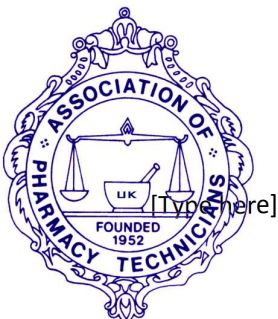
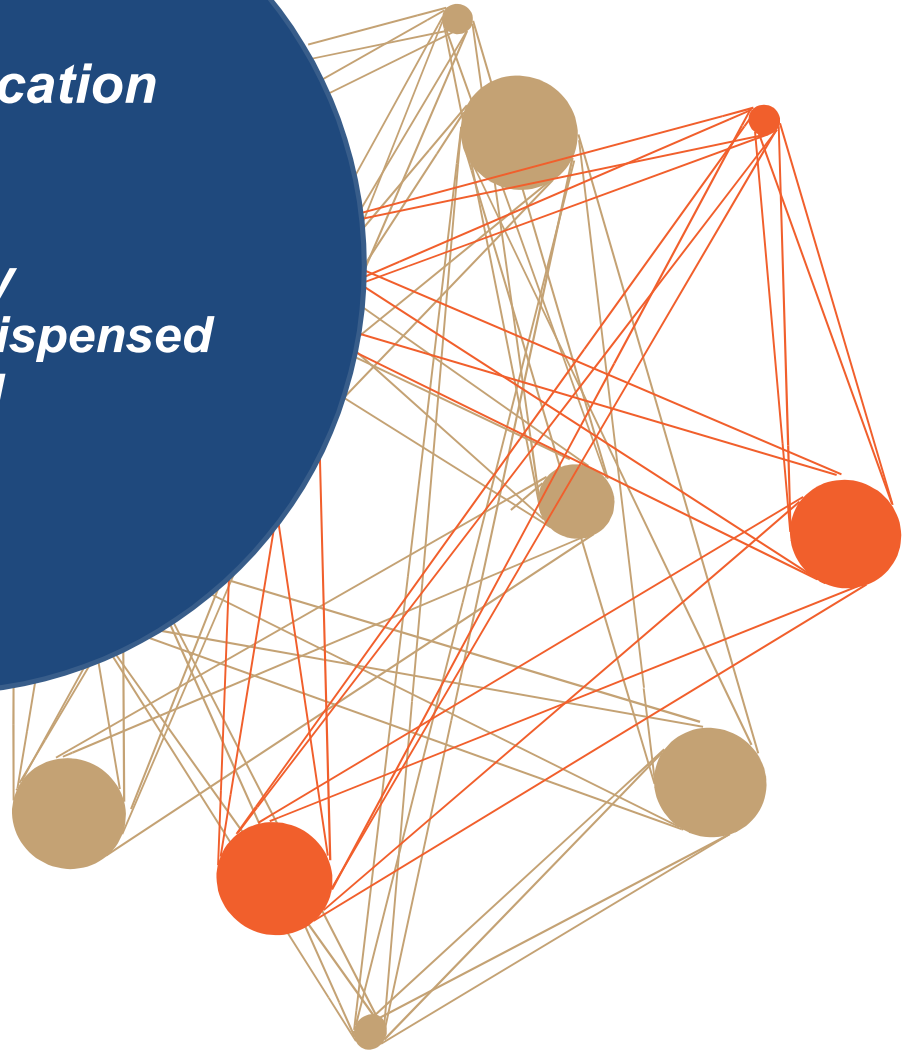


# Association of Pharmacy Technicians UK

## National Education Framework

*National Education  
Framework:*

*Final Accuracy  
Checking of Dispensed  
Medicines and  
Products*



**APTUK National Education Framework**

*The Professional Leadership Body for Pharmacy Technicians*

[www.aptuk.org](http://www.aptuk.org)



## Association of Pharmacy Technicians UK

### National Education Framework

#### Final Accuracy Checking of Dispensed Medicines and Products

##### Introduction to consultation phase:

- i. The Association of Pharmacy Technicians United Kingdom (APTUK) is the professional leadership body for pharmacy technicians across England, Northern Ireland, Scotland and Wales.
- ii. A role for healthcare professional leadership bodies is to promote best practice and to provide guidance directing and maintaining safe and competent pharmacy practice. National Education Frameworks alongside regulatory standards are an important aspect of supporting patient safety in this area.
- iii. The development of this draft National Education Framework document, for the Final Accuracy Checking of Dispensed medicines and products, has been led by the APTUK Accuracy Checking Pharmacy Technician (ACPT) steering group and APTUK ACPT National Education Framework Working Group.
- iv. The Steering group consisted of the APTUK President, Tess Fenn, the APTUK Director of Professional Development, Joanne Nevinson, APTUK National Officer for Foundation Practice, Amy Laflin, and APTUK Honorary Member, Karen Harrowing, in the capacity of an external consultant.
- v. The working group consisted of representation of pharmacy professionals from all sectors of pharmacy and home countries who are asked to provide initial feedback on the draft framework alongside the APTUK Professional Committee before these were consulted on more widely.
- vi. The APTUK Advisory Group, which included members of the pharmacy team across all sectors and all stages of their pharmacy career, education providers, home countries and lay input, were asked to provide comments and feedback.
- vii. Feedback and comments will be considered and included in a final draft document that will be consulted on nationally, by APTUK members, APTUK National Pharmacy Technician Advisory Board, the pharmacy profession and key stakeholders.
- viii. The final draft framework will be posted onto the APTUK website for 6 week open consultation.
- ix. When published the National Education Framework for Final Accuracy Checking of Dispensed medicines and products will be an online resource only and will be supported by an approval process for training providers to receive APTUK recognition that they meet the National Education Framework.

# Contents

Introduction

Section 1: National Education Framework for the Final Accuracy Checking of Dispensed medicines and products

Section 2: Standards for the training and assessment of professionals undertaking final accuracy checking of dispensed medicines and products.

- Part A - The learning outcomes that describe the skills and knowledge that the pharmacy professional must demonstrate at the end of their training and assessment process
- Part B - The requirements for final accuracy checking course providers to deliver the learning outcomes stated in Part A

# Section One: National Education Framework for the Final Accuracy Checking of Dispensed medicines and products

## 1. Introduction:

- 1.1. This National Education Framework for Final Accuracy Checking of Dispensed Medicines and Products has been developed to support the education & training of pharmacy professionals undertaking the role.
- 1.2. Pharmacy professionals are accountable for meeting the regulatory standards set by the General Pharmaceutical Council (GPhC)<sup>1</sup> in Great Britain, and by the Pharmaceutical Society of Northern Ireland (PSNI)<sup>2</sup> in Northern Ireland. In addition, pharmacy professionals must ensure that they follow good practice guidance developed by professional leadership bodies, and other bodies, in order to develop, maintain and improve services provided to patients.
- 1.3. The framework set out below is for providers of education & training programmes for pharmacy professionals undertaking Final Accuracy Checking of Dispensed medicines and products. APTUK considers that providing a national standard which all training providers can adhere to in their programme delivery will support the quality of training delivery and ensure professionalism and safety for patients.

## 2. **Good Practice Guidance for Pharmacy Professionals undertaking Accuracy Checking of Dispensed medicines and products**

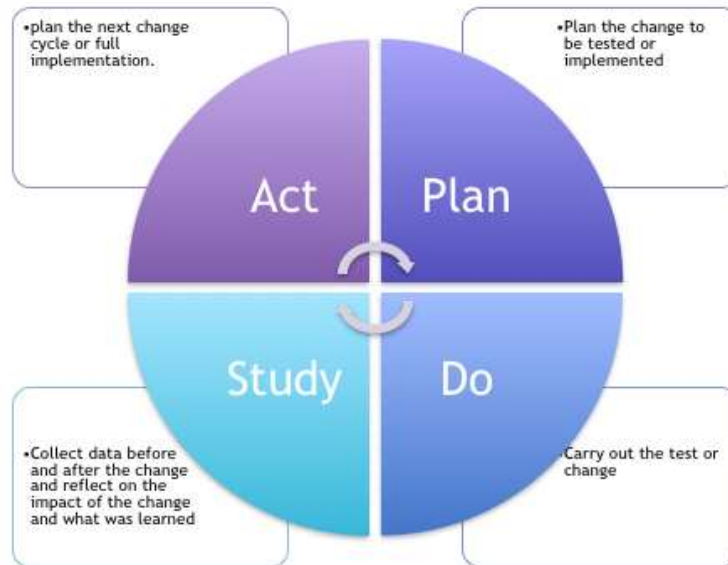
- 2.1. Pharmacy professionals are reminded that in order to be able to demonstrate that they have a defence under the Pharmacy (Preparation and Dispensing Errors – Registered Pharmacies) Order 2018<sup>3</sup> they will have to show that they were “*acting in the course of his or her profession*”.
- 2.2. It is important that pharmacy professionals also understand the context in which the framework is set including, but not limited to, continual quality improvement and risk management.

### **Continual Quality Improvement:**

- 2.3. Setting standards brings clarity to quality management systems. The quality systems resource for pharmacy (<http://www.pharmacyqs.com>) was produced by APTUK, Royal Pharmaceutical Society (RPS) and Pharmacy Forum Northern Ireland (PFNI) and provides guidance on quality systems. This includes information on the use of Plan, Do, Study, Act (PDSA) cycles in pharmacy.
- 2.4. PDSA cycles are one of the most common quality improvement tools and pharmacy professionals should be aware of how to use such tools to improve practice – see figure 1.

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Figure 1: Plan Do Study Act Cycle



2.5. There is a current priority for the professional leadership bodies to produce standards as part of the development and maintenance of a quality systems approach to pharmacy practice. This aligns with the work of the Programme Board for Rebalancing Medicines Legislation and Pharmacy Regulation<sup>4</sup>, which is facilitating a systematic approach to quality in pharmacy, whilst reviewing legislation and regulation.

2.6. The shared view of quality in healthcare systems encompasses the factors that matter most to people who use the services and those factors known to support high quality service delivery. The four dimensions in these standards for Final Accuracy Checking of Dispensed Medicines and Products align with this framework for assuring quality in healthcare systems, namely:

1. **Safe systems**
2. **Patient / customer experience**
3. **Effective outcomes**
4. **Leadership and good governance**



- 2.7. All the above dimensions are important, but safety is the area that is most expected by patients, families and the public to be delivered to a good standard so that people will not be harmed.

**Risk Management:**

- 2.8. Final Accuracy Checking of Dispensed medicines and products occurs at the end of a process that includes procuring / ordering, prescribing, clinical checking, preparation and dispensing. Pharmacy professionals must remain alert to the fact that this may be the last opportunity to intervene in the process before a patient takes, or is given, a medicine.
- 2.9. The checking systems in place must support getting the right medicine, to the right patient, at the right dose, by the right route and at the right time. Pharmacy professionals must be aware how to undertake, document and review risk assessments relevant to the organisation and environment in which they are working.
- 2.10. Where pharmacy professionals undertaking the Final Accuracy Check of Dispensed medicines and products have any doubt about which medicine is intended for the patient they must refer back to the healthcare professional who performed the clinical check, and/or contact the prescriber before the supply is made.
- 2.11. Medicines are the most commonly used healthcare intervention and regimens are becoming increasingly complex with an ageing population. There are increasing concerns about the medication safety and the need to reduce medication errors related to the provision of medicines.
- 2.12. The World Health Organization Global Patient Safety Challenge on Medication Safety<sup>7</sup> focuses on improving medication safety by strengthening the systems for reducing medication errors and avoidable medication-related harm. This framework aligns with principles set out in WHO's Medication without Harm document<sup>7</sup> by identifying good practice to address the weaknesses in the process prior to medicine supply to the end user.
- 2.13. In response to the WHO campaign the Department of Health and Social Care commissioned a review of medication errors and the Short Life Working Group<sup>8</sup> reported in February 2018. Pharmacy professionals must be aware of the important role that technology can play in reducing the risks of medication error. However, pharmacy professionals must also be aware of the risks that can occur when working in different environments that may use manual or electronic system and / or different electronic systems.
- 2.14. Pharmacy professionals should take particular care when final accuracy checking medicines that could be confused with others (i.e. they sound-alike or look-alike). There have been fatal outcomes for patients having received the wrong medicine due to confusion with medicine names or packaging.



- 2.15. It is best practice that the person undertaking the final accuracy check of the dispensed item or product has not been involved in the dispensing process. However, it is recognised that on occasion this may not be practicably possible and the professional undertaking the final accuracy check may have been involved in the dispensing process. In this instance, the pharmacy professional must take account of the additional risk involved and treat the dispensing process and the final accuracy check as two separate processes.
- 2.16. The MHRA, through the Drug Safety Update (DSU)<sup>9</sup>, produces lists showing drug-name confusion based on information received through Yellow Card reports. Pharmacy professionals must ensure that they are familiar with these medicines and report adverse drug reactions, including those arising from medication errors, on a Yellow Card or via local risk management systems that feed into the relevant national system for learning.

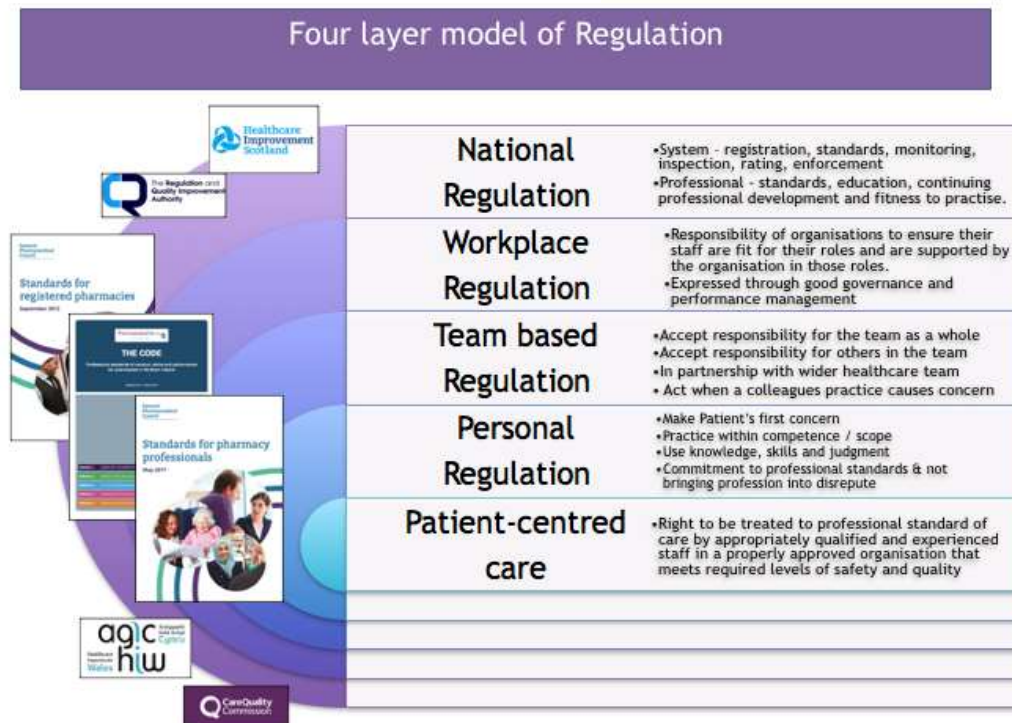
### **3. Scope of the National Education Framework for Final Accuracy Checking of Dispensed medicines and products:**

- 3.1. This National Education Framework for the Final Accuracy Checking of Dispensed medicines and products is primarily developed for training providers of Accuracy Checking programmes for pharmacy professionals, namely pharmacists and pharmacy technicians across the United Kingdom. However, other healthcare professionals could also adopt the framework, where their roles involve dispensing and final accuracy checking medicines.
- 3.2. The National Education Framework may also be of interest to the wider public, to people who use pharmacy and healthcare services, healthcare professionals working with pharmacy teams, regulators and commissioners of pharmacy services.
- 3.3. All regulated healthcare professionals are bound by personal regulation which determines the way in which professionals regulate themselves. This is based upon their commitment to a common set of ethics, values and principles, which put patients first. The first layer in the four layers of regulation is described by the General Medical Council (GMC) in 2005<sup>10</sup>.
- 3.4. The four-layer model also identifies that professionals do not work in isolation but within teams, workplaces and within national regulatory frameworks. Each of these layers is associated with a form of regulation as shown in figure 2, which also shows the patient at the centre of the four-layer model.
- 3.5. Figure 2 identifies the responsibility of organisations to ensure that those they engage are fit for the roles undertaken and are supported by the organisation in those roles. This includes maintaining a culture whereby team members feel able to act when a colleagues practice causes concern and ensuring systems of governance, assurance and improvement are effective.



3.6. This framework is designed to complement other standards and guidance from professional bodies including, but not limited to, the relevant standards for Hospital and Community premises and the Professional standards for the reporting, learning, sharing, taking action and review of incidents<sup>11</sup>.

Figure 2: Four-layer Model of Regulation:



**4. The National Education Framework: Final Accuracy Checking of Dispensed medicines and products:**

4.1. This National Education Framework has been developed using the quality framework defined for the NHS by Lord Darzi5 (Safety, Effectiveness and Patient Experience) with the additional domain of leadership and good governance. Strong, collaborative leadership and good governance have been shown to be associated with safe care<sup>12</sup>.





4.2. The four domains in the framework are all equally important and pharmacy professionals should ensure that they are focused on working in accordance with all of the domains

**1: Safe systems**

- Pharmacy professionals must undertake final accuracy checking as part of a safe system of work that protects people from avoidable harm.

**2: Patient / Customer Experience**

- Pharmacy professionals must provide person-centred care whilst final accuracy checking.

**3: Effective outcomes**

- Pharmacy professionals must develop, maintain and use their professional knowledge and skills in order to final accuracy check.

**4: Leadership and Good Governance**

- Pharmacy professionals must understand their professional responsibility and accountability when final accuracy checking

Figure 3: National Education Framework for Final Accuracy Checking of Dispensed medicines and products





## 5. Applying the Framework:

### Safe systems

**Pharmacy professionals must undertake final accuracy checking as part of a safe system of work that protects people from avoidable harm. Pharmacy professionals must ensure that:**

- 5.1. The maintenance and safe use of the facilities and equipment protects people from avoidable harm including, but not limited to, size, acoustics, cleanliness and hygiene.
- 5.2. Risk assessments are undertaken, and are updated as conditions change, to ensure that the conditions for final accuracy checking are safe (including, risk assessments of patient population/complexity, seasonal impact, skill mix, staff health, facilities/equipment and policy/process change, for example in prescribing or dispensing).
- 5.3. They are aware of particularly high risk elements of the patient pathway where medication error can occur including transfers between different providers and sectors.
- 5.4. There is the necessary information available regarding each patient and evidence of an appropriate independent clinical assessment of the prescription / direction in order to carry out a safe and effective final accuracy check.
- 5.5. They are extra vigilant when final accuracy checking high-risk medicines (for example anticoagulants and insulin) and those with commonly confused drug names to ensure that the intended medicine / dosage is supplied.
- 5.6. There are systems in place to mitigate the risks of medication errors or near-miss events and when things do go wrong incidents are investigated with a duty of candour and action taken to prevent recurrence.
- 5.7. They follow local policies and procedures and the national professional standards<sup>10</sup> for the reporting, learning, sharing, taking action and review of incidents in order that lessons are learned and changes implemented when things go wrong.
- 5.8. There are arrangements in place to respond to relevant external safety alerts, recalls, inquiries, investigations or reviews including, but not limited to, patient safety alerts and drug safety updates.
- 5.9. Concerns are raised when the system of work is not considered to be safe, or the required risk mitigation actions have not been implemented, and people are



exposed to avoidable harm. Pharmacy professionals should be aware of both internal and external systems for raising concerns / whistleblowing.

### **Patient / Customer Experience**

#### **Pharmacy professionals must provide person-centred care whilst final accuracy checking. Pharmacy professionals must:**

- 5.10. Treat people with dignity, respect and privacy including, understanding the personal, cultural, social and religious needs of people, as well as confidentiality relevant to factual accuracy checking of medicines.
- 5.11. Use effective communication skills in order to provide effective, quality education and counselling on the risks, benefits and use of medicines in a way the person/carer can understand (where final accuracy check is associated with supply).
- 5.12. Be assured that the person/carer has been involved in decisions on how to provide their medicines in a way that aids adherence.
- 5.13. Consider the impact of the way the medicines are prepared for the individuals circumstances.
- 5.14. Provide quality written information to the person about their medicines in a way the person/carer can understand.
- 5.15. Encourage and support patients and families to raise any concerns about their medication.
- 5.16. Accept that the person has the right to decide not to take a medicine, in which case the risks and benefits are explained to the person/carer and information communicated to relevant members of the multidisciplinary team.

### **Effective outcomes**

#### **Pharmacy professionals must develop, maintain and use their professional knowledge and skills in order to provide effective outcomes from the final accuracy check process. Pharmacy professionals must:**

- 5.17. Ensure that they are competent to undertake final accuracy checking based on the relevant National Occupational Standard (NOS)<sup>13</sup> or other national knowledge skills framework that may be introduced.
- 5.18. Maintain the skills for final accuracy checking relevant to the scope of practice including, maintaining knowledge of the purpose, usual dose, form, frequency, side effects and counselling points of the medicine prescribed/ordered.



## APTUK National Education Framework

- 5.19. Use up-to-date evidence-based guidance on final accuracy checking to achieve effective outcomes.
- 5.20. Undertake relevant and on-going training in safety systems, processes and practices such as training on human factor theory for example, human error and violations, individual and team performance and limitations, and organisational culture factors.
- 5.21. Ensure the intended outcomes of the final accuracy checking service are delivered within the agreed local performance measures and that these reflect the need of the person / carer.
- 5.22. Maintain involvement in activities to monitor outcomes and propose improvements relevant to any changes in the working environment.
- 5.23. Ensure feedback (positive and negative) from person / carer is sought and there is participation in relevant quality improvement initiatives, such as local and national audits, peer review and benchmarking (where available).
- 5.24. Work in pharmacy teams, and as part of the multidisciplinary teams, in order to work in partnership within and across organisations to deliver a safe, effective, person-centred factual accuracy checking service.
- 5.25. Use continuous quality improvement and learning to develop and maintain a sound understanding of the knowledge and skills required to perform the final accuracy check.

### Leadership and Good Governance

#### **Pharmacy professionals must understand their professional responsibility and accountability when final accuracy checking. Pharmacy professionals must:**

- 5.26. Take responsibility for their actions in working in accordance with these and other relevant professional standards, and leading by example in the delivery of safe, effective and person-centred factual accuracy checking service.
- 5.27. Understand the structures, processes and systems of accountability in the teams in which they work.
- 5.28. Recognise the limits of competence when performing final accuracy checking and understand when to refer to another appropriate pharmacy / healthcare professional.
- 5.29. Use professional judgement to make professional decisions in the interests of the person not in the interests of self or the organisation.
- 5.30. Ensure that the organisations in which they work implement these national standards and provide the relevant risk assessments, standard operating procedures, resources and conditions to meet the standards including:



- People – provision of the right number of competent persons to implement safe, effective and person-centred factual accuracy checking and for the operation and control of its processes
- Support - systems are in place to support an individual professional, encouraging a culture of learning and continuing development when things go wrong
- Infrastructure – provision of premises, equipment, transport, information and communication technology.
- Environment – suitable combination of human and physical factors such as, social (non-discriminatory / diversity, collaborative), psychological (supported /developed, respected, valued), physical (temperature, heat, light, hygiene, noise).

- 5.31. Speak up if the behaviour and performance of colleagues, regardless of seniority, is inconsistent with these standards.
- 5.32. Escalate concerns where actions are not being addressed to mitigate risks or where the culture does not support openness and there is a fear of retribution.
- 5.33. Ensure that they contribute to the assurance and improvement systems by taking time out to evaluate the service of final accuracy checking and providing input into future service development.



## Section Two: The National Education Framework for the training and assessment of professionals undertaking final accuracy checking of dispensed medicines and products

### Contents:

#### Introduction

The national education framework for the training and assessment of professionals undertaking final accuracy checking of dispensed medicines and products consist of two parts:

- Part A - The learning outcomes that describe the skills and knowledge that the trainee must demonstrate at the end of their training and assessment process
- Part B - The requirements for final accuracy checking course providers to deliver the learning outcomes stated in Part A

### 1. Introduction

- 1.1. The national education framework for final accuracy checking of dispensed medicines and products have been developed by APTUK for Accuracy Checking training programme providers.
- 1.2. It is intended that this framework will replace any previous frameworks for final accuracy checking and will be the national education framework going forwards.
- 1.3. Evidence framework guidelines will be available to support the design and delivery of courses to meet these standards and to provide clarity to course providers, employers and pharmacy professionals in how the learning outcomes should be met.
- 1.4. The framework aims to support NHS England's' Five Year Forward View<sup>14</sup>; the Welsh Governments' A Healthier Wales: our Plan for Health and Social Care; the Scottish Governments' Health and Social Care Delivery Plan; and Northern Ireland's' Make Life Better, in delivery of a high quality health service with particular emphasis on patient safety, clinical effectiveness and patient experience.
- 1.5. The GPhC's standards for pharmacy professionals<sup>1</sup> or PSNI<sup>2</sup> in Northern Ireland must be used in addition to this framework in course design and delivery.
- 1.6. The framework has been developed in line with the Skills for Health National Occupational Standard Pharm28 2016<sup>13</sup> which concerns undertaking the final accuracy check for prescribed items which have been dispensed after a



clinical check has been carried out. The final check is made prior to items being released for issue.

- 1.7. To ensure clarity to the different roles of pharmacy professionals in the training and assessment process the pharmacy professional undertaking the training to final accuracy check dispensed medicines and products will be referred to as trainees in this document.
- 1.8. The trainee must work within the parameters of this framework and must have no input into the dispensing process for any medicine or product involved in their practice activity.
- 1.9. Any practice activities involving a final accuracy check of a dispensed item or product must be re-checked by a pharmacy professional with appropriate experience in final accuracy checking to ensure patient safety.

## 2. Aims:

The aim of the framework is:

- 2.1. To ensure the trainee has the knowledge and competence to undertake final accuracy checking of clinically appropriate dispensed medicines and products
- 2.2. To provide a consistent approach to the quality, productivity and efficiency of final accuracy checking training and assessment programmes across the UK
- 2.3. To ensure quality assurance is embedded in the design and delivery of the training and assessment
- 2.4. To enable the practice of final accuracy checking of dispensed medicines and products to be transferable across all sectors of pharmacy

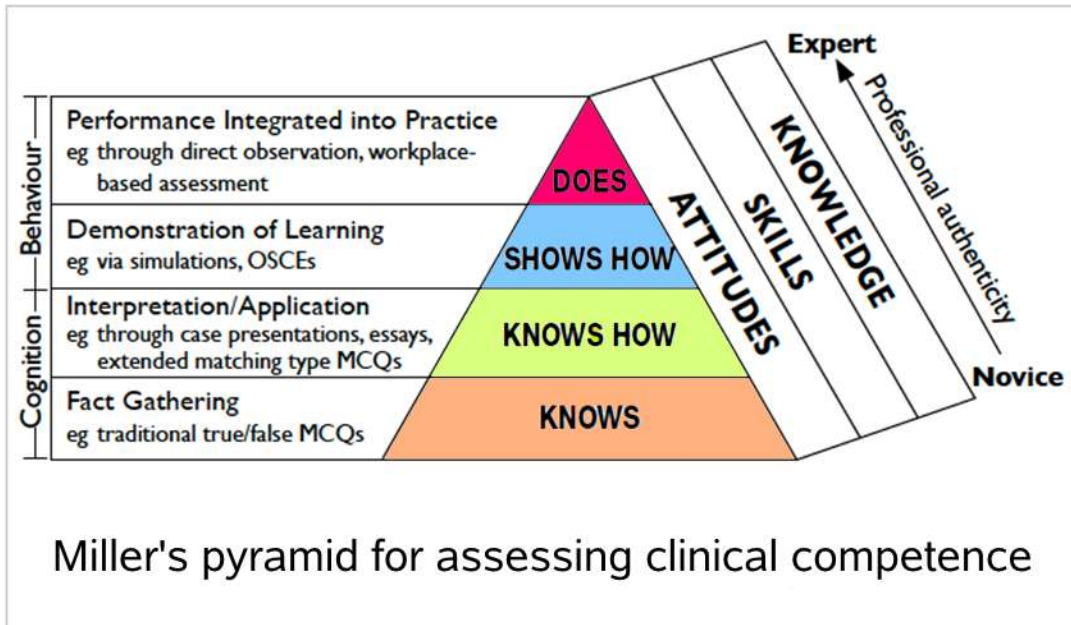
## Part A - Learning Outcomes

On successful completion of the training and assessment for final accuracy checking of dispensed medicines and products, the trainee will have achieved the learning outcomes in the framework.

In alignment with the GPhC Initial Education and Training Standards the learning outcomes in these standards are based on levels of established competence and assessment using the “Miller’s Triangle”.



Figure 1:



**Areas of study**

The learning outcomes fall under four areas of equal importance:

1. Safe systems
2. Person-centred Care
3. Effective Outcomes
4. Leadership and Governance

**1. Safe Systems**

<b>The final accuracy checking trainee will:</b>	
Work within legislation and national, regional and local policies, standard operating procedures and guidelines relating to final accuracy checking of dispensed medicines and products	Shows How
Apply risk assessment skills to ensure a safe dispensing and final accuracy checking environment	Does
Confirm the clinical appropriateness of the prescription / direction is in place	Does
Use information relating to the patient for the final accuracy check as necessary	Does
Identify, rectify and report near misses and dispensing / checking errors	Does



Understands the causes and consequences of dispensing errors and high risks in the dispensing process	Knows
Understand local and national error reporting procedures and communication channels	Knows

## 2. Person-centred Care

<b>The final accuracy checking trainee will:</b>	
Optimise effective communication to identify any person specific needs, views and preferences	Does
Provide the medicine or product to the patient in a form that optimises the effective use of medicines	Does
Give the person all of the relevant information in a way they can understand to support effective use of medicines	Does
Understand their professional responsibility for gaining consent, maintaining confidentiality and informing patients of any errors made (Duty of Candour)	Knows How
Use effective communication skills to provide feedback and support to staff when they make a dispensing error	Does

## 3. Effective Outcomes

<b>The final accuracy checking trainee will:</b>	
Understand the legal requirements for dispensing and final accuracy checking of medicines	Knows How
Understand the responsibility and accountability of the final accuracy checker	Knows How
Obtain relevant information from patient records and other sources of information understanding standard abbreviations and medical terminology	Does
Follow procedures relating to different types of medicines supply, roles and limits of prescribers and the validity of prescriptions and directions	Does
Have an understanding of the medicine or product being final accuracy checked in terms of proprietary and generic name,	Does



strength, form, usual dose, method of administration, action and use, potential drug interactions, contra-indications and counselling points	
Perform calculations to final accuracy check prescriptions in terms of dose requirements, supply quantity and administration rates as necessary	Does
Ensure appropriate requirements for labelling, packaging, storage conditions, expiry dates, supplementary information and ancillary equipment have been met	Does
Ensure the medicine or product being final accuracy checked is fit for purpose in relation to the condition of the product and in line with the falsified medicine directive	Does
Make appropriate records and endorsements to patient records, prescriptions or directions	Does
Communicate information relating to errors effectively to the appropriate person	Does
Acts within the limits of their authority and refers to an appropriate person as necessary	Does

#### 4. Leadership and Governance

<b>The final accuracy checking trainee will:</b>	
Be accountable and responsible to work within the limits of their competence and authority and to seek agreement or permission from others or refer on to an appropriate person as necessary	Does
Promote an open and transparent culture in relation to legal, organisational and policy requirements relevant to their role, the role of others in their organisation and the activities being carried out	Knows How
Adhere to information governance policies and maintain confidentiality	Does
Adhere to the following professional practice standards: <ul style="list-style-type: none"> <li>• GPhC professional practice standards for pharmacy professionals<sup>1</sup></li> <li>• Professional standards for the reporting, learning, sharing, taking action and review of incidents<sup>11</sup></li> </ul>	Knows How



Use professional judgment appropriately to make effective decisions	Shows How
Demonstrate quality improvement in supporting others to learn	Does

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## Part B – Requirements for Final Accuracy Checking of Dispensed Medicines and Products Course Providers

- Requirement 1: Application and entry criteria
- Requirement 2: Equality, diversity and inclusion
- Requirement 3: Management plan and learning agreement
- Requirement 4: Monitoring and evaluation
- Requirement 5: Course design and delivery
- Requirement 6: Assessment strategy
- Requirement 7: Trainee support

### Requirement 1: Application and Entry Criteria

#### Approved education providers of final accuracy checking of dispensed medicines and products courses must:

- 1.1 Ensure the applicant is a registered pharmacy professional with the General Pharmaceutical Council (or a qualified pharmacy technician in Northern Ireland) or is working towards a GPhC approved pre-registration trainee programme.
- 1.2 Ensure the applicant has relevant pharmacy work-based experience completed in the UK under the supervision, direction or guidance of a pharmacy professional to whom they have been directly accountable.
- 1.3 Ensure the applicant has documented evidence to demonstrate they can dispense accurately over the full range of specialty and prescription types at their practice base by means of a 200 item accuracy log.
- 1.4 Ensure the applicant has a knowledge of local standard operating procedures relating to the dispensing process.
- 1.5 Confirm that the applicant has authority and support from their employer to undertake final accuracy checking of dispensed items and products training.
- 1.6 Confirm that the necessary governance structures are in place in the applicants' place of employment, to enable trainees to be adequately supported throughout the course. It is vital that there are safe processes in place and the trainee has access to current Standard Operating Procedures (SOPs) that detail the legal and professional dispensing requirements.

### Requirement 2: Equality, diversity and inclusion

#### Approved education providers of final accuracy checking of dispensed medicines and products courses must:



- 2.1 Embed equality and diversity into the course design.
- 2.2 Make reasonable adjustments to teaching, learning and assessments, when necessary, to help trainees who require specific needs without altering the learning outcomes.

### **Requirement 3: Management plan and learning agreement**

#### **Approved education providers of final accuracy checking of dispensed medicines and products training programmes must:**

- 3.1 Have a structured and transparent management plan that includes:
  - Clarity of the roles, responsibility and accountability of all those involved in all aspects of the course delivery
  - Systems that will be used to manage delivery
  - Systems that will be used to identify and manage any risks
  - A quality assurance system for the implementation of learning agreements
- 3.2 Deliver a learning agreement for the trainee that covers all aspects of the learning environment and includes:
  - The support available for the trainee
  - The allocation of a workplace supervisor who monitors the trainees' progress
- 3.3 Ensure pharmacy professionals involved in the design and delivery of the course have adequate current experience in final accuracy checking of dispensed medicines or products.
- 3.4 Ensure the learning and training environment will have:
  - Sufficient appropriately trained and experienced staff to deliver the course
  - Sufficient resources and facilities to deliver the course

### **Requirement 4: Monitoring and evaluation**

#### **Approved education providers of final accuracy checking of dispensed medicines and products training programmes must:**

- 4.1 Monitor and maintain the quality, consistency and integrity of the delivery and assessment and must include:
  - A system for evaluating the standard of teaching materials, learning and assessment
  - Confirm who is responsible for reporting, reviewing and taking action when appropriate
  - A system for raising concerns so they are resolved in a timely manner and documented
  - The trainee as part of the monitoring, review and evaluation process



## Requirement 5: Course design and delivery

### Approved education providers of final accuracy checking of dispensed medicines and products training programmes must:

- 5.1 Design and deliver courses using coherent teaching and learning strategies which bring together knowledge, competence and final accuracy checking practice activities.
- 5.2 Use the GPhC's standards for pharmacy professionals<sup>1</sup> in the design and delivery of courses.
- 5.3 Have a course teaching and learning strategy which sets out how trainees will achieve the outcomes in part A of the standards.
- 5.4 Design and deliver courses that develop the skills, knowledge, understanding and professional behaviours required to meet the learning outcomes in part A of the standards.
- 5.5 Take into account the views of a range of stakeholders – including trainees, patients, the public and employers – when designing and delivering the course.
- 5.6 Design the course to align with the responsibility and accountability of the final accuracy checking activity.
- 5.7 Design the course to meet the standards in section two so that it can be approved by APTUK.
- 5.8 Be responsive to significant changes in practice to ensure the course remains current.
- 5.9 Supervise trainees in all aspects of the course delivery to ensure patient safety at all times.
- 5.10 Ensure the course is designed and delivered to ensure the trainee, on successful completion of the course, has a transferrable skill and is able to final accuracy check prescribed medicines and products in any pharmacy sector anywhere in the UK.
- 5.11 Inform candidates, the work based ACPT education supervisor and the senior pharmacy manager whether the candidate has achieved a pass or fail within an agreed period of the ACT assessment. Certificates must be provided to all candidates who successfully meet the assessment strategy.





## Requirement 6: Assessment Strategy

### Approved education providers of final accuracy checking of dispensed medicines and products training programmes must:

- 6.1 Ensure the assessment strategy is robust, reliable and valid and guarantees patient safety and includes:
- Assessment of all of the learning outcomes in Part A.
  - The methods that will be used to assess competence against each learning outcome.
  - A system for monitoring assessment processes
  - An independent quality assurance system of the assessment process that is carried out by an appropriately qualified person
  - How trainees will receive feedback on their performance in a timely manner
  - The process for appeal
    - There should be a system in place to allow candidates to appeal against any decision or conduct of any ACT assessment process associated with this framework.
- 6.2 Ensure assessments are carried out by appropriately trained and qualified pharmacy professionals who are competent to assess the performance of trainee final accuracy checkers.
- 6.3 Ensure the assessment strategy includes portfolio of evidence collected between the start of the programme and the final assessment, consisting of:
- A diary log of a minimum of 1000 accurately checked dispensed medicines or products ensuring:
    - A breadth of prescription and specialty types to reflect current practice at their practice base.
    - The diary log is documented using the course leads approved diary log form which are numbered, signed and issued by the work based ACPT education supervisor.
    - The diary log is completed under normal working conditions, and spans a minimum of 3 months to a maximum of 12 months.
  - Reports of dispensing/accuracy checking errors found that have occurred during the practice activity.
    - The candidate will be allowed to have a maximum of three 'less serious' errors, whilst completing the practice activity of 1000 items. No 'serious' errors are permitted (see glossary).
    - If the candidate makes more than three 'less serious' or a 'serious' error they must inform their ACPT education supervisor who must inform the course lead as soon as possible. The ACPT education supervisor will then be informed of the appropriate action to take. Normal practice is that no candidate will be allowed more than two attempts in total at completing the



- collection of 1000 accurately checked items without re-starting the programme
  - Candidates must be counselled after any checking error has occurred and a period of reflection is recommended
  - A minimum of two appraisals of the candidate by the work based ACPT education supervisor.
    - The candidate's progress must be reviewed at regular intervals by their ACPT education supervisor and on a minimum of two occasions
    - At the completion of the practice activity of 1000 items, a summative review must occur.
  - Information about the candidate
    - CV
    - Job description / role
- 6.4 Ensure the assessment strategy includes an interview designed to assess the candidate's professionalism and ability to accept responsibility as an accuracy checking pharmacy technician.
- 6.5 Include a competency-based summative assessment to assess performance and consist of:
- A simulated final accuracy checking assessment of dispensed medicines and products against test prescriptions which is intended to test the professional skills and application of knowledge.
    - The assessment must include twenty items over a range of prescriptions; with 6-8 errors, the time allowed to complete this assessment is a maximum of 60 minutes
    - Candidates must not make any errors in the accuracy checking assessment
    - Candidates will be permitted to re-sit the summative assessment twice. There may be a recommendation or a requirement to undertake relevant remedial work prior to registration for the next assessment. Candidates are permitted to re-sit individual parts of the summative assessment
    - Candidates who are not successful at the practical assessment will collate a further 100 item checking log at work base with no errors and reapply for the next available practical summative assessment
    - Candidates are allowed a total of two attempts of the practical assessment
    - If candidates are still unsuccessful they must re-take the whole framework including tutorials
  - Review of the completed portfolio to ensure it includes the requirements detailed in 6.3

### **Requirement 7: Trainee support**

#### **Approved education providers of final accuracy checking of dispensed medicines and products training programmes must:**



- 7.1. Ensure a range of systems are in place to support the trainee to achieve the learning outcomes in part A of these standards, including:
  - Induction
  - Supervision from a work-based pharmacy professional registered with the GPhC
  - An appropriate and realistic workload
  - Time to learn in the workplace
  - Access to resources in the workplace
- 7.2. Provide thorough training for the work-based supervisor so they fully understand the course components, their area of accountability and how to effectively support the trainee.
- 7.3. Ensure the employer has systems in place for the trainee to meet regularly with their work-based ACPT education supervisor to discuss their progress, to provide support, guidance and constructive feedback.
- 7.4. Ensure there are clear procedures for the trainee to raise concerns. Any concerns must be dealt with promptly, with documented action taken when appropriate.

## Glossary of terms:

Term	Meaning
Final Accuracy Checking of Dispensed medicines and products	The process of undertaking the final accuracy check for prescribed items, which have been dispensed after a clinical check, has been carried out. The final check is made prior to the items being released for issue.
Must	In the context of this framework the term 'must' is used to indicate a requirement for compliance to the standard
Should	In the context of this framework the term 'should' is used to provide an explanation of how to meet the requirement and may also indicate a recommendation
Less serious error	<p><b>Incorrect label:</b></p> <ul style="list-style-type: none"> <li>• Incorrect quantity</li> <li>• Incorrect cost code</li> <li>• Incorrect expiry date</li> <li>• Incorrect batch number</li> <li>• Incorrect spelling</li> <li>• Missing additional warnings</li> <li>• Incorrect ward / location</li> </ul> <p><b>Incorrect contents:</b></p> <ul style="list-style-type: none"> <li>• Incorrect quantity</li> </ul> <p><b>Other:</b></p> <ul style="list-style-type: none"> <li>• Incorrect container/closure</li> <li>• Missing signature</li> </ul>
Serious error	<p><b>Incorrect label:</b></p> <ul style="list-style-type: none"> <li>• Wrong drug name</li> <li>• Wrong drug form</li> <li>• Wrong drug strength</li> <li>• Incorrect patients name</li> <li>• Wrong directions</li> <li>• Missing or inappropriate use of BNF additional warnings</li> </ul> <p><b>Incorrect contents:</b></p> <ul style="list-style-type: none"> <li>• Wrong drug</li> <li>• Wrong drug form</li> <li>• Wrong drug strength</li> </ul> <p><b>Other:</b></p> <ul style="list-style-type: none"> <li>• Expired contents</li> <li>• Missing or incorrect patient information leaflet</li> </ul>



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