Prescriptions: safety, security and communication

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As every pharmacist knows, a prescription for a controlled drug must be in ink and specify in the prescriber’s own handwriting the name and address of the patient, the dose, the form and the total quantity to be supplied. Pharmacist are required to satisfy themselves that the prescriber, the patient and the prescription are each of them genuine. The retention of the prescription and the recording of all of the details, not only of the prescription but also of the purchases and stock balance of controlled drugs in the pharmacy, are all mandated by law. This interlocking set of procedures and requirements provides a number of safeguards for patients and protects the public by limiting the availability and amount of potentially dangerous and addictive drugs in people’s homes.

However, the drawback of these requirements is the susceptibility of the written prescription to forgery. In the early stages of the case, a number of forged prescriptions and of using genuine prescription pads to theft. In 1999 there were 39 prosecutions for possession of a forged prescription and this continues to be a problem in Primary Care. Community pharmacies have increased their security precautions and the Garda Síochana has provided additional help.

However, as the abuse of drugs has become more widespread and more sophisticated, so the use of additional drugs to either enhance the stimulant effects of the abused substance, or reduce the discomfort caused by withdrawal and abstinence has extended the range of drugs targeted by abusers to include some from the Medicinal Products (Prescription and Control of Supply) category. Although the number of computer-printed prescriptions has increased, hand-written prescriptions are common and the theft of prescription pads continues. Demand within the drug abusing community is so high that these drugs can have considerable value for sale or exchange. This has extended the range of prescription drugs for which pharmacists must satisfy themselves that the prescriber, the prescription, the patient and use of the drug are all genuine.

These developments were partly brought to public attention with the case taken by the DPP against journalist Naomi McIntyre in 2006. A prescription pad was printed in response to a telephone order by the journalist. Five prescriptions were written upon notepaper, with the details of the prescriptions and their actions in dispensing them. However, the case collapsed when the judge accepted that the State had not adequately proved that the prescriptions had not come from an appropriate prescriber. A revision centred on the signature that could have been someone’s initials, but it could not be interpreted as a particular prescriber’s signature. The reason the pharmacists were not suspicious of the signature is because so many signatures are indistinguishable.

The continuing problem of forged prescriptions, the increasing use of prescription drugs for abuse, the inadequacy of the regulations and procedures that govern the printing and security of public and private prescriptions, and the practice procedures that pharmacists can use in these circumstances were all serious issues raised by the case. None of them have been addressed.

The pharmacist is the final person who has to check that everything is as it should be, so it falls to them to interview the patient. All of these drugs, whether scheduled under the Misuse of Drugs Act, like morphine, or under the Medicinal Products (Prescription and Control of Supply), are approved for the treatment of symptoms and conditions associated with serious illnesses. The vast majority of prescriptions are written by appropriately qualified prescribers for authorised indications in patients who are suffering a recognised cause of signs and symptoms. The consequences of their condition, such as severe pain or debilitating depression, are that many of these patients may not appear well, have not been able to look after themselves and may not be comfortable communicating about their situation. On occasions therefore, a patient may appear and behave in a similar fashion to someone who has been abusing drugs, thus raising the pharmacist’s suspicions. Conversely, some drug abusers have become so adept at assuming the persona of a patient in need that pharmacists and other healthcare professionals are deceived into thinking them genuine. Trying to assess which of these patients is genuine and how to respond to them also places demands on the pharmacist’s ethical reasoning. Most would accept that beneficence must be balanced by non-maleficence, so that the drug might not be supplied to an individual if its appearance could potentially harm to others. However, although the pharmacist must respect the patient and their autonomy if this means that the patient does not want to enter into a discussion about their condition, what approach should the pharmacist take?

How far would a pharmacist be expected to go to authenticate the patient? The balance between patient care and the protection of public health is finely judged. The Pharmaceutical Society of Ireland issued guidance on this in 2006 which represented the formalisation of its views for many years prior to that. And the document, ‘Standards and guidelines a tool for self-assessment’ drew together much useful material. However, the guidance simply states that prescriptions presented by strangers from unfamiliar practices ‘must be appropriately screened for validity’.

Another complicating factor is that, unlike most of our nearest neighbours, the prescriptions issued in State schemes are neither secure nor tamper-proof, and prescriptions issued for private patients are unregulated. The communication of information about stolen prescription pads has improved to some extent since the IPU began to regularly distribute this information to its members and the PSI started to place it on its website. However, these are not formalised arrangements, nor is it clear whether reporting is required or whether the securing of prescription pads by practitioners is a criterion for assessing a practice.

In the DPP vs McIntyre case, the prescriptions purported to come from private practice. Pharmacists are almost as likely to be presented with a private prescription written upon notepaper, promoting a product, as they are a prescription on headed writing paper, with the details of the practice and its prescribers. What might be called ‘settled practices’ are easily traced but contactless services and the proliferation of walk-in clinics are ideal targets for misrepresentation. It was this type of practice that the reporter simulated, and the ease with which she was able to have prescription pads printed for a non-existent practice was worrying. The credibility given by the pharmacists to those prescriptions stemmed partly from the extraordinary range of pieces of paper utilised as prescriptions in private practice that the pharmacists concerned had previously encountered. The time has long since passed when the use of inappropriate material for prescriptions can remain acceptable practice, private though it may be.

Prescriptions for CD2 and CD3 drugs are supposed to be written by prescribers and signed by them, while others must be in ink and signed by the prescriber. However, in some practices receptionists write prescriptions and doctors check and sign them. Frankly, where drugs that can be used by drug abusers are being prescribed, this additional set of handwriting simply increases the scope that the forger has for making alterations and additions. Prescribers probably don’t think much about their signatures but it would help if they tried to sign their prescriptions consistently. Verifying the existence of a prescriber within a contactors service is usually not too difficult, but walk-in-clinics can be more difficult, partly because many of them are new and their contact details are not readily available and because, as with most practices, of their limited hours.

Prescriptions began as a way of ensuring that the correct ingredients would be mixed in the correct doses and labelled with the intended directions. Prescriptions were written in Latin, the lingua franca of the professional’s world, and the language was used both for communication to another professional and for obfuscation, to prevent patients and others knowing what was intended. Today, orders for compounding are...
written in hospitals, not in Primary Care and patients can understand, or at least recognise the names of the drugs and products that have been prescribed for them. Traditional prescribing and dispensing were a hierarchical, top-down, one way process. Some prescribers still practise as though they accept that their patients need to know their intentions, but there is no reason why the patient should know the truth why the pharmacist should know. The interpretation of the Courts of the responsibilities of those involved in the prescribing-dispensing process was always very different. The concept of ‘care’ was that of professional who should practise to a standard acceptable to their peers, and was to be exercised for the benefit and protection of patients. ‘Only following orders’ was and is not an acceptable defence. In recognition of this, pharmacists have the right not to dispense prescriptions that they consider to be ‘not in the best interest of the patient’. This clause is not invoked very often, because the quality of prescribing is not that bad, but the option is practically and symbolically important. In Australia, some of the potential for using prescriptions as means of communication between prescribers and pharmacists has been explored. It is time this possibility was explored here.

Illegibility has always been an issue. Too often the concern of healthcare professionals has been to shift the blame or the balance of blame. In the ‘Daonil’ for ‘Amoxil’ case, the prescriber tried hard to claim that the pharmacist should have known from the ‘context’ of the dose and duration that amoxicillin and not glibenclamide was the intended drug. The Court decided otherwise, but it made no difference to the patient; his brain function was severely and irreparably compromised. Not only names but dosages, quantities and directions for use all have given rise to errors that have harmed patients.

Illegibility is not just an issue for Primary Care. Over 5% of prescriptions in a hospital study were classified as ‘illegible’. And the tragic cost to patients when an illegible prescription causes harm is complemented by the cost of prevention that this out-dated system forces pharmacists to pay if 5% of GMS prescription items are written illegibly, that represents 2,025m items (at 2006 levels). If in 95% of these cases the PMR or the patient provides confirmation of the intended drug, that leaves 101, 250 items. In these cases, if it takes a pharmacist an average of 4 minutes (a figure drawn from a sample of almost 1,000 pharmacist prescription interventions) to check with the patient and to make the telephone call to the GP or hospital prescribing the drug, it is 6,750 hours or 40 weeks, and almost as much again for the prescriber. Forty weeks of time that could, and should be spent on direct patient care. The system is wasting patients and professional’s time. How long can our Health Service afford the associated opportunity costs that this represents?

Medication errors can occur at any stage in the process of prescribing, dispensing and medicine-taking. Problems can be caused by individuals practising poorly and at present do not appear to do so much, and even the most conscientious can make mistakes. What we need, ‘we’ meaning everyone in Irish society, is a system designed to prevent errors from occurring and one that triggers a response when it does occur. The sequence of events from prescribing to medicine-taking involves a number of people, and each is dependent on the actions of the others. Perhaps that is why the DoHC and HSE have not paid it any attention.

Traditional prescribing and dispensing were a process of prescribing, dispensing and medicine-taking that occurred from the ‘context’ of the dose and duration that the patient must all understand what is expected of each other and of the medicines. Today, prescriptions are a key document in the process of patient care. As they are written at the moment, and as they are required by law to be written, their functions are more likely to be impeded rather than facilitated. The Health Service is wasting an opportunity to improve patient care. One reason for this is that the DoHC and the HSE in their policies and actions continue to treat pharmacists as suppliers of goods. The HSE is acting as though medicines were consumer goods and focusing public attention on the price of supply rather than the cost of care, since they can dissemble that pharmacists are to blame for the former, while they, the HSE have not, so far, been able to optimise the latter.

What is needed?

The DoHC needs to set out a strategy to improve the security and safety of prescriptions throughout the prescribing and dispensing process under our present, hard copy arrangements and consult with all interested parties, including patients. This could then be implemented by the HSE in collaboration with the regulatory and the representative bodies. It should not be implemented piecemeal or by one profession ahead of another. Public and private practice in both primary and hospital care must all be included:

- Specific requirements for the format of prescriptions should be established that incorporate security, traceability and tamper-proof features.
- Guidelines should be issued to provide increased security for prescriptions within all types of practices – and compliance with these guidelines should be monitored.
- Procedures for the reporting of stolen prescription pads should be formalised and widely disseminated – and compliance with these procedures should be monitored.
- Procedures for the reporting of forged prescriptions and the presentation of stolen prescriptions should be formalised within the Health Service.
- Community pharmacists should keep copies of forged prescriptions and log forged prescriptions in the pharmacy. The copies could be used to alert permanent and locum staff to previous episodes, and the log used to alert everyone (including the Gardaí) to the occurrence of an outbreak.
- Before proceeding any further with electronic patient records, the possibilities of using the prescription as a means of communication between prescriber, patient and pharmacist should be thoroughly explored.

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