

Unit 4: Prescription, Minor Ailments, OTC Medicines, Counselling, Adherence and ADR Monitoring

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4.1 The prescription: legal requirements

The prescription is the written, or otherwise validly issued, order of an authorised prescriber directing the supply and use of medicines for a named patient, and it is simultaneously a clinical instruction, a legal document and a record. Its legal requirements begin with the prescriber: a registered medical practitioner or other practitioner authorised within their own field, prescribing within the law that governs the medicines concerned. The prescription must identify the patient, by name and ordinarily age and address or identifying particulars; identify the prescriber, by name, qualification, registration and address, with signature; carry its date, since validity, record keeping and the age of the therapy all run from it; and state the medicines with the particulars the dispensing pharmacist needs, name, preferably in generic form as good practice and several institutional and regulatory directions require, strength, dosage form, quantity and directions for use.

4.2 Interpretation of prescriptions and prescription related problems

Interpretation is the pharmacist's reading of the prescription as a whole: not only what each line says, but whether the whole order makes sense for this patient. The reading confirms the patient, the prescriber and the date; reads each medicine, its strength, form, quantity and directions; translates abbreviations and Latin directions accurately, with suspicion toward any abbreviation that can be read two ways; and then judges the order clinically, the assessment step of Section 3.12. Prescription related problems, the standard catalogue of what this reading finds, divide into problems of form and problems of substance. Problems of form: illegible or incomplete writing, missing strength, form, quantity or directions, an unsigned or undated prescription, an ambiguous abbreviation or a name that could be one of two look alike medicines. Problems of substance: a dose or quantity outside the usual range for the patient as known, duplication of a medicine or class across lines or across prescribers, an interaction with the patient's other medicines, a contraindicated medicine given the patient's allergy, age, pregnancy or condition, an inappropriate form for the patient, or a duration that does not fit the condition.

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Handling a prescription related problem
  Problem found at validation or assessment:
  form, legibility, completeness or clinical safety
    |
    v
  Do not guess and do not dispense around it:
  check the pharmacy's own record of the patient
    |
    v
  Contact the prescriber, state the problem plainly,
  agree the corrected order, record the change
    |
    v
  Dispense against the corrected order, counsel the
  patient on anything that has changed for them
    |
    v
  File the record: the problem, the resolution and
  the supply are all traceable afterwards
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4.3 Responding to symptoms of minor ailments: the assessment method

Responding to symptoms is the structured service by which the community pharmacist deals with a patient who presents a symptom rather than a prescription. A minor ailment is a self limiting condition that can be recognised and managed without medical diagnosis, with self care and, where appropriate, a permitted over the counter medicine. The pharmacist's method protects the boundary of that definition. It begins with a focused history: who the patient is, since age and pregnancy change everything; what the symptom is, where, how severe, how long present and how it has changed; what accompanies it, the associated symptoms that separate the minor from the serious; what has already been tried and with what effect; and the background, other conditions, regular medicines, allergies and previous similar episodes. Standard question frameworks exist to keep this history complete under counter pressure, and the habit they build matters more than their letters: duration, associated features and patient risk factors are never skipped. The history leads to one of three conclusions.

Responding to symptoms: the triage discipline



Every presentation ends in one of three conclusions, and the record shows which

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Figure: The triage discipline. Every presentation ends in management with a review point, self care, or referral, and danger features decide first.

4.4 Responding to headache

Headache is among the commonest counter presentations, and most headaches are the primary headaches, tension type headache and migraine, or accompany minor illness. The pharmacist's history establishes the pattern: the site and character of the pain, its onset and duration, its frequency and previous identical episodes, triggers and relieving factors, associated features such as visual disturbance, nausea or sensitivity to light and sound, fever or neck symptoms, recent head injury, medicines being taken, including very frequent use of pain relieving medicines, which itself becomes a cause of chronic daily headache, and the patient's age and background conditions. Danger features convert the case into a referral, urgently where they suggest an emergency: a sudden, explosive worst ever headache; headache with fever, neck stiffness, rash or altered consciousness; headache after head injury or with weakness, speech or vision loss; a new pattern of headache in later life; headache that is worst on waking, worsening progressively, or changed in character from the patient's usual; and headache in pregnancy with visual symptoms or raised blood pressure features.

4.5 Responding to pyrexia

Pyrexia, fever, is a raised body temperature, a symptom and a defence response rather than a disease, and the pharmacist's task is to judge its context. The history covers: the measured temperature and how it was measured, since the number and the method both matter; the duration of the fever; the accompanying symptoms that point to a source, cough and breathlessness, urinary symptoms, sore throat and ear pain, vomiting and diarrhoea, rash, localised pain; travel, contacts and season, which raise or lower particular possibilities; the patient's age, with fever in a young infant treated as a referral matter in itself; background conditions and medicines, including immune suppression; and what has been taken for it already. Referral is required where fever is high or prolonged, where danger features accompany it, breathlessness, rash that does not fade under pressure, confusion, dehydration, severe pain or a stiff neck, where the patient is very young, pregnant, elderly or chronically unwell, or where fever returns after settling.

4.6 Responding to menstrual pains

Menstrual pain, dysmenorrhoea, divides into primary dysmenorrhoea, the cramping pain of menstruation without pelvic disease, driven by prostaglandin release in the uterus, typically beginning with or just before bleeding in younger patients with regular cycles, and secondary dysmenorrhoea, pain caused by pelvic conditions such as endometriosis or fibroids, which tends to begin later, last longer and change in character. The pharmacist's history establishes: the timing of pain against the cycle and the bleeding; its severity and effect on daily life; its history over time, a stable pattern since adolescence against a new or changing pattern in later years; associated features, pain at other times, abnormal bleeding, discharge or fever, pain with intercourse, fertility history; contraception in use; and other conditions and medicines, especially any that bear on the medicine classes used for pain. Referral is indicated by the secondary pattern and its signs: new or worsening pain, pain outside menstruation, abnormal bleeding, fever or discharge, suspected pregnancy, or pain unrelieved by appropriate self care over successive cycles.

4.7 Responding to food and drug allergy

Allergy presentations at the counter divide by speed, and speed decides everything. The emergency form is anaphylaxis: a rapid reaction with breathing difficulty, wheeze or stridor, swelling of the lips, tongue or throat, widespread urticaria with dizziness, faintness or collapse, following a food, a medicine, a sting or another trigger. This is not managed at the counter beyond immediate emergency action: emergency services are called at once, the patient is not left alone or sent away, and where the patient carries an adrenaline auto injector for their own use, its use is supported without delay. The pharmacist who recognises anaphylaxis and acts in the first minutes has done the most important thing this section teaches. The minor forms, by contrast, are everyday pharmacy work: urticaria and itching, mild skin reactions, hay fever type symptoms after a food or in season, and the patient's report that a food or medicine does not suit them. The history distinguishes true allergy from intolerance, which is not immune mediated and is managed differently: what was taken or eaten and when, what happened and how soon, how it was treated and how it ended, and whether the same exposure has caused the same reaction before.

4.8 OTC medication and the rational use of over the counter medicines

Over the counter medicines are those the law permits to be supplied without a prescription. Their freedom from prescription is a statement about their established safety in self care when used as directed, not a statement that they are harmless, and rational use is the discipline that keeps the two ideas together. Rational OTC use means: a genuine indication, matched to the assessed symptom under Section 4.3, not to the patient's first request alone; the right product, chosen by its active ingredients and the patient's conditions, other medicines, age and allergies, with combination products examined ingredient by ingredient so that the same substance is not taken twice from two boxes; the right use, in the manner and for the duration the label and the pharmacist direct, since OTC status does not extend to unlimited duration;

the right person, with special care in pregnancy, in children, in older patients and in chronic disease, where a permitted medicine for the general public may be the wrong medicine for this patient; and the right stopping point, the review and referral rules of the ailment sections, observed even when the patient asks to continue.

4.9 Medication counselling and the use of patient information leaflets

Medication counselling in the community setting is the pharmacist's structured explanation of a medicine to the patient at supply, and it converts a correctly dispensed product into a correctly used one. Its content, adapted to the patient and the medicine, covers: what the medicine is for, in the patient's own terms; how and when to take it, with food relationships and spacing from other medicines and foods that matter; how much and for how long, including what completing or not completing the course means for that medicine; how to use the form or device, inhalers, drops, patches and measures demonstrated, not merely described; what effects to expect and when; what adverse effects are common and minor, and which are warnings that need medical help; storage, and keeping medicines from children; and what to do about a missed dose for that medicine. The method matters as much as the content: counsel in a space that allows privacy, at the patient's pace and language, check understanding by inviting the patient to say back the key points, and invite questions before closing. Patient information leaflets, the printed inserts supplied with medicines and the pharmacy's own prepared leaflets, are counselling's written partner.

4.10 Medication adherence: definition, factors and strategies

Medication adherence is the extent to which a patient's medicine taking behaviour corresponds with the agreed recommendations of the prescriber: taking the medicine, at the right dose and interval, for the intended duration. It is distinguished from mere compliance by its emphasis on agreement: the regimen is one the patient has understood and accepted, not only been handed. Non adherence is correspondingly divided into unintentional, where the patient means to take the medicine and fails through forgetfulness, confusion, cost, access or regimen complexity, and intentional, where the patient decides not to take it, from disbelief in its need, fear of its effects, feeling well or feeling worse, or distrust. The factors influencing adherence behaviour are conventionally grouped: patient factors, understanding, beliefs, memory, dexterity and eyesight, and the burden of illness itself; medicine factors, number of medicines and doses per day, duration, adverse effects and cost; condition factors, chronic and symptomless conditions such as raised blood pressure being the hardest to sustain; prescriber and system factors, quality of explanation, follow up and continuity; and social and economic factors, family support, work patterns and the price of each refill.

Medication adherence: why doses are missed

THE PATIENT	THE MEDICINE AND CONDITION	THE SYSTEM AROUND THEM
Understanding and beliefs about illness Memory, eyesight and dexterity Feeling well, or feeling worse Fear of adverse effects and stigma	Many medicines, many doses a day Long duration of treatment Adverse effects and refill cost Chronic, symptomless conditions hardest	Quality of the first explanation Follow up and continuity of care Family and social support Work patterns and access to refills

Match the strategy to the cause: simplify, explain, remind, review, never scold

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Figure: Why doses are missed. Adherence fails for grouped, findable reasons, and each group has its own remedies.

4.11 Patient referrals to the doctor

Referral is the pharmacist's formal recognition that a patient's need exceeds pharmacy management, and its quality is judged by its timing, its destination and its information. Referral is immediate and urgent where danger features are present, the red flags of Sections 4.4 to 4.7 and their equivalents in any presentation: the patient is directed to emergency or urgent medical care at once, with the reason stated plainly. Referral is routine where the picture needs diagnosis rather than emergency: symptoms that persist beyond the stated review point, recur repeatedly, change in character, arise in a patient group the pharmacist does not manage, or suggest a condition behind the symptom, together with suspected adverse reactions of significance under Section 4.12 and prescription problems the prescriber must resolve.

4.12 ADR monitoring in community pharmacies

Adverse drug reaction monitoring in the community pharmacy extends pharmacovigilance to the place where most medicines are actually used. The community pharmacist is positioned to detect reactions that hospitals never see: reactions to over the counter medicines and combinations, reactions emerging weeks into chronic therapy, reactions in patients lost to other follow up, and the interaction effects of medicines from several prescribers meeting in one patient. Detection begins with the habit of asking: at refills and counter visits, a direct question about how the medicine is suiting the patient surfaces reactions that patients do not volunteer, because they attribute them to their illness or expect to endure them. When a possible reaction is found, the pharmacist documents the essentials: the patient, the suspect medicine and any others taken, the reaction and its timing against starting, changing or stopping medicines, its severity and course, and what action followed. Causality is judged cautiously at the counter, temporal relationship, known reaction profile, alternative causes, and improvement on withdrawal where that has occurred, without overstating what one case can prove.

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