

NEW PROFESSIONAL BODY

### Transitional committee should start work now

From Mr I. G. Simpson, FRPharmS, and others

In our recent report "Forward from Waterloo", we expressed our broad agreement with the recommendations of the Clarke Inquiry. We agree with Hemant Patel (*PJ*, 10 May, p565) that we have a unique opportunity to build a dynamic new professional body for pharmacy, and we fully support his call for all pharmacists to take an interest and get engaged in the transition process (*ibid*, p555). We would like to see that invitation extended to pharmacy students, pharmaceutical scientists and pharmacy technicians.

We fully agree with Nigel Clarke (*PJ*, 17 May, p583) that it is absolutely vital that the transitional committee is set up as soon as possible, and we were concerned that the consultation proposed by the Society would delay implementation of Clarke's recommendations.

However, at the Guild of Healthcare Pharmacists and United Kingdom Clinical Pharmacy Association national conference on 10 May, we were pleased to receive an assurance from the Royal Pharmaceutical Society's Chief Executive, Jeremy Holmes, that establishment of the transitional committee would run in parallel with the consultation.

In your report (*PJ*, 26 April, p493), you identified those organisations that wish to be an integral part of the new

professional body, and those that wish to work closely with it. We are currently taking steps to identify members who could contribute to the transitional committee, and our intention is that each of the selected members will be supported by a reference group and network. We look for a significant proportionate contribution from the Waterloo Group to the transitional committee.

We are keen to work with the Society to ensure that we produce a prospectus that will encourage all members of the pharmacy profession to join the new professional body, and we urge the Society to appoint the independent chairman and get the transitional committee established so that it can start work immediately. As you say in your editorial (*PJ*, 17 May, p582), it is a great opportunity for the Society's Council to send out a new message.

**Ian Simpson**  
*Chief Executive, College of Pharmacy Practice*

**David Wyatt**  
*Chairman, Academy of Pharmaceutical Sciences*

**Sarah Wilcox**  
*President, Association of Pharmacy Technicians UK*

**Steve Tomlin**  
*Chairman, CPP Faculty of Neonatal and Paediatric Pharmacy*

**Stephen Guy**  
*President, College of Mental Health Pharmacists*

**Richard Cattell**  
*President, Guild of Healthcare Pharmacists*

**Howard McNulty**  
*General Secretary, Institute of Pharmacy Management*

**Barry Strickland-Hodge**  
*Chairman, CPP Faculty of Prescribing and Medicines Management*

**Beryl Bevan**  
*Chairman Designate, Pharmaceutical Advisers Group*

**Rowena McArtney**  
*Chairman, Neonatal and Paediatric Pharmacy Group*

**Paul Spark**  
*Secretary, NHS Pharmaceutical Production Committee*

**Richard Bateman**  
*Chairman, NHS Pharmaceutical Quality Assurance Committee*

**Clive Moss-Barclay**  
*Chairman, NHS Pharmacy Education and Development Committee*

**Lynne Morrison**  
*Chairman, NHS Technical Specialists Education and Training Group*

**Joy Wingfield**  
*Chairman, Pharmacy Law and Ethics Association*

**Shailen Rao**  
*Chairman, Primary Care Pharmacists Association*

**David Green**  
*Chairman, Primary and Community Care Pharmacy Network*

**Ray Fitzpatrick**  
*Chairman, RPSGB Hospital Pharmacists Group*

**Geoff Saunders**  
*Chairman, British Oncology Pharmacy Association Executive Committee, and Chairman, CPP Faculty of Cancer Pharmacy*

**Michael Parker**  
*Chairman, RPSGB Industrial Pharmacists Group*

**Andrew Cairns**  
*Chairman, RPSGB Veterinary Pharmacists Group*

**Catherine Duggan**  
*Chairman, UK Clinical Pharmacy Association*

**Eilish Smith**  
*Chairman, UK Medicines Information Executive*

**Ian Maidment**  
*Chairman, UK Psychiatric Pharmacy Group*

**Peter Rhodes**  
*Chairman, NHS Pharmaceutical Aseptic Services Group*

**Paul Maltby**  
*Chairman, UK Radiopharmacy Group*

#### Broad spectrum

The Broad Spectrum feature is open to any reader. Contributions of around 1,100 words commenting on topical issues should be sent to [graeme.smith@pharmj.org.uk](mailto:graeme.smith@pharmj.org.uk) for consideration

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## Letters to the editor

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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.

## ■ FITNESS TO PRACTISE

### Non-referral to the Investigating Committee

From Mr J. A. Murphy, MRPharmS

The consultation on cases suitable for non-referral to the Royal Pharmaceutical Society Investigating Committee has now closed and the process for analysing responses will begin.

What many pharmacists may not realise is that the Society's Fitness to Practise Directorate can impose additional criteria over and above those published and endorsed by Council in order to direct a single dispensing error to the Investigating Committee, regardless of the fact that the case fits the published criteria for non-referral.

The Pharmacists' Defence Association is aware of at least one case where, because a family member had reported two supply errors in a short period (even though the errors were unconnected and involved two different pharmacists), it was decided that both pharmacists should be referred to the Investigating Committee irrespective of the published criteria.

It is possible that appealing the complainant was behind the decision to instigate a formal referral to a Statutory Committee, but to its credit when challenged by the PDA, the Society withdrew the case and dealt with it according to the rules.

The PDA believes that the application of "hidden" criteria in such circumstances is against the spirit of open and fair regulation and calls on the Fitness to Practise Directorate to be transparent when formulating policy as a result of the recent consultation exercise.

**John Murphy**  
Pharmacists' Defence Association

JACKIE GILTROW, Head of Regulatory Transition, responds: The Society cannot comment on the specific cases highlighted by the Pharmacists' Defence Association. We can, however, reassure the PDA that we are always seeking to improve our processes and to minimise any anomalies or inconsistencies, and that we are committed to operating our regulatory activities in an open and transparent manner.

At the Council meeting in March 2007 it was agreed that single, one-off dispensing errors that are not likely to amount to professional misconduct should not

be referred to the Investigating Committee and should be disposed of by means of a letter. The criteria used to make decisions on cases for non-referral to the Investigating Committee are published on the Society's website and are explained in the minutes and papers of relevant Council meetings.

In December 2007, the Council agreed that the membership and other stakeholders should be consulted on the handling of one-off dispensing errors and other matters but, in the interim period, the scope of dispensing errors should be widened to include errors made from the receipt of a prescription to supply of the dispensed medicine to a patient. That consultation process ended on 18 April and generated a positive response, as a result of which a number of changes to the threshold criteria have been proposed and will be considered by the Council at its meeting in June.

We welcomed the opportunity to hear from a wide range of stakeholders on the subject and further information on any changes made to the threshold criteria will be made available once the Council has had the opportunity to consider the proposals and determine the policy in this area. Following these policy decisions, the Fitness to Practise and Legal Affairs Directorate will ensure, as now, that each case is assessed against the published criteria and considered for non-referral to the Investigating Committee where appropriate. Any case not meeting the threshold for referral will not be referred. There is not, and will not be, any application of "hidden" criteria as this would be contrary to the principle of open and transparent regulation. We believe that the formal fitness-to-practise procedures should be reserved for serious cases in which a registrant's fitness to practise is alleged to be impaired and we hope that proposals due for consideration by Council support this principle.

## ■ MEDICINES USE REVIEWS

### Some claims are fraudulent

From Miss B. E. Pawulska, MRPharmS

I was interested in the comments by the anonymous employee pharmacist (*PJ*, 10 May, p567). As a primary care trust pharmaceutical adviser, I have heard similar stories from locums and agree with

Anonymous that some medicines use review claims are fraudulent. I have been told that MUR fees are claimed for advising a patient to take flucloxacillin on an empty stomach, or explaining how to use nystatin mouthwash. Surely, this sort of advice is an essential service.

The PCT has to pay for this activity, but has no way of ensuring quality. Under contract monitoring arrangements, only a small number of previously anonymised MUR forms can be shown to the PCT pharmacist. My guess is that these would not include examples such as those mentioned above.

**Barbara Pawulska**  
Emsworth, Hampshire

## ■ WORKLOAD

### Change law to enshrine corporate responsibility

From Mr A. J. Jukes, MRPharmS

Rebecca Ellis raised concerns about staffing levels and resources, and included a few general issues about hospital pharmacy (*PJ*, 3 May, p536).

I locum in the south east, London, Essex and elsewhere and am in close contact with colleagues around the UK. The situation in hospital pharmacy seems to have deteriorated over recent years with regard to staffing and the general risk exposure of NHS staff. Many professionals find themselves in situations where errors are made and they are, ultimately, held responsible for them.

I have witnessed and had colleagues mention experiences that give rise to concern, including:

- Days where constant diversion from an original task occurs.
- Having, on average, only 20 seconds to view a patient on a ward.
- Avoiding rest breaks to cover the work demanded.
- Being disturbed several times while trying to screen clinically a chart for a two-day-old baby and calculate dosing.
- Feeling physically and mentally unwell on an ongoing basis due to work pressure.
- Witnessing nurses trying to calculate intravenous drug dosing and rates and being asked to discuss another patient, train someone junior, and answer a phone at the same time.

All professionals are accountable for their own practice, but it is often short staffing that forces

individuals into high-risk situations where errors are more likely. Employers — healthcare trusts — do not seem to be held responsible for this in a lot of cases.

I would like to see legislation introduced that would protect individual employees from being held to account for poor working conditions that have been allowed to develop because of decision-making at a more senior level.

There should be corporate accountability at a trust level for operating malfunctions on wards and departments. Inadequate staffing levels across trusts often create the conditions for errors. I would like better protection in law for individual employees in these circumstances.

If a nurse administers a steroid injection to the wrong patient, she is professionally accountable, but she is not responsible for the dire circumstances on the ward that have resulted from under-staffing, which led to multiple distraction and fragmented working.

Trusts should be held responsible for their part in errors, where it can be shown that adequate staffing levels to facilitate effective risk management were not provided.

**Andrew Jukes**  
Brighton,  
East Sussex

## ■ DISCIPLINARY PROCEDURES

### Who is responsible for errors induced by excessive workload?

From Mr M. R. Sadak, MRPharmS

In its comment on referral of pharmacists to the Society's Investigating Committee the Guild of Healthcare Pharmacists (*PJ*, 3 May, p528) stated it should occur in cases involving "recklessness, harm or financial gain". It would be nice if the guild elaborated its stance further.

We are aware of staff shortages and working time directives being violated in the NHS and staff being forced to or bullied to work without proper breaks, with no overtime payments or time off in lieu, to meet budgetary targets.

If dispensing errors were to occur in this environment and patients harmed, would the pharmacist who made the error or the chief pharmacist who could be said to knowingly and recklessly allow this to happen be held responsible and referred to the investigating committee? With

regards to financial gain, most hospital pharmacies have formularies in place to restrict the use or supply of high-cost drugs. Changing the therapy of an inpatient could occur without full knowledge of the patient's clinical history and could be used to justify cost savings by senior pharmacy managers exceeding budgetary targets. If such changes were forced on staff, would senior managers be held accountable as, arguably, this constitutes financial gain?

In addition, following the High Court decision to overturn the National Institute for Health and Clinical Excellence's refusal to supply dementia drugs, could drugs and therapeutics committees or members and formulary pharmacists be held legally responsible for decisions not to supply medicines on the basis of cost and where this means patient care is compromised?

The guild wants referrals for not supplying patient information leaflets, but we live in a technological age where these can be accessed online at [www.medicines.org.uk](http://www.medicines.org.uk). If patients are referred to this website how could not supplying an information leaflet automatically trigger referral?

One could argue that not all patients know how to access the internet but how many patients know how to read or are bothered about reading leaflets? In addition, if less paper were generated would this not bolster pharmacy's "green" credentials?

The referral on "refusal to supply an emergency supply of a POM" needs clarification because refusal might not always result in patient harm. But it could result in abuse by senior pharmacy managers who might expect on-call pharmacists to respond to each call for medication, even though not justifiable. This could result in violation of the European Working Time Directive and potential dispensing errors through tiredness. Who will be held responsible then?

**Mohamed Riza Sadak**  
*Milton Keynes, Buckinghamshire*

#### ■ ERGOCALCIFEROL

### Supply problems and bone health

From Mr C. R. Jenkins, MRPharmS, and Mr T. P. House, MRPharmS

The current supply problem with ergocalciferol preparations (UCB Pharma) has left specialists in bone

medicine and rheumatology without a key weapon in their treatment arsenal. It is disappointing that no other manufacturers in the UK are able to take over the production until UCB Pharma can continue supplying in the normal way.

That leaves us without what could be the drug of first choice — a high-dose oral and/or injectable colecalciferol preparation. It is interesting that the only forms available in this country are in lower doses combined with other medication, when higher-dose preparations are used commonly in other countries.

Oral colecalciferol is said to result in about 70 per cent higher plasma 25-hydroxyvitamin D than an equivalent amount of ergocalciferol, which could benefit patients with absorption difficulties, such as those with short bowel disease and some elderly patients.

With recent developments to support bone health, no one has stepped forward to provide one of the key medicines in its most useful form. Is any manufacturer willing to invest in such a product?

**Chris Jenkins**  
**Tim House**  
*Addenbrooke's Hospital, Cambridge*

#### ■ FUROSEMIDE

### Expensive mismatch between prescribed and supplied doses

From Mr J. P. Brettle, SGN

Intravenous furosemide is normally supplied in 5ml ampoules of 50mg; yet the most commonly prescribed dose for this preparation is 40mg, or multiples thereof. The mismatch between dose prescribed and supplied means that, typically, for each administration 20 per cent of the supplied preparation is discarded.

A single ml of wastage might not seem like a big deal, but 20 per cent of the total NHS expenditure on IV furosemide is a sizeable quantity in anyone's estimation.

In the context of the current financial restraints on hospital pharmacies — and the resulting disruption of treatments for many inpatients with medicines not on trust-approved formularies — is it not time that wastage on this scale was addressed?

**Paul Brettle**  
*Senior Staff Nurse,  
Sandwell Hospital, Sandwell and West  
Birmingham NHS Trust*

#### ■ OPHTHALMOLOGY

### Confusion over hospital prescriptions

From Mrs C. J. C. Gilbert, MRPharmS

Captain Blanch (*PJ*, 17 May, p594) highlights the confusion over prescriptions for eye drops, which emanate from hospitals. His is not the only hospital department that issues prescriptions that can be interpreted by pharmacists in different ways. It is a common problem with handwritten prescriptions. Will there ever come a time when hospitals routinely issue prescriptions generated on computers that have built-in checks to ensure that all information is present?

Pharmacists have enough to do without having to calculate the number of bottles of eye drops to dispense, requiring us to calculate (number of drops per dose x number of eyes x times per day x treatment length in days) divided by (drops/ml x ml per bottle).

Using Captain Blanch's example — one drop in each eye every hour for 14 days — I calculate the Prescription Pricing Authority should pay me for a quantity of 7 x 5ml bottles. But is

this really the quantity intended? I believe the PPA suggests 16–17 drops/ml and it would be unrealistic to expect that the eye drops would be used every hour.

This type of situation occurs less often with GP prescriptions, because most are computer generated. The British National Formulary states that computer-issued prescriptions "must be printed in English without abbreviation. The dose must be in numbers, frequency in words, and quantity in numbers in brackets".

Handwritten prescriptions should preferably be in English without abbreviation but "it is recognised that some Latin abbreviations are used". I imagine many pharmacists are unfamiliar with the examples of abbreviations that Captain Blanch uses for every hour and every two hours. I am more familiar with the notations of *qh* and *q2h*. Might I suggest that Captain Blanch refamiliarise himself with the sections in the BNF on prescription writing and Latin abbreviations and any pharmacist unsure of how much to supply against a prescription contact the PPA for assistance.

**Christine Gilbert**  
*King's Lynn, Norfolk*

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