Dispensing errors – whose responsibility are they anyway?

The report of a dispensing assistant’s failed appeal against a conviction for a dispensing error (PJ, 31 October, p471) sparked strong opinions in the Letters pages of the PJ. Some correspondents believed that “support staff should not suffer” (PJ, 12 December, p650) whereas others took a less sympathetic stance.

The bald fact is that an error could happen in any pharmacy setting and, as technicians achieve professional status, these sorts of events will take on a sharper focus within their day-to-day practice. Such issues were already considered at the University of Derby’s first pharmacy technicians’ conference last year, at which work-based scenarios were an integral part of the learning experience.

In a session led by a local solicitor, over 100 delegates took part in a courtroom drama where they were presented with the following case and asked to act as jurors:

A hospital prescription for paracetamol 250mg/5ml suspension was dispensed for a two-month old. It had been written by a busy doctor, clinically checked by a pharmacist, dispensed by a band 4 pharmacy technician and checked by a band 5 pharmacy technician who then counselled the baby’s mother. The high dose did not come to light until the baby was admitted to hospital with signs of liver damage.

The question was: who was responsible?

Delegates were asked to vote twice — after they were told the scenario and after a presentation by the solicitor. The results, presented in the Panel, provided an interesting snapshot of technicians’ knowledge of the law of negligence and their notions on responsibility.

Only 2 per cent of votes attributed responsibility to the technicians. This is certainly food for thought and more debate is needed.

With developments such as regulation, remote supervision proposals and accredited checking technicians taking place, it is likely that technicians will become more accountable for their actions and must ensure they offer the highest standards of safe practice in working with patients.

— Sarah Deeming, BTEC professional diploma clinical pharmacy technician programme leader, University of Derby
Improve staff awareness: stage a reconstruction

Rie Hitchmough, chief technician clinical services at Clatterbridge Centre for Oncology NHS Foundation Trust, describes how a reconstruction exercise helped to shed light on areas for improvement and best practices for a complex prescription journey

Clatterbridge Centre for Oncology is a tertiary trust that deals with patients with solid tumours. Treatments include radiotherapy and chemotherapy and the pharmacy department produces in excess of 5,000 chemotherapy products monthly. We provide for day case and inpatients as well as seven satellite clinics based at district general hospitals within Merseyside and Cheshire.

The centre has a small number of patients who are given drugs intrathecally (directly into the spinal fluid). The 2008 update of national guidance on the safe administration of intrathecal chemotherapy demanded that low volume trusts (ie, 10 procedures or fewer per year) perform a risk assessment of their existing intrathecal procedures. Our audit highlighted that although they had all received training, most of the pharmacy staff who potentially would be involved in the supply of intrathecal treatment had never witnessed or participated in an intrathecal prescription journey. As a result, a realistic reconstruction was staged for all the teams involved in intrathecal drugs.

A script providing a step-by-step guide to what should happen in the reconstruction was prepared. This included several red herrings to show how easily minor slip ups could happen and the potential consequences. For example, the date on the prescription chart was deliberately obscured and a vincristine syringe with the patient’s details was left in the intrathecal refrigerator.

The reconstruction began with a dummy prescription for intrathecal methotrexate 12.5mg, cyclophosphamide 1,500mg, Adriamycin 100mg and vincristine 2mg presented to the dispenser. The prescription was initially challenged by the documentation technician because within the trust all intrathecal drugs must be written separately from intravenous chemotherapy, on a pink prescription form. A subsequent pink intrathecal prescription was presented and, once it was confirmed that the prescriber was eligible to prescribe this medicine (in each hospital, all those involved with intrathecal drugs must be named on an intrathecal register), sent for clinical screening.

The prescription had to be returned to the prescriber on more than one occasion — the date was illegible, methotrexate had been abbreviated — and was not forwarded until two pharmacists were happy to sign off the correctly written intrathecal prescription. Once this was done, the raw components were placed in an intrathecal box, which was sent into the appropriate isolator.

The intrathecal product was dispensed and sent back into the assembly room to be checked and the senior technician checked that the dispenser was on the intrathecal register. A second label containing the national guidance warnings needed to be attached. This is colour coded blue whereas vinca alkaloids have a red secondary warning label. The product was then released into the final re-lease room. The pharmacist provided the final check and placed the product in the lockable intrathecal fridge (the syringe with the dummy patient’s name on it and labelled vincristine was found and dealt with).

Both the prescriber and clinical nurse specialist arrived to pick up the intrathecal product. The pharmacist confirmed their registration status verbally and the prescriber and clinical nurse specialist confirmed the registration of the release pharmacist. They all checked the details of the intrathecal product with the accompanying prescription, after which the pharmacist placed the product into intrathecal packaging and sealed the top ready for transportation.

The pharmacist confirmed all intravenous chemotherapy had been given and that the prescription chart reflected this by bearing the appropriate signature.

The prescriber and clinical nurse specialist immediately took the product to the day care unit and the assigned room where the patient was waiting. All the checks were repeated and the prescription chart was used to confirm the patient’s details (the patient was asked to confirm these). He was also asked to remove his iPod before treatment began.

Debrief

After the reconstruction, staff were debriefed. The most benefit gained was that discussion was encouraged and a better understanding of both the theory of the intrathecal procedure and its practical application in a controlled environment was achieved. Many best practice issues were raised and pointers were highlighted for changes and amendments even though they are not in national guidelines (see Panel).

A well co-ordinated reconstruction exercise that takes a multidisciplinary approach can flag areas for improvement from prescription inception to administration to a patient. The exercise helped to:

- Raise awareness for staff of the intrathecal prescription journey
- Test standard operating procedures
- Identify anomalies and potential areas for error
- Test the knowledge of staff
- Test practical resources (eg, intrathecal fridge/keys)
- Test staff use of their right to challenge in practice
- Test all practical processes through to administration
- Identify areas for improvement

More learning outcomes

- The existing intrathecal prescription chart needs to be amended because it was not in line with the current SOPs in the department — there must be two clinical screening checks for all chemotherapy prescription charts and there are no sections on the current intrathecal prescription chart to indicate checks have been done.
- Current labels used cannot accommodate a second warning label so the syringe has to be sealed and the secondary label attached to the package. The SOP needs to be amended to include this additional part of the procedure.
- The day care unit SOP needs to include a clause that encourages patients to have a relative in attendance before and throughout intrathecal therapy because the procedure can be frightening and stressful.
- Patient wrist bands to aid identification should be introduced as standard for outpatients.
What consultation skills can do for you

Helena Herrera and Colin Clarke, from the University of Portsmouth, discuss the importance of pharmacy technicians carrying out effective consultations with patients. They outline how to structure these consultations and give advice on how skills can be developed.

Consulting with patients is central for healthcare provision and an integral part of the role of many pharmacy technicians, both in primary and secondary care. From the sale and supply of medicines to carrying out medicines reconciliation or assessing patients' own drugs, a wide range of healthcare interventions requires effective consultation skills to ensure quality of care and patient satisfaction. Good consultation skills have many benefits, such as increased job satisfaction, enhanced professionalism and patient empowerment. Improved consultations can have a positive impact on clinical governance.

Most pharmacy technicians have extensive experience of communicating with patients in a variety of situations. Moreover, technicians are known for being patient-focused and enjoy direct patient contact. However, little attention is paid to consultation skills during their training, while post-qualification opportunities to develop such skills are few and often not evidence-based. This can lead to poor consultation habits and a checklist approach rather than an individualised consultation. As a consequence, patients may not provide all the relevant information, or may leave with an insufficient understanding of the health message.

Changes in policy and practice, such as the community pharmacy contractual framework, the implementation of medicines management systems in hospitals and the enhancement of the role of the primary care trust technician, bring unprecedented opportunities for technicians to leave dispensaries and enjoy direct patient contact. However, little attention is paid to consultation skills during their training, while post-qualification opportunities to develop such skills are few and often not evidence-based. This can lead to poor consultation habits and a checklist approach rather than an individualised consultation. As a consequence, patients may not provide all the relevant information, or may leave with an insufficient understanding of the health message.

Practice, feedback and reflection are the real key to skills development

Pharmacy technicians at the University of Portsmouth were asked about the skills they had developed as a result of undertaking consultation skills training. They agreed commonly that it built their confidence and that this changed how they approached their own practice. Feedback included “I find myself getting involved in things I would maybe have let run their own course before” and “It has been quite eye opening to actually step back and look at how I communicate with people”.

Key steps in a consultation

Initiating Gathering relevant information about the patient; introducing yourself, checking patients’ identity, confirming the purpose of the consultation and starting to build rapport.

Gathering and providing information The patient is encouraged to provide information. Open questions are followed by closed questions. Listening and summarising are also key.

Explanation and planning The aim is to come to a shared understanding by providing appropriate information in different formats and encouraging patients to explain it back.

Closing The close of the consultation involves checking understanding, forward planning, referral and polite closure.

Criteria for a good consultation

Good consultations follow an appropriate consultation model, which can easily be used at the beginning of the consultation and while acknowledging patients’ concerns and preferences. Open questions should be used at the beginning of the consultation and the technician should check their own understanding of what has been said to them, and ensure the patient has understood what he or she has been told. A model that is often used in healthcare is the Calgary-Cambridge consultation model, which can easily be adapted to pharmacy consultations. The model (left) outlines the different stages necessary to carry out a consultation following this model. It is also important to consider ethical and legal issues relevant to consulting with patients, such as confidentiality and consent, and the needs of different types of patients, such as children or people with disabilities.

It is well known that structure, rapport building, skilled use of questions and active listening impact on consultations. The question is how one can develop these. Although it is often said that practice makes perfect, it can be argued that practice plus feedback and reflection are the real key to skills development. Particularly useful is getting feedback immediately after an observed consultation so individuals can recognise their strengths and identify how they can be more effective.

References:


Learning consultation skills at University of Portsmouth

In order to equip technicians with consultation skills, the University of Portsmouth has developed a consultation skills unit based on the use of simulation and technology that forms part of its foundation degree in medicines management. The unit involves four study days and a number of activities carried out through a virtual learning environment. The study days are based on students carrying out video recorded simulated consultations with actors and receiving feedback from an expert facilitator, actors and other students.

For more information about this initiative e-mail helena.herrera@port.ac.uk
Achieving a foundation degree in pharmacy services and medicines management gave me the impetus to seek further career progression but I recognised that achieving that aim would require diversification. This led me to my current role — pharmacy contracts manager within the medicines management team at NHS Kirklees, the NHS organisation responsible for all health services delivered in the local community across the whole of Kirklees, West Yorkshire.

My role essentially has two main functions: to manage all community pharmacy contracts and pharmacy panels management. This role has involved a huge learning curve and required me to gain knowledge and understanding of the NHS (Pharmaceutical Services) Regulations 2005. Currently, the community pharmacy contract consists of three tiers:

1. Essential services (which must delivered by the pharmacy)
2. Enhanced services (which require extra accreditation for the individual delivering the service and sometimes the premises)
3. Advanced services (which requires accreditation of a consultation room)

The contractual element of my role oversees tier 1 while the development element oversees tiers 2 and 3.

Contractual role
Because the community pharmacy contract is bound by legislation it is important to be thorough and precise — failure to do so could result in legal challenge to the organisation. The major foci of this aspect of the role are operationally to manage the pharmacy panel (the formal committee within the PCT who have responsibility for community pharmacy contracts) and to carry out contract monitoring review visits.

Assessment of pharmacy panel management takes up a significant amount of my time. The panel meets monthly but building the agenda, preparing relevant papers and reading and digesting information that is presented requires daily input. It can take a full day to prepare all of the papers needed for a meeting. File management is crucial for both electronic and paper based systems (a significant proportion of the paperwork is not received electronically).

The panel deals with new pharmacy applications (and any subsequent appeals), permanent or temporary changes to opening hours, breach of contract issues and complaints relating to contractual issues.

Following a meeting, I write all the decision letters and I check and modify the minutes, ensuring that both types of document are accurate, and detail the proceedings so that, if challenged, the primary care trust can show it has followed due process.

Assessment of new applications involves visiting the proposed site and surrounding area and writing a comprehensive report to present to the panel on which to base its decision to approve or reject an application.

Collating changes to opening hours, particularly for statutory bank holidays, is crucial to ensure that GPs and the public are kept fully informed as to which pharmacies are open at any given time. I normally handle actions relating to breach of contract issues and complaints in the first instance.

It is not possible to carry out annual visits to all pharmacies and so most PCTs have a three-year rolling programme. In NHS Kirklees this involves visiting (with my clinical governance pharmacist colleague) approximately 30 pharmacies a year. Each visit takes about two hours because questions need to be asked and evidence looked at, to ensure that each element of the contract is being delivered in a satisfactory manner.

After each visit a report is produced with an action plan so that each contractor (or pharmacy manager) is clear what the PCT’s expectations are in terms of improvement.

A few visits will highlight poor performance and the initial stance taken is to support those pharmacies to enable them to reach an acceptable standard. My previous experience of delivering education, training and facilitation helps greatly in these circumstances because lack of knowledge and its application can often be a contributing factor to poor performance. If it is believed that poor performance relates to professional issues as opposed to contractual issues this will be passed onto the Royal Pharmaceutical Society’s pharmacy inspector.

Developmental role
Each PCT has a suite of enhanced services that are designed to meet the needs of local population. A fair proportion of these services are designed to meet public health needs so close liaison with members of the public health team within the PCT is needed. I also need to liaise with the LPC because it is the statutory body that represents local contractors.

Good negotiating skills are essential during these meetings to ensure that the needs of the commissioner, the contractors and patients are all met in a satisfactory manner.

In previous roles I had a close working relationship with my public health colleagues and have strived to achieve the same in this job. This has been particularly beneficial because I have been able to advise on the practicalities of running pharmacy public health campaigns within busy pharmacies, where space is often restricted.

The future
In April 2011, the basis for control of entry onto a pharmaceutical list will change and new applications will be looked at against a local pharmaceutical needs assessment (PNA). Currently I am heavily involved in drawing up that document. I have to think strategically because a poorly written PNA could have massive financial implications for the PCT in the future.

Part of my own future is already mapped out because I have recently gained a promotion that will see me managing not only community pharmacy contracts but also optometry contracts — once again, I will have a lot of learning to do. In terms of my continuing education, I am currently studying for a master’s degree in leadership and management in health and social care and I am hoping that this will help to provide more career opportunities in the future.