

Use technicians to train nurses to help manage discharge medicines

By Tanya Cameron

With the development of their roles comes the need for pharmacy technicians to find more efficient ways of working. This article looks at a scheme where technicians train nurses to deal with discharge medicines



The time patients spend waiting for their discharge medicines has decreased under the new system

Moves to develop the role of technicians, together with issues of cost effectiveness, mean that there is a need to bring about more efficient ways of working, both on wards and in the pharmacy department. At Cheltenham General Hospital, Gloucestershire, one way in which we thought that efficiency could be improved was to train nurses (who are available on wards at all times, including evenings and weekends) to deal with discharge medicines, where appropriate.

As with many hospitals, a technician-led "one-stop" service is in place on many wards at Cheltenham General Hospital, with pharmacy staff having responsibility for taking medication histories, assessing patients' own drugs for use on the ward as well as managing medicines for discharge. We thought that it would be beneficial for appropriately-trained ward nurses to become more involved.

Our aim is for nurses, working on wards where a one-stop service is in place, to be able to assess the contents of the one-stop locker against the discharge prescription and, where appropriate, discharge the patient without needing further pharmacy input. This article describes the training given to nurses before they are deemed competent to

take on this role, and the support they receive from pharmacy technicians. It also discusses some of the benefits and challenges of this new way of working.

Training

Each participating nurse is trained by the lead medicines management technician (MMT) for that division. This covers the one-stop scheme and discharge arrangements. They are trained to check the discharge prescription against the drug chart to see if any medicines have been missed and to check the contents of the locker against the discharge prescription. They are trained to check that:

- The drugs listed on the discharge prescription exactly match the drugs in a patient's locker
- There is a minimum of seven days supply of any prescribed medicine
- The patient's name on the label matches the patient's name on the discharge prescription
- The directions on the label match those on the discharge prescription
- The label appears to have full directions and warnings

If they find a discrepancy, or there is insufficient supply, nurses are instructed to send the discharge prescription to the pharmacy department or contact the ward MMT. It is emphasised that nurses must not send a

patient home with unlabelled medicines, medicines with labels that have been handwritten or medicines with somebody else's name on them.

We also developed a workbook in which nurses have to answer questions about the one-stop system in general and, more specifically, about discharge prescriptions. The workbooks were originally intended to be a backup for the ward-based training sessions. On some wards, senior nurses decided that all staff should complete these before they started to help with discharge medicines. Other wards decided to use the resources for new staff only or for staff who had made errors at discharge. Workbooks should also be given to bank and agency staff.

The ideal model for a ward starting to use the system consists of completion of the workbook being followed by a formal "sign off" by the ward manager before nursing staff are allowed to deal with discharge medicines without pharmacy input. This model has now been formally adopted by Gloucestershire Hospitals NHS Foundation Trust. Any nurse that the senior ward sister is unhappy to sign off is required to undergo a further period of training and supervision until that senior sister believes they are competent.

When new nurses are recruited, the lead MMT is involved in their induction programmes. The relevant lead MMT can be contacted by pager at any time if their support is needed. Ward MMTs can be asked for help with discharge prescriptions during the times they are working on a ward.

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— Benefits

On the whole, the new system has improved the discharge process. The time patients spend waiting to be discharged has decreased because their medicines are already on the ward, leading to a faster turn-around time for beds. There are now less "last minute" discharge prescriptions being sent to the dispensary. Cost savings have been made where patients can be discharged on the medicines that they brought in with them. Nurses now spend less time chasing pharmacy staff for discharge medicines and so have longer to spend with patients, educating them about their condition and treatment.

Nursing staff were issued with a questionnaire approximately six months after the new system was initiated and most staff indicated that they would not choose to revert back to the old way of working. The new system also enables MMTs to cover more wards than would be possible with a traditional one-stop service.

— Challenges

As with any new way of working, some challenges have arisen. One problem we encountered was that the nurse who was sorting out the discharge medicines was not necessarily the nurse that actually discharged the patient. This was because delays in discharge can occur if, for example, transport is unavailable or doctors are waiting for test results. To address this, we decided to amend our discharge prescriptions. They now include a space in which the nurse who sorts out the discharge medicines indicates that he or she has carried out the necessary checks and handed the medicines to the patient.

It has also taken some time for nurses to be comfortable with the system, and a few mistakes have been made, which have been highlighted to us by community nurses visiting patients after discharge. These include:

- Patients being discharged with unlabelled ward stock boxes of medicines
- Medicines with the wrong directions on the label (because a dose change made close to discharge was not noticed)
- More than one strength of the same medicine being inappropriately supplied (where an old strength was not removed before a new one was supplied)
- Medicines that were not included on the discharge prescription being given out (because they were not removed from the locker when discontinued)

On being informed of such errors, the senior sister of the relevant ward completes an adverse clinical incident form. The MMT and ward pharmacist often collaborate to investigate such matters. If the nurse responsible can be traced through the paperwork he

or she will be told about what has happened and efforts will be made to ensure that they understand the discharge system and to assess whether they have any training needs. If any nurse makes consistent errors it is for the ward sisters to decide whether that nurse should be allowed to carry on their involvement with discharge medicines.

— Audit

We carried out a small audit in July 2005 by analysing that month's discharge prescriptions. The results are summarised in Table 1, with a sample of data collected from wards where nurses have been trained to deal with discharge medicines shown in Table 2.

Surgical wards appear to benefit most from having nurses deal with discharge medicines (as well as from having a one-stop service per se). One reason for this is that there are generally fewer last-minute

dose changes than on the medical wards. However, with the new system in place, it should be noted that the percentage of items available on all wards is high and therefore discharge prescriptions that are sent to the pharmacy department for dispensing are smaller (usually for just one or two items) and take less time to dispense. Items that currently require dispensing (by pharmacy staff) at the time of discharge include:

- Nebules and enteral feeds, because they are too bulky to be stored on wards
- Reducing doses of steroids, because it is difficult to predict the length of courses and how they will reduce
- Antibiotics, because it is difficult to predict the length of courses when used on medical wards
- Controlled Drugs, because of the legal restrictions associated with them

— Future

We are looking at ways to try to further reduce the number of discharge prescriptions that need to be sent to the dispensary. There will be a pilot study with sip feeds (eg, Ensure Plus, Enlive), involving nursing staff and dieticians, that will allow nurses to discharge patients with supplies from ward stock. In addition, we are looking at pre-labelling packs of ramipril and bisoprolol (not currently supplied as part of a one-stop scheme because of dose titration) as discharge packs for the cardiac wards.

ACKNOWLEDGEMENTS Thanks to Pam Adams, senior clinical pharmacist, Kerry Sharland, lead medicines management technician (surgical division) and Isabel McIntosh, Jacqui Mace, Steve Lansley and Jean Tippett, rotational MMTs, all at Cheltenham General Hospital

Table 1: Overall results of the discharge medicines audit

| Ward type | Mean percentage of discharge prescriptions completed on wards (range) |
|--|---|
| Wards on which nurses deal with discharge medicines | 32 (18 to 52) |
| Wards on which nurses do not deal with discharge medicines | 2* (0 to 6) |

*These are incidences where patients had their own medicines and did not require further supply

Table 2: Sample of data collected from wards where nurses deal with discharge medicines

| Ward speciality | Total number of discharge prescriptions | Percentage of prescriptions completed on ward | Total number of discharge items | Percentage of items available on ward |
|--|---|---|---------------------------------|---------------------------------------|
| ■ Vascular surgery | 72 | 40 | 338 | 65 |
| ■ Surgical admissions and colorectal surgery | 174 | 39 | 473 | 56 |
| ■ General medicine — respiratory | 50 | 18 | 336 | 64 |
| ■ General medicine — gastrointestinal | 71 | 24 | 248 | 74 |
| ■ Gynaecology | 48 | 52 | 208 | 82 |
| ■ Endocrinology, general medicine and stroke | 50 | 22 | 269 | 61 |