South East Coast Ambulance Service NHS
NHS Foundation Trust

Pouch Tagging Process
Standard Operating Procedure

Contents

1 Scope

1.1. South East Coast Ambulance (SECAmb) NHS Foundation Trust is committed to providing high quality patient care and the safe and secure management of medicines**.**

1.2. This procedure is designed to provide guidance and instruction in relation to the medicines pouch tagging system used within SECAmb.

1.3. The pouch tagging system is used to ensure that the right medicines are available for staff to administer to patients when needed.

1.4. This SOP describes how tagging the medicines pouches with the correct colour tag allows staff to visually check that pouches are ready for use or need to be returned for replenishment.

1.5. Operational staff **must** tag the outside of each pouch after every use in the manner outlined in this SOP.

2 Procedure

2.1. SECAmb has a dedicated Medicines Distribution Centre (MDC) at Paddock Wood (PW) Make Ready Centre.

2.2. Sealed drug pouches are prepared by Pharmacy Support Workers (PSWs) on a daily basis and delivered to stations and the Telford Place store by the Logistics Team.

2.3. All pouches containing non-controlled drug medicines are prepared using Aceso, a computer based tracking system to ensure full accountability and management of medicines.

2.4. These pouches are colour coded as below:

- POUCH – Arrest Red
- POUCH – Cardiac Yellow
- POUCH – Fluids Black
- POUCH – Hypo Green
- POUCH – Respiratory Blue
- POUCH – Specialist Orange
- POUCH – Black - PP1 – Analgesia
- POUCH – Black - PP2 – Antibiotics Non Penicillin
- POUCH – Black - PP3 – Antibiotics Penicillin based
- POUCH – Black - PP4 – Miscellaneous
- POUCH – White - Volunteer/Community responder Pouch

2.5. Every pouch packed at the MDC goes through an independent quality assurance (QA) check process. The QA process is completed by the senior

Pharmacy Support Workers (SPSWs) or the senior Pharmacy Technicians (PTs). This ensures all medicines are in the correct pouch and have been packed correctly according to the system.

2.6. Should all items be correct and the QA checker is satisfied that the pouch is safe for operational use, a packing list is printed and included for use by operational staff.

POUCH EXPIRY
01 August 2019

South East Coast Ambulance Service NHS
NHS Foundation Trust

Fluids and Infusions Packing List

Packed By:	**yvonne tomkies**	Packed When:	**15/01/2019**	Bag Reference: **f03498**
Quality Checked By:	**jodie allard**	Quality Checked When:	**15/01/2019**	

	Medicine	Batch	Expiration	Incident Number	Date of Incident	Staff Number
RED TAG NOW	1000ml Sodium Chloride 0.9% IV Infusion (Braun)					
	3 Way Tap					
RED TAG NOW	3 Way Tap					
RED TAG NOW	50ml Syringe					
RED TAG NOW	Activated Charcoal Suspension 200ml bottle					
	IV Giving Set					
	IV Giving Set					

2.7. The pouch is then sealed with a GREEN single use padlock seal.

2.8. Green padlock seals are **only** used by the MDC at PW, indicating the pouch has been through the QA process as is ready for first use.

2.9. YELLOW single use padlock seals are included within the sealed pouch and are used to lock a pouch between uses when **more than the minimum stock level** of ALL drugs remain in the pouch.

2.10. RED single use paddlock seals are included within the sealed pouch and are to be used to lock a pouch when **the minimum stock level** of any medication remains, or the pouch is no longer fit for purpose for other reasons.

2.11. Pouches that have reached a minimum stock level should be sealed with a red padlock seal and returned to the MDC via the station's returns locker.

2.12. This will be indicated on the paperwork as a darker line. Once the line on the paperwork has been filled in, the pouch will need to be red tagged.

	Medicine	Batch	Expiration	Incident Number	Date of Incident	Staff Number
	3 Way Tap					
RED TAG NOW	3 Way Tap					
RED TAG NOW	50ml Syringe					
RED TAG NOW	Activated Charcoal Suspension 250ml bottle					
	IV Giving Set	123456	10/2022	12345	06/06/2021	20864424
	IV Giving Set	123456	10/2022	12345	06/06/2021	20864424
	IV Giving Set	123456	10/2022	12345	06/06/2021	20864424
RED TAG NOW	IV Giving Set	123456	10/2022	12345	06/06/2021	20864424
	IV Paracetamol 10mg/ml Solution For inj 100ml					

Filled in = Red Tag

2.13. After each use, all medicines within a pouch should be checked against the paperwork. This is to ensure there is sufficient medication for the next patient.

2.14. The Logistics Team will collect all pouches contained within the returns lockers across the Trust for return to the MDC for replenishment and re-use.

2.15. Each medicine bag will be made up of pre-packed pouches. At the start of every shift, staff must check that the pouch is securely sealed with either a green or yellow single use padlock seal (see Appendix A) AND that the expiry date displayed on each pouch has not passed. The most senior clinician will take responsibility, should inadequate checks be identified.

2.16. If a pouch is yellow tagged, crews should open the pouch to confirm there are no missing drugs prior to using the medicines bag.

2.17. ALL out of date, damaged or recalled medicines other than CDs must be returned to the MDC. This must be done by sealing the pouch with a red single use padlock seal and placing the pouch in a station returns locker, appropriately disposing of any sharps before sealing.

2.18. Once received into the MDC, all details will be recorded within the medicines tracking system.

2.19. Any pouch found to be incorrectly tagged must be returned to the MDC and a DIF1 (Datix) completed, clearly stating the following:

- Nature of problem identified
- Name of medication involved
- Location incident identified

2.20. Should an out of date pouch be found within the live stock, it should be withdrawn from circulation, returned to the MDC and a DIF1 completed as above.

2.21. Spare stocks of Red and Yellow single use padlocks seals are available at each station. Replacements can be obtained via the Logistics bin system used for all consumable products.

3 Definitions

3.1. Pharmacy Support Workers (PSWs) are the staff who work within the Medicines Governance Team

3.2. Datix is the Trust's incident management system.

3.3. DIF1 is the report process used by Datix.

4 Responsibilities

4.1. The **Chief Executive Officer (CEO)** is accountable for Medicines use and governance in the Trust

4.2. The **Chief Medical Officer** through delegation by the CEO, has overall responsibility for medicines governance system design and overall assurance. The Chief Medical Officerhas responsibility for the implementation, review, and thus revision where required, of this procedure.

4.3. The **Chief Pharmacist** is the professional medicines governance lead for the Trust and is responsible for producing robust systems and processes which comply fully with legislation, national guidance, and regulatory requirements to ensure the safe and effective management and use of medicines throughout the Trust. The Chief Pharmacist supports the Chief Medical Officerand Executive Director of Operations providing pharmaceutical professional advice with regards to all medicines related policies, procedures and practices.

4.4. The **Executive Director of Operations**, through delegation by the CEO, has overall responsibility for the implementation, operation and local assurance of this policy. The Executive Director of Operations has overall responsibility for holding his/her staff to account for any deviations from this policy and is responsible for the operational compliance of this procedure.

4.5. The **Executive Director of Operations**, **Chief Medical Officer**and **Chief Pharmacist** are responsible for escalating unresolved concerns to the Medicines Governance Group (MGG).

4.6. The Executive Director of Operations delegates local responsibilities and accountability for this procedure to the **Associate Directors of Operations**, **Operational Unit Managers, Operational Managers, Specialist Managers** and where relevant the **Head of Fleet and Logistics.**

4.7. The **Associate Directors of Operations, Operational Units Managers**, **Operational Managers, Specialist Managers** and where relevant the **Head of Fleet and Logistics** delegate their local responsibility and accountability for this policy to their staff including the **Operational Team Leaders (OTLs), Logistics Manager**, and others.

4.8. The **Executive Director of Nursing and Quality** has responsibility for matters relating to regulatory compliance, risk management, health and safety relating to this procedure.

4.9. **Controlled Drug Accountable Officer** is responsible for the safe management and use of Controlled Drugs within the Trust along with co-operating and sharing information relating to concerns about the Trust's use and management under the Controlled Drug (Supervision of Management and Use) Regulations 2013. These responsibilities include keeping records of the investigation of concerns and acting where appropriate.

4.10. The **Medicines Safety Officer (MSO)** supports local medication error reporting and learning. The MSO acts as the main contact for NHS England and Medicines and Healthcare Products Regulatory Agency (MHRA).

4.11. The **Medicines Governance Group (MGG)** is responsible, for providing strategic direction for the implementation of medicines management and practice within the Trust. The primary objective of MGG is to ensure appropriate clinical and cost effective use of medicines, promoting the highest standards of medicines management and safe practice throughout the Trust, by ensuring that senior managers are aware of issues relating to the use of medicines within the organisation as part of the overall clinical and corporate governance structure.

4.12. The **Medical Gas Subgroup** provides assurance to MGG that medical gases are effectively monitored and managed within the Trust.

4.13. The **Medicines Governance Team (MGT)** are responsible for ensuring the safe and efficient procurement of medicines, including controlled drugs to ensure the quality of the product, safe dispensing/packing into medicines pouches through to safe disposal of pharmaceutical waste. The MGT will support the Chief Pharmacist with drug shortages, drug alerts and relevant information relating to medicines is communicated in a timely manner.

4.14. **All staff** are responsible for their own professional practice. All staff involved in the prescribing, supply, dispensing, handling, storage, administration and disposal of medicines, including controlled drugs, must receive appropriate training and assessment of competence before commencing their roles. All staff who handle medicines are personally accountable for complying with this policy and relevant standard operation procedures, for reporting any concerns and for the safe handling of all medicines.

5 Education and Training

5.1. All staff working with medicines will receive Trust training detailing medicines processes. This may take the form of Transition to Practice training or training for their level of qualification i.e. Emergency Care Support Worker (ECSW) training.

5.2. Medicines processes will also be highlighted and discussed as part of all staff and responder local inductions.

6 Audit and Review (evaluating effectiveness)

6.1. OTLs perform weekly audits and monitor compliance to the tagging process during these audits.

6.2. Concerns arising from any audit that cannot be locally resolved and full compliance assured by next audit, must be escalated to the Director of Operations, Chief Medical Officer and Chief Pharmacist via a DIF1 report.

6.3. Any unexplained loss of medicines or repeated deviation from this SOP must also be reported via a DIF1.

6.4. The Chief Pharmacist and Medicines Governance Team will complete 6-monthly Medicines Security and Storage Audits and report any repeated deviations or other concerns to the Medicines Governance Group.

6.5. Adhoc inspection of medicines security and storage will also take place as part of the Crime Reduction Surveys and Quality Assurance Visits.

6.6. Deviations arising from these inspections must be escalated to the Director of Operations, Chief Medical Officer and Chief Pharmacist via a DIF1 report.

6.7. All procedures have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new policy is approved and disseminated.

6.8. Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

6.9. This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the policy is not working effectively.

6.10. All changes made to this procedure will go through the governance route for development and approval as set out in the Policy on Policies.

7 Financial Checkpoint

7.1. **This document has been confirmed by Finance to have no unbudgeted financial implications.**

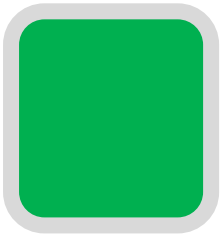
8 Equality Analysis

8.1. The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

8.2. Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.

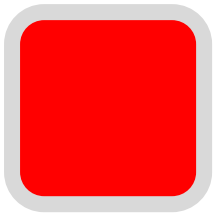
Appendix A: Pouch Tagging System (Pre-Packed Medicine Pouches)

Pouch Tagging System (Pre-packed medicine pouches)



A green seal indicates the pouch has been quality checked by the distribution centre and contains full stock

A Yellow seal **must** be used to seal the pouch when **more than the 'minimum stock level'** remains.



A red seal **must** be used to seal the pouch when the minimum stock level is reached, (as indicated on the packing list).

It is the responsibility of **all members of staff** to ensure that medicines are managed safely and effectively Operational staff MUST therefore seal the outside of every pouch correctly after every use

Appendix B: Pouch Tagging Process flowchar

THINK PATIENT SAFETY. THINK CORRECT PAPERWORK. THINK CORRECT TAG.

Pouch Tagging Process

Open the green/yellow tagged pouch and use the required items

Fill in the paperwork contained in the pouch for **everything** that you have used (do not restock with equipment from outside the pouch)

Are **any** darker shaded lines filled out?

NO

Are **only** lighter coloured lines filled out?
or
Was nothing used from the pouch?

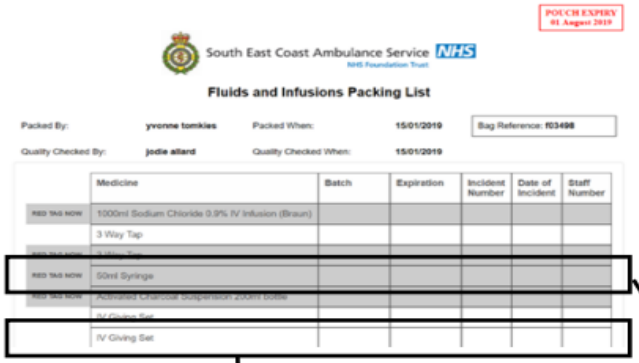
NO

YES

YES

Reseal the pouch using a yellow tag

Reseal using a red tag and place in the returns locker in the medicines room on station



Lighter coloured line

Darker shaded line

- Between April 2021 and April 2022, there have been over **900** reported tagging and incorrect paperwork incidents on DATIX
- The paperwork system is in place to ensure there is always at least one dose left for the next patient
- By tagging the pouch incorrectly, it can cause harm to future patients

Medicines Governance Team — V1.0 — February 2023