

English Pharmacy Board 16 April 2008

PUBLIC BUSINESS

Electronic Prescription Service

Purpose

To discuss issues of the Electronic Transfer of Prescriptions and the implications on pharmacy practice.

Strategic objective domain

The public recognise and use pharmacists as the professionals with expertise in medicines

Action required

Having considered and discussed the relevant issues the EPB members are asked to give a clear steer on the direction of travel in relation to accuracy checking within EPS.

1. Background

An issue has arisen in relation to accuracy checking in EPS Release 2. This issue is being actively discussed with Connecting for Health (CfH) but it is the role of the professional body to issue guidance so that pharmacists can decide how to conduct an accuracy check in the pharmacy.

Currently, when paper prescriptions are received, in order to create the dispensing labels, pharmacy staff will either type this information manually into the pharmacy dispensing system or for items previously prescribed, select these items from the patient medication record. There is a risk of typographical error when preparing dispensing labels. The current accuracy checks in the dispensing process aim to ensure that dispensing labels accurately reflect what is on the prescription and that the product dispensed is the same as the prescribed product.

A number of pharmacy organisations have issued guidance advising pharmacists and accredited checking technicians to check the accuracy of a dispensed product against the paper prescription form to minimise the risk of introducing errors.

Guidance includes:

A. Royal Pharmaceutical Society of Great Britain

Document: Risk Minimisation with regard to Dispensing and Checking, Page 3. Published: 2007

“It is recommended that dispensing labels are produced before any product is selected from the shelf, but dispensing labels should not be used to dispense from.”

More information: <http://www.rpsgb.org.uk/pdfs/restoolriskmin.pdf>

Document: Developing and implementing standard operating procedures for dispensing, Page 10, Point 7.4. Published: 2007

“Consideration should be given within the SOP to error minimisation, for example, not dispensing from labels”

More information: <http://www.rpsgb.org.uk/pdfs/sops.pdf>

B. National Patient Safety Agency

Document: Design for patient safety: A guide to the design of the dispensing environment, Edition 1, page 46 – 47. Published: 2007

“Using dispensing labels rather than the prescription form to select medicine products for assembly may increase risk if a labeling error has been made....If an electronic prescribing system is in use there is no paper prescription form to use in the assembly stage and this may increase the risk of mis-selection”

NPSA Recommendation: “Use the prescription form to select the correct medicine products for assembly. For electronic prescription systems, use a computer screen to confirm the correct medicine product for assembly.”

More information:

<http://www.npsa.nhs.uk/patientsafety/improvingpatientsafety/design/dispensing-environment/>

On discussion with the NPSA they stated the following:

It was not our intention to give the impression that accuracy checking of electronic prescriptions could only be done via a screen. We fully accept that a token may be printed out and this used as the basis for an accuracy check. Our intention was to give pragmatic suggestions as to how accuracy checking could be done when the pharmacist decided not to print off a hard copy token. We had considerable input for this section from the Department of Health who were also keen that we were pragmatic whilst not being prescriptive. We would be happy to revisit the text in our publication for future editions if this helps clarify the situation.

We do however believe that much greater use of screen access will need to be made in the future, and as such think it is important that pharmacy business planning allows for additional screens to be placed in appropriate parts of the pharmacy. This may be in consulting rooms, and at prescription reception and medicines collection as well as in the dispensary. We would advocate clinical checking being carried out at the start of the dispensing process in conjunction with the patient, and the final accuracy check being made by talking the patient through their medication. Both of these activities may require access to the PMR.

We have tried to make it clear that the recommendations in the publications are not mandatory, but simply examples of what we consider to be safe practice. We do of course accept that there may well be other ways of implementing safe practice and are always pleased to hear of them from practitioners

C. National Pharmacy Association

Document: Accuracy in Dispensing course, Page 7

“Make sure that you check the dispensed medicine against the prescription and not against the label which may have been generated incorrectly”

Legal Position

From a legal perspective, pharmacists must dispense in accordance with a prescription but the regulations do not specify whether the accuracy check required in the dispensing process should be undertaken against a representation of the e-prescription on-screen or a representation of the prescription on paper.

There is no reference to this issue specifically in the current Code of Ethics however the first principle of the Code of Ethics is that pharmacists must make the care of patients their first concern. This includes consideration of patient safety.

Summary of relevant changes to the dispensing process in EPS release 2

In certain scenarios in EPS Release 2, there will be no paper prescription flow between the prescriber and the pharmacy, with the electronic prescription message acting as the legal prescription. Therefore there will be no paper prescription for pharmacy staff to use in undertaking the accuracy check.

Medication Item Description	Quantity	Dispense Frequency
Medication Item Description 1	Quantity 1	Dispense Frequency 1
Medication Item Description 2	Quantity 2	Dispense Frequency 2
Medication Item Description 3	Quantity 3	Dispense Frequency 3
Medication Item Description 4	Quantity 4	Dispense Frequency 4

DISPENSING TIMES - (Add to the end of a prescription, when it applies to an individual medicine)

GP A.JONES GP Code

PHARMACY NAME PHOSPHOR

POSTCODE PCT CODE

NHS 1999/0007

Pharmacy staff will be able to view the information contained within the e-prescription on the screen of the pharmacy system. They will also be able print this information on to dispensing labels and optionally print off the prescribed message on to a 'dispensing token' (pictured).

Potential for Systems or User to edit e-prescription information

Viewing on Screen (unconfirmed by CFH)

Different pharmacy systems will display the prescribed information in different ways on the pharmacy system. Systems will record both the prescribed information (from the e-prescription) and the dispensed information (as entered by the user where different from the prescribed item).

Ideally, system suppliers should make it very clear to the user when they are viewing prescribed information and when they are viewing dispensed information. This is a system design issue – if this information is not presented sufficiently clearly on screen, there is the risk of error if the screen is used to check the accuracy of dispensed prescriptions.

The Token (unconfirmed by CFH)

System suppliers have been mandated by NHS CFH to print certain information on the dispensing token (Reference 'Dispensing Token Specification'/ NPFIT-ETP-EDB-0080/Version 17th May) including:

- The patient's name, address and NHS number
- At least the first 2 lines of the GP's address plus a postcode
- Prescription identifier (that links the paper token to the e-prescription)
- Age and date of birth in specified format
- Prescribed Medication dm+d (dictionary of medicines and devices) product name (which includes drug name, strength and formulation), quantity and dosage/frequency.

Suppliers must use the full dm+d name as contained within the prescription message and are not able to use an abbreviated name.

All information printed on the token is taken from the e-prescription issued by the GP and the Patient Demographics Service. Exactly the same prescribed information from the e-prescription that appears on the screen should appear on the dispensing token.

Dispensing Labels: (unconfirmed by CFH)

Pharmacy System Edits: Where required, the System may use the dm+d "Virtual Medicinal Product Abbreviated Name" or the "Actual Medicinal Product Abbreviated Name" on printed medication labels where space restrictions prevent the use of the full dm+d concept description (ref: Point 6.4.6, Dispensing Systems Compliance Specification: NPFIT-ETP-EDB-0024, March 2007). Therefore the label may describe the product differently from the screen and printed token (for example the VMP: 'Salbutamol 100micrograms/dose / Beclometasone 50micrograms/dose inhaler' has the VMP Abbreviated Name 'Salbutamol 100microg/dose / Beclometasone 50microg/dose inh'. If this product was prescribed, the screen and dispensing token would use the VMP, the label would contain either the VMP or the VMP Abbreviated Name.)

User Editing of information: There are a number of occasions where a user may edit the information on the dispensing label so that it is different from the information contained within the e-prescription:

- **Substitute Product Name:** There is potential for there to be occasions where the label contains a different AMP to the AMP prescribed, for example products with the same MA number but different suppliers or substitute different flavours of a product such as a nutritional drink to meet the patient's preference

- Change Strength: This may be necessary to support patient care if the pharmacy is out of stock of a particular strength, for example if the 50mg product is out of stock, the pharmacist may use their professional judgement to double up on the 25mg product
- Change the quantity to be dispensed: For example this will happen with calendar packs and special containers where the regulations allow pharmacists to dispense a different quantity to that prescribed.
- Change the prescribed dosage. This is a particular problem. As the standard dosage syntax has not yet been introduced, if the prescriber uses a GP system shortcut such as '1 TDS', this may be transmitted in the e-prescription message, as it is, so must be edited for presentation on the dispensing label

Therefore dispensing labels will on occasion contain different information to the e-prescription message. There is also the additional risk that a dispensing label is not produced for a particular product, for example if the printer runs out of labels and only prints 3 of 4 items.

Impact of recommending accuracy check performed against a screen only

Increase Pressure on Workstations in Pharmacies: Having to conduct an accuracy check against a computer screen where no prescriber generated paper form is available would substantially increase pressure on work stations in pharmacies.

At present, generally, the desktop is used in **one user session** when dispensing a particular prescription, for example when the labels are being prepared, the clinical check against the patient's record can be undertaken at the same time. Accuracy checks can then be undertaken against the paper prescription without further use of the workstation.

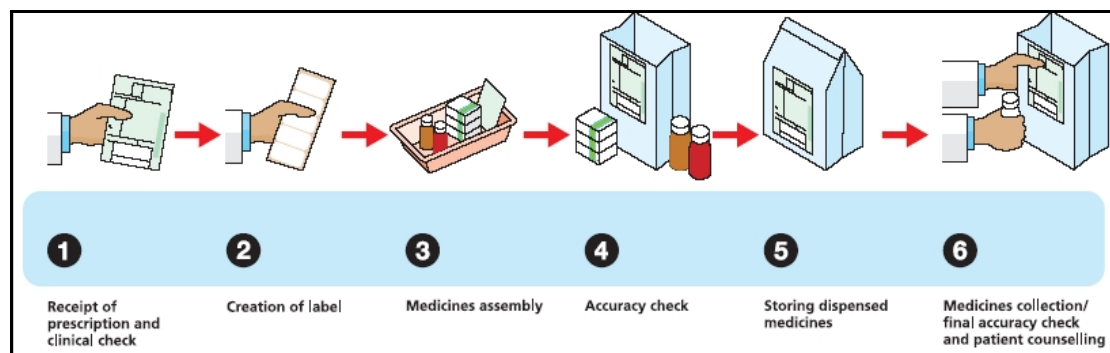


Image Ref: The Dispensing Process, Design for patient safety, NPSA

In EPS Release 2, if the accuracy check must be conducted against the work station only, there would be a need to use the computer in labelling, in carrying out the clinical check, when carrying out the accuracy check and potentially also when carrying out the final check when the product is handed to the patient. This is likely to involve up to **three user sessions** at different times on the work station.

To manage this substantial extra pressure, pharmacies may need to invest not only in additional work stations in the dispensary but also work stations in counselling areas to support the final accuracy check/handing over the medicine to patients.

Costs to Pharmacies and the NHS of Additional Work Stations: The EPS Release 1 Allowance which has been paid to pharmacies includes provision for an additional work station in recognition that will be various changes to the dispensing process in EPS R2 that will increase pressure on workstations. However, one additional work station may not be sufficient if there is a recommendation that pharmacists always conduct accuracy checks against the screen where there is no paper prescription or GP printed token. In particular there may be a need for extra workstations at patient counselling points.

Space Constraints: Some pharmacies may not have the space available for the necessary additional work stations.

Delays in Patient Care: If the additional pressure on work stations slows down the dispensing process, this may lead to delays in patient care, impacting on efficient patient access to medicines from pharmacies.

Health & Safety Considerations: The eyes focus on paper in a different way to focussing on computer screens. Evidence suggests that eye strain and other types of 'visual fatigue' can occur more quickly when reading from a monitor. Some people are more comfortable to print out information from screens for review.

Impact of recommending accuracy check performed against the token only

The NHS will only require pharmacists to print the dispensing token on certain defined occasions, not on every occasion. Therefore conducting an accuracy check against the dispensing token whenever an e-prescription was received and the patient did not present a GP printed token would also result in pharmacy staff more often printing tokens and then disposing of them as confidential waste. This would impact on both workload and costs.

Questions for consideration

1. Where there is no paper prescription form and the prescription has been received electronically, is it safe for pharmacy staff to conduct an accuracy check against;
 - The pharmacy screen?
 - And/or a pharmacy generated dispensing token?
 - And/or dispensing labels?
2. Is the guidance to pharmacy system suppliers sufficiently clear on this issue to ensure both safe dispensing and maximum efficiency in dispensing?
3. If not, should further guidance be issued:
 - As a mandatory requirement for system suppliers in the CFH EPS Compliance Specification?
 - As a recommendation from bodies such as the NPSA and RPSGB?

2. Risk Implications

If no clear guidance is provided to pharmacists in relation to accuracy checking within an EPS then there is a greater risk of errors.

3. Resource Implications

The only resource implications will be related to the production of guidance

Action required

Having considered and discussed the relevant issues the EPB members are asked to give a clear steer on the direction of travel in relation to accuracy checking within EPS

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