

STANDARD 7.0 SUPPLY OF MEDICINES

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

7.1 DISPENSING

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

Examples of evidence
<ul style="list-style-type: none">Processes. Processes are in place to allow pharmacists to screen all prescriptions. Prioritisation process minimise the delay on critical medicines
<ul style="list-style-type: none">Technology and systems design. New technology e.g. automated ward drug cupboards, ward based labelling carts, dispensing robots.
<ul style="list-style-type: none">Skill mix and training. Accredited checking technicians release pharmacist time. Dispensing competency assessments for all new team members.

Example of Practice (See Appendix 2 for more examples)

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 than 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
<ul style="list-style-type: none">Large print and Braille labels are available for patients with impaired vision.
<ul style="list-style-type: none">Additional counselling and support is available.
<ul style="list-style-type: none">Systems in place to control ad hoc labelling.

Example of practice (See Appendix 2 for more examples)

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
<ul style="list-style-type: none">• Policies and SOPs. Safe and secure storage of medicines on wards. Return of medicines to pharmacy.
<ul style="list-style-type: none">• Ward stock control. Processes are in place to ensure wards have appropriate stock. Stock list reviews, audits of expired medicines to reduce wastage.
<ul style="list-style-type: none">• Intranet includes Out of hours information and stock locations.
<ul style="list-style-type: none">• Controlled Drugs. Controlled drugs have different coloured labels and bags. Locked transit containers.
<ul style="list-style-type: none">• Third party inspections. Against Care Quality Commission medicines security standards.

Example of Practice(See Appendix 2 for more examples)

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.