

Still some challenges to overcome — a hospital pharmacy perspective

Patient packs give hospitals important benefits. They are a vital component of modernising medicines management, they enable dispensing to become more efficient and they contribute to patient safety. They also provide an effective, timely and safe way of providing a patient information leaflet (PIL). Although there are barriers to overcome when changing from traditional forms of packaging in hospitals, these are solvable.

The Audit Commission report “A spoonful of sugar” strongly recommended modernising the medicines management process in acute hospitals to the level already achieved in a number of leading edge hospitals. This includes the use of patient packs, reuse of patients’ own drugs (PODs), individual POD lockers for patients, “one-stop dispensing” and self-medication schemes. Along with this goes increased pharmacist clinical input: taking medication histories, attending post-take rounds and working mainly in clinical areas.

CENTRAL TO MODERNISATION

Patient packs are central to this modernisation process. A mixture of differing packs from community and hospital is a recipe for disaster and this is compounded by the fact that traditional hospital issue quantities were primarily for seven days. The introduction of “one-stop dispensing”, where packs issued for inpatient use are labelled with instructions for use and are given to patients on discharge, means that seven days’ supply is inadequate. Bulk packs are still available for some drugs, and hospital prepacking facilities can pack them down. However, most common drugs and all new ones come in patient packs. Common sense says to eliminate this variation with its problems for pharmacy staff, patients and nurses with a single form of package.

To achieve government targets on waiting lists, the NHS has treated many more patients as inpatients and seen many more outpatients. This leads to greater demands on pharmacy services including the provision of medicines. At the same time, research evidence, guidance from the National Institute for Clinical Excellence and national service frameworks have been potent drivers in the number of drugs patients are treated with at any one time. Few hospital pharmacies have received more staff to deal with this extra workload. This has all occurred against a background of high vacancy levels in the service. Patient pack dispensing has considerably fewer steps in the process than traditional bulk dispensing and it needs less infrastructure support in the form of containers, caps, etc. The practice of snipping patient pack strips adds an unnecessary step in the dispensing process as well as introducing risks. In the

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absence of increased investment to deal with increased work one solution is to make the dispensing process more efficient. Patient packs can have a major contribution as they reduce the number of steps in the dispensing process. Additionally they increase the efficiency of checking because packs no longer need to be opened, contents checked, and then replaced.

Patient packs can contribute to patient safety. They eliminate dispensing errors due to strips or cut out tablets being placed into the wrong pack. At ward level, cut strips often have no identity markings and nurses have difficulty in ensuring that the medicines they are about to administer are correct. In the traditional bottle system nurses only ever had to remove one tablet at a time. However with blister strips the whole strip is removed from the container and then returned. A potential source of error is replacing it in the wrong container. Cut strips also frequently fall to the floor or other working areas when the pack is opened (and sometimes even when the pack is not opened). Again this is a potential source of error and nursing staff correctly have voiced concerns over the practice. With a patient pack, although the strip still has to be removed and replaced in the pack it will be complete and have its identifying information. Patient packs also remove the “little white tablet” syndrome where the only identifier for nurses (and patients once they have gone home) is the pharmacist’s label making additional safety checks impossible. The level of identification on a patient pack enables nurses and patients to make an additional check on dispensed medicines.

European Union legislation requires pharmacists to provide patients with a PIL when dispensing a medicine. Patient packs are the only effective way to do this efficiently and safely. All other options such as photocopying PILs to go with redispensed medicines are fraught with difficulty.

The cost to the hospital of providing patient packs is greater than dispensing from bulk. This is because the patient packs themselves are more expensive and greater quantities are supplied. Many hospitals supplied seven days’ of medicines on discharge and the cost of a patient pack, even allowing for the five or so days’ worth used in hospital, will be greater. There is agreement that due to lower hospital procurement costs the overall cost to the local health economy is lower. Transfer of funds from the primary care trust (or other local health organisa-

tion) is necessary. This process has been smoother in some parts of the UK than in others and in some areas not yet resolved, despite the Audit Commission recommendation that it should be implemented immediately. Lack of this funding is a major barrier not only to the introduction of patient packs but also to modernising medicines management.

Storage of patient packs can be a problem because they take up considerably more shelf space than bulk packs. Ward storage can be relieved by the use of POD boxes but innovative storage solutions may be required in the dispensary, especially if it is cramped. This may require investment in modern storage systems.

There are a number of clinical governance issues with patient packs. Although they reduce some medication misadventure risks they introduce a number of their own. Many packs look similar in terms of drug names and strengths of the same drug. Close shelf co-location can lead to selection errors and, because of the similarity of packaging, this may escape the checking process. There is a need to review packaging in purchasing decisions as well as ensuring staff are aware of the potential causes of error. Other strategies, such as flagging locations or physical separation, may be required.

SOME ISSUES UNRESOLVED

Unresolved issues include the limited range of pack sizes, particularly of antibiotics. Manufacturers’ variation on what constitutes a course is not helpful. Packs for five, seven and 10 days exist for varying drugs, without giving a range of these course lengths for each drug. Many departments dispense a patient pack with additional days’ supply and overlabel to discard the excess. Small quantities dispensed for specialist use or single doses dispensed for pre-procedural use cause problems. For example, in obstetrics patients at high risk of aspiration are provided with a small supply of metoclopramide and ranitidine to start taking prophylactically when labour starts. This means that all the advantages of patient packs are not gained, and a number of split packs are left on the shelf. For drugs where there is a reasonable annual volume, NHS licensed prepacking units probably provide the solution. Drugs used infrequently, however, may be difficult to resolve.

Mental health services are loath to move to one-stop dispensing as they often have to limit quantities of medicines patients are given, so again this is an area where work needs to be done.

Patient packs give many benefits to hospital pharmacy once the barriers are overcome, there are still some challenges to meet but most importantly they are here to stay.

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