

## Feedback from Consultation on British Oncology Pharmacy Association Standards for Clinical Pharmacy Verification of Prescriptions for Cancer Medicines

A four week consultation period was undertaken on the standards which ended on 11/12/09. The consultation comments were shared with BOPA committee, reviewed and incorporated as appropriate. 21 sets of comments were received, the BOPA committee would like to acknowledge all those who commented on the standards and thank them on behalf of the membership for their contribution.

Major changes/ comments are noted and addressed below: (note this does not contain a comprehensive list of all comments, however individual consultees are welcome to discuss the response to their comments directly)

### List of contributors:

Name	Title	Organisation
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<b>Page No</b>	<b>Section</b>	<b>Comments (selected)</b>	<b>Response</b>
2	Proposed Target Audience	<p><i>Include Welsh Health Boards and the NI equivalent</i></p> <p><i>Wider circulation for more exposure e.g. UKCPA, Guild and others, New Professional Body</i></p> <p><i>NES (Scotland)</i></p> <p><i>Can we also specifically state Paediatric Oncology Pharmacists</i></p>	<p>Added</p> <p>To pursue.</p> <p>Added</p> <p>Added</p>
2	Proposed Circulation List	<p><i>See above</i></p>	
3	Scope of the standards	<p><b>Comments on reviewers wanting to see 'Supporting Guidance</b> <i>'This needs to be cascaded to the whole membership for review and comment please'</i></p> <p><i>Welsh and NI equivalent Cancer Standards</i></p> <p><i>Skills for Health- Need greater integration into standards</i></p> <p><i>consider adding a statement about ensuring verification takes place in an environment that excludes distractions / interruptions to maximise safety</i></p> <p><i>'Do you need to say anything about out of hours supply '</i></p> <p><i>'As an 'Advisor' on the NCEPOD study, I have huge reservations about the comment 'that there was only evidence of SACT being checked by pharmacists in 53% of cases'. So, I feel strongly that this statement needs qualifying as it paints a much worse picture than I believe is actually the case. '</i></p> <p><i>'As these are Pharmacy Standards should responsibility for them not be with pharmacists.'</i></p>	<p>Supporting standards document to go for consultation to BOPA members in January 2010 before being launched.</p> <p>Added</p> <p>Done, reformatted order of standards (section 4) to make clear that they are consistent with SFH.</p> <p>Not practical to add to standards: for local policies as appropriate</p> <p>Beyond scope of document, should be in local policies as appropriate.</p> <p>Agree with sentiment, but we have to use a direct quote from NECPOD. This document is not an appropriate place to discuss the merits another nationally published document.</p> <p>Need to include Trust lead for chemotherapy services (regardless if they are a pharmacist) as these standards impinge on chemotherapy service.</p>
6	Limitations	<p><i>Even for non-cancer uses similar consideration should be given even if not stating that the standards apply to them.</i></p>	<p>Sentence added to 2.2. 'Pharmacy departments should consider if any of the standards listed can be applied to the verification of these medicines and other high risk medications.'</p>

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7	Professional responsibilities	<p><i>Where e-prescribing takes place a rigorous validation process must be in place to ensure accuracy of calculated doses.</i></p> <p>Add section similar to SFH Pharm57 on working within professional limits</p> <p><i>'Need to find some words that mean the clinical pharmacist understands the need to be flexible and responsive to the individual patients, whilst retaining a function of safe prescribing, the test of is actually unsafe / life threatening, a raised alk phos is most likely the disease and the best chance for the patient is some therapy, therefore should you make allowances, this is always an individual prescribing decision which should be discussed with the pharmacist, but not repeated questioned'</i></p>	<p>Section 1.13 added to comment on use of e-prescribing</p> <p>Section 3.4 added.</p> <p>Difficult to convey this very valid sentiment in the structure of a standards document. Therefore some discussion around this issue will be included in the supporting guidance.</p>
8	BOPA standards	<p><i>Standards 'lost in document'</i></p> <p><b>Identification of prescribers</b> <i>'by referring to list of chemo prescribers'</i> <i>'confirm they are authorised to prescribe the chemotherapy'</i></p> <p><b>Theme emerged around checking weight, height and ability of pharmacist to confirm they are correct and issue of whose responsibility it is to check/confirm.</b> <i>'Suggest checking that transcription of patient demographics onto prescription is correct.'</i> <i>'Many electronic systems which generate prescriptions may not print all the demographics'</i> <i>'It is impossible to check that the height and weight are correct without re-weighing pts etc when verifying prescriptions'</i> <i>'Whose responsibility is it to ensure that the correct height and weight are transcribed correctly to the prescription? If wrong figure then doses will be wrong.'</i></p> <p><b>Theme emerged around governance, regimen approval etc.</b></p> <p><i>'mention of a check of the INTERVAL space between treatments'</i></p>	<p>Added numbering to section 4</p> <p>Point 4.1 amended</p> <p>Wording changed in 4.7 now reads <b>check patient demographics (age, height and weight) have been correctly recorded on prescription.</b></p> <p>Also comment in 4.8 <b>'Note there should be local agreement for frequency of monitoring and checking patients weight'</b></p> <p>Local policies should define how this is done.</p> <p>4.2 'regimen been through local governance procedures' – changed to <b>'Ensure regimen has been through local approval processes e.g. clinical governance and financial approval and/ or is included on a list of locally approved regimens'</b></p> <p>Added to check timing in point 4.6</p>

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<b>8</b>	BOPA standards Continued	Interactions should include drug-drug, drug-food and drug-disease.	Current wording 'drug interactions (including with food)' covers this. No change
		BSA calculations & use of other formulae	Standards do not specify which formulae; supporting guidance has section on this. Local policy needs to define.
		Needs to include dose escalations, about ensuring that an alteration is intentional and consistent	Added
		<b>Theme emerged around practicality of services having access to notes, e.g. oral / out patient scripts checked in dispensaries,</b> <i>'how practical it will be to fulfill points 3, 5 and 7 of the BOPA standards for our dispensary pharmacists who check the majority of haematology oral chemotherapy prescriptions as they won't have access to the patient's notes at the time of checking and dispensing'</i> <i>'many services still have a number of oral chemotherapy prescriptions dealt with directly by dispensary staff following local procedures who clearly only have a prescription &amp; the patient as sources of information and not the medical note'</i> <i>'they are unfeasible in larger centres'</i> <i>'In some centres /units access to notes is limited or almost non-existent.'</i> <i>'clinical notes are unlikely to be readily available for outpatient prescriptions; but treatment plans / chemo diaries might help to check this'</i> <i>'How would an accredited pharmacist in the dispensary check in the medical notes that this was what was intended for an oral chemotherapy prescription, and similarly for a pharmacist in the tech services unit for a day patient chemotherapy script' This model would certainly not work in all hospitals'</i>	<b>Response</b> BOPA noted the concerns and recognised the practical issues in always having access to notes in particular for oral prescriptions and outpatient dispensary prescriptions. However NPSA standards are clear that oral should be treated same as IV. BOPA standards should reflect best practice and what is best for patient safety and must not be set too low in order to account for these issues. It is up to individual services to use the BOPA standards to support service improvement.  Wording has been changed in point 4.4 to state: ...' <b>using the treatment plan, clinical notes or electronic record</b> '. i.e. it is recognised that clinical notes are not the only source of treatment and patient information. Also see new section 2.3
		reference to "other medication" – again this may not always be possible as medication histories may not be easily available for all patients at the point of verifying a prescription	See comments above on access to notes
		<b>Theme on reference to dose adjustments, e.g. for banding</b> <i>'Reference somewhere to the common practice of rounding up or down (generally to within 5% of the dose) and dose banding.'</i> <i>'Dose calculations – probably worthwhile mentioning rounding/dose banding at this point, even if saying that these should be taken into account where applicable'</i>	This is included in some detail in supporting guidance, however sentence added see 4.9.

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		<p><i>Check that any maximum individual doses of cytotoxic have been adhered to e.g. vincristine</i></p>	<p>Added to <b>'and maximum individual dose'</b> to 4.10, further detail included in supporting guidance.</p>
		<p><i>Check other essential..... Is this the role of the pharmacist or the prescriber, its not about whether the test has been undertaken or not it is whether the prescriber has seen the result and acted on when relating that test result to the clinical situation</i></p>	<p>Changed 4.14 to add <b>'as appropriate'</b>. Further detail on this to be included in supporting guidance.</p>
		<p><b>Comments on use of pharmaceutical care plans</b> <i>'how do pharmaceutical care plans fit in with electronic prescriptions'</i></p> <p><i>'1.12 Delete "A structured care planning template <b>may be one (old fashioned) way</b> of supporting effective practice"-suggest inserting "It is considered good practice to document identified pharmaceutical care issues within the patient record/prescription and ensure such records are <u>available to the multidisciplinary team</u>. '</i></p> <p><i>'Should the standard make some reference to the way these checks are recorded and the record maintained on an ongoing basis, trends are far more important in checking a prescription than 'cold' 'isolated' values. I suppose what I'm saying is that the last sentence should be mandatory. I.e. significant care issues interventions and the pharmaceutical care issues should be recorded in the patient's notes or agreed local system for recording the clinical pharmacist may wish to keep a copy or extract of this note. But should not be the sole recipient on any information. Patient safety is best when everyone can access all the information</i></p>	<p>Added electronic record to point 4.4 and 1.12</p> <p>Point 1.12 updated as suggested</p> <p>Final point in section 4 (unnumbered) supports this as does 1.12 and 4.4. Members unable to agree that use of care plans/ e records/ treatment plans by pharmacist should be mandatory.</p>
<b>9&amp; 10</b>	References & Appendix	<p><i>'I do not agree that calculating BSA, checking doses, interactions, sequence/timing, hydration and antiemetics are the ultimate responsibility of the verifying pharmacist – these are the prescriber's ultimate responsibility. '</i></p> <p><i>'Although I appreciate that this is an example template of the guide of responsibilities, I have huge reservations about the section relating to ultimate responsibility. While I agree the stepwise flowchart is helpful, do we have to differentiate?'</i></p>	<p>Appendix removed from standards but retained in supporting guidance document.</p>

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	<p><i>'Appendix Looks nice but what is definition of primary and ultimate responsibility. We debated and the feeling was the prescriber has ultimate responsibility. Pharmacist can't take ultimate responsibility for calculating SA if we haven't heighted &amp; weighed the patient. May be responsible for <b>checking the calculation</b> but not the data... Pharmacist cant be responsible for all drugs prescribed (but could check they are. As we have preprinted Rx now as the norm this shouldn't be the issue? Pharm 57 doesn't appear to recognize the additional issues around this lack of standard Rx etc.</i></p> <p><i>Why does a pharmacist have ultimate responsibility for the Dr to sign the chart?! Agree with stability. Essentially pharmacist stability &amp; checks in the system as defined by local SOPs. The reference to the note at the bottom should refer to a standard preprinted or electronic chart...rather than prehydration etc. Why mannitol? Other co-med may cover more general issues e.g. GCSF, mesna etc in peer review. Also ensuring gaps in prescription if trusts observe 30min rest between cetuximab /pemetrexed &amp; chemo fro e.g. but could just state standard pre-printed chart. If off protocol ensure all necessary drugs etc in correct fluid, time etc. Overall the Appendix suggests lots of duplication and perhaps would be better to ensure all trusts define role of staff in the process at the following stages.'</i></p>	
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