Clinical Pharmacy Standards

Version number :	5.0
Consultation Groups	Pharmacy team ELFT, Medicines Committee
Approved by (Sponsor Group)	Medicines Committee
Ratified by:	Medicines Committee
Date ratified:	14th July 2021
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Implementation Date :	July 2021
Last Review Date	July 2021
Next Review date:	July 2024

Services	Applicable
Trustwide	X
Mental Health and LD	
Community Health Services	

Version Control Summary		
Version	**Date**	**Comments / changes**
1.0	December 2010	No comments
2.0	November 2012	Standardization of writing in RiO notes by pharmacy staff added as an Appendix.
3.0	December 2015	Clear and specific definitions and timeline for achieving certain standards: Medicine reconciliation- to be done with 3 working days of admission. Written medication information to be given to offered and given to patient/ carer within 7 working days of admission. Pharmacist to complete at least 1:1 meeting with patient during the course of the patient's admission. Discharge counselling to be offered and/ or completed leading up to and/ or at the point of discharge. The medicine management technician and / or ward pharmacist can complete the above standards.
4.0	July 2019	Updates reflecting EPMA
5.0	June 2021	Digital platforms for clinical time with patients

Contents

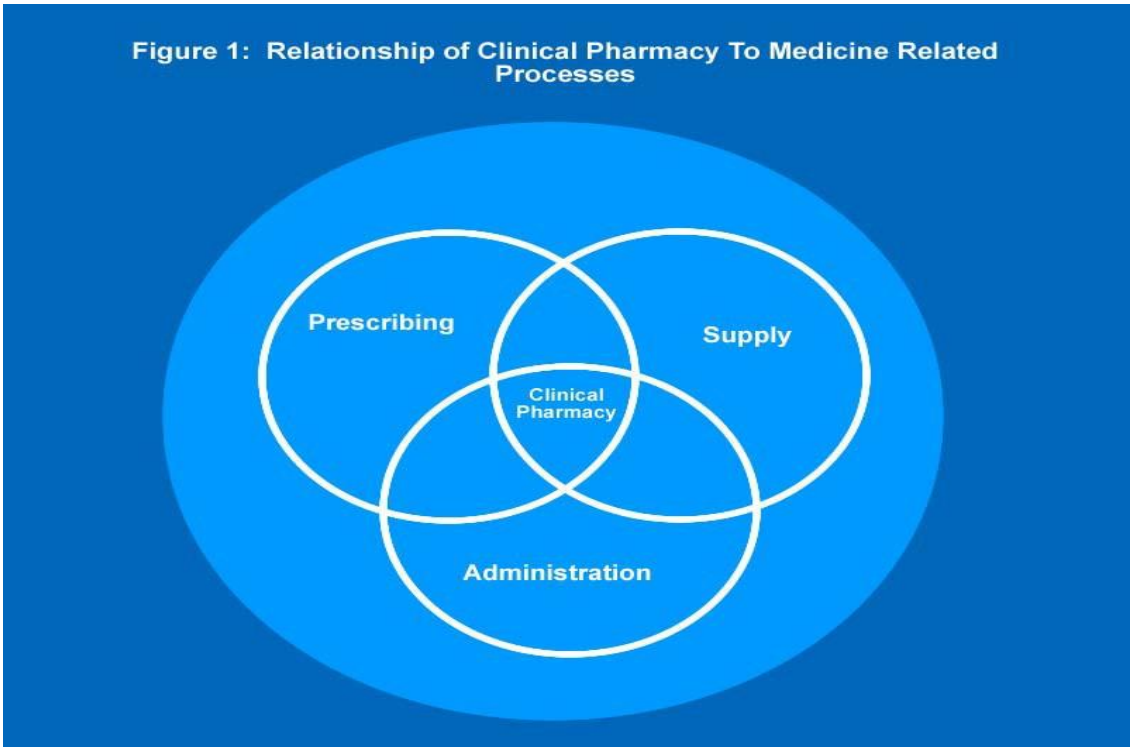
1.0 Introduction

Whether in primary or secondary care, medication is the most common intervention offered in healthcare.

Healthcare professionals are now in the strongest position ever to prescribe the most effective medication. With the advent of evidence based medicine, drugs today must not only be able to demonstrate superiority over placebo, but also equivalence or superiority whilst being cost effective relative to comparators in well-designed clinical studies. At East London Foundation Trust, the Medicines Committee controls the introduction of new medicines, where decisions are made based on efficacy, safety, suitability and cost effectiveness.

Despite the clear benefits of receiving effective treatment, healthcare professionals must also ensure the benefits outweigh the risks. Adverse drug reactions, increasingly complex prescribing regimens, polypharmacy and medicines errors all combine to make medicine use a potentially dangerous process. This has in part, led to the introduction of national strategies to minimize harm. A crucial and fundamental part of this strategy has been the development of clinical pharmacy services that now operate in most healthcare Trusts throughout the UK.

The Clinical Pharmacy service exists to ensure that patients derive maximum benefit from the medicines they take by ensuring that they receive, in a timely fashion, the most effective and safest medicines possible. As figure 1 demonstrates, the service underpins the three main patient related medicine processes that occur; prescribing, dispensing and administration of drugs to the patient.



2.0 Purpose

The purpose of this policy is to set out a framework for the delivery of a safe and effective clinical pharmacy service to all wards and clinical teams within the Trust. . Central to the policy are 8 core clinical pharmacy standards.

In line with Trust and departmental business continuity plans, this policy introduces the concept of variable service provision according to resource levels. Each of the 8 clinical pharmacy standards in this policy are broken down into key components, each of which is affixed level 1, level 2 or level 3. These levels can be described as follows;

Level 1: This level of pharmacy service will be provided when there are limited and reduced staff numbers (for example during periods of annual leave and/or sickness).

Level 2: This level of service will be delivered on a day-to-day basis when normal staffing levels are available.

Level 3: This level is what pharmacy aspires to, subject to staffing/ workload and resource infrastructure.

The guiding principle to providing a clinical pharmacy service is that services across ELFT are equitable.

This policy also sets out the key performance indicators and outcome measures that will be used to demonstrate the performance of the clinical pharmacy service, Trust wide.

Finally, the contents of this policy describe how a clinical pharmacy service will be provided to the Trust within core working hours (9-5pm, Monday to Friday). For services available out of these hours, please consult the on call pharmacy and weekend working service specifications.

3.0 Duties

3.1 Operational Duties

The ***lead pharmacist*** is accountable for;

- Ensuring that they aim to deliver the appropriate level of clinical pharmacy service according to the staffing level within the pharmacy department.

Clinical pharmacists and ***accredited ward technicians*** are accountable for:

- Ensuring that they provide all of the components for the selected level of service within this policy.
- That the level of service provided is equivalent across all 8 clinical standards (i.e. do not provide level 1 service for some standards, when providing level 3 services for others. Instead, a level 2 service should be provided).
- Ensure that they comply with the standards set out in the Medicines Policy and other medicine policies and guidance issued by the Trust.

3.2 Strategic Duties

Strategic duties lie with the Chief Pharmacist, East London Foundation Trust.

4.0 Clinical Pharmacy Standards Matrix

Clinical Pharmacy Standard	Level 1 Components	Level 2 Components	Level 3 Components	Key Performance Indicators	Outcome Measures
Prescription Review	All demographic data and allergy status data (including nature of allergies) is recorded accurately and completely on the EPMA chart The clinical pharmacist clinically screens each newly prescribed medicine or where a dose has changed. This will also include viewing the prescription against Trust protocols, policy and guidance and against national guidance as appropriate. Inappropriate medication is discussed with relevant member of the healthcare team, documented on Rio and the issue resolved. Pharmacist to leave as unverified on EPMA until resolved Appropriate endorsements made (on paper chart /EPMA and added to Rio- e.g. whether patient uses a compliance	Level 1 and 2 Medicines Reconciliation is carried out as within 24hours of admission and identified discrepancies are documented and resolved Re-board accuracy checks (paper charts) Ensuring prescribed medicines correspond with those specified on T2/T3 form. Any discrepancies escalated to Consultant and followed up to check resolved High Dose Antipsychotic Patients – documented as patent note on EPMA	Acting as SOAD consultee when required and professionally appropriate to do so	Activity data on number of prescriptions screened and reviewed. Activity data on proportion of patients receiving Stage 1/2 Medicines Reconciliation within 24 hours of admission. Activity data on number of SOAD consultations	Number of accepted clinical interventions related to patient safety and efficacy of medication Significance of interventions to patient outcome (Using NPSA criteria)
Monitoring of Treatment	Review or verify blood status via ZTAS/DMS/CPMS system prior to ordering clozapine. Review and monitoring of high risk drugs (e.g. clozapine, lithium, anticoagulants, insulin) where necessary Review Conflict Log on EPMA Inpatient charts	Review of blood results where necessary throughout the patient's stay at the hospital. Where abnormalities are observed, the pharmacist will advise the medical team on any necessary dosage adjustments Therapeutic Drug Monitoring Monitoring of patients on high risk or narrow therapeutic index drugs Intermittent monitoring of blood glucose for those patients receiving insulin or oral antihyperglycaemics	Assist or direct side effect monitoring using recognized assessment tools (e.g. LUNSERS) High Dose Antipsychotic and Rapid Tranquillisation monitoring (together with Drs/nurses)	Audit activity data on number of patients where monitoring is carried out in line with the trust audit schedule.	Number of accepted clinical interventions surrounding monitoring of medicines. Significance of interventions to patient outcome (Using NPSA criteria)

Supply of Medication	Supply of medication for requested items only.(Technicians can only order those medicines that have been clinically screened by a pharmacist) indicated by green pen on paper charts and a tick symbol on EPMA Inpatient charts Short-term leave TTAs and Discharge TTAs ordered only when requested by ward. Full stock top up Compliance aids only dispensed when deemed absolutely essential	Short term TTAs ordered in advance. Inpatient items ordered proactively following prescription review using EPMA Interfacing with primary and secondary care services as required for specific patient issues	Nil	TTA activity (Medical vs. Pharmacist) TTA activity Number of TTAs ordered in advance of ward round. Average time to wait for TTAs Stock lists monitored and reviewed on 3 monthly basis	Improved score on patient survey regarding time to wait for TTAs. Questionnaire feedback from MDT regarding access to medication
Ward Rounds and MDT meetings	Nil	Attendance at certain parts of ward rounds when considered necessary and or when specific requests are made for individual patients.	Regular attendance at a specified section of ward round when appropriate Medication Reviews	Number of ward rounds attended and number of patients seen in this setting.	Number of accepted clinical interventions. Significance of interventions on pt. Outcome (NPSA criteria)

Clinical Pharmacy	Level 1 Components	Level 2 Components	Level 3 Components	Key Performance Indicators	Outcome Measures

Standard					
Patient/Carer Counselling and Education	Facilitating the supply of patient information leaflets	Pharmacist to complete at least one 1:1 meeting with the patient/ carer during course of inpatient admission Regular Medication Education Sessions Pharmacist and/ medicine management technician or other health professional to; offer and provide written medication information at an appropriate time in the inpatient admission (when patients are clinically able to receive this) Pharmacist, pharmacy technician or other healthcare professional to complete discharge counselling week leading up to and/ or if practical at point of discharge as appropriate	Pharmacists attending carer forums Adherence Self-administration	Activity data on number of patients counselled per week. Number of patients receiving 1:1 counselling (as per RIO system)	Improved feedback from patients through questionnaires. Feedback from members of multi-disciplinary teams and from patients and carers, both directly and via patient surveys.
Medicines Information	Only urgent MI enquiries answered.	All members of the pharmacy team providing medicines information according to their individual level of expertise, regarding any aspect of drug therapy.	Offering medicines counselling sessions to patients on a 1:1 basis or group sessions as appropriate	Activity data on number of enquiries answered.	Impact of enquiry on pt. outcome Feedback from questionnaires on MI Services or email responses regarding answers provided from enquirers
Self-Administration	Encourage doctors to indicate self-administered medicines using the "Medicines Management" box on EPMA	Self-administration to specific clients only when considered necessary.	Offer self-administration to most appropriate patients early on in admission.	Number of patients undergoing self-administration Number of patients receiving 1:1 counselling and review from pharmacy staff	Number of patients progressing from stage 1 to stage 3 Feedback from patient questionnaires
Discharge Planning	Nil	Assessment for need of compliance aid Handover of pertinent information to GP chemist (e.g. methadone pt. discharged, or MCA needing to be filled or length of supply). Screening and review of all initial discharge forms prior to release to primary care.	Pharmacists to complete discharge counselling week leading up to and/ or if practical at point of discharge appropriate for patients on inpatient wards	Number of discharge prescriptions screened. Number of patients assessed for compliance aid.	Feedback from Trust and pharmacy patient questionnaire.

5.1 Prescription Review

Description

Pharmacists are experts of medicines and should use their knowledge to ensure patient receives appropriate medication and that the medication is safe, effective and cost effective.

Components

Level of Service	Key Components
1	Ensure all demographic data on the front of the drug chart is clear, documented and unambiguous. Ensure allergy box is completed and where allergy is stated, the nature of the allergy recorded. Incomplete, pharmacist will endeavour to complete. On EPMA, all inpatient charts need to have to a complete allergy status in order to allow the prescriber to add medicines. All allergies/hypersensitivities should be documented on RIO. Both systems should be crosschecked on admission, discharge and on screening an outpatient/depot/clozapine prescription. Refusal or inability to obtain the information must be documented as part of Medicines Reconciliation (MR) process. Perform a clinical screen on each newly prescribed medicine. This will also include viewing the prescription against Trust protocols, policy and guidance and against national guidance as appropriate. Inappropriate medication is discussed with the relevant member of the healthcare team and the issue resolved. Following a clinical screen, the prescription is endorsed appropriately (see Appendix 1).
2	Ensure Level 1 and 2 Medicines Reconciliation is carried out as soon as possible following patient admission. Identified discrepancies are documented and resolved with the appropriate healthcare professional. Pertinent information (e.g. whether patient uses a compliance aid) is endorsed appropriately, on the drug chart (see appendix 1). Check all newly re-written drug charts against old chart for accuracy. Any discrepancies should be resolved with the prescriber and the chart endorsed to indicate this check has been done (see Appendix 1). Any prescriptions with outstanding discrepancies should be left unverified by the pharmacist Ensure prescribed medicines correspond with those specified on form T2/T3. Any discrepancies should be resolved with the appropriate healthcare professional. *(MH)* On EPMA, a consent to treatment form should be prescribed for all those with a T2/T3 form as required by the Mental Health Act. The physical copy should be kept in the designated folder which is stored in the treatment room/nurses station. Pharmacy and ward staff are responsible for checking that forms correspond to the prescription, highlighting to medical/nursing staff where it does not, because it could equate to common assault if given without proper documentation. When an erroneous T3/T2/CTO11/CTO12/62 is found contact team Dr, then e-mail the consultant and report on Datix to allow monitoring of erroneous forms Identify patients receiving high dose antipsychotic therapy, ensure appropriate form is completed and that MDT are aware. *(MH)* On EPMA charts, endorse the chart with BNF max percentage using a patient note.
3	Act as a consultee for SOAD when required and professionally appropriate to do so. *(MH)*

Key Performance Indicators

- Activity data on number of prescriptions screened and reviewed.
- Activity data on proportion of patient receiving a stage 1 and 2 Medicines Reconciliation within 24 hours, 48 hours and 72 hours.
- Activity data on the number of SOAD consultations.

Outcomes Measures

- Number of accepted clinical interventions related to patient safety and efficacy of medication.
- Significance of interventions to patient outcome (NPSA criteria)

6.1 Monitoring of Treatment

Description

Clinical pharmacists will monitor parameters relating to the effect of the body on drug metabolism and additionally the effect of drugs on the body. The overall aim is to ensure the safe and appropriate use of medication.

Components

Level of Service	Key Components
1	Review and monitoring of high risk drugs (e.g. Clozapine, lithium, warfarin and insulin) Review of blood status via ZTAS system prior to ordering clozapine. Review of lithium plasma levels prior to ordering lithium The pharmacist will document important information pertaining to high risk monitoring as patient notes on Inpatient EPMA charts
2	The pharmacist will review available blood results where necessary throughout the patient's stay at the hospital. Where abnormalities are observed, the pharmacist will advise the medical team on the necessary dose adjustments required to ensure the drugs in question remain at therapeutic concentrations. Where new medicines are initiated that require extra monitoring, the pharmacist along with the medical team will ensure that these tests are carried out as required. See Physical Healthcare policy and individual SPC for specific monitoring requirements. The pharmacist will advise on and monitor plasma concentrations of various high risk or narrow therapeutic index drugs. Examples might include lithium, clozapine or valproate. The pharmacist will provide intermittent review of blood glucose for those patients receiving insulin or oral antihyperglycaemics.
3	The pharmacist will assist or direct side effect monitoring using recognised assessment tools, for example LUNSERs. *(MH)* The pharmacist, together with doctors, nurses and the whole MDT will ensure that the required monitoring is carried out for patients on High Dose Antipsychotics or receiving rapid tranquillisation. *(MH)*

Key Performance Indicators

- Activity data on the number on the number of patients where monitoring is carried out.

Outcome Measures

- Number of accepted clinical interventions surrounding monitoring of medicines.
- Significance of interventions to patient outcome (NPSA criteria).

7.1 Supply of Medication

Description

Supply of medication to the patient is one of the core roles of pharmacy. Access to medicines needs to be rapid, continuous but also safe.

Components

Level of Service	Key Components
1	Ward pharmacy staff will only supply medication for items requested by ward staff and in the ward communication book or via email. Following ordering the prescription is endorsed as appropriate (see 1). Technicians can only order those medicines that have been clinically screened by a pharmacist. Short term leave medicine requests and discharge TTAs will be ordered only when requested by ward staff and as per communication book or via email. Following ordering the drug chart is endorsed (Appendix 1). Pharmacists and accredited technicians will order short term leave medications short term as appropriate, if doctor is unavailable. Full ward stock top up service provided by assistant/technician. Compliance aids only dispensed when deemed absolutely essential by pharmacy. On EPMA, compliance aids should be indicated by prescribing the “Blister Pack” dummy drug.
2	Ward pharmacy staff pro-actively plan with the MDT for patients likely to be going on short term leave in the near future. TTAs are ordered and the drug chart endorsed appropriately. Inpatient items ordered proactively Ward based dispensing of TTAs (where appropriate at Newham). Interfacing with primary care regarding patient specific issues.
3	Nil

Key Performance Indicators

- TTA activity (Medical vs. Pharmacist)
- TTA activity (dispensary vs. ward).
- Number of TTAs ordered in advance of ward round.
- Average time to wait for TTAs.
- Stock list monitored and reviewed on a 6 monthly basis.

Outcome Measures

- Improved score on patient satisfaction surveys regarding time waiting for TTAs.
- Questionnaire results about access to meds from MDT.

8.1 Ward Rounds and MDT Meetings

Clinical pharmacists will attend consultant ward rounds and/or multi-disciplinary team reviews, when aspects of drug treatment are discussed and pharmaceutical contributions can be anticipated.

Components

Level of Service	Key Components
1	Nil
2	Attendance at certain parts of MDT meetings/ward rounds when considered appropriate and absolutely necessary by pharmacist.
3	Regular attendance at a specified section of ward rounds or MDT meetings, when appropriate. Medication Reviews (MH)

Key Performance Indicators

- Number of ward rounds/MDT teams attended.
- Number of patients seen at ward rounds or MDT meetings.

Outcome Measures

- Number of accepted clinical interventions related to patient safety and efficacy of medication.
- Significance of interventions to patient outcome (NPSA criteria)

9.1 Patient and Carer Counselling and Education

Whenever appropriate, pharmacy staff will counsel patients about their medication, either individually or in organised groups. Pharmacy staff are often well positioned to give patients advice on the correct use of their medication. They can assist in the assessment of patients who are most likely not to comply with their medication regime. They can also provide assistance to other healthcare professionals who identify compliance problems. If face-to-face contact is inaccessible or inappropriate - digital platforms can be used as an alternative pathway to communicate with a patient on a 1:1 basis (see appendix 3).

Components

Level of Service	Key Components
1	Pharmacy staff (Pharmacist and/ or medicine management technician) to offer and provide written Medicine information to patients and/ carers within seven days of inpatient admission.
2	Pharmacist to offer and complete one 1:1 individual medicine counselling session with the patient and/ or carer during the course of the inpatient admission. Pharmacists will conduct regular medication education sessions on wards when considered to be appropriate and required. Discharge counselling where appropriate, including ensuring the patient understands when and how to take their medication and how further supplies are to be obtained. Pharmacist to offer and complete discharge counselling with the patient, if practical at the point of discharge from the inpatient ward. If this is not feasible, to aim to complete in the week leading up to discharge.
3	Pharmacists attending carer forums and groups external to the Trust premises when appropriate. Work on adherence with patients. Pharmacists/accredited technicians are involved in the assessment of patients for self-administration, medication monitoring and counselling.

Key Performance Indicators

- Activity data on number of patients counselled per week.
- Number of patients receiving 1:1 counselling per week (as indicated per RIO system)
- Number of patients undertaking self-administration.

Outcomes Measures

- Improved feedback from patients through questionnaires.
- Feedback from members of multi-disciplinary teams and from patients and carers, both directly and via patient surveys.

10.1 Medicines Information

Description

Healthcare professionals will be provided with information on any aspect of drug therapy. Please note. This clinical standard refers to the medicines Information provided by the clinical pharmacy service.

Components

Level of Service	Key Components
1	Urgent MI enquiries only answered. More complex queries will be diverted or relayed to the ELFT Medicines Information department.
2	All members of the pharmacy team providing medicines information according to their individual level of expertise, regarding any aspect of drug therapy. Pharmacy staff will provide training for members of the MDT where appropriate
3	Offering MI reviews to patients on a 1:1 basis.

Key Performance Indicators

- Number of medicines information enquiries answered.
- Number of medicines information enquiries received by ward pharmacy staff versus medicines information dept.
- Number of medicines information queries diverted on to MI department.
- Number of training sessions undertaken.

Outcomes Measures

- Impact of enquiry on patient outcome (using NPSA grading system).
- Feedback from questionnaires by MDT on MI services.

11.1 Self Administration

Description

Self-administration allows the patient to acquire a greater level of autonomy and independence which is an important aspect of the care process. However, it is time consuming for both nursing and pharmacy staff. Consideration must be given to the maximum number of clients that can self- administer on each ward. For further and more specific details, please refer to Trust Guidelines for The Implementation of Patient Self Administration. On EPMA, pharmacists should ensure that the “patient will self-administer” option is checked in the Medicines Management section of the prescription.

Components

Level of Service	Key Components
1	Nil
2	Self administration for specific clients/patients only where considered to be absolutely necessary.
3	Pharmacy staff will offer self administration to the most appropriate clients/patients early on their admission. Number of patients undertaking self administration will not exceed that set out in the Trust Self Administration Policy.

Key Performance Indicators

- Number of patients undertaking self-administration.
- Number of patients receiving 1:1 counselling and review from pharmacy staff regarding the self-administration process.

Outcome Measures

- Number of patients progressing from initial to final stage of the programme.
- Improved feedback from patients through questionnaires.

12.1 Discharge Planning

Description

Where possible, the pharmacy team will be involved with the pharmaceutical aspects of the discharge planning process.

Components

Level of Service	Key Components
1	Nil
2	Assessment of need for a compliance aid. Handover of pertinent information to the GP, Chemist, or relevant community based team or service. Examples include interfacing with SAU, referral to anticoagulant service and contacting chemist and SAU when a substance misuse patient is admitted/discharged to ensure prescriptions are cancelled or re-instated. Other examples would include handing over to the chemist regarding compliance aids. Screening and review of all initial discharge forms prior to release to primary care.
3	Pharmacists and technicians involved in discharge counselling for selected patients.

Key Performance Indicators

- Number of discharge prescriptions screened.
- Number of patients assessed for compliance aids

Outcome Measures

1. Improved feedback from patients through Trust questionnaire.

13.1 References

1. Healthcare Commission. (2007). Talking About Medicines. The Management of Medicines in Trusts providing Mental Health Services.

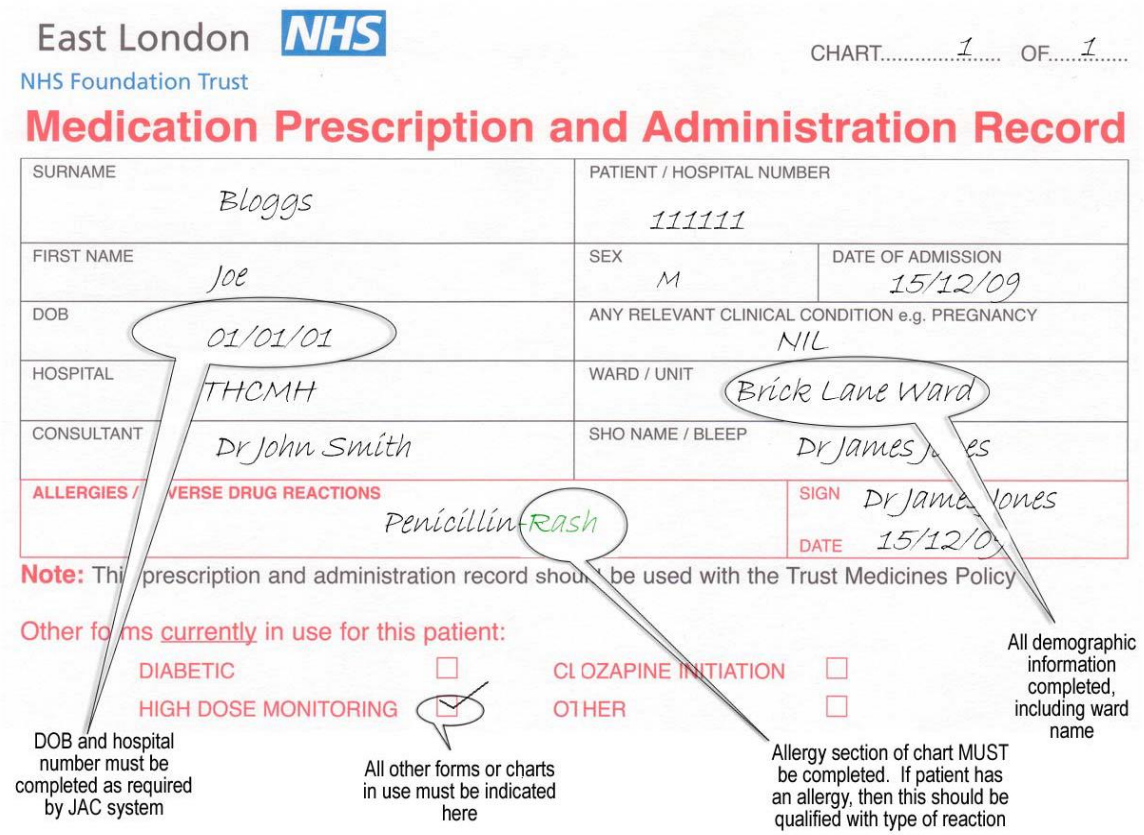
14.0 Monitoring

NHSLA Policy Monitoring								
NHSLA Standard	**Name**	**Element to be monitored**	**Lead**	**Tool**	**Frequency**	**Reporting Arrangements**	**Actions on recommendations and leads**	**Change in practice and lessons to be shared**
Clinical Pharmacy Standards								
6.10	Medicines Management	How medicines are prescribed	Chief Pharmacist	audit	annual	The Chief Pharmacist receives the audit	The Chief Pharmacist will formulate action points and timescales for each Directorate where there is evidence of non-compliance within two weeks of the audit.	The Medicines Committee will receive and discuss the report and monitor the action plan.
		How the organisation makes sure that all prescription charts are accurate						
		How the side effects of prescribed medication are monitored						
		How the organisation learns from medication errors						
		How medication is administered, including patient identification						
		Patient self-administration						
		How a patient's medicines						

NHSLA Policy Monitoring								
NHSLA Standard	**Name**	**Element to be monitored**	**Lead**	**Tool**	**Frequency**	**Reporting Arrangements**	**Actions on recommendations and leads**	**Change in practice and lessons to be shared**
		are managed on handover between care settings						
		How drugs are disposed of safely						

Appendix 1 – Endorsement Standards

On endorsing a drug chart, all instructions and annotations must be appropriate and clear. Wherever possible, communication should be direct with the prescriber. Endorsements should not be used as a means of communicating with the medical staff.



1. All endorsements are made in **green** ink to distinguish pharmaceutical input from the prescribing process.

2. Missing or incorrect patient name, consultant name, cost code, SHO / HO bleep numbers, ward name and date on prescription chart must be corrected/ clarified.

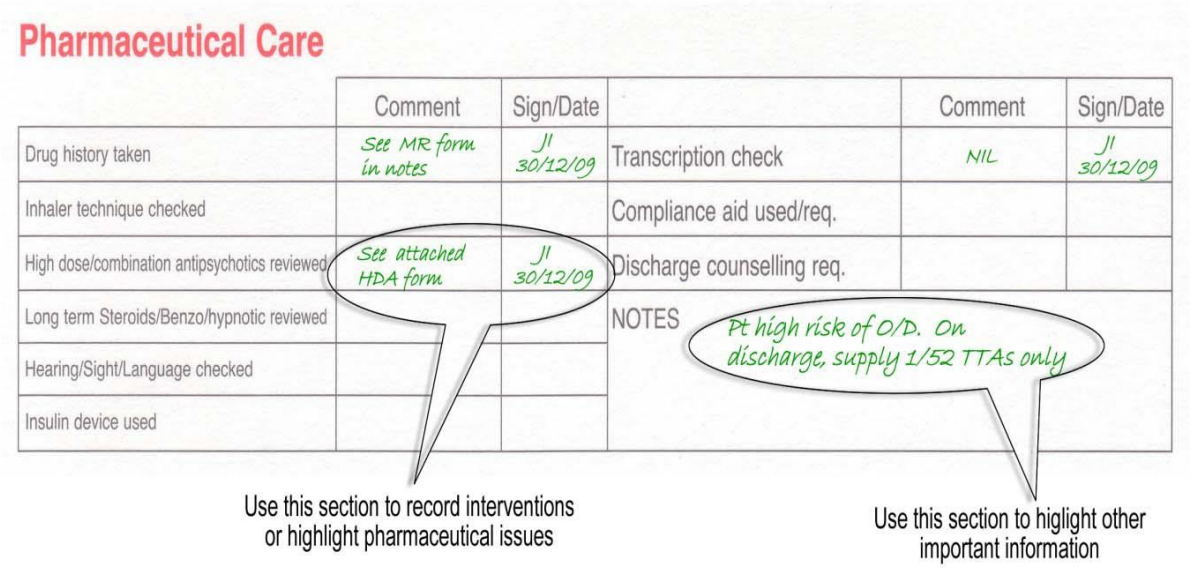
3. The use of other types of chart must be recorded on the main prescription sheet, using the relevant tick boxes.

4. The Adverse Drug Reaction section must be completed to indicate the presence of any known or suspected adverse drug reactions, particularly allergies that may influence the decision to prescribe. Allergies must be checked in the notes and with the patient/carer and one of the following options should be documented and signed and dated by the healthcare professional;
    - none known
    - yes-in which case add the drug name and nature of the reaction
    - not possible to ascertain-requires follow up

5. All items must be screened and appropriately endorsed when a chart is reviewed and not only individual items. At weekends you must provide a clinical safety check* on all items and use your clinical judgment to decide whether a drug history needs confirming on that day or can wait until the next working day. If a drug history is not checked, then the chart should be annotated to indicate this with guidance to follow this up.

* A clinical safety check is confirming that a preparation and dose are clinically suitable for that patient / within BNF dosing guidelines

6. All endorsements are carried over from old to new charts, including allergy status, drug history confirmation, stock, non-stock and supply annotations and the new chart signed and dated where indicated to confirm a re-written check has been completed by the pharmacist.



7. For Medicines Reconciliation:
   - Sign, date, initial when a drug history is taken in the pharmaceutical care section of the drug chart.
   - Medicines Reconciliation must be recorded in the electronic progress notes, clearly indicting the entry is a Medicine Reconciliation (See East London NHS Foundation Trust Medicines Reconciliation Policy)

8. All drugs must be clearly endorsed with their generic names unless brand name prescribing is considered appropriate.

9. Any chemical symbols used e.g. $FESO_4$ should be endorsed with full generic name.

10. All abbreviated drug names, e.g. ISMN, should be endorsed with full generic name. However, GTN is acceptable.

11. Modified-release or enteric-coated formulations should be endorsed with *m/r*, *e/c, LA* etc.

12. Liquid form of preparations must be endorsed to specify the form being used. Endorse with strength only where there is a specific need e.g. to ensure alcohol free preparation is supplied or if a specific flavour or volume is supplied to aid compliance.

13. Combination preparations containing paracetamol are endorsed with *contains paracetamol.*

14. Endorse any antibiotics containing penicillin e.g. Co-amoxiclav as *contains Penicillin*.

15. Avoid numbers that prefix some drug names, e.g. 6-mercaptopurine.

16. The choice of formulation and flavour, where applicable, must always be stated for children.

17. For insulins you must always endorse the type (human / pork), strength, size and device (e.g. disposable) being used (e.g. Human Mixtard 30/70 Penfill 3ml).

Dose section

18. Doses that are less than 1mg or are prescribed using abbreviations e.g. mcg, ug or ng are endorsed in full as *micrograms* or *nanograms* as appropriate.

19. Doses in units are written as *units*, not u or iu.

20. Doses for liquid formulations that are prescribed as ml are converted to the dose in milligrams, micrograms or nanograms, as appropriate.

21. On the regular side, drugs not to be administered daily (e.g. methotrexate) must have the relevant boxes crossed out, and clarify the actual days of administration where appropriate.

22. Ensure dose times and dose intervals are appropriate.

23. Dose changes agreed with prescribers are endorsed as *confirmed with Dr* and include the name or title and bleep number, and are dated and initialled.

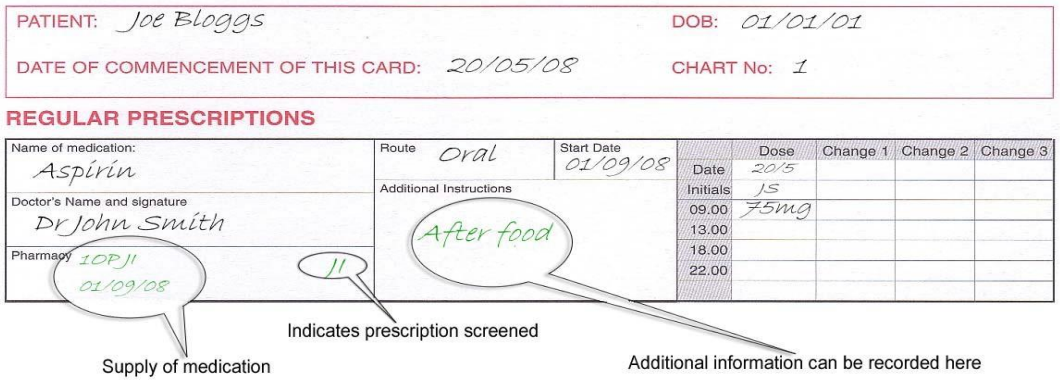
24. Dose changes made by prescribers must be counter-initialled by the pharmacist in the dose changes section to indicate a clinical check.

25. As required drugs are endorsed with their maximum frequency and/or instructions for use.

26. Clarify how a drug is administered if not apparent from prescription. For example *crush tablet*, *empty the contents of a capsule* etc.

27. Bioavailability or formulation differences are clarified; for example, *phenytoin tablets 300mg equivalent to 45ml phenytoin suspension.*

Pharmacy section



28. All drugs are endorsed with:

For stock items

- the pharmacist's initials and *S* to indicate the item is stock

For non-stock items

- the pharmacist's initials and date

- quantity dispensed
- strength if not obvious
- *TTA* for all TTA-labelled items [28-day supply]
- *CD* for controlled drugs
- *POD* where patient's own medication is being used (see 33)

29. For supplies made:
    - clarify if the item is a *special* or *manufactured item, CIVAS, non-Formulary*
    - if a medicine is ordered as a special, then indicate the expected date of arrival
    - clarify any expiry dates where appropriate

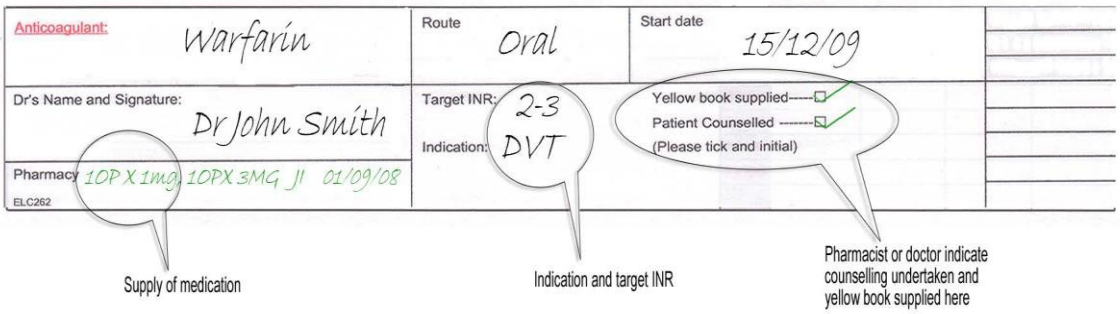
30. Prescription charts for patients who are using their own medicines are endorsed in accordance with the Patient's Own Drugs Procedure and will be endorsed as:
    - *Use Patient's Own* in the 'other instructions box' indicating to ward staff what to use.
    - Initial, date and quantity

31. If a patient is using a dosette box, please state whether the Trust or the Community Pharmacy fills this. Endorse the front of the chart with the Community Pharmacy name and contact number on the front of the drug chart (under additional information). See Trust guidelines for the Use of Medicine Compliance Aids.

32. Medicines stored in the refrigerator are endorsed with *fridge item*.

33. Use of topical medicines should be clarified wherever necessary e.g., which eye is being treated with eye drops, where to apply dressing, creams.

34. For warfarin patients, complete the target INR, indication and tick the appropriate box when the yellow book is supplied and when the patient is counselled.



35. For patients prescribed tinzaparin, check weight and endorse the chart with the dose in mls and units.

36. As required drugs are endorsed with their maximum frequency and/or instructions/reasons for use and the quantity supplied is specified.

37. Appropriate instructions should be added to the prescription in accordance with BNF guidelines, particularly those relating to the administration of medicines.

38. Restricted antimicrobials which have been approved by Microbiology or are part of a protocol are endorsed appropriately with *approved by microbiology*

39. For antibiotic therapy endorse as follows:

- *for____days* for acute therapy
- *started on dd/mm/yy* for courses longer than the duration of the chart
- *prophylaxis* added to relevant prescriptions

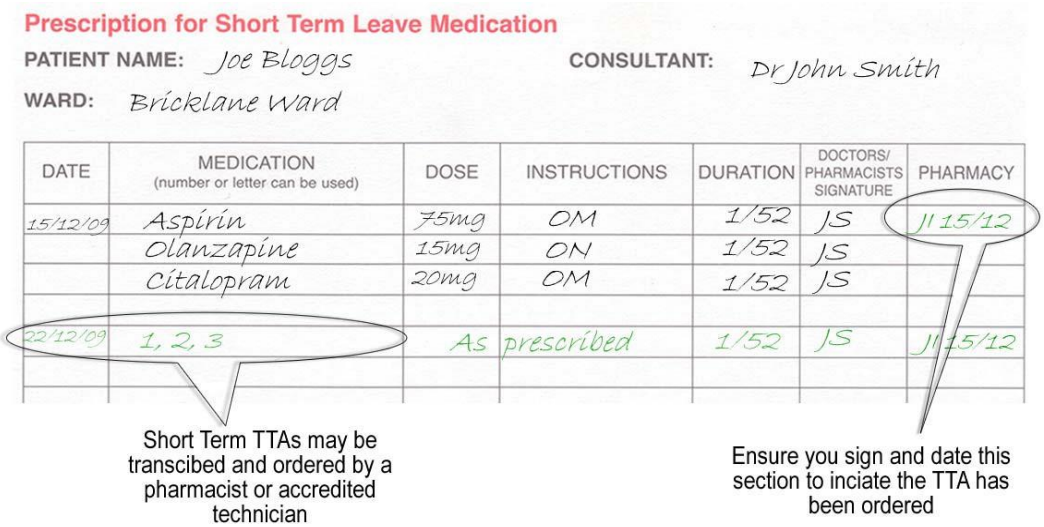
Pharmacy Stickers

40. An orange 'allergy' sticker should be attached to the front of the chart to further highlight that a patient has an allergy to medication.

41. A green 'diabetic' sticker should be attached to the front of the main drug chart to highlight that the patient is diabetic.

42. A yellow 'high risk drug' sticker should be added to the 'additional information section' for each of the following high-risk drugs: **Insulin, methadone, warfarin, lithium and clozapine**

TTA prescriptions



43. Charts for patients who have consented to self-administration are endorsed with self-administering on the front of the drug chart or for individual items as appropriate.

44. The pharmacy box in the short term leave medication section of the drug chart is signed and dated when a TTA is ordered.

45. Something about discharge TTA and also whether to supply up to one month or only as specified.

Clinical standards for EPMA

Consent to Treatment:

A consent to treatment form should be prescribed for all those with a T2/T3 form as required by the Mental Health Act. The physical copy should be kept in the designated folder which is stored in the treatment room/nurses station. Pharmacy and ward staff are responsible for checking that forms

correspond to the prescription, highlighting to medical/nursing staff where it does not, because it could equate to common assault if given without proper documentation. When an erroneous T3/T2/CTO11/CTO12/62 is found contact team Dr, then e-mail the consultant and report on Datix to allow monitoring of erroneous forms

Allergies:
All allergies/hypersensitivities should be documented on RIO and JAC. Both systems should be cross checked on admission, discharge and on screening an outpatient/depot/clozapine prescription. Refusal or inability to obtain the information must be documented & done as part of Medicines Reconciliation (MR) process.

RXDISPU/Unverified Order Reports:
RXDISPU and UOR for all wards should be checked regularly throughout the morning to ensure all new orders are screened and supplied (where appropriate) before the cut off at Mile End dispensary at 2.30pm.

PRN Medications:
PRN hypnotics/rapid tranquilisation should be reviewed weekly and reasons for continued prescribing, if not used in 7 days, documented in Rio.

Medicines Management:
Ensure “Self-Administer” (forensics), “Own Medication”, and “Admitted on drug” boxes, are ticked on JAC on admission for the appropriate medicines so that the correct information goes on prescriptions.

Additional Order notes:
JAC notes should be added for:

- Anti-Infective Prescribing: Indication, duration of therapy, what to do if the infection gets worse (including signs and symptoms) and if the patient has been counselled about the infection and antimicrobial treatment.
- Administration Instructions: If medication is being given in an unlicensed manner – i.e.: covert administration, NG or crushing medicines.
- Clozapine monitoring: ZTAS pin, blood test frequency, next FBC due date and clozapine assay level if available – (Pharmacy intervention note)
- Community pharmacy MUR referral
- Depot Administration: Last administration date and site with (Pharmacy Intervention note)
- High Dose Antipsychotic Therapy: Drugs and percentage of BNF max.
- Lithium: Last lithium level, if patient has a lithium booklet, care plan activated and U&Es/TFTs/calcium are in range
- Mental Health Act: Type of consent to treatment form and date written
- Pharmacy Note: Details of patient’s community pharmacy if they receive blister packs.
- Self-Administration: Level of self-administration patient is currently on and name, quantity of medicines in possession

Ward folders:
Pharmacists to ensure all patient consent to treatment forms/monitoring forms/BM/lithium/warfarin books kept in patient folders in treatment room

Appendix 2 -Guidelines on writing in the patients' paper or electronic medical record

These guidelines are to:

- Ensure the quality and uniformity of the information documented by pharmacy staff in the patient's electronic record.
- Give guidance to pharmacists and pharmacy technicians on what to document when providing pharmaceutical input to patients care.

Pharmacists and pharmacy technicians should follow these guidelines and work within the General Pharmaceutical Council's standards of Conduct, Ethics and Performance here.

Notes validation by a pharmacist is required for:

- Student pharmacists
- Pre-registration pharmacists
- Student technicians
- Assistant technical officers

Guidance

- Documentation should be accurate and communicate the meaning clearly.
- State facts and list as main points
    - Do not mistake assumptions as fact - If you did not see it, hear it or do it, you do not know it.
- Do not include unnecessary abbreviations, jargon, meaningless phrases or irrelevant speculation. Be careful not to write as a stream of consciousness
- Use professional judgment to identify what is relevant.
- Document immediately after intervention.
- Document any refusal of discussion/written information.
- Must be legible.
- Date and time of intervention must be specified
- Title of entry must reflect intervention – e.g. RCODE PHARM02: Pharmacist/pharmacy technician offered patient one-to-one discussion,

Type of information	Examples
	(these lists are not exhaustive)
Name of person undertaking entry	Pharmacist Medicines management technician
Title - Type of discussion	RCODE MEDFO01: Patient provided with written information about medications RCODE PHARM01: Pharmacist/pharmacy technician has had one-to-one discussion with patient Group session RCODE MEDRC01: Medicines reconciliation Interview RCODE PHARM03: Discharge medicines counselling offered, and received Telephone discussion
Those present in discussion	Patient Carer Interpreter Other healthcare professionals
Reason	Referral Patient Carer request Ward round request Nursing request Medical request Routine patient information provision
Length of discussion	Total intervention time (mins)
Names of medication discussed	All medicines documented that information provided on

Pharmaceutical care	Verbal orders from doctors Medicines intervention Interactions Change of treatment Advice High dose antipsychotics Smoking cessation

Content of discussion	Therapeutic uses Mechanism of action Name of medicines e.g. generic and brand Interactions Missed dose information Adverse Drug Reactions – document specific e.g. nausea, sedation, diabetes, weight gain Main counselling points e.g. lithium
Medicines related advice to patient or carer	When to contact doctor Management of adverse drug reactions Antidepressant withdrawal syndrome Adherence Healthy Living information – diet/exercise Smoking cessation Alcohol use and medicines
Rating scales undertaken and outcomes	LUNSERs GASS

Educational material and patient information leaflets given	Trust medicines PILs Drug company PILs How to Use leaflets Lithium Booklet Warfarin Booklet Insulin passport
Patient experience	Patients own thoughts Patient/ carer requests Understanding of information Views on adherence Concerns over treatment

	Experience of treatment – efficacy or ADRs Beliefs about medication
Action PLAN	Any follow-up required Plan for further information Referral to other health professionals Next appointment date and time
Print name and Signature designation and contact phone number	

Examples

RCODE PHARM01: Pharmacist/pharmacy technician has had one-to-one discussion with patient

Present: Myself, Abigail (RMN) and Joe

I met with Joe to discuss medication

Current medicines: Olanzapine 20mg nocte

We discussed therapeutic uses, length of treatment, mental illness, olanzapine adverse drug reactions (diabetes, glucose, weight gain, and sedation), healthy living advice given – diet and exercise

Joe reported feeling sleepy during the day, and finding it difficult to get up in the morning.

Written information given on Olanzapine (trust leaflet)

PLAN

Report sedation at ward round; consider reviewing dose and timing of dose.

29/08/12

Copper ward pharmacy technician entry

Patient receiving high dose antipsychotics – total combined dose 117% Olanzapine

20mg nocte

Haloperidol 5mg mane

Team doctor advised to complete inline high dose antipsychotic form on RiO.

PLAN

Ward pharmacist made aware to discuss further with team doctor

16/07/12

Pharmacist Entry

Medicines interaction: Erythromycin prescribed and patient on high dose antipsychotics, erythromycin can cause QTc prolongation and caution advised when used with other medicines that prolong the QTc.

Contacted Dr Shark and discussed via telephone

PLAN: Medication reviewed and metronidazole 400mg TDS for 5 days prescribed

Appendix 3 – Digital platforms for clinical time with patients

Digital platforms offer an alternative pathway to maintain patient contact when face-to-face contact is not a viable option.

The Trust utilises three digital platforms – Clinic.co, accuRx and Attend Anywhere. Each platform varies in features and one may be more suitable than another, depending on the setting (i.e. inpatient, community etc) it is used within. The table below summarises these features and suggests the *preferred setting*. NB the *preferred setting* is not compulsory to use.

Please refer to the Trust SOP - 'Guidance on the Use of Digital Platforms', for more detailed guidance on how to operate each platform specifically.

	Clinic.co	AccuRx	Attend Anywhere
Preferred setting	Inpatient	Community/HTT	Inpatient/Community/HTT
Requirements for patient	-Smart phone -Electronic device i.e. iPad -Computer/Laptop	-Smart phone -Electronic device i.e. iPad -Computer/Laptop	-Smart phone -Electronic device i.e. iPad -Computer/Laptop
Features	-Screen sharing -Meeting link - single click joining from phone or email -Send instant/scheduled appointment -Personalised message to send to patient – as well as attach a file; patient able to reply -Group clinics – can invite additional participants during consultation --Compulsory equipment test for patients	-Screen sharing -Meeting link -Personalised message to send to patient – as well as attach file -Can save messages as templates -Audit trail of patient progress -Test patient available -Patient list feature -Save patients into search list	-Screen sharing -Personalised messages to send to patient -Waiting room function to view patient list -Wait room accessible via link -Can access patient information leaflets -Group clinics – can invite additional participants during consultation -Test patient available -Compulsory equipment test for patients

Disadvantages	-Patient not identified via NHS number/details -Unable to save patient details	-Patient cannot reply to text message --Can only use ONE phone number/email to send meeting URL link	-Open only during working hours Mon-Fri 9am-5pm -Patient cannot reply to text message -Can only use ONE phone number/email to send meeting URL link