional staff and to those who are permanent employees and that putting stock away in the dispensary is an activity that is covered by these requirements.

The Society's policy is that a new member of staff or an existing staff member with a new role should be enrolled on training within three months of starting that role or as soon as practical within local training arrangements. This gives pharmacists some flexibility within probationary periods to determine that individuals are suited to the roles for which they have been employed and that the investment in training is justified.

Where untrained staff members, including anyone on work-experience placements, are engaged in activities covered by the Society's minimum requirements the onus is on the pharmacist in charge to ensure through appropriate supervision that patient care or public safety is not compromised.

Where a locum has concerns about the employment or work experience of another member of staff, he or she should raise these concerns with either the superintendent or pharmacist owner.

The Society has archived over 34,900 completed declaration of competence or "grandparent" forms that were submitted to the Society in 2004, before the introduction of minimum training

requirements in January 2005, and is able to check whether a record is held of individual staff members. For more information about this please contact the Society's support staff section on 020 7572 2610 or e-mail supportstaff@rpsgb.org.

■ EDUCATION

What recourse is there for bullied students?

From Mir M. E. Q. James, FRPharmS

In browsing pharmacy internet message boards I have encountered some disturbing cases concerning preregistration students who feel badly treated or bullied.

We all complain every so often, but these young men and women are in a peculiarly vulnerable position and it seems that when they seek the advice of the Society the norm is to accept the word of the tutor and, apparently, to dismiss the concerns of the student.

I do not wish to encourage people to complain about conditions at the drop of a hat, as I have been a tutor and can appreciate how situations can deteriorate, especially when only one or two people are involved. I wonder what the process is when the human relationship between tutor and trainee has irretrievably broken down. It cannot surely be accepted as satisfactory that the student simply fails the year and cannot take the examination for a further 12 months, if at all, especially where only one other person is involved, as would be the case in a small organisation.

I have been a tutor in community pharmacy and, looking back, see how easy it would be for a student not to fit in. I have also assisted with tutoring in hospital and recall the gratitude of some students when they came to me, and the relief with which others left. The "some" included students who were regarded elsewhere as less than promising; the "others", students whom I felt would be good pharmacists but where other supervisors disagreed.

To whom can students or tutors turn when such a breakdown occurs? In the past, I have recommended contacting the local branch secretary. Before I am hoist with my own petard and someone contacts me, what is the process in such case?

Miall E. James
Honorary Secretary
Colchester Branch, Royal
Pharmaceutical Society

JEREMY HOLMES, Chief Executive and Registrar replies: The Society's preregistration scheme sets out the standards for the 52-week preregistration training period. The performance standards for preregistration trainees are set out in a workbook and state the outcomes that must be met at the point of registration. There are also standards for tutors and training premises. A tutor information book sets out the responsibilities of a tutor. The tutor is responsible for the delivery of training and assessments that provide the assurance that standards have been met. This training relationship is governed by a learning contract.

The Society plays no part in placing students; students apply for a preregistration post with an employer. Where the employer is not an independent owner, a tutor is assigned by the employer and the Society is notified. The Society has no formal contract with employers or tutors to provide training. The preregistration employment relationship is governed by the terms and conditions of the employment contract.

Although the Society has no legal obligation in this area, we

encourage trainees, tutors and employers to follow best employment practice in resolving issues locally. All employers owe a duty of care to their employees to protect them from bullying. When bullying emerges the Society would expect the employers to have in place formal grievance procedures to deal with this — bullying is not something that should be tolerated. The Society's Code of Ethics makes it clear that all registrants whether they be tutors or employers should demonstrate respect for the dignity, views and rights of colleagues. We expect this to be applied to the tutor/trainee relationship; trainees sign up to this through the learning contract.

The Society is undertaking a number of initiatives in relation to the operation of the preregistration scheme. We recognise that tutors are an important asset and crucial in the delivery of training. We are currently developing tutor support through web-based guidance and training in workplace assessment skills. We also recognise the need to support trainees by developing guidance on addressing training issues in the workplace. This guidance is to be included in the 2008/09 trainee workbook.

Advertisement

■ THE SOCIETY

Lose the arrogance

From Mr B. D. Nathwani

I was appalled to read the answer given by the Royal Pharmaceutical Society to the Disciplinary Committee when asked what two silent partners common were alleged to have done wrong when the third partner had made endorsement errors (*PJ*, 1 March, p235).

The reply was "that the Society did not have to answer" and the Society referred the Disciplinary Committee to the Code of Ethics for Pharmacists and Pharmacy Technicians.

This highlights the reason why so many have lost confidence in the ability of the Society (both as a regulatory body and a professional body) to engage meaningfully in simple, commonsense dialogue with any entity (individual or statutory).

The code of ethics (item 6.8) to which the Society referred the Disciplinary Committee also states that pharmacists should "respond honestly, openly and courteously to complaints and criticism". Would the reply given by the Society to the Disciplinary Committee fall within this ethos?

An aggravating feature of this case is that the members will have to foot the bill for the Society's incompetence. Can we be assured that the individuals responsible for taking this case forward will face some disciplinary action for failing to do their jobs properly?

It is of note that in its 2004–05 performance report the Council for Healthcare Regulatory Excellence hinted that the Society may want to "commission an external audit of decision-making at the Infringements Committee stage for quality assurance". It is even more galling that the Society in June 2007 had the audacity to advise the General Medical Council: "The Society considers that there should be an independent audit, and report published on the use of undertakings as a method of disposal." Given that the Society understands and knows the value of an independent external audit (for other regulators) as best practice we can legitimately ask why has the Society failed to apply this best practice of an independent external annual audit for its own fitness to practise processes and cases.

Incidentally, Item 6.1 of the code of ethics also states that pharmacists should comply with

legal requirements, mandatory professional standards and accepted best practice guidance.

Presumably this best practice, like many others, does not apply to the Society or its staff.

Bharat Nathwani

Pinner, Middlesex

JEREMY HOLMES, Chief Executive and Registrar, Royal Pharmaceutical Society, replies: The Society does not normally comment on individual cases, but has decided to make an exception given the criticisms made by Mr Nathwani in relation to one of the Society's recent disciplinary cases.

This letter refers to a case involving "small pack endorsing" which was heard by the Disciplinary Committee (sitting as the Statutory Committee) on 7 to 11 January 2008. The case was brought against three partners who jointly owned a pharmacy business. One partner was alleged to have endorsed NHS prescriptions for Gaviscon liquid to indicate that small pack sizes had been dispensed, when, in fact, large pack sizes had been dispensed. The Disciplinary Committee found this partner guilty of misconduct and issued a reprimand. The case against the other two partners was that they all had a responsibility under Part 2 of the code of ethics, at paragraph A2 (a), to ensure the observance of all legal and professional requirements in relation to the business, and therefore a responsibility to ensure that the claims made to the Prescription Pricing Authority were accurate.

The information on which this case was based was received from the NHS Counter Fraud and Security Management Service. The Society had a statutory duty to investigate the allegations. These were properly considered by the Infringements Committee and the Committee referred all three partners to the Statutory Committee. Given the personal professional responsibilities imposed on all pharmacy owners by the Code of Ethics, the Society considers that it was entirely proper for the case to proceed against all three partners.

It is not correct that the Society "said that it did not have to answer" when asked what the two partners were alleged to have done wrong. This issue was considered at a case management meeting in August 2007 where the legal representatives had the opportunity to raise any concerns. At that meeting, the Society clarified the

legal basis for the charges against the second and third partners. The case then proceeded to a hearing before the Disciplinary Committee on that basis. On the particular facts of this case, the Disciplinary Committee decided to halt the proceedings against the second and third partners in the pharmacy.

The letter refers to the need for independent external audit of the Society's Fitness to Practise processes and cases. Since 2007 the Infringements Committee has been replaced by the independently appointed Investigating Committee, members of which have received extensive training. All disciplinary cases are subject to the external independent scrutiny of the Council for Healthcare Regulatory Excellence (CHRE). The Society is also subject to an annual performance review by CHRE. The Society has been working for some time with CHRE and the other healthcare regulators to devise an appropriate audit scheme. This work is now being taken forward by CHRE and guidance, which will apply to all healthcare regulators, is expected shortly.

The Society is committed to discharging its regulatory role in the public interest, in compliance with all proper legal requirements and in accordance with best practice, which is stipulated and monitored by CHRE.

The determinations in this case are available on the Society's website, www.rpsgb.org.

■ MANUFACTURING

When capsules are disguised tablets

From Dr M.-L. Truong, MRPharmS

Further to Stephen Carey's comments (*PJ*, 23 February, p214), it is usually expected that an omeprazole capsule contains either powder, granules or liquid. Doctors prescribe them because they offer an alternative to tablets. Does a tablet become a capsule by dint of being inserted into one? For me the answer is simple, tablets placed within a capsules are not capsules: they are merely disguised tablets.

As pharmacists, we do not want to have to look inside capsules to make sure that we are really dispensing capsules. This manufacturing method is misleading and should be abandoned.

Minh-Loc Truong

Coventry

■ WHITE PAPER

England expects . . .

From Mr J. A. S. Buisson, MRPharmS

Publication of the long-awaited White Paper on pharmacy in England is imminent. We must hope that the Department of Health is now preparing to take action on many of the issues facing pharmacy. Above all, the department must take steps to integrate pharmacy services across primary, community and secondary care.

What we do not need is another long explanation of the problems. These have been clearly outlined by the All Party Pharmacy Group and are understood by all pharmacy bodies, including the English Pharmacy Board.

At the recent Darzi engagement event in London it was clear that there was an emerging consensus among those present about both the nature of the problem and the necessary changes. This meeting, like its counterpart in Manchester, was attended by representatives covering all parts of pharmacy involved with the NHS in England. The unanimity of the views expressed was striking and I hope that this was noted by Lord Darzi and the DoH officials present.

The English Pharmacy Board has, naturally, made Lord Darzi's review of the NHS and the pharmacy White Paper two of its six key objectives for 2008. We want to ensure that the undoubtedly warm words we can expect about pharmacy are translated into practical actions that benefit patients and pharmacists alike. This is why I am standing for election to the board this year.

Urgent action is needed to deal with the cashflow-wrecking aspects of Category M changes, the emerging chaos of EPS Release 2, the ragged patchwork of enhanced services commissioning, and the way patients can fall between the gaps when discharged from secondary to primary care rather than receiving proper pharmaceutical care.

Winston Churchill (whose wartime bunker is but a stone's throw from the DoH's own in Whitehall) would dismiss promises and demand "Action this day". England expects nothing less from the White Paper.

Jonathan Buisson

English Pharmacy Board Election

Candidate

Feltham, Middlesex

■ CHILDREN'S BNF

Near-miss error

From Dr C.F. Green, MRPharmS, and others

We wish to share the learning from a "near miss" patient safety incident, which was contributed to by the layout and indexing of the Children's BNF 2007. In this near miss, a neonate was at risk because of confusion between epoprostenol and dinoprostone.

A prescription was received in pharmacy requesting prostaglandin for a neonate. The pharmacist dealing with the prescription looked up the drug in the Children's BNF, which gives two options, anticoagulant or eye, but not ductus arteriosus, which was the reason prostaglandin was being given to this infant. Eye was the least appropriate route, so the pharmacist referred to the entry for anticoagulant on p148 (section 2.8.1).

On the page for anticoagulant, the only drug that is related to prostaglandin is epoprostenol; alprostadil and dinoprostone are not mentioned at all. Although the indication for anticoagulation is described, its use in pulmonary

hypertension is referred to in section 2.5.1.2.

Moving to section 2.5.1.2, the indication and dose for persistent pulmonary hypertension of the newborn is listed. Unfortunately, the dose prescribed for the neonate matched the dose range listed for epoprostenol as well as the intended drug, dinoprostone.

The entry for prostaglandin in the main BNF is more helpful and lists several clinical indications including ductus arteriosus. However, even this would not have led to the intended drug, dinoprostone, being given since the section referred to contains alprostadil but not dinoprostone.

Clarity about the indexing of prostaglandins in the BNFC is important for prescribers and particularly for pharmacists who are only occasionally requested to prepare the prostaglandin, dinoprostone, for infusion.

Dinoprostone is given to infants in an emergency when a ductus-arteriosus dependent cardiac lesion is suspected. This is a temporary measure to maintain ductal patency pending an urgent cardiac procedure to improve oxygenation. Rarely, such a procedure is not feasible initially and an infant may require a

dinoprostone infusion until a cardiac procedure can be performed later. It is in these uncommon circumstances that pharmacists may be asked to prepare dinoprostone for infusion.

Clearly, there are a number of other issues that contributed to the error and the incident could be described in classic 'Swiss cheese' modelling. These issues are being addressed internally by the multidisciplinary team members concerned. The role of the BNFC in this near miss could be avoided if the index entry for prostaglandin listed epoprostenol, dinoprostone and alprostadil and possibly a cautionary note about the use of the term prostaglandin when prescribing or dispensing medicines. If the clinical indications are to be listed under the index entry for prostaglandin then it is important to include patency of the ductus arteriosus.

Chris Green

Director of Pharmacy and Medicines Management

Jos Wickett

Deputy Aseptic Services Manager

John Gibbs

*Clinical Director, Women and Children's Services
Countess of Chester NHS Foundation Trust*

SEJAL AMIN, staff editor, BNF Publications, replies: We are sorry to hear about this medication near-miss.

A number of issues contributed to this incident. It is important that information in BNFC is interpreted in the light of professional knowledge and supplemented as necessary by specialised publications. The use of correct nomenclature is of paramount importance in ensuring that the patient receives the right drug. We are surprised that a prescription requesting prostaglandin for a neonate did not set off more alarm bells. One would expect the actual drug required rather than the drug class to be specified on the prescription. For example, indexing under the term corticosteroids is considerable but one would not expect prednisolone to be prescribed as corticosteroid on the prescription. Also, one might expect a slightly different sequence of events to determine the intentions of the prescriber.

Dr Green's feedback is valuable and appreciated. We will, of course, review the indexing of these terms and make improvements wherever possible.