

## Community Pharmacy Multidisciplinary Audit 2009-2010

'as directed'

***The annual PCT multidisciplinary clinical audit is part of the essential services requirement of the pharmacy contract.***

NHS Devon's multidisciplinary audit was undertaken during the week commencing 19<sup>th</sup> October 2009. The aims of the audit were as follows

- To check that the patient knows the instructions for their prescribed medications when they are not stated on the prescription (excluding dressings and appliances)
- To prevent accidental overdose or misuse of prescribed medication
- To prevent accidental sub therapeutic regimes
- To highlight the situations in a community pharmacy where it is difficult to check if a patient knows the instruction for his/her prescribed medication
- To find a way around the aforementioned situation
- To demonstrate the pharmacist's input into improving patient compliance with prescribers instructions in these circumstances

### **Standard:**

100% of clients presenting a prescription with unspecified directions know how to use/take their medication safely and correctly on leaving the pharmacy.

### **Results:**

There are 138 community pharmacies in NHS Devon, who should have participated in the multidisciplinary audit for 2009/2010. Only 112 (81%) actually participated. Included in this total are 28 forms (20%) returned to NHS Devon with no indication as to which pharmacy they were from, and a further 5 forms (4%) returned with part of the audit missing.

During the audit period a total of 2633 items were processed as 'as directed' (excluding dressings and appliances). A total of 2314 (88%) were successfully counselled, leaving 319 (12%) unsuccessfully counselled.

The unsuccessfully counselled patients divided into 219 (69%) where the patient was not present, 67 (21%) where the pharmacist was unable to speak to the patient, and 33 (10%) others. Comments included were that they were delivery items, nursing home patients, or collected by carers so the patient was not spoken to.

The top five BNF sections which had 'as directed' instructions were:

- 2.8 to 2.9 Anticoagulants to antiplatelets
- 3.1 to 3.1.5 Bronchodilators
- 3.2 Corticosteroids
- 7.3 Contraceptives

- 6.1 Diabetes

### **Conclusion**

The main obstacle to confirming if the patient understood how to take the prescribed medicine was the absence of the patient. One solution may be to invite the patient to phone the pharmacy if there was any uncertainty as to the dosage instructions.

There may be an opportunity to target Medicines Use Reviews (MUR) on the patient with no instructions on their inhalers, counselling on use and stepping up and down.

Prescriptions for insulin very rarely have instructions for dosage, which makes it difficult to counsel patients and to ensure appropriate dosing.

Prescriptions for warfarin usually have no clear instructions for the pharmacist, but it is important the pharmacist checks the patient has dosage instructions and regular INR tests, which are noted in their yellow book. Pharmacists should follow the NPSA guidance on warfarin prescribing.

At a local level the results of the audit may be shared with prescribers who may be unaware of the extent of the problem.