# Jockey Club PHARM+ Community Medication Service Network - Roundtable Meeting on Community Pharmacy Good Practice Alignment

**LEE, Tommy Ka-Ho**
*Pharmacist, Department of Pharmacology and Pharmacy, The University of Hong Kong*

## INTRODUCTION

In the Jockey Club PHARM+ Community Medication Service Network Project, the Department of Pharmacology and Pharmacy, The University of Hong Kong (HKU) is committed to develop operational guidelines for community pharmacy, evaluate project effectiveness and promote professional development to ensure service quality, efficiency and consistence. Taking a leading role in fostering the establishment of primary care pharmacy model, HKU creates a network among providers of community pharmacy services to foster knowledge exchange, collaborative learning and stakeholder engagement. Regular roundtable meetings are organised for different stakeholders to exchange ideas and resources on service delivery, interprofessional collaboration and medication safety.

Organised by HKU, Roundtable Meeting on Community Pharmacy Good Practice Alignment (the Roundtable) was successfully held online on 6th September 2024. Bringing together frontline pharmacists and key stakeholders in the industry to discuss and explore better pharmacy practices in the community, this meeting aims to:

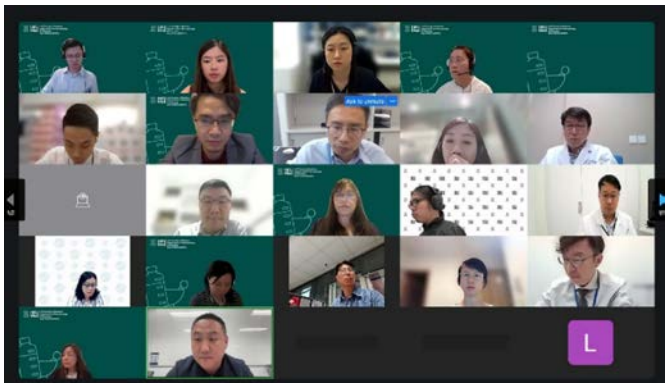
- Identify common operational challenges faced by community pharmacies and discuss good practice to overcome them
- Discuss successful and effective strategies for improving medication safety and practice in community pharmacy
- Foster good practice alignment in operation of community pharmacy

The meeting has invited guest speakers and participants from non-governmental organisation (NGO) pharmacies, chain pharmacies and district health centres. During the roundtable meeting, HKU shared findings of pre-event survey and several frontline community pharmacists shared their experience and practice in different areas of a community pharmacy:

- Labelling of the dispensed medicines
- Handling of prescription
- Record keeping

During the event, speakers and the participants contributed valuable opinions and exchanged ideas through the group discussion sessions.

This report presents key insights and significant consensus made in the Roundtable Meeting regarding alignment of good pharmacy practice.



## KEY INSIGHT AND CONSENSUS

### Good Practice on Labelling of Dispensed Medicines

***Current Challenge***

The essential requirement for labelling of dispensed medicines is set in the Code of Practice for Authorized Seller of Poisons (the Code), which provides the information to be printed on the drug labels. However, currently there is no reference or guidance on how the information can be presented to the patient. For example, one may refer to a medication by its generic name, while another may use the brand name. This inconsistency can cause confusion when transferring patients between healthcare settings, leading to errors in medication administration or documentation. Another common aspect is precautionary statement. One medication label may use “Do not crush” to indicate that the medication should not be crushed before administration, while another label may use the phrase “Swallow whole” to convey the same precautionary information.

Standardising drug labelling across the industry is significant in terms of communication and quality assurance. This facilitates clear and effective communication between different healthcare providers and patients. When community pharmacies use similar labelling format and terminology, there is less room for misunderstandings or errors in medication management. In the meantime, consistent drug labelling standards could promote uniformity and accuracy in medication management practice.

***Key Insights***

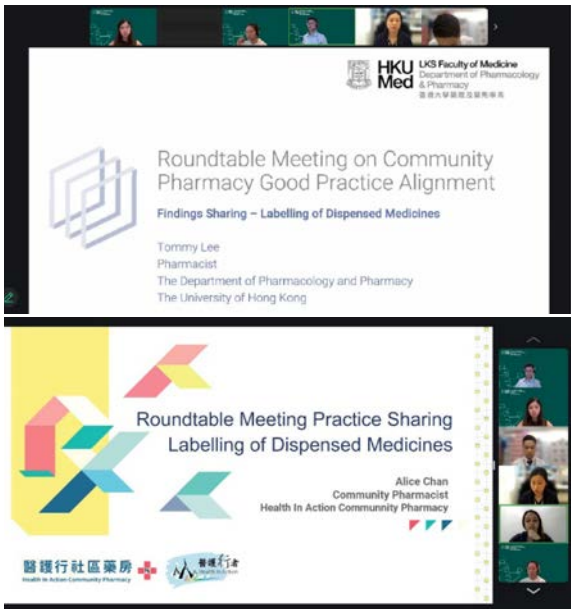
- Displaying legal classification of the medicines on the drug label can better educate the public about proper drug access in the community. For example:

| Legal Classification | English Wordings | Chinese Wordings |
|---|---|---|
| Part 1 Third Schedule Poisons | Prescription Drug | 處方藥物 |
| Part 1 Poisons, Part 1 First Schedule Poisons | Drug Under Supervised Sales | 監督售賣藥物 |

- Precautionary statements are significant information on drug labels to ensure medication safety. To enhance the readability and understandings of the precautionary statement in layman's terms, concerted efforts among the pharmacy professional should be made to establish a common reference so that individual pharmacies could adopt and prepare a tailor-made precautionary list for their own use.
- The development of precautionary statements can be based on some tertiary reference such as British National Formulary and Lexicomp, and product insert.
- The following suggestions are good features for labelling of dispensed medicines:
  - o The labels should be printed with single language, for example, Chinese or English, to fit the needs of the clients
  - o Maximise the font size of the words
  - o Given limited space on the labels, additional information can be supplemented by corresponding leaflets or other resources

***The Way Forward***

- Developing Community Pharmacy Operation Manual that outlines the standards and guidelines of a community pharmacy in Hong Kong, HKU serves to drive the collaborative change and establish knowledge that transform pharmacy practice. The consensus and good practice on labelling made during the Roundtable will be incorporated into the development of Community Pharmacy Operation Manual.




**Good Practice on Dispensing Against Prescription**

***Current Challenge***

Community dispensing service is one of the crucial elements in the primary care pharmacy model. Dispensing against prescription requires diligence and care in reviewing, assembling, checking and recording of prescription. Frontline pharmacists reflected that generic substitution, expiry of prescription and communication with prescribers were the major challenges faced by them during daily operation.

While the Code stated that where a prescriber specifies a particular branded product on the prescription, the registered pharmacist is required to dispense the product specified. Pharmacists cannot supply a different equivalent brand without consulting prescriber, however, there is grey area about the method of consultation with prescriber. It is not uncommon that the patients would like to use generic drugs and the prescribers has no concerns, unfortunately it is often that prescription of brand drug is written unintentionally. This becomes hurdles for frontline pharmacists that they have no choice but to reject dispensing of generic drugs.

At the same time, pharmacists might discover some clinical problems while reviewing the prescription, unfortunately there is no established mechanism for pharmacists to communicate with prescribers.

***Generic Substitution for Prescription***

- Patient interest and willingness are always the priority. Given that the patient is willing to use generic drug, pharmacist shall consult the prescriber before supplying a different equivalent brand to the patient, if that is not specified on the prescription.

This suggestion does not apply to prescription of dangerous drugs.

- Consulting prescriber can be achieved through any forms of communication such as phone call, email and fax. Appropriate documentation of the communication should be made on the prescription.
- The documentation might include:
  - Who to confirm with?
  - When does confirmation be done?
  - How to consult with prescriber?
  - What has been confirmed?
  - Which pharmacist confirms the substitution arrangement?
- Examples of proper documentation:

| Scenario | Example |
|---|---|
| Directly consult with prescriber | c/w *(Prescriber Name)* on *(Date and Time)* via *(Communication Channel e.g. phone call)*, that generic substitution is allowed.<br>By *(Pharmacist Name)*<br>*(Signature of Pharmacist)* |

- Appropriate documentation (e.g. intervention letter) should be sent to the prescriber as well to ensure such information is well-documented in the prescriber setting.

***Expiry of Prescription***

- Although the statutory requirements do not highlight the expiry of a prescription, it is agreed that the expiry date should be taken into account for checking validity of a prescription, which is based on the prescribed period and clinical judgement.
- In general, if there is no relevant statement or instruction regarding expiry on prescription, the prescribed duration and prescribing date shall conclude the validity of the prescription.
- For prescriptions issued by Hospital Authority (HA), specifically the self-financed items (SFIs), there is a statement 'This prescription is only valid for one month from the date of issue'. The statement brings ambiguity to the community pharmacies when the patient comes late for purchasing. Reasons of purchasing drugs late are discussed and summarised below:
  - Patients have own stock on hand and only purchase when the drugs are running out of stock at home
  - Drugs has been received from private clinics or hospital earlier, hence delay the time to use HA SFI prescription
  - Poor compliance leads to overstocking of the drugs at home
  - Hospitalisation during the prescribed period with supply of the SFI drugs leads to accumulation home stock
- Given the long follow up period in some specialty in Hospital Authority, separate dispensing might be necessary as the expiry date of drugs may not be long enough to cover the entire prescribing period. The statement about validity of prescription confuses the community pharmacy and patient.
- The overdue HA SFI prescription does not necessarily imply that the patient is not clinically suitable for the drug. Instead, with clinical judgement of pharmacists and evidence from the patient, pharmacists shall dispense the drug if it deems appropriate for the sake of patient safety.
- To dispense an overdue, yet within the validity, HA SFI prescription, the following practices are suggested:
  - Review the medication history of patients from eHealth and/ or HA Go to ensure that there are no changes recently regarding the corresponding drug and learn about the follow-up date of the corresponding specialty.
  - Based on the professional judgment, drugs can be dispensed to patients according to the instructions from prescriber
  - Appropriate documentation should be made on the prescription. Information includes:
    - When does the decision be made? (Date and Time)
    - What is the decision made?
    - What has been noticed and reviewed?
    - Which pharmacist confirms?
    - Signature of the corresponding pharmacist
  - Examples of proper documentation:

| Scenario | Example |
|---|---|
| Overdue, yet within the validity, HA SFI prescription | c/w *(name of prescriber)* or checked *(eHealth/ HA Go)* and drug of sufficient quantity is dispensed based on instruction from prescriber.<br>By *(Pharmacist Name)*<br>*(Signature of Pharmacist)* |

***Amendment of Prescription and Pharmacist Intervention on Prescription***

- In addition to checking statutory requirements of a prescription, pharmacists also review the clinical appropriateness upon receiving the prescription. The following situations are occasionally encountered:
  - Inappropriate dose
  - Inappropriate dosage form
  - Inappropriate frequency
  - Inappropriate treatment regimen (e.g. stepping up, stepping down)
  - Inappropriate drug choice
  - Missing drugs
- Patient's safety is always the primary focus of the process of medicine dispensing upon a prescription. Pharmacist intervention is of uttermost importance to safeguard the patient's health conditions. It is

encouraged that pharmacists go the extra mile in resolving the medication therapy problems identified in the prescription, apart from solely reverting the patient back to the prescriber for further follow-up.

- Effective communication with prescribers is the key to success for pharmacist interventions. There are often challenges for community pharmacists to reach out to the prescribers as they are not working under the same healthcare units, especially doctors working in Hospital Authority. Meanwhile, proper documentation of the dialogue and consensus between community pharmacists and prescribers is difficult as there is no shared system or platform, which might pose negative impacts on the accuracy of the clinical documentation.
- Understanding that limitations exist currently, the following suggestions, which is not applicable to prescription of dangerous drugs, are made in the Roundtable:
  - o Classify the potential medication therapy problem identified in the prescription according to the severity on patient's safety and respond as follows:

| Severity on Patient's Safety | Example | Action |
|---|---|---|
| Minor | • Spelling mistake of the drug name<br>• Overseas brand-name drug of which active ingredient is available in Hong Kong | 1. Communicate with prescriber via any form of communication (e.g. phone conversations, email) to confirm the right drug to be dispensed.<br>2. Make appropriate documentation on the prescription for the intervention:<br>• Who to confirm with?<br>• What has been reviewed and confirmed?<br>• Who confirm it?<br>• Signature of the corresponding pharmacist<br>• When does the confirmation be made? |
| Major | • Inappropriate dosage<br>• Inappropriate frequency<br>• Inappropriate regimen | 1. Communicate with prescriber verbally.<br>2. Based on the discussion with prescriber, either:<br>• Pharmacy informs the doctor to reach out to the patient and issue a new prescription to him/her; or<br>• Prescriber sends a copy of amended prescription to the pharmacy via telecommunication (e.g. instant message, email) and pharmacist attaches it to the original copy of the prescription as a supporting document; or<br>• Prescriber sends an original copy of amended prescriptions via mail to the pharmacy so that the pharmacy can dispense accordingly. |

***The Way Forward***

- Resources can be made available to the community pharmacy to facilitate appropriate documentation of intervention. HKU will develop relevant templates such as intervention letters which respective community pharmacy could take reference from.
- Ensuring patient's safety is the primary focus of the process of medicine dispensing upon a prescription. The better the layout and composition of a prescription, the more efficient the community pharmacy can dispense against prescription. The format of HA SFI prescription (e.g. the statements on 1-month validity and generic substitution) could be further reviewed and improved to suite the latest practice in community pharmacy. Playing an indispensable role in connecting the community pharmacy sector and HA, HKU serves to lead and reinforce communication with HA.
- The consensus and good practice on handling prescription during the Roundtable will be incorporated into the development of Community Pharmacy Operation Manual.
- Strengthening communication between community pharmacy and prescriber is important. Establishing a communication platform or mechanism will be crucial and further exploration is needed.

## Good Practice on Record Keeping

***Current Challenges***

Traditionally pharmacy-related records such as Prescription Book and Poison Book are kept as hard copies in a handwritten manner. On the one hand this is not efficient in operation, especially when handling large volumes of dispensing services, and on the other hand the handwritten records are difficult to trace, search and review. There is certainly ambiguity regarding how to conduct proper recordkeeping as the Code only mentions what is to be recorded and the duration of recordkeeping. Whether electronic recordkeeping is allowed remains unclear to the community pharmacy.

***Key Insights***

- Digitalisation of pharmacy-related records is highly encouraged.

- A phase-by-phase approach is suggested for digitalisation of pharmacy-related records. Prescription Book and Poison Book could be piloted in the first place.
- Eletronic record could be accessed via an electronic system, or a file stored in the local drive of the computer of the community pharmacy. A printed record can also be kept physically in the community pharmacy. This could streamline the dispensing process and enhance the accuracy and traceability of the record. Both electronic records and printed records should be made readily available for inspection by the Department of Health.
- The printed record could be made available at a designated time point (e.g. every day or every week). Related personnel shall then sign and date on the printed record.
- Information technology security is a key to driving the advancement of digitalisation of pharmacy-related records. The following aspects are identified for further review and discussion:
  - o Access control
  - o Audit trail
  - o Protection of personal privacy

***The Way Forward***

- It is promising that digitalisation of record keeping will be the mainstream practice. More information regarding IT security is needed to support the implementation of digitalisation of pharmacy-related records.

## SUMMARY

The Roundtable showcases the importance of collaboration, knowledge sharing, and continuous improvement in community pharmacy practice. Fostering the establishment of primary care pharmacy model in Hong Kong, HKU will continue creating networking opportunity among providers of community pharmacy services to enhance the service quality through concerted efforts.

**Author's background**
***LEE, Tommy Ka-Ho*** *is the Pharmacist at the Department of Pharmacology and Pharmacy, the University of Hong Kong. His email is tkhlee@hku.hk*