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<th>SOP Title</th>
<th>Clinical Check of Prescriptions in Ward Areas</th>
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| Author name and designation: | Gareth Price  
Deputy Director of Pharmacy – Clinical Services |
| Pharmacy Team responsible for production: | Clinical Team |
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Clinical Team |
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| Wholesale Dealer’s Licence? | No |
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| Specials Manufacturing Licence? | No |
Background information:
It is a legal requirement that a prescription is clinically checked by a qualified pharmacist before the dispensing process is complete and the medicine is given to the patient. At Wirral University Teaching Hospitals NHS Foundation Trust (WUTH) the pharmacist undertakes this task before the medicine is dispensed. Ideally for in-patients this should take place on the ward where all the relevant information is available. A clinical check involves ensuring the prescription is legal, legible, safe, clinically appropriate and compliant with the Trust formulary. A clinical check is indicated on the electronic prescribing system (PCIS) as a “v” to the left of the drug name.

Objectives:
• To ensure that all prescriptions have a clinical check undertaken by a pharmacist at WUTH in line with Trust policies and procedures.
• To ensure that all prescriptions comply with the Trust formulary, or if not, have gone through the appropriate process to authorise use.
• To ensure that the pharmacist clinical check is clearly documented.

Scope:
This procedure provides instruction for the pharmacist clinical check of prescriptions on the wards at WUTH. It includes all prescription types authorised for use on the wards at WUTH. This procedure does not cover the pharmacist clinical check of prescriptions in the dispensary (see SOP DISP08 ‘Clinical Checking of Prescriptions in the Dispensaries’).

Responsibility:
All pharmacists working on the wards at WUTH must ensure that they follow this procedure when clinically checking prescriptions on the wards.

Stages of the procedure:
This procedure has 2 sections. The first section contains the general principles that apply to the clinical check of all prescriptions. The second section contains information relating to the clinical check of specific types of prescriptions.
Section A – General Principles

A clinical check of all prescriptions should include a check of the following details. 1 – 10 should be present on the prescription, and 4 – 15 should be checked to ensure they are clinically appropriate.

1. Patient’s demographics
   - Patient’s name
   - Hospital number and NHS number
   - Date of birth
   - Consultant
   - Patient’s weight if it is necessary for dose calculation

2. Prescriber’s signature (this may be an electronic signature if PCIS / Cerner or otherwise handwritten in indelible ink)

3. Date

4. Approved medicine name, which is usually the generic name, but may need to include the brand name (e.g. for diltiazem or theophylline)

5. Route of administration

6. Dose

7. Medicine form if this is not clear from the dose or route of administration

8. For liquid / injectable formulations ensure the dose is measurable

9. Frequency

10. Allergy status

11. Check for interactions with other medicines the patient is known to be taking

12. Check for drug – patient or drug disease state interactions

13. Check for an appropriate indication

14. Formulary status

15. Consider any special precautions for specific medicines (see section B)

If any problems are identified during the above checks the prescription may need to be referred to the prescriber to amend or it be amended by the pharmacist in line with Trust Policy 045i – Pharmacist Amendment of Prescribing Regimens and Compiling Lists of Take Home Medication Policy and Procedure. In many cases this will involve discussing the issue with the prescriber to agree the changes to be made.
Section B – Special Considerations

(i) Checking handwritten prescriptions
Prescriptions should be checked according to points 1-15 in section A. Legibility and legality may be more of a problem with handwritten prescriptions, and issues must be resolved before completion of the clinical check. Specific examples of handwritten prescriptions include:

   a) Intravenous/subcutaneous blue prescription cards.
      • Ensure that all medicines and diluents are prescribed in full and no abbreviations are used
      • Ensure that the route is clearly stated
      • Ensure that duration of administration / rate of infusion is stated
      • Ensure that volume of fluid is clearly stated where applicable
      • Ensure compatibility where appropriate, e.g. syringe drivers.

   b) Green chemotherapy prescription cards (pre printed)
      • These should be clinically checked by a haematology specialist pharmacist, or a pharmacist who has undertaken the appropriate training
      • Check that the regimen is documented on the chart
      • Check that the full cycle has elapsed before the new cycle is being started
      • Check that all blood results have been completed incase dose adjustments or treatment delays are needed.

   c) Green chemotherapy prescription cards (not pre printed)
      • These should be clinically checked by a haematology specialist pharmacist, or a pharmacist who has undertaken the appropriate training
      • Check that the regimen is documented on the chart
      • Check that the full cycle has elapsed before the new cycle is being started
      • Check that all blood results have been completed
      • Check that dose adjustments or delays in treatment are not needed in response to the blood results.

Information on regimes and on any adjustments needed in response to blood results can be found at the Merseyside and Cheshire Cancer Network (MCCN) website www.mccn.nhs.uk

   d) Critical care prescription charts
      • Guidelines on use of common parenteral medicines in critical care can be found on the intranet.
• Patients often have many infusions going through various lines, important checks are that the route is appropriate (central or peripheral), the rate is clear and documented, all medicines being administered together are compatible

• The clinical condition of the patient may change quickly and therefore renal and liver function must be closely monitored and adjustments to doses recommended in response to changes.

e) Maternity prescription charts
• Ensure that any medicines written in the section for midwives to administer under their professional practice are appropriate for this use. This list can be found on MHRA website www.mhra.gov.uk.

f) Special Care Baby Unit (NNU) prescription charts
• Check intravenous medication against the Neonatal Unit Intravenous Guidelines. These can be found on the intranet
• Check with nursing staff if has an individual patient care plan
• Use paediatric common meds pathway which can be found on PCIS and in the dispensary wherever possible to check medicine doses according to patient weight and severity of condition.

g) Anticoagulant prescription charts
• Check that page 1 has been completed by the prescriber. Pharmacist should sign and date this to indicate that they concur with information provided
• Ensure that all columns completed in dosing information (page 3). Sign to indicate that this has occurred
• Pharmacist to clinically check daily against the dose and INR to indicate they have been checked. This may be a retrospective signature but conveys that the trend is correct. If the dose does not look correct enter details and recommendations in the medical notes, contact and discuss the changes with the relevant prescriber and indicate that this has occurred on the dosing chart
• The person who completes each stage of the ABCD process at discharge should sign and date on the chart that they have completed this
• For further information consult SOP CLIN01: ‘Dealing with a Prescription for Anticoagulants’.

h) Insulin prescription and monitoring charts
• Ensure that all blood glucose results have been entered appropriately
• Ensure that insulin and device have been specified
• Pharmacist to clinically check against the dose to indicate that they have been checked. This may be a retrospective signature but conveys that the trend is correct. If the dose does not look correct enter details and recommendations in the medical notes, contact and discuss the changes with the relevant prescriber and indicate that this has occurred on the dosing chart.

(ii) Clinical Checks for Specific Medicines

Some medicines require specific checks. This may be because they are higher risk, unusual or subject to a NPSA alert. These are:

a) Anticoagulation prescription charts
   See advice above and SOP CLIN01 – ‘Dealing with a Prescription for Anticoagulants’

b) Liquid medicines
   • Dose should always be expressed in units of strength not volume (e.g. mg not ml) as different strengths of same medicines may exist.
   • Ensure route is always oral or via feeding tube and never parenteral.
   • If the liquid is going via a feeding tube check the relevant guidance (e.g. NEWT book) to ensure it is not too viscous for the tube.
   • When reordering medicines ensure that instructions for the dose and volume are provided (e.g. if the strength of the solution is 5mg/1ml and the dose is 10mg then 2ml should be typed into the free type area of the reorder screen).

c) Methotrexate
   An SOP for this is under development.
   • Check patient has NPSA booklet and that it is regularly completed.
   • Check that the dose prescribed is the same as in the book and if not that the reason for deviation is clearly indicated in medical notes.
   • Check that the patient only has 2.5mg tablets and that they have folic acid prescribed.
   • Check FBC, U&Es and LFTs. If abnormal or changed from last check refer to shared care guidance on methotrexate for advice.
   • Ensure that the patient is having regular blood tests as recommended in shared care guidance. New patients will need counselling on the need for this alongside usual methotrexate counselling.

d) Lithium
   Refer to SOP CLIN06: ‘Clinically Checking an Inpatient Prescription for Lithium’

e) Potassium
Refer to Trust Policy 045d ‘Intravenous Potassium’ for advice.
f) Gentamicin, vancomycin, tobramycin and other antibiotic medicines subject to pharmacokinetic monitoring.
   • All pharmacists must have successfully completed the competency assessment before they can provide advice on these agents.
   • For further assistance contact Lead Pharmacist – Microbiology or a member of the pharmacokinetics team within pharmacy.
g) Oxygen
   • Ensure that the target saturation range is stated
   • Ensure that the inhalation device is stated
   • Ensure that the flow rate / concentration is stated
   • Ensure that the duration of therapy is stated.
   For further information see Trust Policy 045g ‘Oxygen Therapy – Use in Adults’.

(iii) Medicines that require counselling
There are some medicines that carry greater risk of serious side effects than others. These are generally the subject of a CSM warning. In this case the patient must be counselled on the use and potential side effects of the medicines and the discussion documented in the medical notes. For further advice and a list of medicines this affects see Pharmaceutical Care Standards, standard 3.

(iv) Special Patient Cohorts
Certain cohorts of patients require additional aspects to be taken into consideration when clinically checking their prescription. The pharmacist must be mindful that adjustments to doses, strengths, frequencies or therapeutic substitutions may need to be recommended. These cohorts include:

   a) Patients with renal impairment. The standard method of measuring renal impairment is through use of the Cockroft-Gault formula. If there is a degree of renal impairment then dose adjustments may need to be made to their medicines. Liaise with the medical team to achieve this. Usual reference sources are the BNF, the SPC and the Renal Drug Handbook.

   b) Patients with liver impairments. If there is a degree of liver impairment then dose adjustments may need to be made to their medicines. Liaise with the medical team to achieve this. Usual reference sources are the BNF and the SPC.
c) Paediatric patients

d) Patients who are breastfeeding or pregnant.

e) Patients at risk of falls. See Pharmaceutical Care Standards for more information.

(v) Checking discharge prescriptions (TTHs) on the ward

Prescriptions should be checked according to points 1-15 in section A. Legibility and legality may be more of a problem with handwritten prescriptions. The following must also occur:

1. Check TTH against the current list of inpatient medicines to ensure that no medicines that the patient should continue to take at home have been missed off without good reason, and if appropriate check against the medicines reconciliation form.

2. Add any additional endorsements necessary e.g.

   (a) CD prescription – the details that are handwritten by the prescriber on to the signed copy that prints off with the TTH should be checked by the pharmacist for legality. The pharmacist must sign the signed copy as well as the TTH and ensure that the name of the prescriber is easily identifiable.

   (b) Compliance aids – the top of the prescription should be endorsed with the type of compliance aid and / or compliance sheet. Compliance aids available in the dispensary include large print PILs, winged tops for bottles, handihalers and tablet cutters. In addition a request can be made for the Braille on tablet containers to be avoided when dispensing labels are applied. Other compliance aids that patients may be able to use include dose recording devices, tacki liquid, tube squeezers, eye drops aids and multilingual labels but these are not currently available from the dispensaries.

In the case of compliance aids such as Venalink® or Medidose® the prescription should be further endorsed as specified in SOP DISP09 ‘Dispensing Compliance Aids’.

The clinical check should also include an assessment of the drug’s suitability for inclusion in a compliance aid. Indicate on the left hand side of the prescription if the drug is ‘IN’ or ‘OUT’ of the compliance aid.

(c) If the TTH is for an IV infusion or subcutaneous syringe driver it is also necessary to clinically check the primary care administration card. These cards are used as instructions to the district nurses. They should be checked and signed by the pharmacist but cannot be used to make a supply from. These may be used for dressings where requested by primary care for an individual patient. If they have been used then they must be clinically checked.
4. Sign and date the TTH in space reserved for ‘pharmacist check’ on every page. If there is not a space for a clinical check use the dispensary stamp or the words ‘Clinical check’ or ‘CC’ before the signature to allow for clear identification of the clinical check.

5. Any handwritten amendments to the prescription should be initialed by the pharmacist, changes must also be made on PCIS in line with Trust Policy 045i – Pharmacist Amendment of Prescribing Regimens and Compiling Lists of Take Home Medication Policy and Procedure.

6. If there are multiple pages ensure that they are all for the same patient before stapling them together. Good practice would be to number the pages (e.g. 1 of 2, 2 of 2 etc).

7. Discard any unnecessary paperwork before stapling the TTH together e.g. TTH back copy.

8. Endorse the TTH with items to supply – this can be done by a pharmacist or WBT, who must sign the prescription to indicate a locker check has been done.

(vi) Payment by Results (PBR) excluded medication

This is a group of medicines for which the Trust receives funding for specific indications. When clinically checking these prescriptions check that the indication is one that we will receive payment for and endorse the indication on the prescription. If this is not an approved indication a Health Treatment Panel (HTP) may be required or the Division will need to confirm they will fund the treatment.

Signing the prescription/indication a clinical check on a prescription

To indicate that a clinical check has been undertaken on PCIS the pharmacist must verify the medication through the master guide. Once this has occurred a “v” will be seen to the left of the medication on print outs. This is not evident from a screen shot. Clinical checks on handwritten prescription and / or monitoring charts will be indicated by the pharmacist initialling next to the relevant entry. It is also good practice to date this entry.
## Pharmacy Department

### Stages of approval, implementation, audit and the updating of SOPs

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Complete a new form for each updated version.