



# ADMINISTRATION OF MEDICINES BY A PHARMACY TECHNICIAN: GETTING IT RIGHT EVERY TIME.

Mid Cheshire Hospitals NHS Foundation Trust Julie Powell – Pharmacy Technician





# **How the Project Started**

- National Drive to look at workforce redesign
- Nurse Vacancies
- National Agenda to optimise medications
- How could we improve on the current service?





### **TRAINING**

- Ward Training
- Dispensary Training
- Medicines Management Course
- I V Training





# **CHALLENGES**

- Community based background
- Nurse perception of role
- Integration into new team
- Communication with patients





# **IMPROVING PATIENT SAFETY**

- Taking MURs to another level
- Identifying and Remedying
- Continuity of Care
- Safe
- Facilitation of medication rounds





## **TYPICAL DAILY ROUTINE**

- Receive handover from nurse in charge
- Morning medication round
- Ordering
- Lunchtime medication round
- Liaise with other Healthcare Professionals Ward doctor, Dietician
- Clean and tidy drug trolleys
- Handover to Nurses



#### **MEDICATION ADMISTRATION PROCEDURE**

- Introduction to patient Hello, my name is.......
- Check EWS and handover.
- Prescription chart.
- Prepare medication.
- Confirm patient identity Wristband.
- Check if patient Normal Diet and Fluids.
- Explain what medication is being given.
- Assist if required.
- Sign and check prescription chart.





# What is a medication error?

Medication errors are any incident where there has been an error in the process of prescribing, dispensing, preparing, administration, monitoring or providing medicines advice, regardless of whether any harm occurred or was possible.

(National Patient Safety Agency)







# What is prescribed on the following slides?

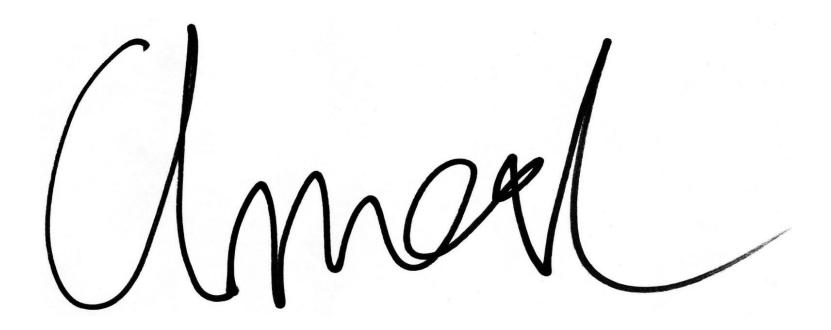
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- First item levothyroxine, dose unclear, unit not written appropriately.
- Second item salbutamol inhaler, should be prescribed generically, dose unclear/no dose unit stated.

# Not legible







- Case Law
- Prescription from a GP for Amoxil (amoxicillin) was read by a pharmacist as Daonil® (glibenclamide).
- Patient took the glibenclamide, and suffered from hypoglycaemia-related brain injury.
- The court found responsibility was shared by the prescriber, for poor handwriting, and pharmacist, for guessing rather than seeking clarification.
- Prescribers have a duty of care to make sure their prescriptions are legible.





#### Is it a clear instruction to administer?

- When a prescriber 'pre-scribes' a medication they are instructing another healthcare professional to either administer it or dispense it.
- Therefore it needs to clear.
- Are the following clear instructions to administer?

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# Is it legal?

- For a nurse or pharmacy technician to administer or a pharmacist to dispense an 'instruction to administer' requires the following:
- Signature
- Printed name of prescriber
- Date





#### **IMPROVEMENTS**

- Reduction in omitted doses.
- Helping patients to self manage.
- Interventions.
- Communication with community.
- Waste reduction/Control of ward stock.
- Security.
- Lessen workload in dispensary.
- Improve discharges.





#### PROJECT RECOGNITION

- HSJ Value in Healthcare Awards Nominated in 3 categories.
- Nursing Times- Patient Safety Awards.
- Celebration of Achievement Awards –
   Outstanding Contribution to Quality and
   Safety.



# Scope for the Future

- Other Trusts have come to visit the ward and have introduced these posts
- Acute medical and Surgical wards
- Pharmacy and nursing networks
- Nursing homes
- Community pharmacy
- Lord Carter report



# **Summary**

- Investing to get it right every time.
- The final step is the most important??
- Hugh Scope for the future.

Thank you for your time.





# Patient Feedback 'He has never taken his medicines this well.' '... Julie's knowledge of the drugs she is dispensing and her willingness to help anyone in need..' 'Thank you for the help and support with the tablets'.