Process for ensuring the accuracy of prescription charts – Pharmacist Clinical Checks

Visit Frequency

The pharmacy service has 3 levels of pharmacist visit frequency offered to wards. This is determined by the ward turnover and the ward’s pharmacy related workload (e.g. drug issues, leave / discharge requests etc). Each inpatient unit / ward is classified into a level and this determines number of visits that ward / unit will regularly receive from a pharmacist. The list is available on the intranet (hyperlink). This will be regularly reviewed at the Clinical Pharmacy Service Managers meeting.

The levels offered are:

- Level 1 wards will be visited by a pharmacist a minimum of 3 times a week
- Level 2 wards will be visited by a pharmacist a minimum of weekly
- Level 3 wards will be visited by a pharmacist a minimum of once every 2 weeks

Inpatient Prescription Charts

- At their scheduled ward visit the pharmacist will check the inpatient prescription charts for the following:
  - All patient details are completed.
  - Completion and accuracy of the drug allergies / sensitivities / precautions section on the chart
  - All prescribed medication entries must comply with relevant NTW standards e.g. prescribing standards (UHM PGN 02)
  - The appropriateness of the prescribed medication regimen with due consideration of medical and psychiatric history, age and ethnicity.
  - Appropriateness and accuracy of each prescribed dose and frequency.
  - Review of ‘when required’ (PRN) prescribing.
  - Interactions with other drugs or food.
  - Compliance with any monitoring guidelines (where appropriate).
  - Endorsing of any relevant administration details e.g. before/after food.
- The presence of any medication which is covered by specific procedures or PGNs, these will be followed e.g. lithium (PPT PGN 19), hypnotics (PPT PGN 21), high dose antipsychotic (PPT PGN 10).
- Any off label or unlicensed prescribing - the relevant PGN will be followed (UHM PGN 02).
- Appropriate use of stop dates / codes.
- Adherence to NICE guidelines or other applicable guidelines.
- Compliance with the formulary.

**Dispensary Clinical Checks**

- In the trust dispensaries, pharmacist will be required to clinically check a variety of prescriptions, including outpatient and community team requests

- Clinical checks for prescribed medication will be undertaken according to the level of information available about prescribed medication. Clinical checks will follow the guidance in section 3 dependant on available information

- Where patient safety cannot be assured from the information available, further information should be sought and the prescription should not be dispensed until this concern can be satisfied

**Dealing with Concerns**

- When the clinical check on a prescription chart highlights a discrepancy or a need for clarification this will be communicated to the prescriber and/or ward staff as appropriate

- Where serious concerns or issues that will affect patient safety are identified, the prescriber must be contacted immediately to discuss these verbally. If the prescriber is not available, a covering prescriber must be contacted

- Where pharmacy staff have serious concerns about a prescription and the prescriber does not share these concerns or is unwilling to take action, this must be discussed with a Lead Clinical Pharmacist

**Documentation**

- The pharmacy box on the prescription chart must be initialled and dated on completion of the clinical check.

- Where issues have been raised that have a significant impact on patient care, these must be recorded on the patient’s RiO record.
• IR2 forms must be completed for all significant clinical interventions made by the pharmacist during this process.

**Monitoring**

This SOP will be monitored using the following mechanisms:

• Regular review of clinical pharmacist interventions
• Prescribing standards audit
• Clinical Pharmacy services Take 5 audit
• Pharmacist clinical 1:1s and KSF process
• Dispensary error reports
• IR2 reports and Safeguard records