English Pharmacy Board 4 March 2009 **PUBLIC BUSINESS**

Electronic Prescription Service – Accuracy Checking

Purpose
To discuss issues of the Electronic Transfer of Prescriptions (EPS r2) and the implications on pharmacy practice, with specific reference to checking the accuracy of the final dispensed product.

Strategic objective domain
The public recognise and use pharmacists as the professionals with expertise in medicines, fully responsible for the safe and accurate dispensing and supply of medicines.

Action required
Having considered and discussed the relevant issues, the EPB members are asked to endorse the recommendations set out below concerning accuracy checking with EPS r2.

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. The professional body also has a role in providing advice to system suppliers relating to design of appropriate functionality to enable good practice accuracy checking.

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. This includes guidance from the RPSGB

2. 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.

3. Questions for consideration

i. 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?
- A pharmacy generated prescription or dispensing token?
- A pharmacy system generated paper docket, giving the prescription information (NB a separate pharmacy system facility with some systems, not the EPS generated prescription or dispensing token)
- Dispensing labels?

ii. Is the guidance to pharmacy system suppliers sufficiently clear on this issue to ensure both safe dispensing and maximum efficiency in dispensing?

iii. 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?

4. Feedback to date from EPB members

The general consensus is that there will be different ways in different working environments to make the electronic system safe and workable. This should be dependent on the workflow, the staffing mix and the physical placement of any hardware required.

Other comments included:

- Who will pay for any extra screens required in the pharmacy?
- What if the pharmacy does not have enough space for more screens?
- What about the Health and Safety issues of spending all day staring at a screen?

5. 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 prescription checking errors. However, it is important therefore that guidance issued should not be excessively prescriptive for either pharmacists or system suppliers, as risks may be introduced if one particular approach is mandated.

6. Resource Implications

The only resource implications will be related to the production of guidance for pharmacists and system suppliers.

Action required

Having considered and discussed the relevant issues the EPB members are asked to endorse the following recommendations concerning accuracy checking and the EPS:

- Clear guidance should be produced for system suppliers concerning appropriate functionality to support accuracy checking by pharmacists and accredited checking technicians. This may include a) provision of a prescription information screen (maybe a facsimile of the FP10 prescription form) to enable on-screen checking; b) routine printing of all prescription tokens so that they may be used for prescription accuracy checking; c) generation of a separate paper docket, with the prescription information, to be used for accuracy checking. It would be recommended that the functionality for these approaches be available as configuration options, so that the pharmacy system could be configured to the working processes of the pharmacy, to ensure optimum efficiency and safety in the dispensing process. However, all accuracy checking functions should use unedited prescription information from the Spine.

- Guidance should be produced for pharmacists concerning accuracy checking of prescriptions when using EPS r2. This guidance will advise pharmacists on approaches to accuracy checking, which might include on screen checking (if

resources are available for a second pharmacy system screen, distinct from the labelling workstation), routine checking from the prescription token, or from a paper docket of prescribing information produced separately by the pharmacy system for the purpose of accuracy checking. Accuracy checking only from dispensing labels would not be recommended, for the reasons discussed above. It is envisaged that this guidance would be part of a broader RPSGB document concerning good dispensing practice using the EPS.

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