Humber Teaching
NHS Foundation Trust

WARD BASED DISPENSING PROCEDURE

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Author/Lead **Job Title**	Eleanor Wastling Principal Pharmacy Technician
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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.1	*May2021*	*Amendmetns to section 4* *Addition of 4.7 and 4.8* *Addition of Section 5*
1.2	*July 2021*	*Amendments to section 4.3 and 4.5 - Added requirement to obtain wet signature for Leave/discharge prescriptions containing Schedule 2 and 3 CDs.*
1.3	*March 2022*	*Update to section 4.*
1.4	*Sept 2022*	*Update to section 4* *Update to Appendix 1* *Addition of Appendix 2* *Approved at DTG (29/09/22)*
1.5	*Oct 22*	*Update to section 4* *Update to section 4.1* *Update to section 4.3* *Update to section 4.6* *Approved at DTG (24/11/22)*
1.6	*July 23*	*Update to section 4 - Inforamtion regarding the check sheets. Added supplying a copy of the discharge prescription to the patient.* *Update to section 4.5 – clarification regarding DOMMARs* *Addition of Appendix 4 - Dispensing Area Quality Check Sheet*
1.7	*Sept 2023*	*Update to section 4.2 – authorisation of leave by nominated pharmacy technicians* *Added section 4.3 – Controlled Drugs*
1.8	*Sept 2024*	*Addition of section 4.9* *Amendment to section 4.7 regarding the accuracy checking process* *Approved at Drugs and Therapeutics Group (26 September 2024).*

Contents

1. INTRODUCTION

This standard operating procedure (SOP) aims to ensure that all unit/ward-based pharmacy technicians are able to obtain, label and assemble prescribed medication on in-patient wards safely and efficiently. The medication may be used for administration, leave or discharge.

2. SCOPE

This SOP applies to all Unit/Ward-Based Medicine Optimisation Technicians employed by the Trust, who will be responsible for obtaining, labelling and assembly of prescribed medicines for in-patient wards for administration, leave and discharge.

3. DUTIES AND RESPONSIBILITIES

Chief Pharmacist and Controlled Drugs Accountable Officer
The Chief Pharmacist is responsible for optimising the use of medicines within the Trust, ensuring that the relevant standards relating to medicines optimisation set by the Care Quality Commission (CQC) and the National Institute for Health and Clinical Excellence (NICE) are achieved. The Chief Pharmacist is also the Controlled Drugs Accountable Officer (CDAO) who is responsible for the safe and effective use of Controlled Drugs within the Trust.

Clinical Pharmacists
These Pharmacists are responsible for ensuring prescribed medications have been assessed as clinically appropriate via clinical screening (SystmOne), clinical verification (Lorenzo) or by endorsement (paper-based MAR charts).

Ward-Based Medicine Optimisation Technicians
These Medicine Optimisation Technicians are responsible for obtaining, labelling and assembly of prescribed medicines for in-patient wards for administration, leave and discharge.

Non Ward-Based Medicine Optimisation Technicians
These Medicine Optimisation Technicians will be responsible for being available to complete a check (either physically or via remote video checking) on assembled and labelled medicines. They will also provide guidance and assistance to the ward-based pharmacy technicians, where required.

Practitioner
A member of staff who is competent in the safe and secure handling of medicines and medicines optimisation.

It is the responsibility of the administering practitioner to ensure any patient labelled medicines correspond to the direction to administer medicines as prescribed.

It is the responsibility of the discharging practitioner to ensure that all medication supplied to a patient/carer at point of discharge (and leave) corresponds with the discharge (or leave) prescription form and that the patient/carer understands the medication being supplied, as per Safe and Secure Handling of Medicines Procedure.

4. PROCEDURES

Medication that requires to be labelled must be done so to comply with The Medicines Act 1968 and the Medicines, Ethics and Practice.

Medicines that are not on the units agreed stock list and any patient specific medicine (i.e. inhalers, topical preparations) must have a dispensing label/addressograph applied before administration.

It is the responsibility of pharmacy staff to approve the re-labelling of any patients' own drugs (PODs) as appropriate. After the PODs have been assessed for use, if they have to be relabelled the following extra statement must be added to the label **'Patients own medicines re-labelled'**. The directions on the label must be deleted and the new label attached so that the original supplier's name and address are clearly visible.

All medication issued to patients for their own use must be accompanied with a patient information leaflet (PIL), which can be obtained from the following websites (if not available from the original container or a different format is required):

- https://www.medicines.org.uk/emc/
- https://www.choiceandmedication.org/humber/
- https://patient.info/medicine

Medication that is required to be repackaged from the original container, the new container/dispensing label should include the batch number and expiry date of the original product. Completed and annotated leave and discharge prescriptions should be scanned into the patients notes.

Lorenzo users should scan and save to letters and documents.

SystmOne users should make the entry in the tabbed journal.

Copies of the paperwork should be filed in the patients notes.

A copy of the discharge should be supplied to the patient as a record of the medication supplied. To facilitate timely supply of discharge and leave medication, where possible ward-based technicians should utilise 'One stop dispensing'.

Medication should not be labelled for a patient, with directions unless it has been clinically verified. Items should not be released for leave/discharge unless all the items on the MAR have been clinically verified.

14-day minimum supply on discharge unless otherwise agreed in MDT, taking into consideration any risk factors for the patient.

Ward based technicians should also consider having a leave supply ready for informal patients. Where the dose is half a tablet, the tablet should be supplied in a bottle with a tablet cutter. If the tablets are being supplied to the patient already halved, they should be labelled accordingly. i.e. "tablets already halved".

Ordering flow charts are available on the intranet:
https://intranet.humber.nhs.uk/directorates/ordering-medicines.htm

Members of the pharmacy team will be assigned initials which are to be clearly visible on the label when signing the "dispensed by" or "checked by" boxes on the dispensing label.
A record of the initials assigned are stored on the v:drive here: V:\Corporate\Pharmacy\Pharmacy Team\Shared\Ward-Based Dispensing

Where medicines are dispensed at headquarters which is not part of an inpatient unit the quality check list (Appendix 4) must be completed daily to ensure good practice. At the end of each month the check list must be scanned onto the V drive.

V:\Corporate\Pharmacy\Pharmacy Team\Shared\Ward-Based Dispensing\Quality Check Sheets

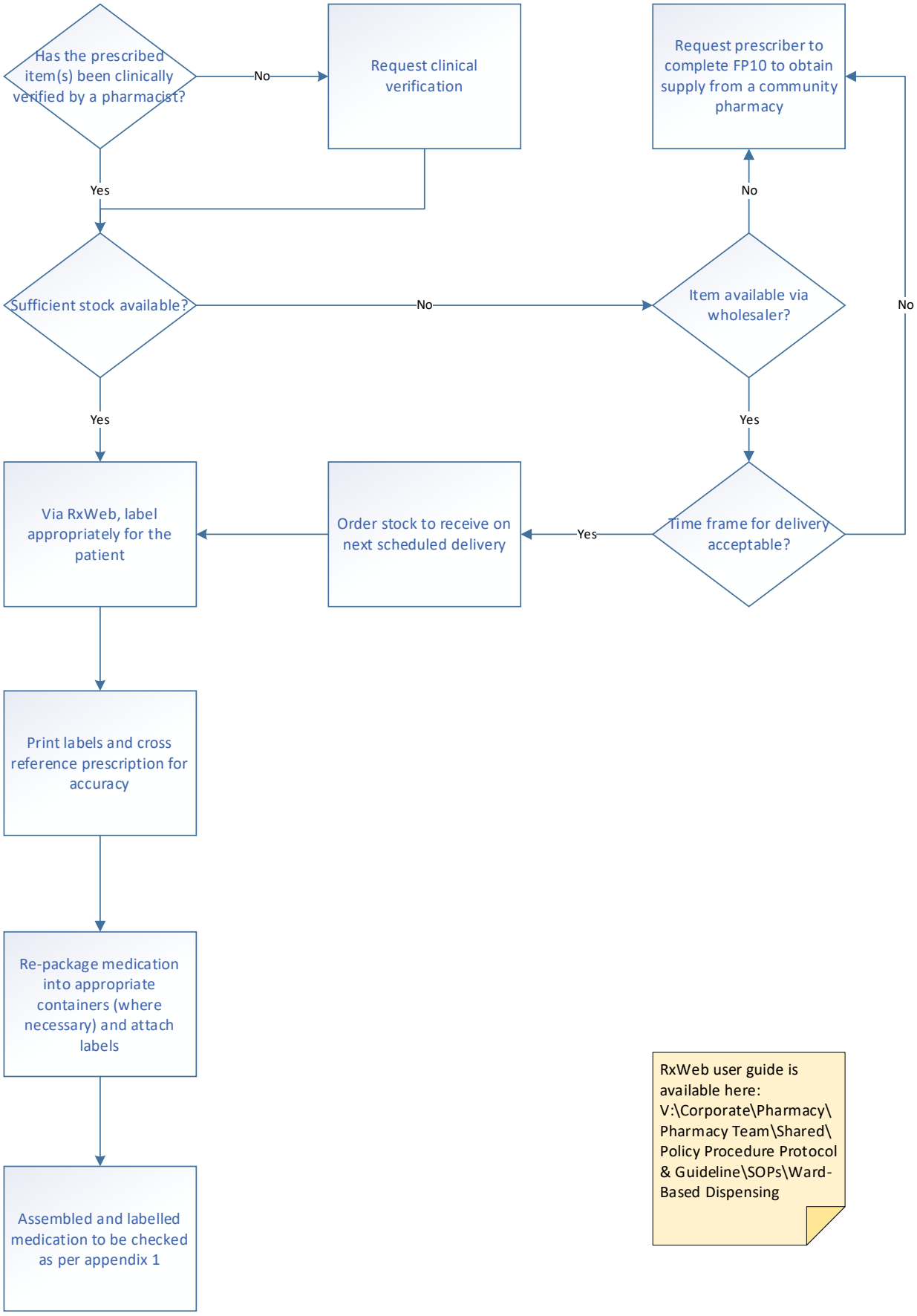
4.1. Supply and Labelling of Inpatient Medicines

Non-Stock Medicines (NSMs) are medicines not kept as stock on the unit.
Before a supply can be obtained, they must first be prescribed on the MAR Chart.

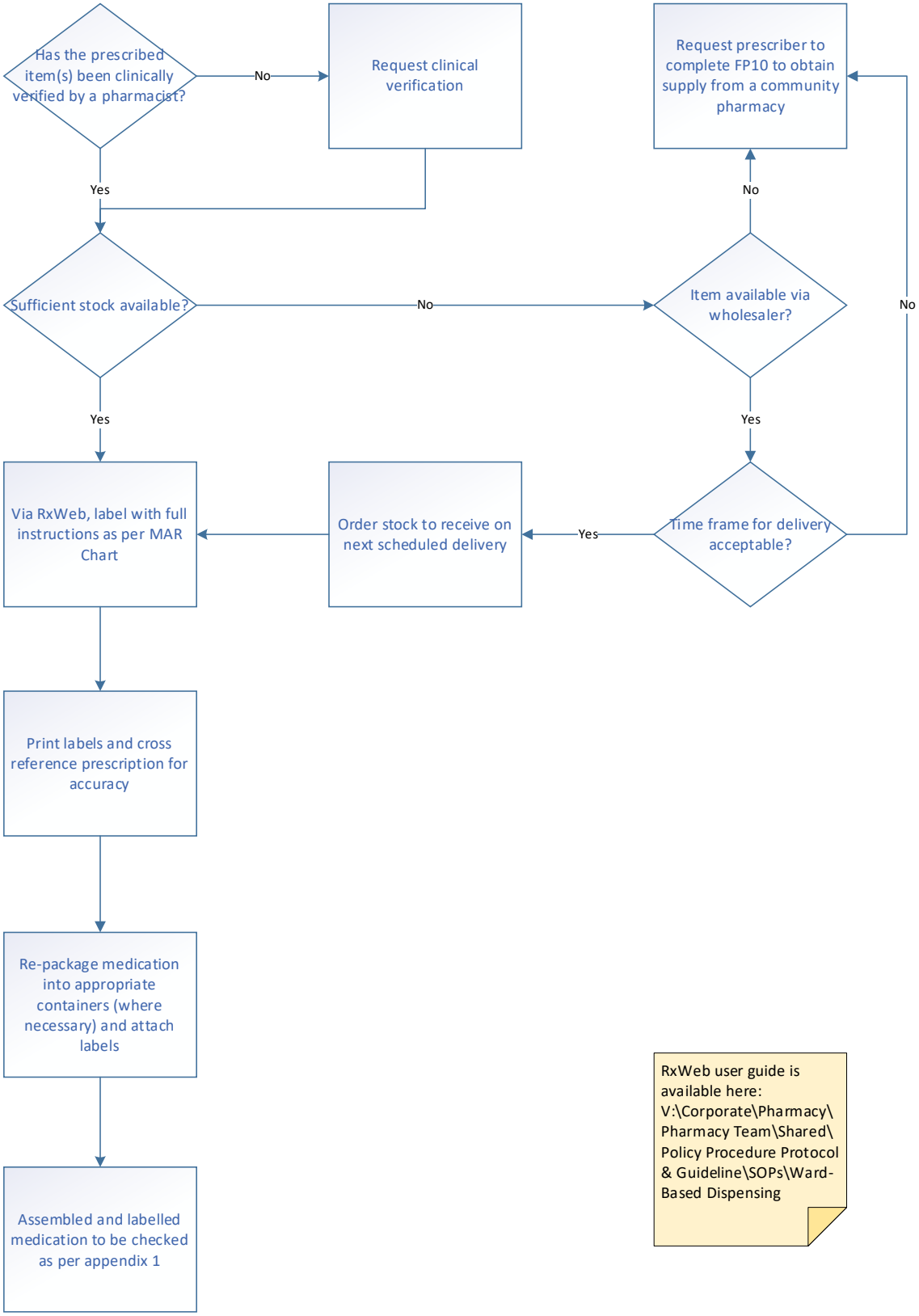
The following items should be labelled for the patient with full instructions:

- Clozapine
- Creams
- Eye/ear/nasal preparations
- Inhalers
- Medicines the patient will be self-administering (SAMs)
- One Stop Dispensing

NSMs not in the list above should be labelled for the patient with “Use as per Medication Administration Record” in place of the administration instructions.


Has the prescribed item(s) been clinically verified by a pharmacist?
No
Request clinical verification
Request prescriber to complete FP10 to obtain supply from a community pharmacy
Yes
No
Sufficient stock available?
No
Item available via wholesaler?
No
Yes
Yes
Via RxWeb, label appropriately for the patient
Order stock to receive on next scheduled delivery
Yes
Time frame for delivery acceptable?
Print labels and cross reference prescription for accuracy
Re-package medication into appropriate containers (where necessary) and attach labels
Assembled and labelled medication to be checked as per appendix 1
RxWeb user guide is available here: V:\Corporate\Pharmacy\ Pharmacy Team\Shared\ Policy Procedure Protocol & Guideline\SOPs\Ward-Based Dispensing

4.2. Labelling and supply of Leave/Discharge Medicines



For the supply of leave medication, this can be authorised for supply by a nominated pharmacy technician, as per *Pilot standard operating procedure authorisation of leave prescriptions by Medicines Optimisation Technicians*.

For the supply of discharge medication, the discharge prescription must be clinically verified by a pharmacist.

A copy of the discharge should be supplied to the patient as a record of the medication supplied. Discharge medication must only be issued to a patient when the record indicates “discharge medication verified and complete”

4.3. Controlled Drugs

If CDs are dispensed for Discharge/Leave and not handed out immediately, they should be entered out of the stock and entered as PODs in the appropriate section of the CDWRB (see section 10.6 of SSHMP).

The CDs must remain locked in the CD cabinet until they are issued to the patient or their representative.
Once issued, the appropriate entry should be made in the CD register (see section 10.9 of SSHMP)

4.4. Use of FP10s

When unable to supply medication via the preferred route, FP10s may be used to facilitate supply. FP10s used to facilitate supply to an in-patient ward should be collected be a member of HTFT staff (or via the Taxi procedure). The FP10 should **not** be given to the patient to allow them to collect their own discharge medication from the community pharmacy.

When an FP10 is produced this must be scanned into the patients Lorenzo/SystmOne record unless it has been generated by Lorenzo in which case it will automatically save and the FP10 log should be completed.

When an FP10 is used to facilitate supply of leave/discharge medication the leave/discharge process must still be completed on Lorenzo/S1.

4.5. Near miss and error reporting

Near misses are to be recorded on the Near Miss Log (appendix 3).

A copy of the near miss log should be printed and available during the dispensing and accuracy checking phase of the process.

Completed sheets should be scanned and saved on the v:drive here:
V:\Corporate\Pharmacy\Pharmacy Team\Shared\Ward-Based Dispensing\Near Miss Log
Once scanned onto the v:drive, paper copies can be disposed of via confidential waste.

All dispensing errors must be reported via Datix.

4.6. Compliance aids

If a multi-compartment compliance aid (MCA) is required, then the ward-based pharmacy technician must liaise with the patients nominated community pharmacy.

If required for rehabilitation whilst as an inpatient, FP10 prescriptions should be utilised for the nominated community pharmacy to dispense and return to the inpatient unit.

For discharge, either utilise FP10 prescriptions or liaise with both the patients GP and nominated community pharmacy to arrange supply.

Please note: the supplying community pharmacy will require weekly FP10 prescriptions in order to process the MCA request.

Where a DOMMAR/MAR is required for discharge; the medicines optimisation technician will check with the social worker that they have provided the patients GP and local pharmacy with a Fullers Assessment. The medicines optimisation technician should document this in the communications section of EPMA. If required DOMMAR and MAR charts can be obtained from Trust HQ. The ward medicines optimisation technician will dispense 28 days supply and ensure corresponding labels are placed on the DOMMAR/MAR chart.

4.7. Accuracy Checking Process

This section covers the way in which prescribed medicines that have been dispensed (assembled and labelled) are checked. This is referred to as an accuracy check.

An accuracy check is required during the dispensing process and must be completed prior to the medication being made available for administration. A nurse checking medication prior to administration is **not** an accuracy check.

An accuracy check should be completed by a registered professional.

It is preferable for the accuracy check to be completed at the site of dispensing however when this is not possible, pharmacy technician or a pharmacist remote check via Teams is acceptable.

When an accuracy check is completed remotely, this should be recorded on the checking label by placing an R in front of the checkers initials.

Only colleagues registered with the GPhC can accuracy check medication dispensed by pharmacy assistants and first year pharmacy students.

4.7.1. Self-check

A self-check can only be carried out if all options listed above have been attempted and are not achievable to ensure there is no disruption to patient care and a 2nd check must be obtained at the next earliest opportunity.

- A Datix must be completed when a self-check is carried out (Category – 'Medication Incident' Sub-category – 'Unable to obtain Accuracy check')
- When completing the monthly Ward Based Dispensing self- check audit the following information regarding the self-check must be added in the comments section of the relevant question; Date, item & Patient initials and the Datix Web number must be added in the comments section when recording that a Datix has been submitted.

4.8. Community In-patient wards

If it has not been possible to gain an accuracy check and the items are not required for administration before another member of the pharmacy team visits the ward:

- Quarantine the items using sealed bags and tamper evident labelled stickers
- Complete appendix 2 "Community worksheet"

- Write progress note in patients to record the items dispensed and that an accuracy check is required
- Accuracy check to be completed within 24 hours.
- Recorded the completed accuracy check on the worksheet and as a progress note in the patients notes.

Note: any items required for administration before another member of the pharmacy team is on the ward, the process outlined in 4.6 should be followed.

If quarantined items have been used before being released by pharmacy, a DATIX should be completed.

4.9. Student Accuracy Checking Logs

When a student technician is completing their accuracy checking logs they will perform the accuracy check and sign for the checks in red pen.

The prescription and dispensed item must then be checked and signed by a qualified technician/pharmacist before it can be released to the patient.

The qualified technician/pharmacist performing the final check should then sign the students accuracy checking logs.

If an error is found the student should be informed and a near miss log entry must be completed

5. OVERLABELLING AND REPACKAGING FOR MIU AND 136 SUITE

Medicine Optimisation Technicians and Pharmacists completing this process must be follow the guidance published on the Specialist Pharmacy Service website: GUIDANCE ON REPACKAGING AND OVER-LABELLING SMALL BATCHES OF MEDICINES IN PHARMACY DEPARTMENTS

As described in the guidance worksheets must be completed for all repackaged and over labelled products. These worksheets must be retained for 5 years after release or for one year after the product's expiry, whichever is the longer, for audit and management purposes.

Copies of the worksheets to be completed can be found on the v:drive here: V:\Pharmacy\PD(OL)\HTFT PD(OL)

Completed worksheets will be filed and retained in the clinic room from where it was released.

6. REFERENCES

Medicines Optimisation Policy (M-006)

Safe and Secure Handling of Medicines Procedures (Proc431)

The Medicines Act 1968

Medicines, Ethics and Practice

Hull and East Riding Prescribing Committee (HERPC)

Sussex Partnership NHS Foundation Trust

Dispensing Doctors' Association Ltd

Prescription Stationery Guidance note

Appendix 1 – Accuracy Checking process

Check the product:

- Check the medicine name on the bulk pack/patient pack
- Check the strength
- Multiple patient packs - check they are the same medication and the same strength
- Check the form of the medicine
- Bulk packs - visual check on the contents to ensure they match
- Patient packs, open all unsealed packs checking that the contents are correct, the number of strips present in each pack is correct, and that there are no loose blisters or tablets
- Check that the correct quantity has been dispensed
- For controlled drugs, double-check and count the number of dosage units dispensed
- Check the expiry date
- Check that the pack contains the relevant PIL

Check the label:

- Check the label against the MAR chart/ In-patient medication tab (Lorenzo) /prescription to ensure that it contains the correct patient name, medication name, strength, form and quantity
- Check that the dose and usage instructions on the label correspond

Complete the checks:

- When the check is complete, initial the “Checked By” box on the dispensing label with clear initials
- If any of the above steps reveals that an error has been made, this must be brought to the attention of the dispenser concerned. Near misses are to be recorded on the Near Miss Log.
- For leave and discharge, count the number of items on the prescription and then count the corresponding number of dispensed items (not packs) into an appropriately sized bag
- For leave and discharge, complete the ‘For Pharmacy Use’ section
- Check that you have not included any stock containers in the bag
- If the dispensed items have special storage requirements, e.g. items needing refrigeration or controlled drugs, ensure that the prescription form is annotated accordingly
- Ensure that 5ml spoons, oral syringes, etc. are included if necessary

Appendix 2 – Community Ward Worksheet

Date:

Wing:

Bed	Pt	NOMAD?	Actions to do (tick when completed)	Actions still required

Community Ward worksheet v1
V:\Corporate\Pharmacy\Pharmacy Team\Shared\Policy Procedure Protocol & Guideline\SOPs\Ward-Based Dispensing

Appendix 3 – Near Miss Log

Near miss log

Unit:_____

Humber Teaching NHS Foundation Trust

Date	Time	Name and brand of drug prescribed	Type of error	Dispensed by	Checked by	Possible cause/other information	Action taken

Key: Type of error										
D= incorrect drug	F = incorrect form	Q = incorrect quantity	S = incorrect strength	E = out of date	X = transposed labels	P = misread prescription	MDS= monitored dosage system	N = incorrect patient name	M = missing item	O=other (please detail)

Reviewed by:	Signed:	Dated:

Near Miss Log v1

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Appendix 4 – Dispensing Area Quality Check Sheet

Month_____ Year_____ Area_____

	Surfaces Cleaned	Triangles Cleaned	Biobin Secure	All Medicines Secure	Temps Recorded	Exp Dates (monthly)		Surfaces Cleaned	Triangles Cleaned	Biobin Secure	All Medicines Secure	Temps Recorded	Exp Dates (monthly)
1							16						
2							17						
3							18						
4							19						
5							20						
6							21						
7							22						
8							23						
9							24						
10							25						
11							26						
12							27						
13							29						
14							29						
15							30						
Please sign box once job completed At end of month scan to Vdrive:corporate/pharmacy/pharmacyteam/shared/wardbaseddispensing/qualitychecksheet							31						