

Unit 5: Health Promotion, National Health Programs, Home Medicines Review and Research

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5.1 Health promotion: definition and activities

Health promotion is the process of enabling people to increase control over, and to improve, their health: not only the treatment of disease but the building of the conditions and habits that keep disease from arising. In community pharmacy practice it is the organised use of the pharmacy's accessibility and trust for prevention, and it converts the pharmacist from a supplier who waits for prescriptions into a health worker the neighbourhood consults while it is still well. Health promotion activities in the pharmacy take standard forms. Information and education: accurate, plain language teaching on risk factors and healthy living, delivered in conversation, in leaflets and displays, and in talks to schools, workplaces and community groups. Risk factor work: helping individual patients identify and change the behaviours that drive the common chronic diseases, smoking, harmful alcohol use, unhealthy diet, inactivity, and supporting medicine taking that prevents events in patients already at risk. Screening and early detection, the subject of Section 5.3, which finds risk and early disease and routes both into care. Immunisation support: promoting uptake, answering vaccine concerns with evidence, and participating in delivery where the regulations authorise it.

5.2 Family planning services in community pharmacy

Family planning is the means by which individuals and couples decide the number and spacing of their children, and the community pharmacist supports it as supplier, adviser and referrer. As supplier, the pharmacy stocks and supplies contraceptive products: barrier methods available over the counter, supplied freely and without embarrassment, and hormonal and other prescription methods supplied against prescription, with the same accuracy and record standards as any medicine. As adviser, the pharmacist explains the methods the pharmacy supplies: how each is used correctly, since failure of barrier and oral methods is more often a failure of use than of the method; what to do when use goes wrong, a missed pill or a failed barrier, with honest direction to timely medical or pharmacy services where the response is time limited; the interactions and medical cautions that make a method unsuitable for a particular patient, which are prescriber questions the pharmacist flags rather than settles; and the distinction between contraception and protection against sexually transmitted infections, which only barrier methods provide, a counselling point of particular importance for younger patients.

5.3 Health screening services

Health screening services in the community pharmacy are the structured measurement of health indicators in people without symptoms, to detect risk factors and early disease and to refer what is found into medical care. The standard pharmacy screening set includes: blood pressure measurement, the highest value service of the group, since raised blood pressure is common, symptomless and dangerous, and is regularly discovered at the pharmacy counter; blood glucose testing, as a pointer toward diabetes and its control in known patients; body weight, height and body mass index, and waist measurement where offered, as the entry to weight and lifestyle advice; and, in pharmacies equipped and authorised for them, further point of care tests under their own protocols. A screening service is defined by its discipline, not by its device. The measurement follows a written procedure: correct technique, a rested and correctly positioned patient for

blood pressure, calibrated and maintained equipment, and repeat measurement where the first reading demands it. Results are interpreted against stated reference ranges by category, not improvised: the patient is told the result, what it means and what it does not mean, since a screening result is a pointer and never a diagnosis.

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A pharmacy screening encounter, end to end
  Person attends or is offered screening, consent
  and relevant background recorded
    |
    v
  Measurement taken by the written procedure:
  correct technique, calibrated equipment,
  repeated where the procedure requires
    |
    v
  Result read against the service's stated ranges:
  reassuring, refer routinely, or refer urgently
    |
    v
  Result explained honestly: a pointer toward care,
  never a diagnosis at the counter
    |
    v
  Referral made and documented, record kept,
  service totals audited over time
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5.4 First aid in community pharmacy practice

First aid is the immediate care given to a person who is injured or suddenly unwell, before professional medical help takes over, and the community pharmacy is a recognised first aid point in its neighbourhood: people come to the pharmacy with injuries because it is open, near and staffed by a health professional. The pharmacist's first aid role has three parts. Readiness: a stocked and in date first aid provision in the pharmacy, staff who know where it is and what they are competent to do, and the emergency numbers and referral routes displayed where staff can reach them at once.

5.5 Prevention of communicable and non communicable diseases

Prevention in community pharmacy divides by the two great families of disease. For communicable diseases, prevention rests on interrupting transmission and building immunity, and the pharmacist's contributions are: hygiene education, hand washing, safe water and food handling, and respiratory etiquette, taught at the counter and in campaigns; immunisation promotion, correcting misconceptions, reminding due patients where records allow, and supplying and, where authorised, supporting vaccination services; safe practice supplies and advice, including sterile injecting equipment policies where lawful schemes exist and the safe disposal of sharps; early recognition and referral of the infectious presentations of Unit 4, with the programme routes for malaria and tuberculosis of Section 5.8 followed exactly; and outbreak cooperation, where the pharmacy relays official guidance, counters rumour with the health authority's current advice, and maintains supply of the genuinely needed items without fuelling panic buying.

5.6 Smoking cessation services

Smoking cessation is the most developed single health promotion service in community pharmacy, because tobacco is the largest preventable cause of disease in the pharmacist's patient population and because quitting usually takes several supported attempts. The service follows a behavioural structure. Ask and record: smoking status is asked about and noted for regular patients, so the service has a population, not only volunteers. Advise: the smoker is told, personally and plainly, that stopping is the most effective step

available for their health, linked where possible to their own conditions and medicines. Assess readiness: the willing are helped now; the unwilling are left with a respectful open door and information, since pressure without readiness wastes the attempt. Assist: a quit plan is built with the patient, a quit date set, triggers and routines examined, family and social support enlisted, follow up appointments at the pharmacy arranged, and pharmacotherapy discussed: nicotine replacement therapy in its several forms, supplied over the counter with instruction in correct use, since under use and early abandonment are its commonest failure modes, and the prescription cessation medicines, whose patients the pharmacist supports and monitors in cooperation with the prescriber.

5.7 Child and mother care services

Child and mother care is the community pharmacy's service to women in pregnancy and after delivery, and to infants and children, a population in whom medicines questions are constant and the cost of wrong answers is high. For mothers, the pharmacy's work includes: supplying the supplements and medicines of pregnancy and the postnatal period against prescription and advice, with vigilance for the medicines that pregnancy forbids, which the pharmacist checks on every supply to a woman of childbearing age where the medicine demands it; supporting breastfeeding with accurate medicines information, since most medicines questions in lactation end in reassurance based on evidence, and wrong advice costs a baby its feeding; family planning continuity under Section 5.2; and recognising and referring the danger presentations of pregnancy and the postnatal period, bleeding, severe headache and visual symptoms, reduced fetal movement as reported by the mother, fever, and the signs of postnatal depression, which the pharmacist who knows the family may be well placed to notice and route into care.

5.8 National health programs: the community pharmacist in malaria and TB control

National health programs convert national disease priorities into organised local action, and the syllabus names the community pharmacist's role in two of them, malaria and tuberculosis control, as the worked examples of a general duty: the pharmacist supports the program's strategy in the pharmacy's own place, refers into its services, and never runs a private parallel system that undermines it. In malaria control, the pharmacist's roles are: recognising the febrile patient who may have malaria and referring for testing under the program rather than supplying symptomatic treatment alone, since fever in an endemic setting is a test first presentation; supporting the correct and complete use of antimalarial treatment where it is dispensed, with adherence counselling of the kind in Section 4.10, because partial treatment breeds both relapse and resistance; promoting prevention, the use of insecticide treated nets and the other vector measures the program teaches, and stocking them where the program's channels allow; and recording and reporting as the program requires, since case data from every provider feed the surveillance on which control depends.

5.9 Home Medicines Review: definition, objectives, guidelines, method and outcomes

Home Medicines Review is a structured, comprehensive review of a patient's medicines, conducted in the patient's home, in which a pharmacist examines everything the patient actually takes and how they take it, and reports to the patient's doctor so that the regimen can be optimised. Its definition contains its method: home, because the truth about medicine taking lives there, in the cupboard with the duplicates, the expired items, the borrowed medicines and the aids or their absence; review, because the product is an assessment and recommendations, not a supply. Its objectives are: to maximise the benefit of the patient's medicines by identifying and resolving drug related problems; to detect the problems that consulting room and counter cannot see, duplication across prescribers, hoarding and sharing, wrong storage, confusion between similar packs, non adherence with its reasons under Section 4.10, and adverse effects accepted as age; to improve the patient's own understanding and organisation of their medicines; and to strengthen the working link between the patient's doctor, community pharmacist and the reviewing pharmacist.

Home Medicines Review: referral to follow up



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Figure: Home Medicines Review. The home visit finds what the counter cannot see, and the doctor decides on the reviewer's report.

5.10 Research in community pharmacy practice

Research in community pharmacy practice is the systematic study of what community pharmacists do, what it achieves and how it can improve, and it closes the syllabus because every other topic in this unit claims benefits that only research can verify. Its subjects follow the work of the whole subject: practice research on how services are actually delivered, dispensing accuracy, counselling quality, screening yield and referral completion; outcome research on whether pharmacy interventions change what matters, adherence, control of pressure and glucose, quit rates, adverse events detected; patient research on experience, understanding and behaviour; and workforce and business research on the models of Sections 3.10 and 3.14. Its methods are those suited to a practice setting: audits, the simplest form, in which the pharmacy measures itself against a standard and re measures after a change; surveys and interviews of patients and staff; observational studies of records and refill data; and, where partnerships with academic institutions allow, controlled studies of new services.

Frequently Asked Questions

Q: What is a hospital formulary and who maintains it? A: The hospital formulary is the continuously revised list of medicines approved for use in the hospital, together with the information needed to use them well. It is maintained by the Pharmacy and Therapeutics Committee, which decides additions, deletions and restrictions on evidence, with the pharmacy department doing the working preparation, publication and stock alignment. The formulary system behind the list evaluates, selects, monitors and reviews medicines continuously, concentrates purchasing, supports therapeutic guidelines and guarantees availability and quality for the medicines that matter most.

Q: How do the individual prescription, floor stock and unit dose distribution systems differ? A: In the individual prescription system, medicines are dispensed for a named patient against that patient's order, labelled for that patient. In the floor stock system, a stock of common medicines is held on the ward and administered from it, which is fast but gives the pharmacist no sight of the individual order. In the unit dose system, each dose for each patient is separately packaged and labelled ready to administer, against a pharmacist verified order. Modern practice combines them: pharmacy verified supply for most medicines, with limited floor stock for emergency and commonly used items.

Q: What are ABC and VED analysis in inventory control? A: ABC analysis classifies stock items by annual consumption value: the few class A items carry most of the value and receive tight control, class B moderate control, and the many low value class C items simple bulk control. VED analysis classifies by criticality: vital items whose absence endangers life or stops a service, essential items whose absence degrades care, and desirable items whose absence is an inconvenience. Combined into a matrix, they ensure a cheap vital item is protected for availability while a costly desirable item is controlled for value.

Q: What is the Pharmacy and Therapeutics Committee and what does it do? A: The Pharmacy and Therapeutics Committee is the standing advisory committee of the medical staff and administration that runs the hospital drug policy. Composed of senior physicians, the chief pharmacist, who commonly serves as member secretary, nursing leadership and administration, it approves medicines for the formulary on efficacy, safety, quality and cost, approves therapeutic guidelines, reviews drug utilisation and medication safety including adverse reactions and errors, and communicates its decisions to all prescribers.

Q: What is an intravenous admixture service and why is it centralised in the pharmacy? A: An intravenous admixture service prepares medicines added to intravenous fluids centrally in the pharmacy, by trained staff in a controlled clean environment, against pharmacist verified orders, with standardised compatibility and stability references, labelling and traceability records. Centralisation replaces improvised ward preparation under interruption with aseptic technique, checked calculations and products whose every component and batch can be traced, which is why it is one of the clearest safety advances in hospital pharmacy. Total parenteral nutrition, the most complex admixture, is prepared within the same service.

Q: What are the steps of good dispensing practice in a community pharmacy? A: Good dispensing practice is one unbroken sequence: receive and validate the prescription; interpret and assess it clinically for the patient, their allergies, other medicines and duplication; assemble the product with checks on name, strength, form and expiry; perform a final check against the prescription before labelling; label with the patient name, medicine, clear directions, date and warnings; and hand over with counselling, recording the supply. Any doubt stops the sequence until it is resolved, because most dispensing errors are born in skipped steps.

Q: How should a community pharmacist respond to a patient presenting a minor ailment? A: By a focused history first: who the patient is, the symptom and its duration and severity, associated symptoms, what has been tried, other conditions, regular medicines and allergies. The history leads to one of three conclusions: manage at the pharmacy with self care and a permitted medicine where indicated, with a stated review point; advise self care without a medicine where time and measures are the right treatment; or refer, at once where danger features are present and routinely where diagnosis is needed. Recurrent presentations are themselves a reason to refer.

Q: What is medication adherence and how can a pharmacist improve it? A: Medication adherence is the extent to which a patient's medicine taking corresponds with the agreed recommendations: the right medicine, dose, interval and duration. It fails unintentionally through forgetfulness, confusion, cost and complexity, and intentionally through disbelief, fear of effects or feeling well. The pharmacist improves it by matching strategies to the cause: simplifying regimens with the prescriber, explaining purpose at every supply, reminders, packaging aids and refill synchronisation, honest review of adverse effects fed back to the prescriber, and a non judgemental tone that finds out what is actually happening.

Q: What is Home Medicines Review? A: Home Medicines Review is a structured, comprehensive review of a patient's medicines conducted in the patient's home, usually on the doctor's referral and with the patient's consent. The reviewing pharmacist examines everything the patient actually takes, prescription, over the counter and complementary medicines, identifies drug related problems such as duplication, hoarding, wrong storage, non adherence and adverse effects, and reports recommendations to the doctor,

who decides the changes. Agreed changes are then implemented with the patient and followed up.

Q: What is the community pharmacist's role in malaria and tuberculosis control programs? A: The pharmacist supports the national program's strategy rather than running a parallel system. In malaria control: referring the febrile patient for testing instead of supplying symptomatic treatment alone, supporting complete and correct use of antimalarial treatment, promoting preventive measures such as insecticide treated nets, and recording and reporting as the program requires. In tuberculosis control: recognising the persistent cough and referring for the program's free diagnosis, supporting patients through treatment with adherence encouragement and adverse effect awareness, countering stigma, and never selling anti tuberculosis medicines casually outside the program system.

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