Mersey Care NHS
NHS Foundation Trust

MERSEY CARE NHS TRUST – HOW WE MANAGE MEDICINES

Medicines Management Services aim to ensure that

(i) Service users receive their medicines at times that they need them and in a safe way.

(ii) Information on medicines is available to staff, service users and their

What we do to check the accuracy of inpatient prescription charts. MM04

KEY ISSUES

MM04 (High Secure Services have a separate procedure)

This procedure sets out the tasks that will be undertaken by the pharmacist when prescriptions are reviewed to give assurance that inpatient prescription cards are written in a clear, accurate and safe manner.

OBJECTIVES

- **To ensure that all relevant staff follow standard procedures when dealing with Medicines Reconciliation**
- **To provide a standard for Medicines Reconciliation within Mersey Care NHS Trust that provides and auditable process.**
- **To ensure that all members of staff working within Mersey Care NHS Trust are aware of their roles, responsibilities and limitations with respect to Prescription Card Accuracy.**

Medicines Management Procedure – MM04
Approved by Drugs and Therapeutics Committee
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The following tasks will be undertaken by the pharmacist when prescriptions are reviewed to give assurance that inpatient prescription cards are written in a clear, accurate and safe manner

- The pharmacist will consolidate the medicine reconciliation has been carried out for new admissions by the prescriber in accordance with the Trust's medicines reconciliation procedure. Their role is to consolidate the information using appropriate source(s) that are listed in the Trust's medicines reconciliation procedure.

- As part of the above process the pharmacist will complete a clinical profile for each service user on admission which will include details of:-
    - Service user name
    - Date of birth
    - Date of admission
    - Consultant
    - Pharmacy plan
    - Brief medical history and psychiatric history
    - Blood results if relevant
    - Any obvious pharmaceutical issues e.g. concordance, requirement of compliance aids

This information will be obtained from the service user's medication card and ePEX or Care Notes (or Rio following roll out)

Exceptional circumstances – in some cases it may not be possible to obtain full information due to individual service user circumstances. However every effort should be made to ensure the prescription is safe and appropriate for that individual and if possible a full history should be obtained at the first opportunity.

This form will also be used to note any information from the MDT meetings.

After discharge or transfer to another ward or unit these forms will be passed to the pharmacy department secretary who will archive them in an appropriate place for two years.

All clinical interventions made will be recorded on the pharmacy clinical intervention database.

Process

A pharmacist will review prescriptions in accordance with local procedure, the following aspects should be undertaken at each ward visit where appropriate:-

- Inappropriate, unsafe, ineffective and uneconomic medicines are discussed with a relevant member of the health care team
- Prescriptions are checked for transcription errors when cards are rewritten
- Clinically significant drug interactions are managed appropriately
- Prescriptions must be written clearly by generic name, dose must be written in full if less than 1mg
- Any medication prescribed above BNF limits is noted in the client's clinical notes after discussion with the prescriber
- Prn doses are checked to ensure the 24 hour maximum dose, as prescribed, has not been exceeded
- Missed doses are challenged on the ward with the nursing staff
- Treatment course lengths are monitored and stopped once finished e.g. antibiotics
- Discretionary medication is checked to ensure policy is adhered to
  Any discrepancies must be reported to nurse in charge and also a DATIX form must be completed

- All pharmacist clinical interventions will be recorded on the pharmacy clinical intervention database
- Information or advice that may have significant impact on patient care is recorded on ePEX

The ward pharmacist must sign the ward attendance sheet that is kept in the trust pharmacy department following each ward visit. The record of ward visits will be audited on a quarterly basis.

Ward rounds

Pharmacists will attend MDT meetings on a regular basis where resources allow. Pharmacists will be available to contribute to the pharmaceutical care of the patient and provide medicines information to the MDT. A record should be kept of all contributions made to patient care. This includes all medicines information given, whether at the MDT or subsequently

Service user counselling

If a service user wishes to discuss their medication with a pharmacist a convenient time should be arranged and relevant information provided. This may be verbal or written. This information must be in an accessible format and can be found on the trust webpages or via

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Medicines Information Service.

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All wards within the Trust will have the following minimum number of pharmacist visits per week

Locality	**Ward**	**Minimum number of pharmacist visits per week**
Liverpool	Albert	Pharmacist based at Broadoak Mon-Fri
	Brunswick	
	Harrington	
	Windsor House	Two
	PICU	Two
	Oak	Two
	Acorn	Two
	Heys Court	Once a week
Sefton and Southport	Clock View Wards	Medicines Optimisation – ward based team Mon-Fri
	Park Unit	Two
	Boothroyd	Two
Addictions Services	KWU	Two
	Windsor Clinic	Two
Medium and Low Secure Services	Scott Clinic – 5 wards & Reed Lodge	Two
	Allerton Ward	One
	Childwall Ward	One

Learning Disabilities and Brian Injuries	STAR unit	Two
	Wavertree Bungalow	One
	Rathbone rehab unit	One
	Brain Injuries Unit	Two
Locality SLDD	**Ward**	**Minimum number of pharmacist visits per month**
Learning Disabilities	1 Woodview	Four
	2 Woodview	Four
	3 Woodview	Four
	Gisburn Lodge	Four
	Maplewood 1	Two
	Maplewood 2	Two
	Maplewood 3	Two
	LSU West Drive	Two
	2 West Drive	One
	3 West Drive	One
	Periphery Houses	One
	Lancaster Services	One
	Scott House	One

This will ensure that newly written prescriptions are reviewed and medicines reconciled within 4 working days for acute wards and within 5 working days for long stay wards in the Local Division, LSU and MSU. This may change in weeks that include Bank Holidays; a separate rota will be produced for these times. Specialist Division the maximum period between reviews in supported services should be one month.