National Education Framework

Final Accuracy Checking of Dispensed Medicines and Products

Association of Pharmacy Technicians UK

National Education Framework for the Final Accuracy Checking of Dispensed Medicines and Products

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Section One: National Education Framework for the Final Accuracy Checking of Dispensed Medicines and Products

Development of the framework:

The Association of Pharmacy Technicians United Kingdom (APTUK) is the professional leadership body for pharmacy technicians across England, Northern Ireland, Scotland and Wales.

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. APTUK has a key role to play in providing the tools and resources to support the profession in delivering excellence throughout our roles and services.

With final accuracy checking of dispensed medicines and products now seen as a core responsibility for pharmacy technicians and therefore included in the GPhC Initial Education and Training standards[1], there is perhaps a greater need than ever for a nationally agreed education framework. The requirement for ACPT training programmes that meet this framework will also be imperative to up-skill the legacy workforce over the next few years.

The National Education Framework for final accuracy checking of dispensed medicines and products is intended to support the safe practice of pharmacy technicians undertaking the final accuracy checking role. The development of the draft document has been led by APTUK in conjunction with APTUK honorary member, Karen Harrowing, in the voluntary capacity of external consultant. The APTUK Advisory Group, which provided professional representation from all sectors and home countries and lay input, were asked to provide initial comments and feedback. (Appendix 4 for membership)

As part of this work, APTUK has been awarded the stewardship of the current National Framework for ACPT from the former NHS Pharmacy Education & Development Committee (PEDEC)[2]. This framework has traditionally been used by providers of training and assessment programmes in ACPT to standardise the delivery of the learning objectives and assessment methodology. This standardisation has enabled providers to award a transferable qualification with an assurance that it meets the nationally agreed framework.

This APTUK framework supersedes the NHS PEDEC Framework.

Following the transfer of stewardship to APTUK, the APTUK consulted with providers of training and assessment programmes in ACPT, by means of a questionnaire, to gain their expertise as training providers to inform this piece of work. A final draft framework was produced and posted onto the APTUK website for a six week open consultation, to which 54 organisations and individuals responded.

The National Education Framework for Final Accuracy Checking of Dispensed medicines and products is an online resource only and APTUK will provide training providers with a process by which they can obtain APTUK endorsement that their programme meets this National Education Framework.

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)3 in Great Britain, and by the Pharmaceutical Society of Northern Ireland (PSNI)[4] 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.

1.4
A suggested training process is provided in section two, part B.

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

2.1
Pharmacy professionals are reminded that in the event of any involvement in an error, in order to be able to demonstrate that they have a defence under the Pharmacy (Preparation and Dispensing Errors – Registered Pharmacies) Order 2018[5] they will have to show that they were "acting in the course of his or her profession".

2.2
The National Occupation Standard Pharm 28. 2016 Undertake the final accuracy check of dispensed medicines and products[6] should be used alongside this framework to encourage good practice.

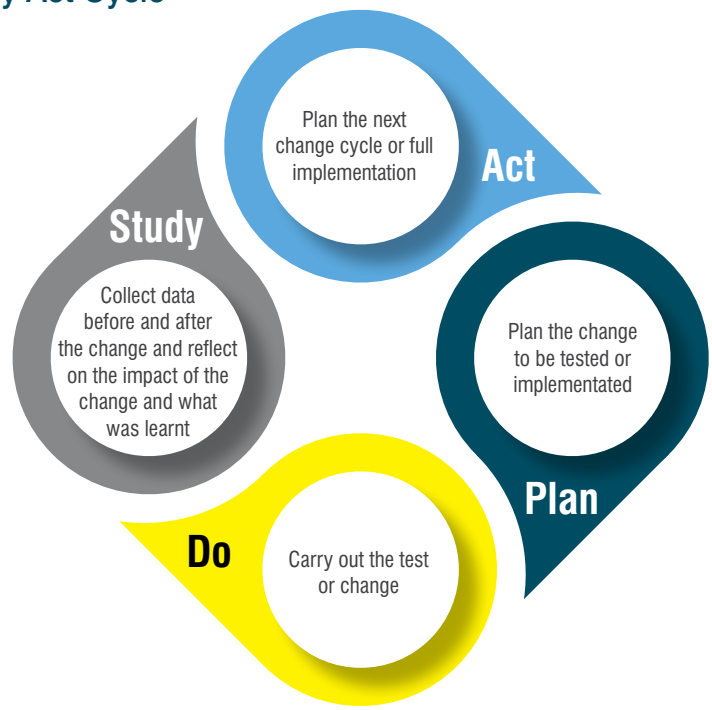
2.3
It is important that pharmacy professionals also understand the context in which the framework is set including, but not limited to, continual quality improvement and risk management.

Continual Quality Improvement:

2.4
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.

2.5
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.

Figure 1: Plan Do Study Act Cycle



2.6
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[7], which is facilitating a systematic approach to quality in pharmacy, whilst reviewing legislation and regulation.

2.7
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 domains 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

2.8
All the above domains are important, however patients carers and the public have high expectations in regards to safety and the standards they receive.

Risk Management:

2.9
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.

2.10
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.

2.11
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.

2.12
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.

2.13
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.

2.14
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.

2.15
The World Health Organization Global Patient Safety Challenge on Medication Safety[8] 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[8] by identifying good practice to address the weaknesses in the process prior to medicine supply to the end user.

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2.16
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[9] 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.

2.17
The MHRA, through the Drug Safety Update (DSU)[10], 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.

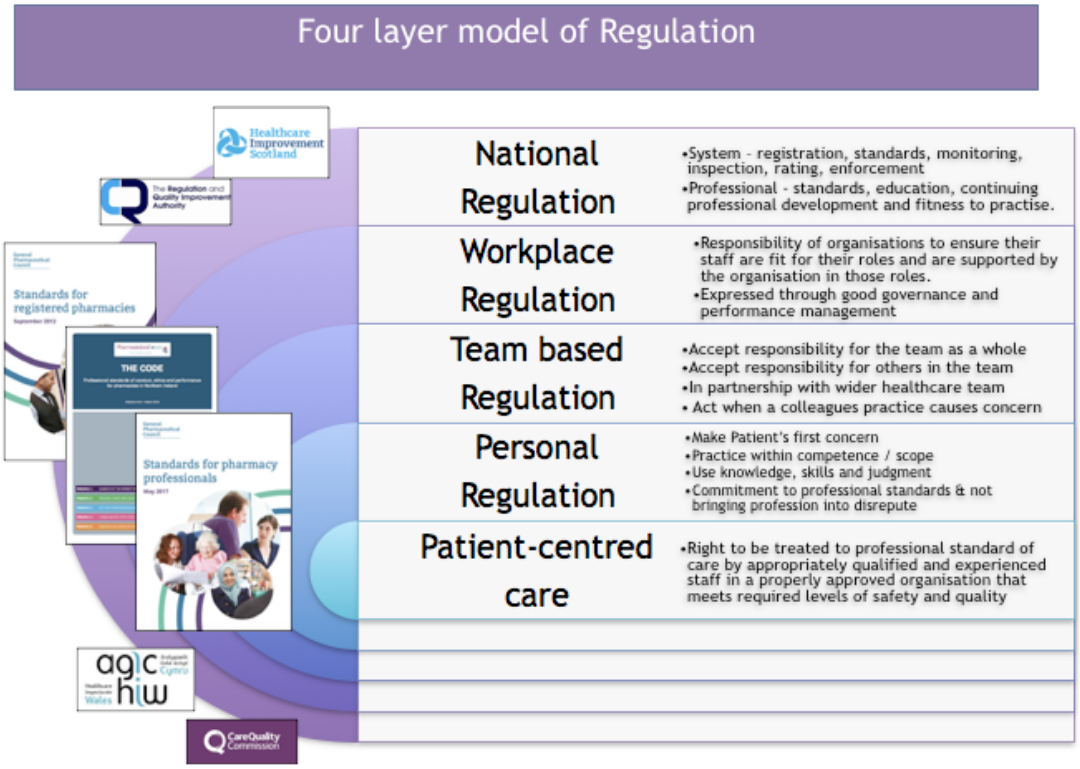
3.3
All regulated healthcare professionals are bound by personal regulation which determines the way in which professionals regulate themselves. This is based upon their commitment to a common set of ethics, values and principles, which put patients first. The first layer in the four layers of regulation is described by the General Medical Council (GMC) in 2005[11].

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[12].

Figure 2: Four-layer Model of Regulation



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4. The APTUK National Education Framework for the final accuracy check of dispensed medicines and products:

4.1
This APTUK National Education Framework has been developed using the quality framework defined for the NHS by Lord Darzi (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[13].

4.2
The principles of the quality framework will be applied to all APTUK education frameworks.

4.3
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

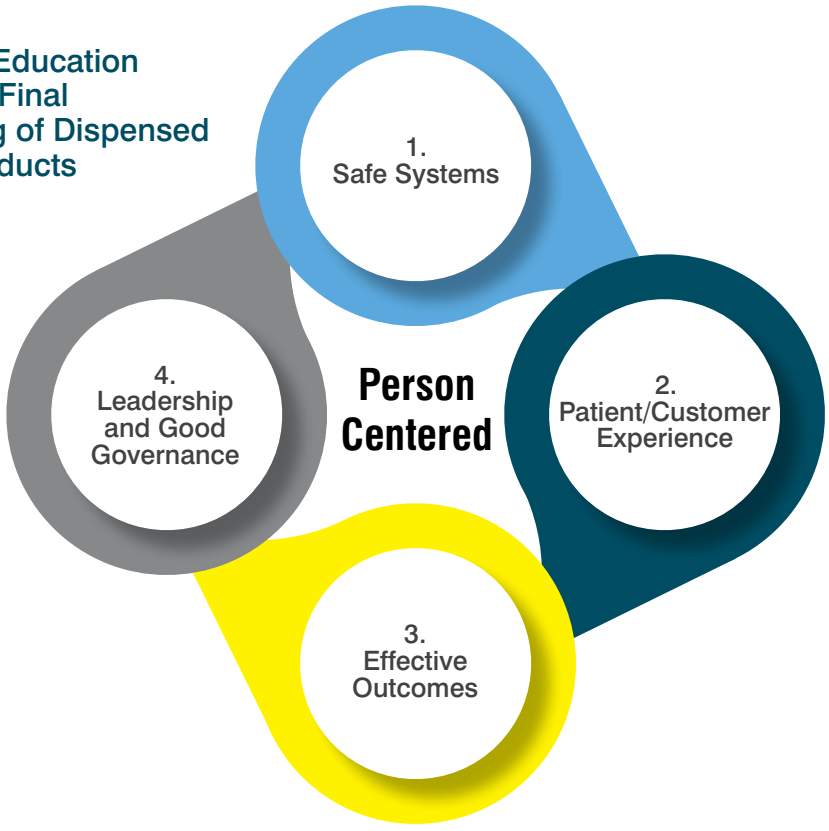
1. Safe systems
Pharmacy professionals must undertake final accuracy checking as part of a safe system of work that protects people from avoidable harm.

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 2: National Education Framework for the 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. Processes must be place to 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
Pharmacy professionals 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
Pharmacy professionals understand the risk 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 and dosage is supplied.

5.6
There are systems in place to mitigate the risks of medication errors or near-miss events and incidents are investigated with a duty of candour and action taken to prevent recurrence.

5.7
Pharmacy professionals reflect on their errors and follow local policies and procedures and the national professional standards[12] for the reporting, learning, sharing, taking action and review of incidents in order that lessons are learned and changes implemented when incidents occur.

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 / whistle-blowing.

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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 there is a process in place to involve the person/carer 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 carers 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 ensure there is a process in place to explain the risks and benefits 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)[6] or other national knowledge skills framework that may be introduced.

5.1
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.

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 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
Be aware of how the organisations in which they work implement this national framework and provide the relevant risk assessments, standard operating procedures, resources and conditions to meet the framework including:

- People – provision of the right number of competent persons to implement safe, effective and person-centred 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.
- 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

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 Long Term Plan[14]; the Welsh Governments' A Healthier Wales: our Plan for Health and Social Care[14]; the Scottish Governments' Health and Social Care Delivery Plan[16]; and Northern Irelands' Making Life Better[17], 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[3] or PSNI[4] 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[6] 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 provide trainees with knowledge of the causes and consequences of dispensing errors and of methods that can be used to prevent errors and improve patient safety

2.5
To enable the practice of final accuracy checking of dispensed medicines and products to be transferable across all sectors of pharmacy

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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.

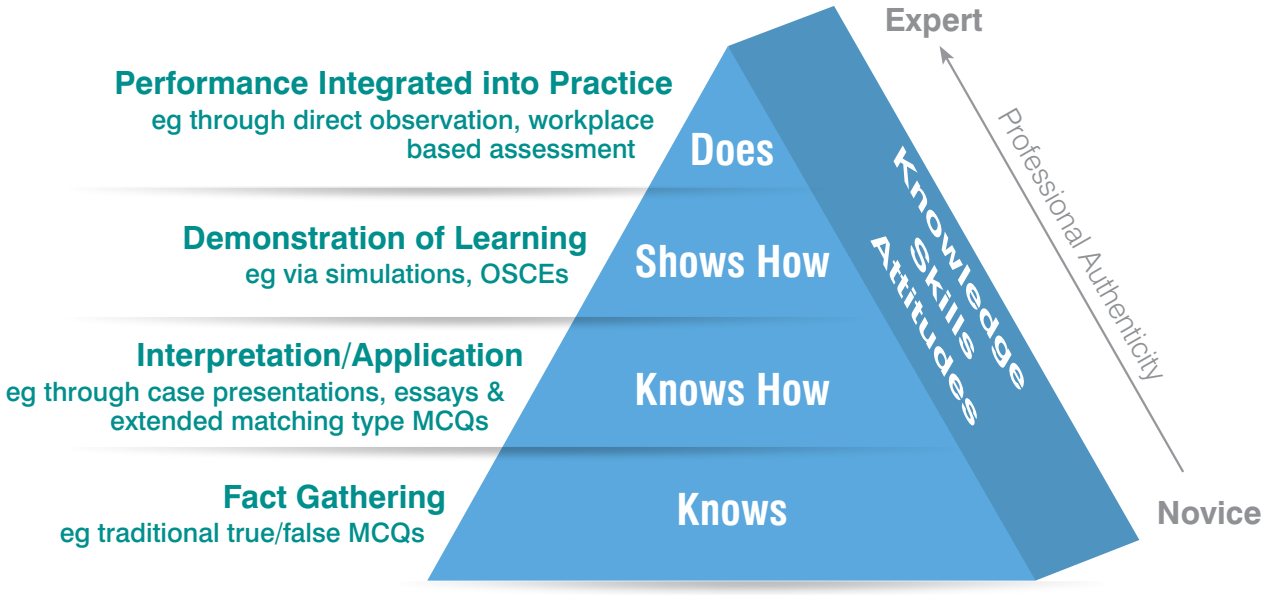
In alignment with the GPhC Initial Education and Training Standards[1] the learning outcomes in these standards are based on levels of established competence and assessment using the "Miller's Triangle".

Areas of study

The learning outcomes fall under four areas or equal importance:

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

Figure 3: Miller's Pyramid



1. Safe Systems

The final accuracy checking trainee will:	
Work within legislation and national, regional and local policies, standard operating procedures and guidelines relating to final accuracy checking of dispensed medicines and products	Does
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
Employ information relating to the patient for the final accuracy check as necessary	Does
Identify, rectify and report near misses and dispensing / checking errors	Does
Describe the causes and consequences of dispensing errors and high risks in the dispensing process	Knows
Outline local and national error reporting procedures and communication channels	Knows

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2. Person-centred Care

The final accuracy checking trainee will:	
Modify 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
Provide the person with all of the relevant information in a way they can understand to support effective use of medicines	Does
Apply their professional responsibility for gaining consent, maintaining confidentiality and informing patients of any errors made (Duty of Candour)	Does
Modify communication skills to provide effective feedback and support to staff when they make a dispensing error	Does

3. Effective Outcomes

The final accuracy checking trainee will:	
Recognise the legal requirements for dispensing and final accuracy checking of medicines	Knows How
Recognise the responsibility and accountability of the final accuracy checker	Knows How
Analyse 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
Demonstrate a knowledge of the medicine or product being final accuracy checked in terms of proprietary and generic name, strength, form, usual dose, method of administration, action and use, potential drug interactions, contra-indications and counselling points	Does
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

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

4. Leadership and Governance

The final accuracy checking trainee will:	
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
Operate within 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	Does
Adhere to information governance policies and maintain confidentiality	Does
Apply the following professional practice standards: • GPhC professional practice standards for pharmacy professionals[3] or PSNI professional standards of conduct, ethics and performance for pharmacists[4] • Professional standards for the reporting, learning, sharing, taking action and review of incidents[12]	Does
Demonstrate the use of appropriate professional judgment to make effective decisions	Does
Demonstrate quality improvement in supporting others to learn	Does

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.

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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 with adequate current experience in final accuracy checking of dispensed medicines or products are involved in the design and delivery of the course.

3.4
Ensure all learning and training environments 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 professionals3 or PSNI professional standards of conduct, ethics and performance for pharmacists4 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
Ensure a workplace education supervisor is assigned to supervise trainees in all aspects of the course delivery to ensure patient safety at all times.

5.10
Education supervisors should have a full understanding of the course programme and their roles and responsibilities.

5.11
Ensure the course is designed and delivered to ensure the trainee, on successful completion of the course, has a transferable skill and is able to final accuracy check prescribed medicines and products in any pharmacy sector anywhere in the UK.

5.12
Inform trainees, the work based ACPT education supervisor and the senior pharmacy manager whether the trainee has achieved a pass or fail within an agreed period of the ACT assessment. Certificates must be provided to all trainees 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 trainees 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.

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

6.3

Ensure the assessment strategy includes portfolio of evidence collected between the start of the programme and the final assessment, consisting of:

- An itemised 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 itemised log is documented using the training provider's approved diary log form which must be numbered, signed and issued by the work based ACPT education supervisor.
  - ~ The itemised log is completed under normal working conditions, and spans a minimum of 3 months to a maximum of 12 months.
  - ~ A record of errors identified by the training during their evidence collection and description of how the error was fed back and rectified.

- Reports of accuracy checking errors made by the trainee that have occurred during the practice activity.
  - ~ The trainee will be permitted a maximum of three 'less serious' errors, whilst completing the practice activity of 1000 items. No 'serious' errors are permitted (see glossary).
  - ~ If the trainee makes more than three 'less serious' or a 'serious' error they must inform their ACPT education supervisor who must inform the training provider as soon as possible.
  - ~ Following one serious error or more than three less serious errors the trainee should:
    Continue with the collection of the 1000 accurately checked dispensed medicines or products.
    Complete an additional 250 accurately checked item without error.
  - ~ If the trainee makes a further error of any severity and is unsuccessful at collecting their 1250 items, then a full restart of their 1000 itemised log is required.
  - ~ If the trainee is again unsuccessful the training provider must be informed and the trainee must fully re-start the programme.
  - ~ The superintendent or chief pharmacist in conjunction with the trainees line manager is responsible for determining the trainees suitability to re-sit the programme.
  - ~ Trainees must meet with their educational supervisor after any checking error has occurred and a period of reflection is required, including a written reflection by the trainee of the error and any learning in relation to their checking process.

- A minimum of three reviews of the trainee by the work based ACPT education supervisor as follows:
  - ~ The trainee'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 trainee

- Job description / role to ensure a final accuracy checking is within their scope of practice.

6.4

Ensure the assessment strategy includes an interview designed to assess the trainee's professionalism and ability to accept responsibility as an accuracy checking pharmacy technician.

6.5
A simulated final accuracy checking assessment of dispensed medicines and products against test prescriptions which are intended to test the trainee's professional skills and application of knowledge and process.

- ~ 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
- ~ Trainees must not make any errors in the accuracy checking assessment
- ~ Trainees will be permitted one re-sit of the simulated checking assessment and/or the assessment interview is unsuccessful. There may be a recommendation or a requirement to undertake relevant remedial work prior to registration for the next appropriate assessment.
- ~ Trainees are allowed a total of two attempts at the assessment
- ~ If trainees are unsuccessful following the second attempt at the itemised log or either part of the assessment they must re-take the training programme following a period of reflection on the previous attempt. An action plan must be developed with the workplace education supervisor to address any particular support required. This may include revisiting some or all of the theory tutorials.
- ~ A further itemised log of a minimum of 500 accurately checked medicines or products must be completed by those that were unsuccessful at the simulated assessment. (More than 500 will be required for those who did not complete 1000 items in the previous attempt so that there is a minimum of 1500 accurately checked medicines or products)
- ~ The superintendent or chief pharmacist is responsible for determining the trainees suitability to re-sit the programme

• 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/pre-course work/underpinning knowledge.
- 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

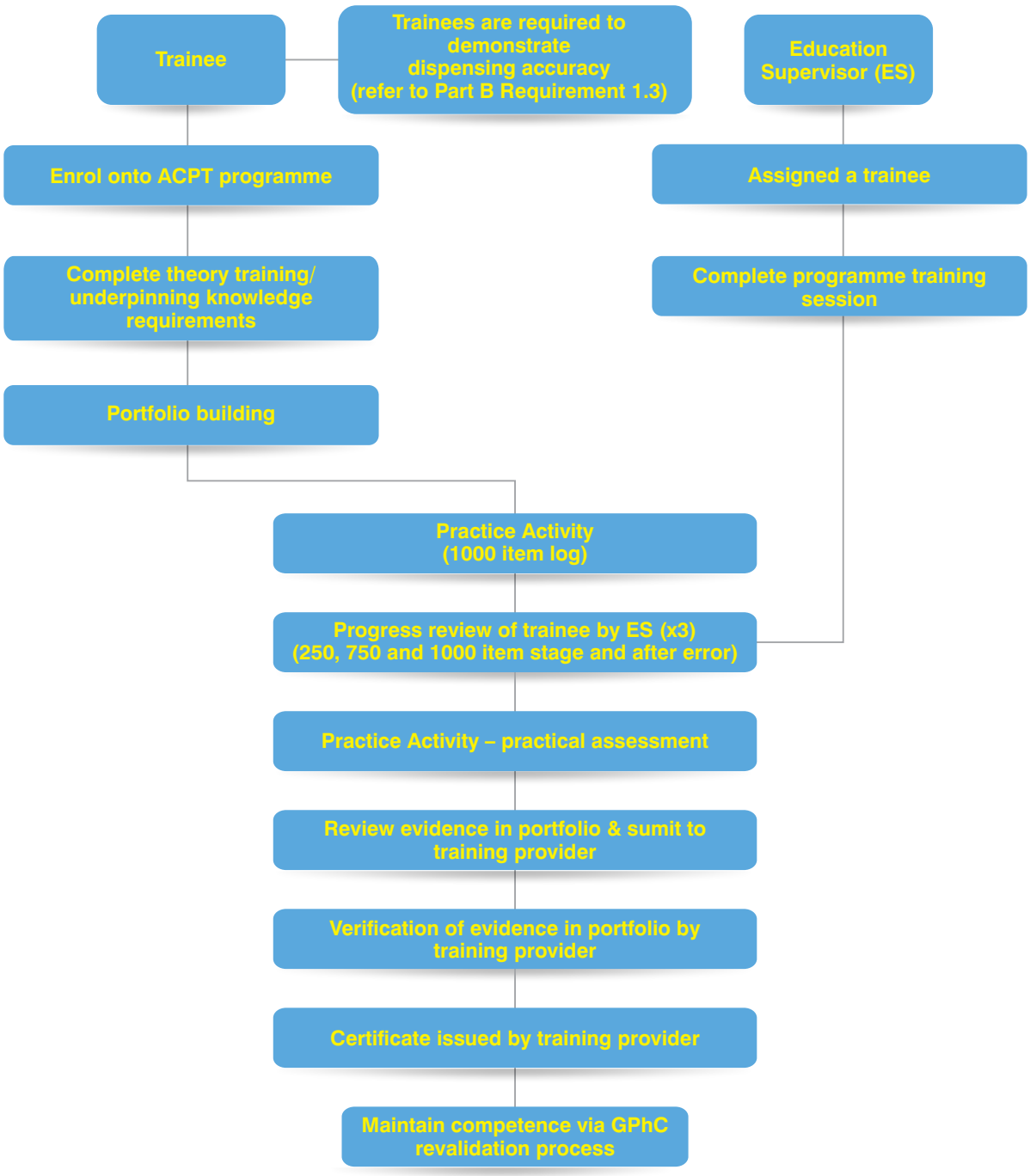
7.2
Provide thorough training for the work-based supervisor so they fully understand the course components, their area of accountability and how to effectively support the trainee.

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.

Appendix 1

Framework Structure



Appendix 2

Glossary of terms

Term	Meaning
Errors: Less serious error	Incorrect label: • Incorrect cost code • Incorrect expiry date • Incorrect batch number • Incorrect spelling • Missing additional warnings (not BNF warnings) • Incorrect ward / location Other: • Incorrect container/closure • Incorrect or missing oral measure eg 5mL spoon • Missing dispensers signature
Errors: Serious error	Incorrect label: • Wrong drug name • Wrong drug form • Wrong drug strength • Incorrect quantity • Incorrect patients name • Wrong directions • Missing or inappropriate use of BNF additional warnings Incorrect contents: • Wrong drug • Wrong drug form • Wrong drug strength • Incorrect quantity Other: • Expired contents • Missing medication • Missing sundry eg oral syringe; anticoagulant record book • Missing or incorrect patient information leaflet • Missing warning or alert card • Prescription not clinically screened / approved by a pharmacist
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.
Healthcare professional	A person who is qualified and allowed by regulatory bodies to provide a healthcare service to a patient.
Must	In the context of this framework the term ‘must’ is used to indicate a requirement for compliance to the standard.
Pharmacy professional(s)	Pharmacists and pharmacy technicians registered with the General Pharmaceutical Council in England, Scotland and Wales. Pharmacists registered with the Pharmaceutical Society in Northern Ireland. Pharmacy technicians working in Northern Ireland.
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.

Appendix 3

1. The General Pharmaceutical Council. Standards for the Initial Education and Training of Pharmacy Technicians. 2017
https://www.pharmacyregulation.org/sites/default/files/standards_for_the_initial_education_and_training_of_pharmacy_technicians_october_2017.pdf

2. NHS Pharmacy Education and Development Committee
http://www.nhspedc.nhs.uk/

3. The General Pharmaceutical Council. Standards for Pharmacy Professionals. 2017
https://www.pharmacyregulation.org/spp

4. The Pharmaceutical Society of Northern Ireland. The Code: Professional standards of conduct, ethics and performance for pharmacists. 2016
http://www.psni.org.uk/about/code-of-ethics-and-standards/

5. The Pharmacy (Preparation and Dispensing Errors – Registered Pharmacies) Order 2018
http://www.legislation.gov.uk/uksi/2018/181/made

6. National Occupation Standards Pharm28
https://tools.skillsforhealth.org.uk/competence/show/html/id/4217/

7. Department of Health and Social Care. Rebalancing Medicines Legislation and Pharmacy Regulation Programme Board – Terms of Reference. 2013
https://www.gov.uk/government/groups/pharmacy-regulation-programme-board

8. WHO Global Patient Safety Challenge: Medication Without Harm.
http://www.who.int/patientsafety/medication-safety/en/

9. Department of Health and Social Care. The Report of the Short Life Working Group on reducing medication related harm, 2018
https://www.gov.uk/government/publications/medication-errors-short-life-working-group-report

10. MHRA, Drug Safety Update Volume 11 issue 6; January 2018:3- Drug Name Confusion: reminder to be vigilant for potential errors).
https://www.gov.uk/drug-safety-update/drug-name-confusion-reminder-to-be-vigilant-for-potential-errors

11. General Medical Council. Annual Review 2004/05
http://www.gmc-uk.org/annual_review_2004_5.pdf_25418022.pdf

12. RPS, APTUK, PFNI. Professional standards for the reporting, learning, sharing, taking action, and review of incidents November 2016
https://www.rpharms.com/resources/professional-standards/professional-standards-for-error-reporting

13. Department of Health. High Quality Care for All, Lord Darzi
http://webarchive.nationalarchives.gov.uk/20130105053023/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

14. NHS England Long Term Plan. 2019
https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

15. Welsh Government. A Healthier Wales, Our Plan for Health and Social Care
https://gweddill.gov.wales/docs/dhss/publications/180608healthier-wales-mainen.pdf

16. Scottish Government. Health and Social Care Delivery Plan
https://www.gov.scot/publications/health-social-care-delivery-plan/

17. Northern Ireland Department of Health. Making Life Better
https://www.health-ni.gov.uk/articles/making-life-better-strategic-framework-public-health

Appendix 4

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