ROYAL PHARMACEUTICAL SOCIETY

SECTION 3:
PUTTING THE STANDARDS INTO PRACTICE

Professional Standards For Hospital Pharmacy Services

One year on – sharing experience from the development sites

September 2013

SECTION 3 Putting the standards into practice

This section gives a snapshot of the experiences of the development sites. It looks at each of the ten standards (illustrated in Figure 1) and their dimensions and gives examples of the sort of evidence, and in some cases measures, that the sites used as a way of illustrating that they are meeting the standard. In a table at the end of each standard there are also examples of actions identified by the development sites as a result of using the standards.

The information and examples in this section are a distillation of data and are meant to give a sense of what a quality pharmacy service in an acute, mental health, private or community service might look like. By sharing experiences and practice examples we want to stimulate other Trusts to review and improve their services.

"Really invigorating to see why you have gaps and finding new, innovative ways of making changes, within available resources." [Alex Kelso, Belford Hospital, Fort William]

3.1 Overview of the process

This section is informed by data generated by thirty five development sites that have been looking at how the RPS standards might be implemented in practice. Over a year the sites reviewed the standards, their domains and indicators, and assessed how their own services were meeting those standards.

The sites provided examples of the evidence and measures that they might use to illustrate that they are meeting the standards. The examples of evidence and measures are by no means exhaustive and there may be alternatives that could be applied or developed which better suit the context of different hospital settings and services. The sites then RAG rated their services against the individual statements in the standards and gave examples of gaps and actions that they wanted to take to improve their services.

3.2 How the data were analysed

For each dimension of the ten standards, the development sites were asked to:

- provide examples of evidence which demonstrated implementation of the dimension within their setting
- provide examples of measures they are currently using to demonstrate, in a quantifiable way, the achievement of the dimension
- identify any gaps within their organisation which inhibited achieving the dimension

Thirty five sites returned information to the RPS research team. For each dimension, the information from the sites was collated to produce a list of evidence and measures that the development sites used. The research team considered that EVIDENCE is information on practice or service delivery which clearly shows that this standard (or dimension) is being implemented whilst a MEASURE is information that shows, in a quantifiable or measureable way, the achievement of this standard (or dimension).

In order to produce a report which could be used by other trusts to help develop their own services, all the data submitted were reviewed by a small development sites steering group (see Appendix 1). Several workshop meetings were used to reach a consensus on which examples would provide a snapshot of practice that demonstrated implementation of the standard and encouraged other trusts to use the standards to develop their services.
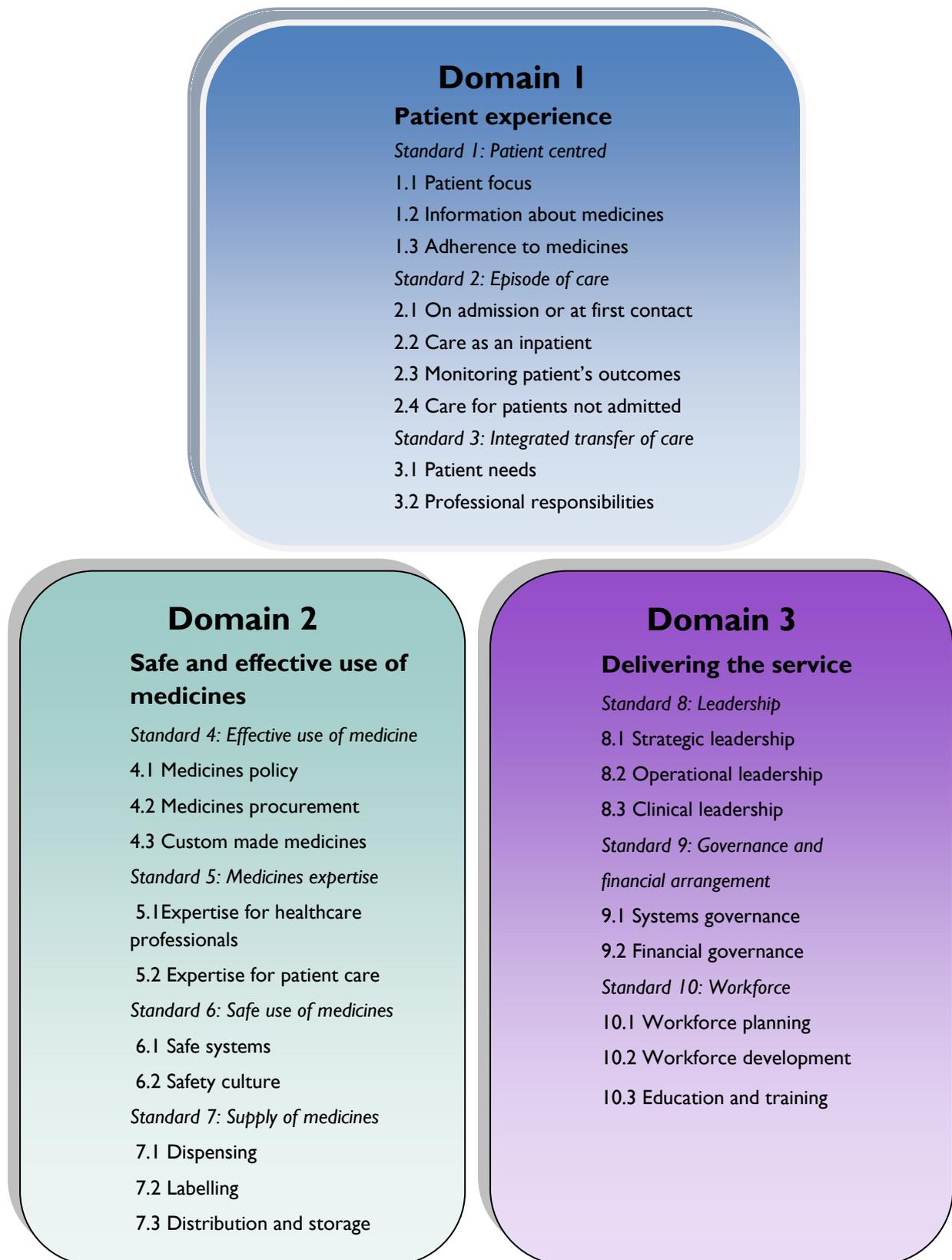
3.3 Some general findings

The majority of the data submitted was evidence that standards were being put into practice, measures of implementation overall were less common. There were few data that made a direct link to patient outcome.

There was often overlap in the evidence and measures provided by the development sites, however there was also variation. At times this variation illustrated that there are many ways to evidence the dimensions and, likewise, more than one way to measure the degree to which the dimension is being achieved. At other times the variation seemed to suggest a lack of clarity over how that dimension should or could be evidenced and / or measured.

It is worth noting however that there will always be variation in the evidence used to demonstrate the delivery of the standards, and the processes used to measure the achievement of the standards, in different organisations. The evidence and measures contained in the report therefore remain illustrative rather than prescriptive.

3.4 The ten hospital standards

Figure 1 the ten standards for hospital pharmacy services

Domain 1
Patient experience

Standard 1: Patient centred

1.1 Patient focus

1.2 Information about medicines

1.3 Adherence to medicines

Standard 2: Episode of care

2.1 On admission or at first contact

2.2 Care as an inpatient

2.3 Monitoring patient's outcomes

2.4 Care for patients not admitted

Standard 3: Integrated transfer of care

3.1 Patient needs

3.2 Professional responsibilities

Domain 2
Safe and effective use of medicines

Standard 4: Effective use of medicine

4.1 Medicines policy

4.2 Medicines procurement

4.3 Custom made medicines

Standard 5: Medicines expertise

5.1 Expertise for healthcare professionals

5.2 Expertise for patient care

Standard 6: Safe use of medicines

6.1 Safe systems

6.2 Safety culture

Standard 7: Supply of medicines

7.1 Dispensing

7.2 Labelling

7.3 Distribution and storage

Domain 3
Delivering the service

Standard 8: Leadership

8.1 Strategic leadership

8.2 Operational leadership

8.3 Clinical leadership

Standard 9: Governance and financial arrangement

9.1 Systems governance

9.2 Financial governance

Standard 10: Workforce

10.1 Workforce planning

10.2 Workforce development

10.3 Education and training

STANDARD 1.0 PATIENT CENTRED
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Patients (and/or carers) are supported in their decision-making about medicines.
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1.1 PATIENT FOCUS

Communication and the involvement of patients and carers is an integral component of effective pharmacy services.

Examples of evidence
• Policies and documentation;   ■ policies that document clearly expectations around behaviours and actions in the work place

• Patient input;
   ■ national inpatient and outpatient surveys prompting an action plan
   ■ surveys of patients' experiences of pharmacy services e.g. medicines information help lines, chemotherapy services
   ■ medicines groups in the organisation have patient input
   ■ patients are involved in the design/redesign of services and contribute to the design of information resources

• Staff training

Example of Practice (see Appendix 2 for more examples)

Northumbria Healthcare has a Trust-wide scheme to elicit views from patients (**"2 minutes of your time"**) about their hospital stay. The feedback is relayed to all departments involved in the patient's care, including pharmacy, as a number of questions are medicines related. The outcomes and feedback from this survey are used to improve services and the overall patient experience. Pharmacy have introduced and/or tested several changes such as using posters about medicines to raise awareness; issued leaflets at the bedside; delivered more patient counselling; follow-up post discharge via phone calls and referral to community pharmacy for support etc. This Trust-wide scheme has enabled Northumbria Healthcare to deliver a better end-to-end service, becoming one of the best performing Trusts in patient experience in their region.**Northumbria Healthcare Trust**

1.2 INFORMATION ABOUT MEDICINES

Patients (and/or carers) have access to information and support in order to make informed choices about the use of medicines or the implications of choosing not to take them.

Examples of evidence

• Patient Information;
   ■ patients are given written information on their medicines and how to use them. For example patient information leaflets (PILs) are available for all medicines.
   ■ ward staff are trained to ensure that patients discharged without seeing a pharmacist get a PIL

• Pharmacist contact;
   ■ a helpline is available, for example, advertised on PIL and in outpatient bags
   ■ pharmacy staff on the wards available to answer any queries from patients

• Pharmacy support;   ■ ward staff refer patients to pharmacy if patients need additional medicines support such as counselling. For example, through a ward pharmacists visit or via a telephone helpline.
• Health promotion and wellbeing services;   ■ signposting to smoking cessation and alcohol services
• High risk medicines;   ■ counselling checklists for all high risk medicines; pharmacists and ward staff are trained to use them

Example of Practice (see Appendix 2 for more examples)

Medicines; A Patient Profile Summary (MAPS) – this is a web based resource developed by a private company, which has been bought by the Trust. The website lists all the medicines available in the BNF. Pharmacists are able to select the medicines a patient is on and print out summarised patient information to discuss with the patient. The aim is to improve information delivery, providing patients with information about their medicines in an easy to use format, which they can then review at a later stage. The Trust are currently in the planning stages for this scheme, reviewing issues such as when would be the best point to undertake this type of information delivery e.g. at discharge, or earlier on during hospital stay, so as to give patients the best possible support. **Kings College Hospital NHS Foundation Trust.**

1.3 ADHERENCE TO MEDICINES

Systems are in place to identify patients who may need adherence support, or to allow patients to request support.

Examples of evidence
• Systems and SOPs;   ▪ in place to identify problems with medicines use on medicines reconciliation; medication history taking; assessments for patients own drugs; monitoring medicines use.
• Polypharmacy;   ▪ STOPP and START tool is used to enable patient medicines to be simplified
• SOP and standards for referral to, or liaison with, the intermediate care team, domiciliary support services and community pharmacists
• Documentation and training include the principles of medicines optimisation. See RPS good practice guidance on medicines optimisation (England only) http://www.rpharms.com/medicines-safety/medicines-optimisation.asp

<u>Example of Practice (see Appendix 2 for more examples)</u>

As part of the Trust's commitment to support on-going adherence and medicines optimisation, the Interface Pharmacy Technician (IPT) attends meetings and liaises with a range of care providers including Trust MDT discharge meetings, Domiciliary Care Providers and is the link person for the Community Health Services Pharmacist. They also refer patients to the Community Based Pharmacy Technicians and liaise with any other external agencies involved in the patients care to ensure that the patient is supported in their care. Monitored Dosage Systems (MDS) have been a particular issue. Where, following an 'Equality Act' assessment, if the patient is not eligible but is still receiving an MDS in primary care, the IPT will liaise with relevant agencies to resolve any issues and provide seamless care In addition the Trust also has an SLA with a local community pharmacy to provide MDS, for patients whose regular local community pharmacy cannot provide a timely service at discharge or for patients newly started on an MDS.**Luton and Dunstable University Hospital NHS Foundation Trust**

Examples of how some sites are achieving delivery of standard 1.0 patient centred:
- survey results are monitored on a continuous basis to measure improvements.
- key performance indicators for patients verbally counselled about high risk medicines
- local patient experience tracker (measure indicated patients do not think that they get enough information)
- ward referrals of patients and carers for pharmacy counselling audited
- audit of referral rates to follow-up services that support medicines use (e.g. New Medicine Service, Chronic Medication Service, Discharge Medicines Review Service or targeted Medicines Use Reviews). Uptake also audited.
- audit of medicines reconciliation rates

Examples of areas for development identified for standard 1.0 patient centred
- develop a programme for ongoing counselling training to incorporate with induction training and refresher training of all staff
- develop the advanced counselling skills of pharmacists
- audit patient experience, currently no standard audit or questionnaire available
- need to improve figures for those counselled as not all patients are identified for counselling
- adapt the Trust medicines reminder card by directorate
- need to do more on information for the blind; pictorial information for illiterate patients; magnifying glasses; non English language
- look more at how to implement and audit NICE guideline 76 (Medicines Adherence)
- put in place formal systems to routinely assess adherence
- prioritise to a greater level advice about ongoing supplies to minimise inconvenience and potential missed doses
- clarify systems in use to liaise with healthcare professionals outside the organisation

STANDARD 2.0 EPISODE OF CARE

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Patients' medicines requirements are regularly assessed and responded to in order to optimise their outcomes from medicines.

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2.1 ON ADMISSION OR AT FIRST CONTACT

Patients' medicines are reviewed to ensure an accurate medication history, for clinical appropriateness and to identify patients in need of further pharmacy support.

Examples of evidence
• SOPs;   ▪ in place for medicines reconciliation in all newly admitted patients

• Skill mix;
    ▪ pharmacy technicians trained in medicines reconciliation (MR) and drug history taking
    ▪ nurses are trained in medicines reconciliation

• Systems to support access;   ▪ use of patients' own drugs, emergency cupboards, ward adjusted stock, comprehensive 24/7 on call service.

<u>Example of Practice (see Appendix 2 for more examples)</u>

Every week, 10 case notes are checked to see if MR has met the appropriate criteria and the standard of 95% of all patients have MR undertaken within 24 hours of admission – in line with Scottish Patient Safety Programme requirements. A monthly audit is carried out across the hospital to see if this standard has been met. The pharmacy department regularly provide training for pharmacists to undertake MR and ensure that the service is meeting the required standards. **Lanarkshire**

2.2 CARE AS AN INPATIENT

Patients have their medicines reviewed by a clinical pharmacist to ensure that their medicines are clinically appropriate and to optimise their outcomes from their medicines.

Examples of evidence

• Polices;
    ▪ omitted dose policy in line with NPSA guidance
    ▪ self administration policy is in place, supported by training for nurses to assess a patient's suitability for self administration

• Training;
    ▪ nursing staff trained to minimise missed/delayed medicines
    ▪ a critical medicines list is available on each ward

• Ward pharmacy services;
    ▪ pharmacists contactable by bleep or pagers
    ▪ pharmacists record in clinical notes their recommendations/interventions. Junior staff are supervised/peer reviewed.
    ▪ key performance indicators for ward services

• Contribution monitoring. Contributions made by pharmacists are monitored monthly, or collected on certain days, or certain ward rounds.

Clinical Standards aim to prioritise patients with the most needs and help to manage clinical services to wards. Within a day of admission to acute receiving wards 95% of patients will have a documented medication history, a pharmaceutical care plan with a priority code attached and the NHS Tayside Prescribing and Administration Record screened. The priority codes are assigned based on the patient's age, number of medicines, any high risk medicines taken and frailty; each code determines how often the patient is visited by a pharmacist on ward, based on agreed timescales e.g. every 24 hours etc. The service has been very well received by medical, nursing and pharmacy staff, and there are plans to look at patient feedback around the service. Pharmacists now have more time available for the most complex patients and are able to attend clinical ward rounds with medical staff. **NHS Tayside.**

2.3 MONITORING PATIENTS' OUTCOMES

Patients' outcomes from and experiences of treatment with medicines are documented, monitored and reviewed.

Examples of evidence

• Policies and SOPs;
  ▪ medicines management policy defines the roles and responsibilities of the MDT in monitoring patients' response to medicines.
  ▪ clinical pharmacy standards and guidelines. Audits to measure how well they are followed for example, antibiotic audits including the monitoring of allergy documentation.

• Targeted monitoring. Pharmacists monitor blood pressure for hypertensives, INR for warfarin, CRP and WCC for antibiotics, Parkinson's medications.

Example of Practice (see Appendix 2 for more examples)

Electronic prescribing web portal identifies lab results that are out of range and potentially highlights drugs that are an issue. Electronic notes can be left for doctors to review the drugs and/or any drug related issues. Some of the benefits of this system are that it gives pharmacists the ability to highlight issues more easily and quickly than before; prioritises patients for pharmacy in-put and ensures that complex patients are monitored more closely; highlights suitable preventative measures e.g. Deep Vein Thrombosis risk. The system is also able to link to lab sensitivity data, so that appropriate antibiotic prescribing can be monitored. The data can be accessed anywhere inside or outside hospital and is a useful resource for the on-call pharmacy service, ensuring that patients are clinically monitored on a regular basis. **Aintree University Hospitals NHS FT**

2.4 CARE FOR PATIENTS NOT ADMITTED (e.g. outpatients, outreach, homecare)

Patients who are taking medicines at home or in non-acute care settings have access to continuing supplies of medicines and to pharmacy services and support appropriate to their care.

Examples of evidence
• Policy procedures and SOPs;   ▪ medicines management policy covers processes for patients not admitted, e.g. outpatients and day-case patients
• Homecare;   ▪ homecare systems are in place (consistent with *Professional Standards for Homecare Services. Royal Pharmaceutical Society. In press*).
• Availability of advice;   ▪ medicines information helpline and/or an on-call/resident pharmacist are available 24/7 for the MDT and patients.
• Surveys;   ▪ outpatient satisfaction surveys, homecare surveys.

Examples of how some sites are achieving delivery of standard 2.0 episode of care:

- Medicines reconciliation rates are audited in line with NICE guidance on medicines reconciliation.
- Missed and/or delayed doses routinely audited.
- Numbers of patients self administering high risk medicines e.g. insulin and Parkinson's medication are audited.
- Audits to measure how well clinical pharmacy standards and guidelines are followed, for example, antibiotic audits including the monitoring of allergy documentation.
- KPIs for the number of patients seen by a pharmacist and or a technician.
- Outpatient satisfaction survey is tracked over time to monitor patient satisfaction.
- KPIs are in place and monitored for the delivery of homecare services (*Professional Standards for Homecare Services.* Royal Pharmaceutical Society. In press).

Examples of areas for development identified for standard 2.0 episode of care:

- Training in medicines reconciliation is needed for the multidisciplinary team for example for doctors to reconcile medicines when pharmacy is closed, and nurses in the pre-admissions clinic
- Introduce a more formal approach to attending ward rounds and monitor the impact of having pharmacists there.
- Service is essentially reactive with regard to monitoring so needs to look at being more proactive especially with regard to high risk medicines.
- Pharmacist documenting of interventions and contributions to patient care in patients' clinical notes is not well embedded into practice within the trust.
- Need to roll out peer review of medicines administration rounds.
- Need to raise awareness of MUR and NMS amongst staff and discuss with the CCGs how best to refer into those services, as currently not using any of the community pharmacy schemes in a planned way.

STANDARD 3.0 INTEGRATED TRANSFER OF CARE

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Patients experience an uninterrupted supply of medicines when they move care settings and the healthcare team taking over their care receives accurate and timely information about the patient's medicines.

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3.1 PATIENT NEEDS

Patients (and/or carers) are given information about their medicines and have their expressed needs for information met.

Examples of evidence/measures

• Patient information;
   ▪ Patients are provided with a copy of the electronic discharge letter sent to their GP with information about future treatment included.
   ▪ National booklets are supplied for relevant conditions (for example anticoagulation packs, insulin passports etc).

• Skill Mix;
   ▪ pharmacy technicians at ward level trained in patient counselling on discharge
   ▪ nurse training

• Targeted additional care on discharge;   ▪ pharmacy team work with high risk patients to give support during and after discharge

<u>Example of Practice (see Appendix 2 for more examples)</u>

The MyMeds service is an end-to-end service; patients are encouraged to bring in their own medicines; following a medicines reconciliation review, they use their own medicines during the hospital stay. On discharge, a copy of the discharge prescription, with a letter explaining any changes is sent to the patient's GP and regular community pharmacist. Pharmacists and GPs are able to contact the MyMeds team if required. This system aims to encourage appropriate medicines use and reduce medicines wastage. **New Victoria Hospital**

3.2 PROFESSIONAL RESPONSIBILITIES

Accurate information about the patient's medicines is transferred to the healthcare professional(s) taking over care of the patient at the time of transfer. Arrangements are in place to ensure a supply of medicines for the patient.

Examples of evidence/measures
▪ Professional liaison. The patient's community pharmacy is faxed if the patient has specific pharmaceutical requirements, e.g. monitored dosage systems, specials/unlicensed medicines are required.
▪ Targets. CQUIN (England only) used to improve quality of discharge letter (including information about medicines).

The **Safely HERE Safely HOME** scheme aims to ensure that information about medicines is accurate - during admission, on discharge and/or transfer of care. During admission, consultants and nurses use a ward round checklist; this captures any changes to medication on the prescription chart and 'forces' clinicians to record the rationale behind these changes. Discharge planning is initiated following admission, so that all medicines and information regarding them is accurately communicated, via letter, to all care providers for the patient e.g. GP, community nurses etc. Matrons audit the Safely HERE Safely HOME scheme for compliance with its standards and this includes checking a random sample of charts for changes to medication and whether the rationale has been captured. The scheme aims to demonstrate national leadership in this field and has been adopted across different departments in the Trust as a driver for quality services. **East Lancashire Hospital Trust**

Examples of how some sites are achieving delivery of standard 3.0 integrated transfer of care:
- Audits to establish whether changes to medication and the rational for those changes have been captured and communicated on discharge. In line with the RPS good practice guidance on transfer of care.
- Targeted audits in older people of readmissions to establish whether medicines were the cause of readmission.

Examples of areas for development identified for standard 3.0 integrated transfer of care:
- Need to establish support post-discharge for patients identified as high risk.
- Audit the timeliness and quality of discharge information.
- Need an agreed system for communication with community pharmacists
- Need to map all the systems currently used to counsel patients across the trust.
- Need to routinely inform patients who they need to contact if they need more information about their medicines, who will prescribe further treatment and how to access ongoing supplies.

STANDARD 4.0 EFFECTIVE USE OF MEDICINES

Medicines used in the organisation are chosen to maximise safety, effectiveness and adherence to treatment.

4.1 MEDICINES POLICY

The pharmacy team supports an integrated approach to the choice of safe and clinically effective medicines for patients.

Examples of evidence/measures
• Multidisciplinary medicines management groups. Groups are active across the organisation. E.g. Medicines Incident Committee, Antimicrobial Management Committee, Drug and Therapeutics Committee (DTC), Medicines Governance Group. Attendance and implementation of actions monitored.
• Area prescribing committees. Active participation for example in horizon scanning and the management of new medicines, shared care guidelines, joint formularies etc. Attendance and implementation of actions monitored.
• Policies, procedures and SOPs. In place and updated e.g. medicines policies, formulary systems
• Sharing practice. Attendance at local/regional specialist meetings. Virtual Network membership. Conference attendance. Participation in specialist networks.

<u>Example of Practice (see Appendix 2 for more examples)</u>

The **Greater Manchester Medicines Management Group (GMMMG)** acts on behalf of 12 CCGs for Greater Manchester. They work together on a range of medicines related issues e.g. new therapies, horizon scanning, formulary etc, for treatment across the region. Patients often travel from all over the region to access specialist services. To enable some degree of continuity of care closer to their homes, GMMMG have developed a 'traffic light' system; listing medicines they would expect GPs to prescribe for complex regimes. Red – GP would not be expected to prescribe; green - would expect the GP to prescribe; amber - could be prescribed by the patients GP under a shared care protocol with the secondary care trust. The hospital provides comprehensive shared care guidelines that detail information on areas such as defined responsibilities of the primary and secondary care team, patient criteria, GP led monitoring etc.

4.2 MEDICINES PROCUREMENT

Medicines procurement is managed by pharmacy in a transparent and professional way. Quality assured medicines are procured through robust and appropriate processes.

Examples of evidence
• Policies and SOPs. Organogram showing local senior pharmacist responsibility & accountability for medicines procurement
• Accredited/recognised training. Chartered Institute of Procurement membership, Evidence of participation in Procurement and Interest Distribution Group (PDIG) recommended training
• Group & network membership. Minutes and Terms of Reference of e.g. local procurement consortium meetings. Evidence of attendance at e.g. PDIG meetings
• Participation in regional and national benchmarking and audit. Purchasing according to CMU contacts. Minutes of trust and local health economy QIPP group meetings. QIPP dashboards. Outputs from e.g. Define®

The Regional QC Office facilitates regular 'Recall Exercises'. A 'mock' situation of a drug recall usually occurs out of hours. The on-call pharmacist is contacted by the QC office and given details about a faulty batch or product. The pharmacist then follows a defined protocol based on identifying and isolating the batch; making risk assessments about patient safety, suitability of recall etc. They will also inform the Trust Chief Pharmacist and any other relevant people. There is a clear audit trail of all their actions, especially as the on-call pharmacists will be working alone out of hours. Any learning outcomes are collected by the regional QC office and used to update the process/protocol. These exercises ensure that staff are suitably trained, competent and ready for a real-life situation. **Southport and Ormskirk Hospital NHS Trust.**

4.3 CUSTOM-MADE MEDICINES

Any medicines custom made by, or for, the organisation are quality assured and appropriate for their intended use.

Examples of evidence
• Policies and SOPs. Product and service specifications. Provider Service Level Agreements if no local Quality Assurance/Quality Control presence. Drug and Therapeutics Committee/clinical governance committee records.
• Prospective product and supply chain risk assessments. Completed assessments, SLAs with providers. Product and service specifications. Performance monitoring reports.
• Medicines produced on site are covered by Good Manufacturing Practice.

Examples of how some sites are achieving delivery of standard 4.0 effective use of medicines:
- Audits on processes and systems that support implementation of medicines policy in the organisation. Implementation of NICE technology appraisals and clinical guidelines, local shared care protocols, clinical trials audits, formulary compliance, clinical audits.
- Regional or local audits, for example, using the audit framework adopted by the National Pharmaceutical Supplies Group (NPSG); *Standards for NHS purchasing and supply of pharmaceuticals. An audit tool.*
- Monitoring of product quality and supplier performance for custom made medicines. For example trend analysis, defective product reports, certificates of analysis and conformity, product specifications, flagging of unlicensed medicinal products on dispensing software, quality assurance release records.

Examples of areas for development identified for standard 4.0 effective use of medicine:
- No formal robust process for horizon scanning is in place.
- Current policies and SOPs need revising and updating.
- Look at the gaps in how we implement some of the decisions taken by guidelines groups.
- Identified a need for education and training around off label use of medicines.

STANDARD 5.0 MEDICINES EXPERTISE

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Medicines used in the organisation are chosen to maximise safety, effectiveness and adherence to treatment.

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5.1 EXPERTISE FOR HEALTHCARE PROFESSIONALS

Healthcare professionals prescribing, administering and monitoring the effects of medicines have relevant, up-to-date, evidence based information and pharmaceutical expertise available to them at the point of care.

Examples of evidence

• Training;
   ▪ pharmacy delivers or reviews the medicines component of induction training for all relevant staff. E.g. doctors, nursing staff, non-medical prescribers, theatre staff.
   ▪ feedback is sought on training to assess whether outcomes have been met.

• Surveys;   ▪ ward staff are surveyed to ask if they know how contact the pharmacy team

• Medicines information;
   ▪ all pharmacists trained to level 1-2 for answering of MI queries
   ▪ access to a quality assured MI service (either on or off site)

• Reference sources;   ▪ prescribers have access to up-to-date pharmacy resources via hospital intranet site, traffic is analysed for number of hits, audits undertaken to ensure compliance with formulary/guidelines.

<u>Example of Practice (see Appendix 2 for more examples)</u>

Pharmacy and medical teams have developed an electronic dose calculator for staff working in Paediatric Intensive Care Units (PICU), which gives Prescribers access to a safe way of calculating doses on a mg/kg basis. It does not provide any decision support. The Trust are currently developing an application that accesses the organisational paediatric formulary, providing a quick reference to important issues to around drugs in paediatrics as well as giving the dose. Information is easily accessible to prescribers and future developments will look to incorporate drug calculations as well. **Evelina London Children's Hospital, Guy's and St Thomas' NHS Foundation Trust.**

5.2 EXPERTISE FOR PATIENT CARE

Pharmacists are integrated into clinical teams across the organisation and provide clinical care direct to patients.

Examples of evidence/measures

• Integration;
   ▪ pharmacists integrated into clinical teams with formal links to the management team and lead clinician
   ▪ pharmacists contribute to MDT research activities

• Impact on patient outcome;   ▪ interventions recorded, cardexes audited, outcome monitored
• Clinic involvement;   ▪ for example, chemotherapy/oncology, erythropoietin, heart failure, cystic fibrosis, smoking cessation, anticoagulant/warfarin, HIV adherence clinics, preadmission clinics, chronic pain, diabetes, tuberculosis and liver, rheumatology, cardiology, and GUM clinics
• High risk medicines;   ▪ list on all wards, ward guidelines in place, mandatory training, audits and outcome monitoring

<u>Example of Practice (see Appendix 2 for more examples)</u>

In a Community NHS Trust, a specialist community pharmacist provides care for patients with long term conditions. Following a community nurse referral, the pharmacist visits the patient in their home and conducts a full clinical review of their medication. This is supported by GP notes and patient lab data. The outcomes and any recommendations are sent to the GP, community pharmacist the original referrer. The service is targeted at high intensity users of primary and secondary services and aims to identify medication issues that could result in unplanned hospital admissions; to reduce prescribing costs and to provide education and support to patients and carers in order to help them with taking their medicines ([The Pharmaceutical Journal2009;282:83](#)).The Trust is looking to expand this service for other areas such as a pharmacist on the rapid response team. The vision is patients that stay well, stay out of hospital.

Sussex Community Hospitals Trust

Examples of how some sites are achieving delivery of standard 5.0 medicines expertise:
- Measure of time pharmacists spend training the MDT; e.g. contact teaching hours
- Surveys of nursing teams; e.g. to establish if they know how and when to contact pharmacy
- Audit availability of pharmacists on ward rounds. In line with Royal College of Physicians and Royal College of Nurses best practice on ward rounds guidance.
- Pharmacist contributions monitored to evaluate impact of interventions on patient care and to input into raining of MDT members.

Examples of areas for development identified for standard 5.0 medicines expertise:
- Need to input into the training of all relevant professionals, for example senior grade doctors, nursing staff and ODP induction training.
- Need to look again at how to make sure prescribers can access relevant information through the hospital IT system.
- Need to address gaps in pharmacist input in some specialist services.
- Need to look at how many of the pharmacist prescribers are actively prescribing.

STANDARD 6.0 SAFE USE OF MEDICINES
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The pharmacy team ensure that safe medication practices are embedded in the organisation (included contracted or directly outsourced services and third part suppliers).
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6.1 SAFE SYSTEMS

The chief pharmacist (or equivalent) leads on ensuring that all aspects of medicines use within the organisation are safe.

Examples of evidence
• Involvement. Groups and committees looking at the design and updating of prescription and administration systems include members of the pharmacy team.
• Designated post. Named individual has responsibility for electronic prescribing.
• Audit. Charts, medicines reconciliation forms, medication histories are audited to ensure that an identifiable pharmacist has screened them.
• National standards. National alerts are incorporated into Trust policies, procedures and guidelines.
• Recording in patients notes. Standards are in place for pharmacists documenting actions in patient notes.
• Omitted and delayed doses. Policy documents and SOPs are in place.

<u>Example of Practice (See Appendix 2 for more examples)</u>

The on-call pharmacist is supplied with a Blackberry linked to MHRA email alerts. This enables any product recalls to be made on a 24 hour basis and helps ensure patient safety. The RPS Hospital Standards were used to help highlight this issue and implement change. **Wrexham Maelor Hospital , Betsi Cadwaladr , University Health Board**

6.2 SAFETY CULTURE

The chief pharmacist (or equivalent) leads on promoting a "just" culture in which medication safety has a high profile both within the organisation and its partners.

Examples of evidence/measures
• Incident reporting. Systems are used to report and analyse medication incidents e.g. DATIX, SBAR. Reporting is actively encouraged.
• Shared learning. Newsletters, updates and safety reports published and promoted, medicines incident away day, reporting to relevant committees, learning from incident sessions, incorporating learning into training.
• Action. Root cause analysis of serious incidents involving medicines must involve a pharmacist.

<u>Example of Practice (See Appendix 2 for more examples)</u>

A Trust wide reporting system includes medication errors. Once a month, all medication errors that are scored as category 4 or 5 (i.e. serious) are highlighted on the dashboard, with the aim of raising awareness, improving learning and preventing re-occurrence. **Central Manchester University Hospitals NHS Foundation Trust**

Examples of how some sites are achieving delivery of standard 6.0 safe use of medicine:

- National safety alerts are audited on a regular basis to demonstrate compliance e.g. NPSA guidance on delayed and omitted doses.
- Serious incidents and never events involving medicines are investigated.
- Medication incident reports are audited and trends investigated. Action plans developed to avoid recurrence.
- Reports on DATIX are regularly reviewed alongside contributions data. Issues identified are investigated and steps put in place to avoid recurrence.
- Quality of pharmacist recording of recommendations in patients' notes is audited.

Examples of areas for development identified for standard 6 safe use of medicines:

- Not all prescriptions are screened by a pharmacist, some are not seen and others have a minimal clinical check.
- Our monitoring of ongoing compliance with NPSA alerts is not as good as it could be.
- Communication and shared learning from events could be more targeted we currently produce a newsletter which may not get to all relevant groups.
- There is sometimes a limited review of Serious Incident action plans and little or no evidence of recommendations being acted upon.

STANDARD 7.0 SUPPLY OF MEDICINES

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Medicines are supplied, distributed, stored and if necessary disposed of in a legal, safe and timely way.

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7.1 DISPENSING

Medicines are dispensed or prepared accurately, available when needed and clinically appropriate.

Examples of evidence
• Processes. Processes are in place to allow pharmacists to screen all prescriptions. Prioritisation process minimise the delay on critical medicines
• Technology and systems design. New technology e.g. automated ward drug cupboards, ward based labelling carts, dispensing robots.
• Skill mix and training. Accredited checking technicians release pharmacist time. Dispensing competency assessments for all new team members.

<u>Example of Practice (See Appendix 2 for more examples)</u>

An electronic tracking system tracks the turnaround time for prescriptions coming into the main dispensary. All prescriptions are identified with a bar code that is scanned at each stage, from receipt by dispensary, throughout the dispensing process and up until the prescription leaving the department. The process time is fed into a central system, whereby ward staff are able to monitor the prescription and assess when it will be ready. There is no tracking system in the near ward pharmacy area but they implement a manually recorded workload throughout the day, with the turnaround time, which is quicker that the main dispensary. LEAN audit has demonstrated an overall reduction in phone calls to the department with this system. The turnaround time for prescriptions can also be audited using the tracking system and changes to the service implemented where required. **Wishaw General Hospital**

7.2 LABELLING

Medicines dispensed or prepared are labelled for safety in line with legal requirements.

Examples of evidence
• Large print and Braille labels are available for patients with impaired vision.
• Additional counselling and support is available.
• Systems in place to control ad hoc labelling.

<u>Example of practice (See Appendix 2 for more examples)</u>

A resource pack developed to aid patients with visual impairment / literacy problems includes resources such as:
* Medicine reminder charts
* Pictorial aids
* Talking labels - these attach to medicines boxes and enable the drug and dosing directions to be recorded. Patients can listen to the recording to identify the drug and follow dosing instructions. The Trust is currently in the planning stages and reviewing issues such as continuity of care following discharge from the Trust, re-usability of the labels and who will manage the service in the community etc. This range of labelling helps to take into account the diversity of patients accessing medicines and meet their needs.

County Durham and Darlington NHS FT

7.3 DISTRIBUTION AND STORAGE

Medicines are safely and securely distributed from a pharmacy and stored in a secure and suitable environment prior to administration.

Examples of evidence
• Policies and SOPs. Safe and secure storage of medicines on wards. Return of medicines to pharmacy.
• Ward stock control. Processes are in place to ensure wards have appropriate stock. Stock list reviews, audits of expired medicines to reduce wastage.
• Intranet includes Out of hours information and stock locations.
• Controlled Drugs. Controlled drugs have different coloured labels and bags. Locked transit containers.
• Third party inspections. Against Care Quality Commission medicines security standards.

<u>Example of Practice(See Appendix 2 for more examples)</u>

Senior nursing staff do a monthly audit on the storage of medicines on their wards using a routine "Quality of care" tool. The measures are based on Care Quality Commission requirements e.g. fridge temperatures, drugs cupboards locked etc. The pharmacy team monitors this via the Medicines Governance Committee, reviewing outcomes and feeding back any recommendations or actions required. **University Hospital Bristol**

Examples of how some sites are achieving delivery of standard 7.0 supply of medicines:
- Key Performance Indicators. Used for the turn around on inpatient and outpatient prescriptions e.g. from the time of arrival in pharmacy to the time leaving. Time taken to dispense critical medicines.
- Audits. Audit of the dispensing of critical medicines where administration has been compromised.
- Error monitoring. Dispensing errors are recorded and monitored through DATIX and investigated and reviewed. Investigation of all near misses.
- Audit of controlled drugs.
- Ward based audits and inspections test compliance with policies for the safe and secure storage of medicines.

Examples of areas for development identified for standard 7.0 supply of medicines:
- We need a tracking system for inpatient prescriptions.
- We need to instigate a system to monitor internal error types and identify necessary action to improve practice.
- We need to work out the best way of identifying patients needs around labelling.
- At ward level there can be a lack of engagement with the policies and procedures.

STANDARD 8.0 LEADERSHIP

Pharmacy has strong leadership, a clear strategic vision and the governance and assurance necessary to ensure that patients get the best from their medicines.

8.1 STRATEGIC LEADERSHIP

The chief pharmacist (or equivalent) ensures that the organisation maintains a clear vision for pharmacy services and optimal use of medicines across the organisation.

Examples of evidence
• Chief pharmacist. Job description and role profile. Clear line of reporting to the Board. Chief pharmacist regularly reports to the Board on progress against strategy.
• Medicines strategy. A medicines strategy that optimises patient outcomes is in place linked to the Trusts overall clinical strategy.
• Overarching medicines policy. The Chief Pharmacist attends or reports to groups with a remit on the safe and secure handling of medicines.
• Service improvement and innovation. The Chief Pharmacist ensures that improvement and innovation is part of individual and departmental objectives.
• Minutes and action plans. Chief Pharmacist or a representative attends all relevant groups. Minutes and action plans are acted upon.
• Participation in national and regional collaborative audits and initiatives where possible.

8.2 OPERATIONAL LEADERSHIP

Pharmacy services are patient centred and aligned with organisational priorities and the range and level of healthcare commissioned/purchased.

Examples of evidence
• Operational plans. Service, capacity and workforce plans are in place. Risk register used to highlight staffing issues.
• Benchmarking. Across the region, with typical peers and equivalent trusts.
• Organogram .Organisational structure in place supported by regular appraisal and performance development reviews.
• Patient/user engagement. Comments are encouraged, and complaints monitored.

8.3 CLINICAL LEADERSHIP

The pharmacy team is recognised as leading on medicines issues in the organisation.

Examples of evidence
• New policies or procedures are not approved by clinical standards unless they have been reviewed by a pharmacist.
• Education and training. Pharmacists are involved in education and training activities throughout the Trust.
• Directorate pharmacists. Colleagues in their specialities are supported with information about medicines.
• Consultant pharmacists. Key areas of medicine activity have clinical leadership from Consultant pharmacists e.g. critical care, antimicrobials, medicines safety, cardiovascular.
• Service design. Pharmacy must be involved in all business cases if there is a medicines management component.

Example of Practice (See Appendix 2 for more examples)

Across **Scottish Health Boards**, there is an on-going audit for 'empirical antimicrobial prescribing,' which highlights any reasons for non-compliance with the formulary and, where relevant, why an indication for antimicrobial therapy hasn't been documented. This on-going work is reviewing how we can use this data to improve empirical prescribing and ultimately achieve good antimicrobial stewardship, to improve patient care.

Examples of how some sites are achieving delivery of standard 8.0 leadership:
- Chief Pharmacist reports to the Executive Committee quarterly on progress against medicines strategy plan.
- Metrics. Specific metrics developed for key deliverables in the medicines strategy.
- Performance monitoring. Monthly Key Performance Indicators are reported via the CSU dashboard. Performance is monitored at the Pharmacy Board/Pharmacy Quality Board.
- For services provided under SLA we review KPIs at a monthly contract meeting.

Examples of areas for development identified for standard 8.0 leadership:
- We lack feedback on out reports from senior management, we need to work on improving understanding.
- Need to review the best way of engaging with the health community following changes to commissioning arrangements in England.
- Medicines management strategy currently does not go to the Board for approval or support.
- Not all wards have pharmacist cover and we have no resources to provide a weekend service.
- KPIs across all pharmacy service areas need to be defined.
- Under pressure for weekend service provision to increase and seven day working.
- Processes are in place for the development of new SLAs but need to review existing ones as there are gaps in provision.
- Need to get more routinely involved with multidisciplinary audit as tend to focus on internal audit.

STANDARD 9 GOVERNANCE AND FINANCIAL MANAGEMENT
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Safe systems of work are established and pharmacy services have sound financial management.
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9.1 SYSTEMS GOVERNANCE (see also safe and effective use of medicines domain)

Systems of work are established that are safe, productive, support continuous quality improvement, are regularly audited and comply with relevant regulations.

Examples of evidence (see also standards 4-7 for overlapping evidence)
• Policies and SOPs. In place across the board to support systems governance.
• Monitoring and audit. Programme of regular audit and monitoring as part of continuous improvement.
• Information Governance. Mandatory training. Policies and procedures in place.
• Health and safety audits. Environmental monitoring. Inspections by regional Quality Assurance and Quality Control services.

<u>Example of Practice (See Appendix 2 for more examples)</u>

All patients admitted for planned surgery are screened (level 2 medicines reconciliation) on admission by a pharmacy technician or a pharmacist, to see if they are taking high-risk drugs, as defined by the NPSA. Patients currently taking high-risk drugs are highlighted by putting a sticker on the drug chart; this prompts ward staff to contact pharmacy to check the appropriateness of the discharge medicines and letter and ensure accurate communication about their medicines. This process has helped to ensure that over 80% of patients on high risk medicines admitted to Colchester University Hospital are monitored and reviewed before discharge. Pharmacists will also check prescriptions and discharge communications retrospectively to check for any problems, following up with the patient's GP or primary carer, if required. The service is consistently audited, looking at a number of parameters to ensure appropriate coverage of patients and target appropriate pharmacy resources. The outcomes are used for continuous improvement of the service and minimise risks for patient on high-risk medicines during and after discharge.

Colchester Hospital University NHS Foundation Trust

9.2 FINANCIAL GOVERNANCE

Robust business planning, financial planning and reporting are undertaken.

Examples of evidence
• Annual priorities and ongoing work identified ahead of business planning. Linked to the organisations strategic plan.
• Annual plan implemented and monitored on a regular basis.
• Directorate expenditure reports produced regularly for discussion with clinical directors and general managers.
• Engagement with local commissioner groups (England).

Examples of how some sites are achieving delivery of standard 9.0 governance and financial management:
- Implementation of actions emerging from the programme of audit and continuous quality improvement.
- Controlled drugs. Local Intelligence Network (LIN) reports. Care Quality Commission self assessment. KPIs for CD audits.
- External audit. For example NHS Litigation authority, regional Quality Control and Quality Assurance.
- Information Governance reports and incident monitoring,
- Legal requirements for the ongoing registration and licensing of premises and facilities.
- Monitoring of expenditure against KPIs, use of dashboards to highlight variance.

Examples of areas for development identified for standard 9.0 governance and financial management:
- We need to embed reporting our care contributions more to CSUs
- The majority of our CD audits are still six monthly rather than three monthly
- We need to do more work on patients' own CDs that they bring into hospital with them.
- No clear policy for how we work collaboratively with the pharmaceutical industry.
- We are weak on having a programme that can inform continuous improvement and development of systems.

STANDARD 10.0 WORKFORCE

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The pharmacy team has the right skill mix and the capability and capacity to develop and provide quality services to patients.
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10.1 WORKFORCE PLANNING

The pharmacy workforce is planned and appropriately resourced in order to support service quality, productivity and safety.

Examples of evidence
• Regular workforce review and plan linked to Trusts business strategy.
• Workforce plan is revised and updated every six months. Posts are reviewed when vacancies arise.
• Deficiencies and shortfalls are identified on the risk register and action of the risk register is monitored.
• Staff given the opportunity for supported secondment to more senior posts to develop their skills and experience
• National staffing shortfall areas have a targeted focus for key roles which are hard to recruit.
• Ongoing dialogue with the Local Education and Training Boards.
• Skill mix benchmarked against similar trusts and for specific activities.

<u>Example of Practice (See Appendix 2 for more examples)</u>

The pharmacy department is managed as an independent business unit, within the Trust, that aligns to overall Trust vision and planning. As one of the Trust business units, pharmacy has an ongoing transformation plan that prioritises key projects for efficiencies and workforce, to meet the needs of the service and budget targets e.g. save money on drug procurement; appropriate skill-mix of staff; keeping certain posts empty due to budget constraints etc. There is an overarching workforce plan, aligned with the Trust, which aims to meet service needs and developments, so that recruitment drives, training needs etc can be planned and delivered.**Royal Derby NHS FT**

10.2 WORKFORCE DEVELOPMENT

Pharmacy has an effective performance management and personal development planning process linked to workforce planning

Examples of evidence
• Job roles and responsibilities and the annual appraisal process.
• Personal development plans with objectives following appraisal. Six monthly review of progress.
• Capability policy and HR procedures in place for managing poor performance.
• Frameworks and assessment tools used. For example, General Level framework and Advan, NVQ, ACtced level framework. NVQ levels 1 and 2 and BTEC programmes.

10.3 EDUCATION AND TRAINING

Induction and ongoing learning and development are provided for all members of the pharmacy team

Examples of evidence
• Training programmes available. For example, Clinical diploma, General Level Framework/Advanced Consultant Level Framework
• Engagement with regional Education and Training team.
• Support. Named mentors and NVQ assessors, teacher practitioners, buddies for new staff.
• Training needs and opportunities are highlighted at appraisals.

Examples of how some sites are achieving delivery of standard 10.0 workforce:
- Percentage of staff appraisals completed on time.
- Review of training programmes by the scheduled review date.

- Feedback from staff attending training programmes and competency assessment post training.
- Number of staff taking training and development opportunities.

Examples of areas for development identified for standard 10.0 workforce:
- Education for higher grades of staff is ad hoc we need to develop a more consistent plan. Need to do more for specialist pharmacists.
- Leadership skills need to be developed more across the team.
- Benchmarking is difficult because of variability between organisations.
- Need to introduce competency assessments after training.
- Need to think about development for pharmacy support workers and clerical staff.
- The induction training programme needs review and updating.
- Need to encourage people to put themselves forward for training more.