Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Safe and Secure Handling of MEDICINES POLICY

PART A

Please Note: This policy is currently under review and is still fit for purpose.

This procedural document supersedes: PAT/MM 1 A v.9 (amended 10 Jan 2018) – Safe and Secure Handling of Medicines Policy Part A

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Author/reviewer: (this version)	John Bane, Deputy Chief Pharmacist
Date written/revised:	2nd January 2019
Approved by:	Drug and Therapeutic Committee
Date of approval:	9th January 2019
Date issued:	7th February 2019
Next review date:	January 2022- **Extended to January 2023**
Target audience:	All Trust Staff

Amendment Form

Please record brief details of the changes made alongside the next version number.

If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date	Brief Summary of Changes	Author
10	7 February 2019	• Add section on exemptions for administration of medicines bt radiopharmaceutical operators and chiropodist • Amended 4.10 to include reference to the RMOC guidance for free of charge medicines schemes • Added reference to the Human Medicines Act 2012 • Removed reference to care groups and replaced with divisions	John Bane
9 (Amended 10 Jan 2018)	Aug 2017 Jan 2018	• Added section 3.6.1 on management of prescription forms with associated Appendicies XII and XIII • Section 5.3 – Added Immunosuppressants / Anti-rejections medicines (e.g.tacrolimus) • Added Magnesium 50% to section 19.1 to help mitigate risk of accidental overdose	John Bane
8	30 Sept 2016	• Updated section 2.14.1 to include all professionals who can qualify as an NMP. • Updated section 3.4.1.1 Emergency Drugs to include information about what the process for making medicines available for Emergency Situations that are not stored in tamper-proof containers. • Section 4.3.2 updated to include the Clinical Site Manager as a point of contact to order non-stock medicines out of hours. • Section 4.6.6, 7.4.2 and 17.9 updated to include an expiry date check.	John Bane

		• Section 9 updated to include addition of PRESCRIBING SAFETY ASSESSMENT for new Foundation doctors as a form of training and competency for prescribing. • Section 21.1 updated to refer to the new Non-medical Prescribing Policy • Section 21.2 updated by replacing pharmacist with non-medical prescriber • Section 22 updated to include reference to electronic versions of the BNF and BNF and removal of last year's edition as a recommended source. • Section 24.4 updated to remove midodrine as an example of an unlicensed medicine.	
7.2	22/04/2016	• Updated the section 3.3 to include electronic locks as the basic standard for drug cupboards where there is a new fit or refurbishment.	John Bane
7.1	13/04/2016	• Section 4.6.6 Updated to reflect current requirements for discharge with electronic prescriptions and findings from audit	John Bane
7	9 July 2015	• Single Nurse checking approved for paediatric and neonatal patients	Roger Hancocks
6	31 March 2015	• Addition to section 3.4.2.1 concerning room temperatures • Section 4.2 Updated to reflect the Appointed person responsibility to ensure expiry dates of medicines are checked • Section 4.6.6 Updated to reflect current requirements for discharge with electronic prescriptions • Changes to section 5.1 to permit the use of non-POM s without a prescription, subject to D&T authorisation •	Roger Hancocks
5	31 July 2013	• Changes to section 3.4 with respect to exemption to safe storage requirement • Section 4.5. Transport security allow personal carriage of medicines by	Roger Hancocks

		pharmacy and nursing staff without the need for a tamper evident pack or locked box • Section 4.9 Clinical Trial. Removal of the need for Medical Director indemnity approval which is no longer required • 4.12.1 Discrepancies of Controlled Drugs must be reported to the Chief Pharmacist • Section 6.2.3. Where a prescribed medicines is not administered as scheduled and electronic prescribing is used, an electronic note should be used to explain the reason if necessary • Section 5.6 Removal of the procedure to discharge using medicines supplied from ward stock. • Section 8.6. Allow the use of pharmacy prepared monitored dosage systems. • Section 9 Training and Competence has been redrafted The Clinical Director is responsible for ensuring staff in their DIVISION are competent and safe to undertake the various medicines management roles, including prescribing and administration • Appendix I – the PGD template has been removed • Appendix II – Medicines Reconciliation – Section reviewed please read. Includes a requirement for prescribers to prescribe all medicine on admission including those not intended to be continued • Appendix V - strong potassium. SCBU added as area authorised to hold strong potassium injections • Appendix IX – Updated to reflect the use of Ecoflac Mix reconstitution devices • Appendix X – New appendix relating to the provision of information to patients	

4	31/12/10	• The order of the sections within the policy has been changed to reduce duplication and create a series of chapters that define standards for security, stock control, prescribing, administration, and patient's own medicines. • The section concerning self administration has been removed and published as a separate policy. • The sample ward and department policies have been removed. • Ward and department managers now need to make a declaration that the policy is being implemented in their area as described and report this to their Matron. • Section 2.7 - classes of person authorised to administer medicines has been extended. • Section 2.9 - dispensed for discharge medicines is defined. • Section 3.4.2 - monitoring of medicines refrigerators has been made more explicit. • Section 5.1 - authorisation to supply under a Patient Group Direction extended to non registered healthcare professional provided the medicine involved is not a Prescription Only Medicine. • Section 5.2 - makes explicit the requirement for a new medicines chart or JAC ePrescribing record for each episode of care. • Section 5.3 - new section added regarding the timeliness of prescribing added and the use of stat doses. • Section 6.2 - the range of medicines that require to be checked by a second person has been revised.	Medicines Risk Management Sub Group

		• A new appendix IX describes those injectable medicines exempt from this second check. • Section 6.3 - new section added regarding timeliness of administration added and actions to be taken where medicines are not available. • Section 7.4 - the assessment of patients' own medicine prior to use has been revised. The requirement for Pharmacy staff prior approval has been removed. • Section 8 – new section added to encourage learning from incidents by sharing incidents and action plans between Clinical Service Units. • Section 9 – new requirement added for prescribers to make a self declaration of competence and address any deficiencies with their clinical supervisor. • Section 10 – now includes adverse drug reaction reporting via the MHRA Yellow Card system. • Section 11 – Audit program updated. • Appendix II – Medicines reconciliation process changed so that requirement to use the Medication History Pathway by the clerking prescriber is not necessary provided the information is documented in the clinical record correctly. • Appendices III and IV – new documents for self declaration of compliance to the policy by ward managers. • Appendix VII – Model non medical prescribing policy updated to reflect use of unlicensed medicines.	

		• Appendix VIII – new section added referring to information resources available on wards have been added	
3	February 2007	• Terminology has changed – See Glossary • Policy now define standards for cupboards security – Section 3.3 • Policy clarifies the process checking of administration of medicines – Section 4.9 • Policy now requires risk assessment of medicines to be undertaken by the Nurse in Charge or Head of Department Section 4.17 • New Appendix – model operational policy for non-medical prescribers Appendix IX	Medicines Risk Management Sub Group

Contents

1 INTRODUCTION

This is the eight edition of the Policy for the Safe and Secure Handling of Medicines of the Doncaster and Bassetlaw Hospitals NHS Foundation Trust. The main chapters now define the standards expected for:

- Security.
- Stock control and stock management.
- Prescribing and prescriptions.
- Medicines administration.
- The use of patients' own medicines.

Previously the document provided a generic model policy that each ward or department was expected to follow, and where there was a local variance the ward or department could write and have approved their own local policy, this policy takes a different approach.

The Appointed Person responsible in each area that handles medicines is expected to make a declaration that the policy is being followed. In some cases where there appears to be a variance, that variance will need to be approved by the Drug and Therapeutic Committee before the declaration can be made.

This does not preclude a local and more specific policy being developed where it is thought that it will provide clarity, provided that the principles of this policy are adhered to. Any local policy will need the approval of the Drug and Therapeutics Committee.

The policy has been written to take in to account NPSA guidance where this guidance impacts on the safe and secure handling of medicines. Any clinical guidance contained in these alerts is reflected in the appropriate formulary guidance.

The overall responsibility for the organisation, monitoring and reporting of the Trust's safe and secure handling of medicines continues to lie with the Chief Pharmacist. However, the responsibility for the procedural detail of how any clinical area complies with the policy's requirements rests with the management team of the Clinical Service Unit and Division concerned.

This policy has been written in consultation with representatives of medical, pharmacy and nursing staff and is issued as a Trust policy by the Trust Drug and Therapeutics Committee. It represents the minimum standards applied in any Clinical Service Unit for the handling of medicines. Clinical Service Units may develop their own specific procedures to suit their individual needs but must always apply these minimum standards.

It applies to all health care professionals treating clients of the Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust regardless of employing organisation.

2 GLOSSARY

2.1 Appointed Person:

The individual having overall responsibility for the safe and secure handling of medicines on the ward or department. Where there is a nurse, the Appointed Nurse in Charge with 24-hour responsibility for the ward, or in non-nursing departments the professional head of the department. Although this person may delegate duties to a designated person the responsibilities always lies with the Appointed Person.

2.2 Approved Supplier:

An organisation identified jointly by the Appointed Person and the Chief Pharmacist as a legitimate supplier of medicines to the ward or department.

2.3 Assigned Individual in Charge

Assigned Individual in Charge of a ward or department at a given time. Where there is a nurse, the Assigned Nurse in Charge of the ward, or in non nursing departments the professional head of the department or nominated deputy.

2.4 Community Based / Visiting Staff

Any member of staff who in the course of their contracted duties has reason to practise beyond the confines of Trust premises.

2.5 Controlled Drugs:

Any substance or product for the time being specified in Parts I, II, and III of Schedule 2 of the Misuse of Drugs Act.

2.6 Controlled Stationery:

All stationery that in the wrong hands could be used to fraudulently obtain medicines, e.g. Requisition books, Trust Prescription forms or FP10 forms.

2.7 Individual Authorised to Administer Medicines:

An individual who has undergone appropriate training and competence assessment to enable them to administer medicines within their area of practice without supervision.

Restrictions may be placed upon the range of medicines an individual is authorised to administer e.g. intravenous medication, intrathecal medication and cytotoxic drugs.

The following members of staff satisfy these requirements:

- A person whose name appears on Sub Part 1 of the Nurses part of the NMC register
- A person whose name appears on Sub Part 2 of the Nurses part of the NMC register and who has undergone approved additional training and who has been awarded a medicines proficiency certificate. There are two levels of the certificate which allow:
    - Administration of medicines excluding Controlled Drugs.
    - Administration of Controlled Drugs.
- A person whose name appears on the Midwives part of the NMC register
- A person whose name appears on the Specialist community public health nurses part of the NMC register
- A medical practitioner

Other staff, with the approval of the Drug and Therapeutics Committee may be authorised to administer medicines. This may include other registered health care professionals such as Operating Department Practitioners and Radiographers who have undertaken appropriate training, either as part of the core qualification or in addition to their core training.

In specific circumstances the Drug and Therapeutics Committee may authorise the administration of medicines by support staff such as healthcare assistants. A local procedure approved by the Drug and Therapeutics Committee will be required which will include a risk assessment of the process.

2.8 Individual Patient Cabinet:

A lockable cabinet approved by the Chief Pharmacist, located at, or near the patient's bedside, used exclusively for the storage of medicines used in the current treatment of that patient. These cabinets must not be readily portable

2.9 Medicine:

A substance administered to a person for the purpose of treating or preventing disease; diagnosing disease or ascertaining the existence, degree or extent of a physiological condition; contraception; inducing anaesthesia; otherwise preventing or interfering with the normal operation of a physiological function.

2.9.1 Stock Medicine

A medicine routinely held on a ward or department.

2.9.2 Non Stock Medicine

A medicine not routinely held as stock. Supply of a non stock medicine requires the authorisation of a pharmacist.

2.9.3 Pre-labelled Stock Medicine

A stock medicine pre-labelled with directions for use. The name of the patient for whom it is intended and date of supply is added when the supply is made.

Whilst they may be used during an inpatient stay they must not be supplied to the patient to take home until they have been prescribed for that patient specifically at discharge

2.9.4 Dispensed for Discharge Medicine

A medicine supplied to a ward for a specific inpatient that has been labelled with directions that are suitable for supply at discharge.

Whilst they may be used during an inpatient stay they must not be supplied to the patient to take home until they have been prescribed for that patient specifically at discharge

2.9.5 Patient's Own Medicines

A medicine brought into hospital by a patient. The medicine have been may be prescribed prior to admission by a GP or hospital doctor or may have been purchased by the patient. It is and remains the property of the patient

2.10 Medicines Refrigerator:

A lockable refrigerator specifically designed for the purpose, used exclusively for the storage of medicines. It is intended to maintain the temperature of the medicines between 2C and 8C.
(A domestic refrigerator, even when used exclusively for the storage of medicines, will not meet this definition).

2.11 Monitored Dosage System

A device that is used as a compliance aid by a patient that is prepared under the supervision of the patient's Pharmacist. The device is typically divided by days of the week and time of day. All stable medicines for a particular time and day being held in a single tamper evident compartment. The device is labelled with its contents and direction.

2.12 Patient Group Direction

A written instruction to enable a healthcare professional to supply and/or administered a medicine to groups of patients who may not be individually identified before presentation for treatment.

2.13 Patient Specific Direction

A written or electronic instruction from a prescriber for a medicine to be administered or supplied to a named patient.

2.14 Prescriber:

An individual designated by the Medicines Act 1968 / Human Medicines Regulations 2012 or any relevant secondary legislation as allowed to prescribe medicines. This group include doctors and non medical prescribers such as nurses and pharmacists.

2.14.1 Non-medical Prescribing

2.14.1.1 Independent prescribing

Independent prescribers are practitioners responsible and accountable for the assessment of patients with undiagnosed and diagnosed conditions and for decisions about the clinical management required, including prescribing. Within medicines legislation the term used is 'appropriate practitioner' and include:

- nurse and pharmacist independent prescribers are able to prescribe any medicine for any medical condition within their competence, including any controlled drug in Schedule 2,3,4 or 5 of the MDR 2002 Regulations, as amended
- optometrist Independent Prescribers can prescribe any licensed medicine for ocular conditions affecting the eye and surrounding tissue, but cannot prescribe any controlled drugs
- physiotherapists and podiatrists or chiropodists can prescribe any licensed medicine provided it falls within their individual area of competence and respective scope of practice as independent prescribers, but cannot prescribe any controlled drugs

2.14.1.2 Community Practitioner Nurse Prescribers

Previously known as District Nurse / Health Visitor prescribers.
Following training, eligible nurses can prescribe from the Nurse Prescribers' Formulary for Community Practitioners (formerly known as the Nurse Prescribers' Formulary for District Nurses and Health Visitors). Details of this formulary, which consists of appliances, dressings and some medicines are found in the *BNF* and Part XVIIB(I) of the Drug Tariff.

2.14.1.3 Supplementary Prescriber

Supplementary prescribing is defined as a voluntary partnership between an independent prescriber (doctor or dentist) and a supplementary prescriber to implement an agreed patient-specific clinical management plan (CMP) with the patient's agreement. Supplementary prescribers may prescribe any medicine (including controlled drugs), within the framework of a patient-specific clinical management plan, which has been agreed with a doctor.

Nurses, pharmacists, physiotherapists, chiropodists or podiatrists, radiographers and optometrists may train and register as a supplementary prescriber

2.14.1.4 Clinical management plan (CMP)

The *CMP* is the foundation stone of supplementary prescribing. Before supplementary prescribing can take place, it is obligatory for an agreed CMP to be in place (written or electronic) relating to a named patient and to that patient's specific condition(s) to be managed by the supplementary prescriber. This can include Controlled Drugs and unlicensed medicines for any medical condition, provided these are prescribed within the terms of the CMP.

2.15 Single Person Administration System

System of administration where an individual authorised to administer medicines may administer the medicines to a patient, without the need for a second individual authorised to administer medicines, to check the administration.

3 STANDARDS FOR MEDICINES SECURITY AND STORAGE

3.1 Management Arrangements

The Chief Pharmacist is responsible for the organisation, monitoring and reporting of compliance with the standards applied to the safe and secure handling of medicines specified in this policy.

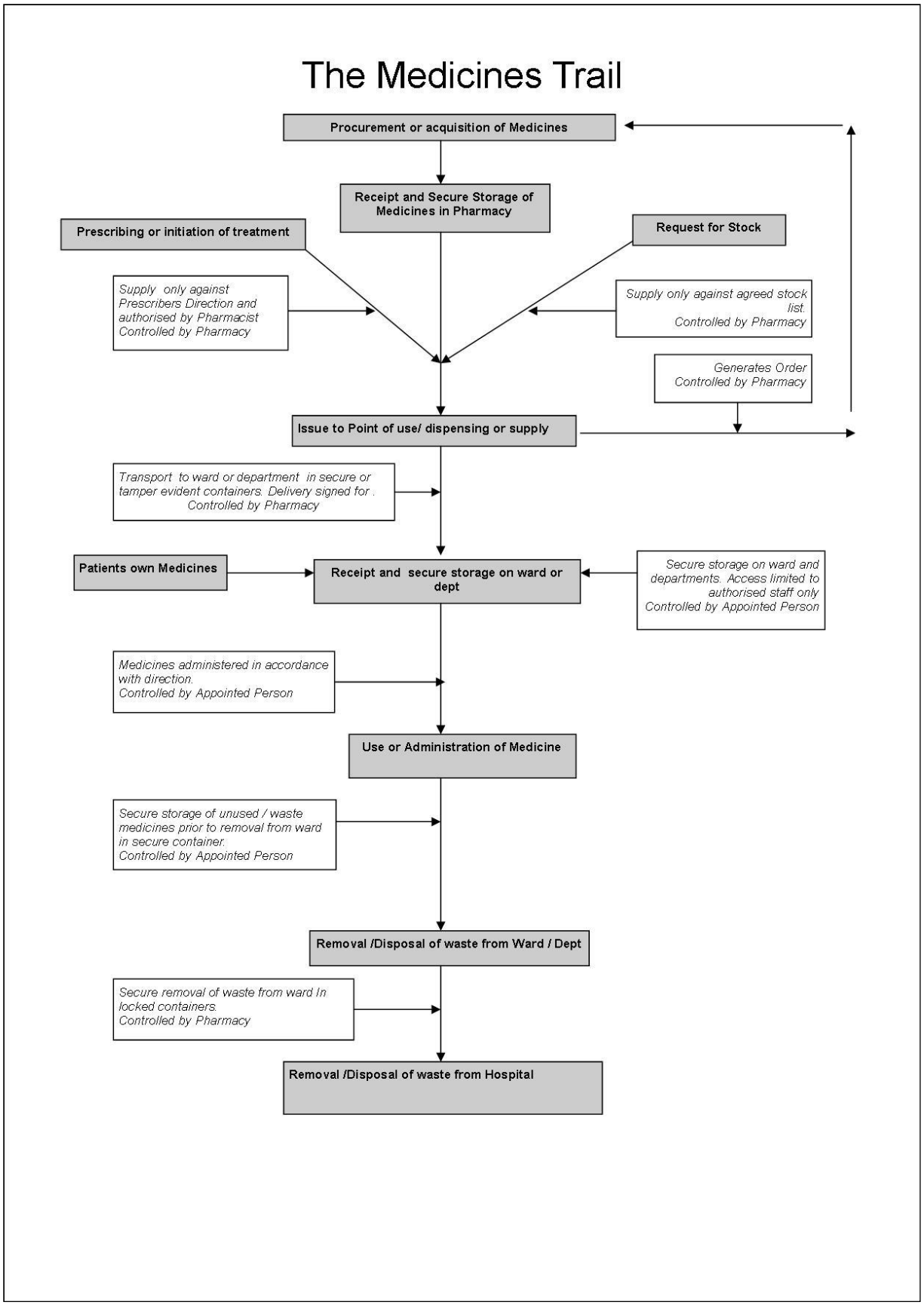
This responsibility will be discharged through the review and approval of all relevant procedures and reports by the Trust Drug and Therapeutics Committee on an annual basis.

The responsibility for the preparation and dissemination of approved procedures detailing how the standards specified in this policy are met within all Clinical Service Units that handle medicines lies with the Management Team of the Division concerned.

3.2 The Medicines Trail

All medicines used within the Trust will follow a pathway summarised on the next page unless alternative arrangements have been approved in advance.

As this is a multistage process there is a need to introduce controlled links between the stages. Within and between stages there will nearly always be the transfer of information and often materials. This policy is written to ensure adequate communication occurs and where medicines moves product integrity is maintained, products are handled safely and personnel are not exposed to hazards.


The Medicines Trail
Procurement or acquisition of Medicines
Receipt and Secure Storage of Medicines in Pharmacy
Prescribing or initiation of treatment
Request for Stock
Supply only against Prescribers Direction and authorised by Pharmacist Controlled by Pharmacy
Supply only against agreed stock list. Controlled by Pharmacy
Generates Order Controlled by Pharmacy
Issue to Point of use/ dispensing or supply
Transport to ward or department in secure or tamper evident containers. Delivery signed for . Controlled by Pharmacy
Patients own Medicines
Receipt and secure storage on ward or dept
Secure storage on ward and departments. Access limited to authorised staff only Controlled by Appointed Person
Medicines administered in accordance with direction. Controlled by Appointed Person
Use or Administration of Medicine
Secure storage of unused / waste medicines prior to removal from ward in secure container. Controlled by Appointed Person
Removal /Disposal of waste from Ward / Dept
Secure removal of waste from ward In locked containers. Controlled by Pharmacy
Removal /Disposal of waste from Hospital

3.3 Physical Security

All premises used for the storage of medicines will comply with the recommendations of the Security Manager based upon guidance laid down in the NAHA NHS Security Manual. These recommendations will consider the following:

- Denial; suitable physical and electronic barriers to ensure that the time necessary to breach security will facilitate detection.

- Deterrence; suitable physical and electronic barriers that will in themselves act as a deterrent.

- Detection; systems designed such that any attempted breach will be immediately apparent.

- Response; plans to ensure effective response should a security breach occur.

Cupboards for the storage of medicines should comply with the requirements of BS 2881:1989. Where this is not the case cupboards must approved by the Chief Pharmacist.

During new builds and refurbishment the opportunity must be taken to replace any cupboards that do not reach this British Standard and incorporate electronic or computer controlled lock mechanism. The standard defines three security levels and the intended use of the service will inform the required security level.

Where electronic or computer controlled locks are used they should offer the same level of security as the traditional mechanical locks they replace. They should meet the following minimum standards.

1. In the event of power failure locks should fail closed and have a mechanical override.
2. Where PIN numbers are used they should be individual and not shared.
3. Where close proximity fobs are used they should be individual and not shared.
4. Software should track access to the cupboards by users.
5. Appointed Person, who has 24 hours responsibility for the ward or department, is responsible for controlling access to the medicines cupboards.

Mechanical digital locks are not appropriate for controlling access to medicines.

All breaches in the physical security of premises used for the storage of medicines will be reported to the Appointed Person and their line manager of the premises concerned, the Security Manager and the Chief Pharmacist, who will arrange an appropriate investigation. Such breaches will be considered to include:

- The physical diversion of medicines or Controlled Stationery.

- The presence of unauthorised persons on the ward or department.
- The discovery of evidence of tampering with medicines.

- The delivery of medicines from a non-Approved Supplier.

- The delivery of medicines to a non-designated person.

The physical security of medicines, including Controlled Drugs and Patient's Own Medicines, stored on all wards and departments holding medicines in the Trust will be checked periodically. See Section 4.12 Stock Balances, Losses, and Discrepancies. This inspection will include audit and reconciliation where necessary.

The Appointed Person will ensure that the staff performing physical security checks and stock reconciliation are appropriately rotated to ensure secure delegation is maintained.

All exceptions and/or discrepancies, regardless of when and by whom they are detected, will be reported to the Appointed Person, who will arrange for an appropriate investigation and formal reporting to take place. See Section 4.12 Stock Balances, Losses, and Discrepancies

3.4 The Storage of Medicines

The Appointed Person is responsible for the safekeeping of medicines on the ward or department and will ensure the following at all times:

The following classes of stock medicines will be stored in locked cupboards, approved as suitable by the Chief Pharmacist unless Individual Patient Cabinets are employed on the ward or department, or alternative arrangements have been approved by the Chief Pharmacist:

• Controlled Drugs
• Medicines for Internal Use
• Medicines for External Use

Controlled Drugs shall be stored in a separate Controlled Drug Cabinet used solely for that purpose.

Where internal medicines are store in the same cupboard as external medicines, they shall be segregated on different shelves.

The following medicines shall also be considered as Controlled Drugs for the purpose of storage:

- Morphine Sulphate Oral Solution 10mg/5ml
- Temazepam preparations
- Schedule 3 Controlled Drugs such as barbiturates, but see midazolam below
- Midazolam 10mg in 2ml Injection, but not other midazolam preparations
- Strong Potassium Injections

Non-stock medicines labelled for individual patients will be stored together either in a Medicine Trolley or an Individual Patient Cabinet.

Stock medicines in current use for patient administration will be stored together either in a Medicine Trolley or an Individual Patient Cabinet.

If in the course their duties visiting wards, Pharmacy Staff observe circumstances where the security of ward medicines are compromised they should bring this to attention of the Individual in Charge who will resolve the breach. Where they find this on repeated occasions they should bring it to the attention of the Individual in Charge and an datix incident form completed with the Appointed Person appointed as the handler.

3.4.1 Exemption from Secure Storage Requirements

The following items will be held in separate storage areas, approved as suitable by the Chief Pharmacist:

- Intravenous, Urological and Sterile Topical Fluids.
- Medical Gases.
- Water for injection and Sodium Chloride 0.9% for Injections ampoules and vials, provided they are stored in their original containers and within the clinical room which is secured by a mechanical digital lock or similar

Products that are medicinal products that have been approved by Drug and Therapeutic Committee for supply by NHS Supply Chain are exempt from safe storage as medicines. These product should be stored as any other product supplied by Supply Chain in a manner consistent to the risk they present.

3.4.1.1 Emergency Drugs

Where the ward or department holds a supply of medicines for use in a medical emergency this will be held in a tamper evident container. The container need not be kept in a locked cupboard, but will be located in an area that is most likely to have a constant staff presence that is not obvious to the general public. If there is a requirement for medicines other than those kept in the tamper evident container for a medical emergency, separate arrangement should made for their availability and that these arrangements are documented and communicated to all those concerned.

This should be led by the trust's lead Resuscitation officer and the patient safety review group.

3.4.1.2 Other Specified Medicines

To enable timely treatment the following medicines are exempted from locked storage and may be stored on bedside lockers for immediate use

- GTN tablets and Spray for the treatment of anginal pain
- Inhalers
- Emollient Creams and Ointments
- Chlorhexidine Mouthwashes

An individual authorised to administer medicines may assess a patient as suitable to have control of and take these medicine themselves provided the following conditions are met:

- The patient understands what their medicines are for and the how to take them correctly.
- Suitable safe keeping arrangements are available to prevent misuse by others.
- The medicines are labelled with the patient's name and instructions for use.
- A record of the dose and frequency of administration is made on the in-patient medicine administration record.

All medicine cupboards and refrigerators will be used solely for the purposes of storing medicines and will not contain other items.

Any medicine trolley employed on the ward or department will be lockable and immobilised or otherwise securely stored when not in use.

The Appointed Person will ensure that access to medicines is restricted, by control of keys to the medicine cupboards and refrigerators, or other alternative approved storage areas. This responsibility remains with the Appointed Person even if they decide to delegate this duty.

Where a duplicate set of keys to the medicine cupboards of the ward or department exists, the Management Team responsible for the clinical area will be responsible for their safe storage. A record of their issue will be maintained.

3.4.2 Medicine Refrigerators

Except for access the refrigerator must be kept locked at all times.

The medicine refrigerator may only be used to store medicines. Food, samples or other materials which are not medicines should be stored elsewhere.

3.4.2.1 Temperature Monitoring

The majority of medicines that do not require cold storage need to be stored at or below 25° Celsius. Some are specified as below 30° Celsius, and occasionally a range is specified, usually 15° to 25° C. Where a minimum is specified this is because the formulation may be susceptible to extremes of cold, often liquid or semi-solid medicines. Therefore wards should aim to store medicines in the range 15° to 25° C. Routine storage above 25°C should be investigated and remedied.

Short periods outside the range 15° to 25°C are permissible providing the mean temperature remains in the recommended range. Temperature spikes above 30°C may also be allowed but these should always be discussed with a pharmacist before any of the medicines are used.

Where, due to hot weather, staff are aware (or suspect) that temperatures in medicines storage areas have reached in excess of 30°C, they should seek advice by contacting Medicines Information at DRI on ext 3317 or a member of their ward pharmacy team. **Where there is reason to believe that the temperature has exceeded 30°C for the whole of a period of 24 hours, or the temperature has exceeded 40°C for any period of time, this advice should be sought before any of the medicines are used** (in these circumstances out of hours advice can be obtained via the on-call pharmacy staff).

Medicines requiring refrigeration should always be stored in a medicines refrigerator which is monitored **at least once every 24 hours** to ensure it is in working order and that the temperature is maintained between 2 and 8°C. Where the temperature has not been maintained in this range for significant periods (the whole of a period of 3 hours or longer) pharmacy advice should be obtained.

The temperature the medicines refrigerator must be monitored and recorded on each working day.

The following readings should be recorded:

- Current temperature
- Maximum temperature and more importantly the MINIMUM temperature
- The date of the record and the person making the record
- Any actions taken if the temperature is out of range

The temperature should be measured at the same time each day if possible. The thermometer must be reset after each reading is taken.

If the refrigerator is working properly and the door has been closed for some time the current temperature will be in the range 2 — 8° Celsius. If it is not the individual in charge must investigate. Consistently seeing the current temperature in the range 2 – 8° Celsius will re-assure Appointed Person that the refrigerator is working properly.

The minimum temperature should not go below 2° Celsius, if it does the individual in charge will investigate. If the minimum temperature is zero or below, or the stock is suspected as having been frozen, the stock must quarantined and the advice of the pharmacist sought before use.

The Appointed Person is responsible to ensure that where these records indicate the medicines are being stored outside the recommended range action is taken to ensure the quality of the medicines before use.

3.5 Transport Security

The Chief Pharmacist will ensure that the transport of medicines to the wards or departments is consistent with the following requirements.

Arrangement for the delivery of medicines will be made by the Pharmacy Service. This delivery will be achieved by one of the following methods.

- An Approved Supplier's own transport facilities.

- Transport facilities contracted by the Pharmacy
- Transport facilities provided directly by the Trust.

- Designated staff employed by the Trust.

- Postal services.

Medicines will be received only by a Designated Person.

Medicines will be transported in locked or sealed, tamper evident containers, or by being personally carried by an authorised member of the Pharmacy Staff or a member of the ward or department who is a Registered Nurse staff person and using a system considered by the Chief Pharmacist to be appropriate to the risk of diversion.

Tamper evident containers may be used when transportation is under personal control. Secured containers in secured vehicles should be used when the medicines are not under personal control throughout the transportation.

Upon delivery, containers will be either unpacked immediately or stored in a secure location until unpacked.

The Appointed Person will ensure that medicines awaiting return to the Pharmacy Department shall be stored securely on the ward or department

3.6 Controlled Stationery

The Appointed Person will ensure that all Controlled Stationery on the ward or department is held securely.

Any loss or theft of any item of Controlled Stationery will be reported to the Appointed Person for the ward or department and their Line Manager, and to the Chief Pharmacist at the earliest opportunity.

3.6.1 Guidance for the Use of Outpatient & FP10HNC Prescription Form in Clinics and Departments

Outpatient and FP10 HNC forms are prescription forms used in outpatient settings. Outpatient prescription forms can only be dispensed at either Well Pharmacy at DRI or the dispensary at Bassetlaw Pharmacy whereas FP10 HNC forms are issued for dispensing by community pharmacies. Patients who are given FP10 HNC Forms should be advised to go to their community pharmacy, not hospital dispensaries.

3.6.1.1 Security and Storage

The Appointed Person is responsible for safe and secure storage of prescription pads held in their department. These prescription forms are treated as controlled stationery. When not in use they should be secured in a locked cupboard to which only the Medicines cupboard key holder has access.

The Appointed Person must put in place processes to enable them to account for the pads in their possession. This needs to include use of a Controlled Stationery Register (Appendix XII) to log and monitor the use of prescription forms. The Assigned Individual in Charge of the clinic is responsible for issuing prescription pads to users. On taking receipt of a prescription pad, the number on the top prescription form should be noted in the register and the receiver prints and signs their names. This process is repeated when the prescription is returned for safe keeping.

Replacement prescription pads are ordered from Pharmacy using a signed requisition. The requisition must be accompanied by empty pads with its reference numbers and copy of the completed Controlled Stationery Register. These are accounted for in the Pharmacy issue and return log. Whilst in use in clinic rooms, measures should be taken to ensure pads and forms are not at risk of theft. Pads should not be left unattended in rooms when patients are present.

3.6.1.2 Use

Pads are supplied for exclusive use within the clinic to which they are issued. Prescription forms must not be used outside those clinics or for writing discharge prescriptions. FP10 prescription pads are allocated to specific services and Divisions. The medicine and dispensing costs associated with wrong use will be allocated to the service to which the pad was originally issued. Unless a person is a *bona fide* registered

NHS patient attending a DBH clinic, FP10HNC forms must not be used for prescribing to staff members, family or friends; such use will result in disciplinary action as it may be constituted as theft.

3.6.1.3 Loss of Pads

The loss or theft of prescription forms must be investigated immediately and reported to the Chief Pharmacist or his/her deputy. The reporter must detail the prescription numbers involved. The Chief Pharmacist will complete an incident form, notify NHS England North where it involves FP10 HNC prescriptions and notify local security management specialist (LSMS) who will in turn notify NHS Protect as appropriate. The LSMS will notify NHS Protect using the missing/lost/stolen prescription notification form (Appendix XIII) and initiate an investigation, if required. NHS Protect may advise the Prescriber to write and sign all prescriptions in a particular coloured ink for the next two months. The LSMS must also inform the Local Counter Fraud Specialist (LCFS) who, if appropriate, will arrange for an alert notice to relevant pharmacies.

3.7 Ward or Department Closures

Medicine holding wards or departments will be considered to be closed in one of three circumstances:

3.7.1 Routine Closures

These closures will occur as part of the normal cycle of activity of the ward or department e.g. five day wards, outpatient departments.

The Appointed Person will ensure that all medicines are stored in cupboards as specified in Section 3.4

The Assigned Individual in Charge at the time of each closure will be responsible for ensuring the keys are stored in a secure place agreed as suitable between the Appointed Person and the Chief Pharmacist.

Wherever possible, the doors to the ward or department will be locked during the period of closure.

3.7.2 Temporary Closures

NB. Routine closures of departments e.g 5 day wards, departments or theatres are not within this definition

These closures will occur when the ward or department shuts for a planned period of time.

When the period of time is no greater than two weeks the Appointed Person will be responsible for:

- Ensuring all medicines will be stored in cupboards as specified in Section 3.4
- Ensuring the keys will be stored in a secure place agreed as suitable between the Appointed Person and the Chief Pharmacist.
- Ensuring wherever possible, the doors to the ward or department will be locked during the period of closure.

When the period of temporary closure is greater than four days Controlled Drugs will be returned to the local pharmacy for storage. The Appointed Person will ensure a stock check is undertaken with a designated member of the Pharmacy Staff who will remove the medicines and Controlled Drugs Register for safe storage. On re-opening the Appointed Person will undertake a stock check with a designated member of the Pharmacy Staff to confirm the correct return of the Controlled Drugs to the ward or department.

When the period of time is greater than two weeks the Appointed Person will be responsible for:

- Making arrangements with the local Pharmacy for the return and storage of all medicines during the period of the closure.
- Creating a list of all drugs to be returned.
- Reconciling all medicines returned when the ward or department re-opens.

3.7.3 Permanent Closures

These closures will occur when the ward or department shuts on a permanent basis.

The Management Team will be responsible for clinical area will notify the Chief Pharmacist of the permanent closure.

The Chief Pharmacist will be responsible for arranging the return and credit or disposal (as appropriate) of all medicines stocked on the ward or department.

3.8 Medicines Held by Community Based / Visiting Staff

The security of medicines issued to Community Based / Visiting Staff will be the responsibility of the individual authorised to administer or Prescriber to whom they are issued.

All medicines will be stored in a locked container.

Except when carried on the person of the individual authorised to administer or Prescriber the container will be kept locked out of sight at all times.

Only in exceptional circumstances will it be acceptable for Community Based / Visiting Staff to retain medicines under their control at home overnight. In any such circumstance, the medicines will be placed in a secure lockable fixture.

3.9 Handling Medicines following the Death of a Patient

Following the death of a patient, medicines shall normally be sent to the Pharmacy for destruction in the ward/department transit box. However, where harm is suspected as a result of medicines administered, any medicines in use shall be retained on the ward until the death certificate and /or investigation has been completed.

4 STANDARDS FOR STOCK MANAGEMENT AND CONTROL

4.1 Responsibility

An Appointed Person will be identified who is responsible for ensuring this Policy is followed and that the security of medicines on the ward or department is maintained.

The Appointed Person may delegate some of the duties described, but the responsibility always remains with the Appointed Person.

4.2 Medicines Identified As Stock

A list of common medicines (including those legally classified as Controlled Drugs) and the appropriate quantity to be stocked on the ward or department will be decided by Pharmacy Services in consultation with the Appointed Person.

The stock list will be subject to a review at specified intervals not exceeding 12months. All changes will be communicated to the Appointed Person together with a copy of the updated list.

The Appointed Person will ensure procedures are in place to ensure all staff involved in their use are familiar with the range of medicines stocked on the ward or department.

The Appointed Person shall ensure that procedures are in place to ensure the expiry dates of medicines are checked on an appropriate and regular basis. Where the Pharmacy Service provides a topping up service a quarterly check of expiry dates shall also be undertaken during the stock top up service.

4.3 The Ordering of Medicines

4.3.1 Stock Medicines

For areas that receive a pharmacy-based top-up service, Pharmacy Services are responsible for the ordering of medicines to maintain stock levels, at those times agreed between Pharmacy Services and the ward or department.

For those areas that receive a self-listed top-up service, the Assigned Individual in Charge at the time is responsible for the regular completion of top-up sheets ordering medicines from Pharmacy to maintain stock levels, at those times agreed between Pharmacy Services and the ward or department.

At all other times and under all other circumstances the Assigned Individual in Charge of an area is responsible for the ordering of medicines to maintain stock levels through contact with the local pharmacy. When an item is considered to be

required urgently it is the responsibility of the Assigned Individual in Charge to communicate this to the local pharmacy.

For those wards or departments using top-up sheets and requisition books, the sheets and books are considered Controlled Stationery. The Appointed Person is responsible for ensuring they are stored in a secure location at all times.

4.3.2 Non-Stock Medicines

The Assigned Individual in Charge of an area is responsible for ordering non-stock medicines for individual patient use. This will be through one or more of the following routes depending on the service model agreed between Pharmacy Services and the ward or department.

- Contact with the Pharmacist providing clinical services to the ward or department.

- Carriage of a requisition to the local dispensary together with the patient's prescription chart.

- Contact with the On Call Pharmacist providing emergency out-of-hours cover for the Trust or the Clinical Site Manager.

- In the case of non stock Controlled Drugs through carriage of a completed Controlled Drug Requisition Book to the local dispensary.

4.3.3 Controlled Drugs

Refer to the Policy for the Safe and Secure Handling of Medicines Part B Controlled Drugs

The following medicines shall also be considered as Controlled Drugs for the purpose of ordering:

- Morphine Sulphate Oral Solution 10mg/5ml
- Temazepam preparations
- Schedule 3 Controlled Drugs such as barbiturates, midazolam preparations
- Strong Potassium Injections

4.4 The Receipt of Medicines on Wards and Department

4.4.1 Stock Medicines

A designated person will check stock medicines coming into the ward or department against the delivery note. They will sign and date the delivery note. Any discrepancies noted will be referred to the Assigned Individual in Charge who will immediately inform the appropriate local pharmacy.

The Appointed Person will ensure that delivery notes are retained on a ward or department for a specified period to be not less than twelve months from the date of issue.

4.4.2 Non-Stock Medicines

Non-stock medicines coming onto the ward or department will not be accompanied by an issue note but will be received by a designated person.

The designated person will ensure the medicines received are appropriate for the intended recipient by reference to the relevant Authority for Administration/Supply. Any discrepancy is referred to the Assigned Individual in Charge, who will immediately inform the appropriate local pharmacy.

Where the intended recipient has been transferred to another location within the Trust the designated person will arrange the transfer of the medicines to that location and record this on the Inpatient Transfer Checklist.

4.4.3 Controlled Drugs

Refer to the Policy for the Safe and Secure Handling of Medicines Part B Controlled Drugs.

The following medicines shall also be considered as Controlled Drugs for the purpose of receipt:

- Schedule 3 CDs e.g. Barbiturates, Buprenorphine, Temazepam, Flunitrazepam, diethylpropion
- Midazolam 10mg/2ml Injection (but not other midazolam preparations)
- Morphine Sulphate 10mg/5ml Oral Solution
- Strong Potassium Injections

4.5 Supply of Medicines for In-Patient Administration

Following the authorisation to administer by a prescriber, the authorisation of a pharmacist is required before the supply of a non stock medicine is made to a ward or department.

This authorisation is given in a number of ways depending upon the model of service provided.

- The written prescription is signed as approved for dispensing by a pharmacist.
- The computerised prescription is verified for dispensing by a pharmacist by means of a password controlled electronic signature.

Medicines for in-patient administration that are not stocked on the ward or department will be dispensed by a member of the Pharmacy Staff who has been certified as competent to dispense by the Chief Pharmacist.

All dispensing will be carried out under the provisions of a separate procedure. The Chief Pharmacist will approve this. It will comply with all the legal and professional requirements laid down in the Medicines Act 1968 / Human Medicines Regulations 2012 and The Misuse of Drugs Act 1971.

4.6 Supply of Medicines for Discharge, or to Outpatients, or Patients Attending A&E

The authorisation of a Prescriber will be obtained before any medicine is supplied to a patient of the Trust. See section 5.1

4.6.1 Authorisation by a Pharmacist

Where supply is by means of a prescription, the supply also requires the additional authorisation of a pharmacist.

This authorisation is given in a number of ways depending upon the model of service provided.

- Where pre-labelled medicines are provided as stock, authorisation to supply these medicines is automatically granted by the pharmacist who approves the addition of these medicines to the stock list
- The written prescription is signed as approved for dispensing by a pharmacist
- The computerised prescription is verified for dispensing by a pharmacist by means of a password controlled electronic signature.

In the exceptional circumstances where all the medicines are available and appropriately labelled on the ward, and the discharging nurse decides it is best interest of the patient that the patient should be discharge without the prescription first being authorised by a pharmacist, the nurse will take responsibility for the safe supply of the medicines.

The supply of medicines for discharged patients may be undertaken in a number of ways depending upon the model of service in place on the ward. The persons supplying and checking the medicines shall annotate the authorisation to supply to indicate the quantity supplied and the individuals involved in the supply.

The patient may receive their medicines by one or more of the methods detailed below.

4.6.2 Supply of Medicines by the Pharmacy Service

Where a requirement exists for medicines to be supplied to a patient that are not available on the ward or department in a suitable form such as a pre-labelled stock, the patients own medicines or medicines labelled for discharge, they will be dispensed against a prescription by a member of the Pharmacy Staff who has been certified as competent to dispense by the Chief Pharmacist.

All dispensing will be carried out under the provisions of a separate procedure, approved by the Chief Pharmacist. This procedure will comply with all the legal and professional requirements laid down in the Medicines Act 1968 / Human Medicines Regulations 2012 and The Misuse of Drugs Act 1971.

All medicines shall be checked by an individual authorised to administer medicines (or authorised member of the pharmacy staff) prior to handling over to the patient or their representative. See section 4.6.6 Assembly of Medicines at Discharge.

4.6.3 Supply of Pre-Labelled Stock Medicines

Where appropriate, a list of pre-labelled stock medicines shall be made available to the ward or department. The Senior Clinical Pharmacist responsible for the area concerned shall decide upon the range of pre-labelled stock medicines available. These may be issued against a patient specific prescription or a Patient Group Direction.

The packs will be labelled with appropriate instructions and the person supplying the medicine will ensure the patient's name and the date of dispensing are added. A Patient Information Leaflet must be supplied with each medicine.

The stock list will be subject to a review of every 12 months, with all changes being communicated to the Appointed Person together with a copy of the updated list.

The Appointed Person will ensure that all staff involved in their use are familiar with the range of medicines stocked on the ward or department for supply under these circumstances. This will include any necessary information to be given to the patient on their issue.

The supply of any pre-labelled stock medicine will be made only by an individual authorised to administer medicines or by members of the Pharmacy Staff who have been certified as competent to dispense by the Chief Pharmacist.

The supply shall be checked by another individual authorised to administer medicines or a member of the Pharmacy Staff who has been certified as competent to check by the Chief Pharmacist.

This check may take place at the point of assembly by an individual authorised to administer medicines (or authorised member of the pharmacy staff) prior to

handling over to the patient or their representative. See section 4.6.6 Assembly of Medicines at Discharge.

4.6.4 Supply of Medicines Dispensed for Discharge

Medicines supplied during the patients stay may be supplied to the ward ready labelled for the patient to take home, i.e. dispensed for discharge. Provided that a valid authorisation to supply exists and the instructions are correct, these medicines may be supplied to the patient at discharge. A Patient Information Leaflet must be supplied with each medicine.

The supply of any dispensed for discharge medicine will be made only by an individual authorised to administer medicines or by members of the Pharmacy Staff who have been certified as competent to dispense by the Chief Pharmacist.

All medicines shall be checked by an individual authorised to administer medicines (or authorised member of the pharmacy staff) prior to handling over to the patient or their representative. See section 4.6.6 Assembly of Medicines at Discharge.

4.6.5 Return of Patients' Own Medicines at Discharge

Suitable patients' own medicines may form part of the discharge prescription. Section 7 gives further details for the criteria where re-use is permitted.

All medicines shall be checked by an individual authorised to administer medicines (or authorised member of the pharmacy staff) prior to handling over to the patient or their representative. See section 4.6.6 Assembly of Medicines at Discharge.

4.6.6 Assembly of Medicines at Discharge

All medicines shall be checked by an individual authorised to administer medicines (or authorised member of the pharmacy staff) prior to handing over to the patient or their representative.

Medicines for discharge may come from a variety of sources.

- Medicines brought in on admission.
- Pre-labelled medicines from stock; these require the patient's name and date of supply adding.
- Medicines supplied during the patient's stay ready labelled for discharge.
- Medicines dispensed by the Pharmacy or exceptionally on the ward at the point of discharge.

Before handing over the discharge medicines to the patient the following checks or actions must be made.

For Patients with Paper In-Patient Charts and Discharge Prescription

- The discharge prescription is checked against the current inpatient prescription .This is to ensure that alterations have not been made to the inpatient prescription since the discharge prescription was written. If there is a difference, these problems must be resolved first by contacting the prescriber or pharmacist.
- The discharge medication is assembled from the individual patient cabinet and those items supplied by Pharmacy.
- These medicines are checked against the discharge prescription. Check:
    - The patient's name.
    - The medicine.
    - The dose.
    - The contents agree with the packaging or that the tamper evident seal is intact.
    - The expiry date (only applicable to medicines **NOT** dispensed by Pharmacy during admission)
- The notes copy prescription shall be marked and signed by the individual authorised to administer medicines to indicate these checks have been performed

For Patients with Electronic Inpatient and Discharge Prescriptions

- At the point the patients is ready to be discharged and the medicines are on the ward, the discharge letter is printed.
- The discharge medication is assembled from the individual patient cabinet and those items supplied by Pharmacy.
- These medicines are checked against the discharge prescription. The following are checked:
    - The patient's name.
    - The medicine
    - The dose.
    - The contents agree with the packaging or that the tamper evident seal is intact.
    - The expiry date
- The discharge letter shall be signed and dated by the individual authorised to administer medicines to indicate these checks have been performed.
- The patient is immediately discharged from JAC when checks are complete and a correct copy of the discharge letter is filed in the clinical records.
- If the process cannot be completed the discharge letter should be destroyed. It should be reprinted at the point the checks can be completed.

For All Patients

Where a pre-labelled medicine is supplied at discharge, the patient's name and date of supply shall be added by the individual authorised to administer medicines who has dispensed it.

If any patient's own medicines are returned, the patients' own medicines checks shall be undertaken including a check that the medicines belong to the patient and they have not exceeded their expiry date.

The individual authorised to administer medicines shall hand the medicines to the patient or their representative, together the patient copy of the discharge letter. They will make sure they understand how the medicines are taken and how to obtain further supplies.

The notes and GP copies shall by processed and filed according to ward procedures.

4.7 Return of Unwanted Medicines

The Appointed Person will ensure that medicines awaiting return to the Pharmacy Department be stored securely on the ward or department. This includes ward stocks, non-stock items and patients own medicines awaiting destruction. Routine return of medicines to the Pharmacy Department will be by the locked drug box.

4.7.1 Return of Unwanted Controlled Drugs

Refer to the Policy for the Safe and Secure Handling of Medicine Part B Controlled Drugs.

4.8 Disposal of Medicines

All medicines will be disposed of in accordance with the requirements of the Trust Waste Disposal Policy.

Non Controlled Drugs for disposal must be returned to the Pharmacy for destruction. Whilst awaiting removal from the ward the Appointed Person is responsible for ensuring that the potentially waste medicines are held in a secure manner.
For Controlled Drugs - Refer to the Policy for the Safe and Secure Handling of Medicine Part B Controlled Drugs.

Medicines wasted during administration, for example, by patient refusal must be disposed of in a sharps bin as clinical waste.

4.9 Medicines Supplied Through Clinical Trials

Clinical Trial are regulated by the EU Clinical Trial Directive (EC Directive 2001/20/EC) published in April 2001 and transposed into UK legislation by Regulations in May 2004.

Prior to commencement of any clinical trial the Clinical Investigator will be responsible for ensuring that:

- Approval has been obtained from an appropriate ethics committee.

- Authorisation from the MHRA has been obtained.

The ordering, distribution, and receipt of clinical trial medicines will follow the requirements specified in Sections 4.3, 3.5, and 4.4 respectively.

The storage of clinical trial medicines will be restricted to Pharmacy premises. Stocks will not be maintained in wards, clinics, departments or private offices unless the trial involves a medicine used in an emergency situation, when sufficient stocks should be held for immediate use; specific written guidance is will be included the trial's supply procedure.

The relevant Pharmacist will hold copies of all trial protocols, including codes and all patient information sheets.

The Clinical Investigator will be responsible for ensuring the processes in place within the relevant Clinical area for managing the introduction of new medicines are considered, and that continued treatment for individual patients, where appropriate, is guaranteed when the trial is complete.

4.10 Medicines Supplied as Free Samples or part of a free of charge scheme

Accepting free samples of medicines or participating with a free of charge medicines scheme need to be approved by the trust Drugs & Therapeutics Committee and only after receiving a request from the the following individuals:

- Prescribers who carry overall clinical responsibility for the patient(s) the medicines will be administered / supplied to.

- Pharmacists acting with the knowledge of the Divisional Director of the Clinical area concerned.

In making a decision, the committee should refer to Regional Medicines Optimisation Committee's advice on Free of charge (FOC) medicines schemes[1].
Free samples of medicines will be received into the Trust solely through the Pharmacy, and will only be accepted where authorisation has been approved.

The individual requesting the stock will be responsible for ensuring the processes in place within the relevant Clinical area for managing the introduction of new medicines are in place.

[1] Free of charge (FOC)medicines schemes. Regional Medicines Optimisation Committee, 2018. https://www.sps.nhs.uk/wp-content/uploads/2018/07/FOC-medicine-scheme-policy-v-1.0Final.docx

4.11 Unlicensed Medicines

Prescribers who carry overall clinical responsibility for patients may use unlicensed medicines in the course of their practice.

However the use of unlicensed medicines may present a risk both to the patient and the Trust. Further guidance should be sought from the Trust's Policy concerning the use on unlicensed medicines, PAT/MM 4.

By their nature the effects of an unlicensed medicine may be less well known than a licensed product. Health care professionals are reminded of their duty always to act in the best interest of their patient. In the case of an unlicensed medicine this may mean refusing to administer an unlicensed medicine where they have grounds to believe it may be unsafe.

The Trust Drug & Therapeutics Committee will act to resolve any conflicts regarding the use of unlicensed medicines or medicines used outside of their licensed indications.

4.12 Stock Balances, Losses and Discrepancies

4.12.1 Controlled Drugs

Stock balance and discrepancies will be handled according to the Policy for the Safe and Secure Handling of Medicines Part B Controlled Drugs.

4.12.2 Investigation of Drug Discrepancy or Loss Occurring in the Hospital or Community

It is acknowledged that in the community setting the drugs are prescribed by the general practitioner and owned by the patient, but the following procedure will apply throughout the Trust.

Any knowledge or suspicion of drug loss or discrepancy must be reported immediately to the Appointed Person and their line manager. In particular any discrepancy between the stock balance and the Controlled Drugs Record Book must be reported to the Chief Pharmacist (or out of hours the Senior Pharmacist Manager On Call) and be investigated immediately. Discretion must apply in all instances.

Where an incident is due to suspected theft or burglary by a person external to the Trust, staff will refer to the Security Policy and the Police must be informed.

The investigation will proceed through the following stages:

Stage One

An initial investigation by the Appointed Person must be implemented without delay. The initial investigation will attempt to quantify the discrepancy.

Stage Two

If the outcome of the initial investigation still gives rise to concern, the Appointed Person will notify their line manager/Matron and the Chief Pharmacist, (or out of hours the Senior Pharmacist Manager On Call.) They will agree any further action to be taken. Where a discrepancy involves a Controlled Drug, the Director of Nursing and Clinical Director will be informed.

Where there is suspicion of drug abuse:

- A stock balance should be recorded and regular checks introduced.
- If this shows discrepancies the medicine should be made subject to the procedure for Controlled Drugs. A register should be kept and entries made when the medicine is administered.
- Other action may be instituted at the discretion of the Directorate General Manager/Matron or the Chief Pharmacist.

Stage Three

If the incident is still unresolved and still gives cause for serious concern a Nominated Investigating Officer will be appointed to act as a co-ordinator for further enquiries, liaising with the Director of Nursing, Clinical Director, Chief Pharmacist, and Senior Management Staff as required.

Stage Four

If the involvement of the Police Authorities is thought necessary the Chief Executive will be notified through the Chief Pharmacist.

In all cases an incident form will be completed

5 STANDARDS FOR PRESCRIBING, PRESCRIPTIONS AND THE AUTHORISATIONS TO ADMINISTER OR SUPPLY MEDICINES

5.1 Authorisation for the Administration or Supply of Medicines to Patients

Unless a healthcare professional, e.g midwives or chiropodist, is exempt from the requirements for a prescription under the Medicines Act 1968 / Human Medicines Regulations 2012, the authorisation of a Prescriber will be obtained before any prescription only medicine is administered or supplied to a patient of the Trust. Where the healthcare professional is exempt from the requirements of a prescription the medicines which may be administered under this exemption shall be listed in a local policy approved by the Drug and Therapeutics Committee.

In all other cases the authorisation of a prescriber will be given in one of five ways.

1) An indelible instruction, signed and dated by a Prescriber written:
- **a)** on a prescription form and/or label approved by Drug and Therapeutics Committee; where the instruction is in the form of a pre-printed label, the label shall be non-peelable.
- **b)** in the medical record.

2) A computerised prescription held on a Trust approved computerised prescribing system, entered by a Prescriber and validated by password controlled electronic signature.

3) A Patient Group Direction approved by the Trust Drug and Therapeutics Committee and Trust Clinical Governance Lead.

4) For a non Prescription Only Medicines, for staff who otherwise cannot use a Patient Group Direction, a group direction approved by the Trust Drug and Therapeutics Committee and Trust Clinical Governance Lead.

5) In exceptional circumstance by a verbal order (see below)

In the case of non-prescription only medicines, the above provisions shall also apply unless authority to supply or administer is granted in a protocol that forms part of the medicines formulary, approved by the Drug and Therapeutics Committee

5.1.1 Verbal Orders for Administration

Under exceptional circumstances, the individual authorised to administer medicines may accept a verbal order from a prescriber to administer a medicine.

In any such situation the individual authorised to administer medicines will be responsible for the following:

- That the medicine is not a Controlled Drug.
- That the medicine has been prescribed previously and that the request is for a dose change.
- That the order is countersigned within 24 hours of receiving the message.
- Satisfying themselves through discussion with the Prescriber that the situation is urgent and treatment cannot be delayed until the Prescriber can provide a prescription.
- Satisfying themselves of the identity of the Prescriber who must be personally known to them.
- Recording details of the drug, dose, and Prescriber on the appropriate documented record of medicine administration/supply.
- Reading back the details recorded as confirmation with the prescriber prior to administration.
- That a second person authorised to administer medicines reads the message back to the Prescriber to confirm the message.
- Refusing to proceed if they are not satisfied that the Prescriber's instructions are sufficiently clear, and taking further advice from their available line manager.

In an emergency situation, for example when a Resuscitation Team responds to the sudden collapse of a patient, an individual authorised to administer medicines will act on the verbal instructions of a prescriber.

Immediately after the incident the prescriber will make an entry in the patient's notes detailing the drugs and doses administered which is countersigned by the individual who administered them.

5.1.2 Verbal Orders to Supply

Under exceptional circumstances, the Pharmacist may accept a verbal order to supply medicines from a prescriber by telephone request from a Prescriber to a Pharmacist, where the drug concerned is not a Controlled Drug.

Under these circumstances the Prescriber will provide a prescription within 72 hours of the conversation. The Pharmacist will be responsible for the following:

- That the medicine is not a Controlled Drug.

- Satisfying themselves through discussion with the prescriber that the situation is urgent and treatment cannot be delayed until the prescriber can provide a prescription.

- Satisfying themselves of the identity of the Medical Practitioner who must be personally known to them.

- Recording details of the drug name, form, strength, dose and quantity of the medicines prescribed.

- The name and address of the patient to whom the supply is made.

- Reading back the details recorded as confirmation with the prescriber prior to supply.

- Refusing to proceed if they are not satisfied that the prescriber's instructions are sufficiently clear, and taking further advice from their available line manager.

5.2 Standards for Prescriptions

Where the prescription or direction to supply or administer is not generate electronically it will be written in a clearly legible hand, and will carry sufficient information to make the prescriber's intention clear.

Any prescription or direction that is of questionable legibility, incomplete, or ambiguous to the Authorised Individual responsible for its administration or pharmacist will result in medication being withheld until the prescription has been checked with the prescriber or a new prescription issued.

5.2.1 In Patient Prescriptions

A new paper prescription record or new electronic record will be commenced on each admission

Unless the prescribing is clinically urgent prescribing on admission should take place after the prescriber has assessed the patient and taken a full and accurate medication history. See Appendix II Medication Reconciliation

The minimum information set considered sufficient to make the prescriber's intentions clear will be as follows:

- Drug, name expressed as the Recommended International Non-Proprietary Name (rINN), unless;
  - It is a combination product for which no rINN exists.
  - It is a modified release preparation where brand substitution could potentially lead to symptomatic change.
- Route of administration.
- Dose.
- Start date.
  - When a medicine has been started prior to admission the letters 'OA' should be written in the start date box.

  - When an administration chart has been re-written the original start date should be used.
- Stop date if appropriate.
- Times of administration. In the case of 'as required' medicines the minimum interval between doses and an indication.

Prescriptions will be reviewed at regular intervals.

The dose or route of administration of a prescription may be changed by a Prescriber. When this takes place the alteration will be made in the following way.

- **By the prescription being re-written in full.**

The use of two current prescription forms will only be considered good practice where the number of current active prescriptions exceeds the space available on a single form. In these circumstances each form will be clearly marked '*Sheet 1 of 2*' and '*Sheet 2 of 2*' and kept together at all times.

In-patient prescriptions will be cancelled by a diagonal line through the prescribing section and the Prescriber will sign and date across the administration section to prevent further administration.

5.2.2 Outpatient and Discharge Prescriptions

The minimum information set considered sufficient to make the prescriber's intentions clear will be as follows:

- Drug, name expressed as the Recommended International Non-Proprietary Name (rINN), unless;
  - It is a combination product for which no rINN exists.
  - It is a modified release preparation where brand substitution could potentially lead to symptomatic change.
- Route of administration.
- Dose.
- Directions for administration.
- Duration or quantity of supply.

5.3 Timeliness of Prescribing

Prescribers are responsible for the timeliness of the prescription in relation to the patient's clinical need. Whilst standard prescription times will meet the needs of most patients, prescribers must consider when they may not; for example medicines for Parkinson's disease which need to be taken throughout the day.

Prescribers should be aware of the potential for delays in administration on admission or when initiating treatment using standard administration times.

When the standard administration times cause a clinically significant delay prescribers should consider using STAT doses to ensure prompt treatment. Where a STAT dose is prescribed it is the responsibility of the prescriber to ensure nurse is aware of the need to administer this urgent medicine.

Critical medicines may include:

- Analgesics
- Anticonvulsants
- Anticoagulant medicines
- Anti-epileptic medicines
- Anti-infectives
- Antipsychotic medicines
- Insulin
- Medicines for Parkinson's Disease
- Immunosuppressants / Anti-rejections medicines (e.g.tacrolimus)
- Any other medicine as determined by the Drug and Therapeutics Committee

5.4 Prescribing Abbreviations

Drug names will not be abbreviated under any circumstances. However, the following abbreviations will be acceptable in the writing of prescriptions:

5.4.1 Dosage

Gram	g		
Milligram	mg	Litres	L
Microgram	in full	Millilitres	ml
Nanogram	in full	Millimoles	mmol

N.B. To avoid misinterpretation

Units must be written in full and not abbreviated

Microgram must be written in full and not abbreviated

Nanogram must be written in full and not abbreviated

5.4.2 Dosage Form

Tablet	Tab	Suppository	Sup
Capsule	Cap	Eye Drops	G
Syrup	Syr	Eye Ointment	Occ
Suspension	Susp		
Injection	Inj		

5.4.3 Route of Administration

Oral	PO	Sublingual	SL
Intravenous	IV	Rectal	PR
Intramuscular	IM	Vaginal	PV
Subcutaneous	Subcut, SC		
Inhaled	Inh		
Nebulised	Neb		

N.B. To avoid misinterpretation

Intrathecal and Epidural will always be written in full and not abbreviated

5.4.4 Dosage Frequency

Once Daily	OD	As Directed	MDU
Twice Daily	BD	As Required	PRN
Three Times Daily	TDS	At Once	STAT
Four Times Daily	QDS		
In the Morning	OM		
At Night	ON		

5.4.5 Tablet and Capsule Release Characteristics

Enteric Coated EC

Modified Release MR for preparations described as slow release, prolonged release, sustained release, etc.

6 STANDARDS FOR MEDICINES ADMINISTRATION

The administration of medicines within the Trust is effected by authorised individuals.

The aim behind medicine administration is to ensure that the correct medicine is given to the correct person, in the correct quantity, at the correct time and via the correct route.

6.1 Principles of Administration

The individual authorised to administer medicines will be responsible for ensuring they have an understanding of the use, action, usual dose, side effects and handling hazards of the medicine(s) being administered.

This person will ensure they are certain of the identity of the patient to whom the medicine is to be administered before initiating any administration activity.

Within an in-patient setting this will be interpreted as confirming the name and hospital number expressed on the authorisation for administration corresponds with that on the patient's identity bracelet, and wherever possible, verbally confirming this detail with the patient themselves.

Within an out-patient or community based setting, or where an in-patient is not wearing an identity bracelet, this will be interpreted as verbally confirming the name, address and date of birth expressed on the authorisation for administration with the patient, or where appropriate, the patient's carer.

The individual authorised to administer medicines will check that the authorisation for administration is correct, clear, legible, unambiguous, complete and understood. Wherever they are not fully satisfied about one or more of these issues they are responsible for confirming them with the prescriber before administration.

Before administering the medicine, the individual authorised to administer the medicine will then perform the following:

1) Check that the label of the medicine intended to be administered is described as the same name expressed on the authorisation for administration.

2) Check that the medicine to be administered has not past its expiry date.

3) Measure / prepare the correct dose, checking that it is appropriate for the medicine concerned.

   a) Where a liquid medicine is prescribed and the dose is not a multiple of 5ml, an **oral syringe** must be used to prepare and/or administer the dose.

- **Syringes compatible with IV canulae must not be used for oral administration.**

b) Where insulin is prepared from a vial a **specific insulin syringe** shall be used to measure the dose.

c) In preparing the dose the individual authorised to administer medicines will consider the nature of the pack:
   i) Where a calendar or compliance aid pack is used, it is used in accordance with its instruction to maintain the compliance function.
   ii) Where multiple packs are available one pack will be used at a time as these may be supplied to the patient at discharge.

d) NOTE: An individual authorised to administer will refuse to administer any medicine for injection that has been prepared in advance of its immediate use unless the preparation has taken place under controlled conditions within the Pharmacy Department. Similarly, they will refuse to administer any medicine placed in a container or drawn up by another individual outside their presence, unless this took place in the Pharmacy Department.

4) Check the route of administration and that the formulation used is appropriate to that route.

5) Check that the medicine is to be administered is at the time specified on the authorisation for administration. Check that the dose has not already been given and that any minimum dose interval between this dose and previous doses has been observed.

6) Where more than one medicine is specified for administration, consider whether any of the medicines may dangerously interact with each other.

At completion of administration the individual authorised to administer medicines will sign for the medicines used either on an approved prescription form, or record use by means of electronic password on a computerised administration record.

Following administration the individual authorised to administer will observe the patient to monitor both the positive and negative effects of the medicine(s) administered.

6.2 Administration of Medicines to Patients

Following authorisation, the administration of medicines to patients will be undertaken in one of six ways:

1. By an individual authorised to administer medicines.

2. By an inpatient or patient's carer checked and supervised by an individual authorised to administer medicines.

3. By an in-patient or patient's carer, where an approved self-administration programme is in place on the ward or department.

4. By an outpatient or patient's carer following the authorisation of administration by a Prescriber.

5. By an individual authorised to administer medicines who is exempted from the requirements of a prescription under the Medicines Act 1968 / Human Medicines Regulations 2012, who initiates and administers treatment themselves. This includes an exemption for administration of radiopharmaceuticals when given by an operator in accordance with procedures and protocols, including guidelines issued by the ARSAC certificate holder. Furthermore, The Medicines for Human Use (Administration and Sale or Supply) (Miscellaneous Amendments) Order 2006 allows for prescription only medicines (POMs), such as frusemide or thyroid blocking agents, that are an essential part of some nuclear medicine examinations, to be administered by an operator without patient specific direction or patient group direction. It also extends the rang of medicines supplied or administered by Chiropodists.

6. By a Prescriber who initiates and administers treatment themselves.

Circumstances 1, 2, 3, and 4 describe administration following the written instructions of another person, i.e. the prescriber. Circumstance 5 and 6 involves administration of a medicine following the assessment of the patient by the same person who administers that medicine.

Where a prescription is of questionable legibility, incomplete, or ambiguous to the individual authorised to administer, the medicine will be withheld until the prescription has been checked with the prescriber or a new prescription issued.

6.2.1 Checking the Administration following the written directions of another person

Single person administration system is the normal method of administration **except** where the following types of medicines are involved.

- Any cytotoxic medicines.
- Controlled Drugs.
- Any medicines where the dose is expressed by weight or surface area.
- Injectable Medicines unless exempted by the Drug and Therapeutics Committee. See Appendix IX.

The second authorised individual checks the administration, although the responsibility remains with the administering individual.
The checking person's role includes verification of the following:

- The medication is prescribed and it is due for administration.
- The correct medication is selected.
- Any calculations made are correct.
- The medication and dose are prepared for use correctly.
- The patient to whom it is being administered is correct.
- The route is correct.
- In the case of a Controlled Drug witnessing the actual administration

The process of double checking involves two people working together, but staff should be aware that this can present dangers where staff prompt each other to reach the same conclusion.

The following medicines shall also be considered as Controlled Drugs for the purpose of administration:

- Schedule 3 CDs e.g. Barbiturates
  - Including Midazolam 10mg/2ml injection (**but not** other preparations)
- Strong Potassium Injections such as Potassium Chloride 15%

For the purpose of administration, single person administration is permitted the following medicines:

- Temazepam,
- Midazolam preparations except 10mg in 2ml injection
- Tramadol
- Morphine Sulphate 10mg/5ml Oral Solution

6.2.2 Checking Administration by a Prescriber or other Healthcare Professional who initiates and administers treatment themselves

There are circumstances where a healthcare professional initiates and administers medicines to a patient, e.g:

- a patient under the direct supervision of an anaesthetist in theatres.
- A patient who receive a parenteral medicine in an Outpatient department.
- A patient who receives a radiopharmaceiutical or medicine as part of a nuclear medicine procedure

These circumstances may compromise the validity of the checking process by a second person, as the person administering the medicines may be titrating the

response of the patient to the medicines administered and the instruction may not be written in advance.

6.2.2.1 Non Controlled Drugs

It is recommended that the person administering a medicine will confirm with a second authorised to administer medicine the identity of the medicine being used. However, the responsibility for the correct administration remains with the person giving the medicine.

6.2.2.2 Controlled Drugs

Refer to the Policy for the Safe and Secure Handling of Medicines Part B Controlled Drugs.

6.2.3 Recording Administration

A record of all medicines administered to any patient will be made on an approved prescription form, electronic administration record, anaesthetic record, or patients notes unless an alternative location has been approved. This record will contain as a minimum the following information:

- Date.
- Time.
- Dose administered (where appropriate).
- Signature (or recognised abbreviation) or electronic signature of the person responsible for administration and, where appropriate, of the person who performs a check. (The responsibility for administration will lie with the administering individual).

Where administration by the intravenous or subcutaneous routes is by any means other than a bolus dose prepared and given immediately by the individual authorised to administer, (e.g. continuous infusion, syringe driver, patient controlled analgesia etc.) the following will apply:

- A record of all individuals involved in the preparation and setting-up of the medication will be made.

- The medication will be given an expiry date not exceeding 24 hours from the time of preparation unless:
    - It has been prepared under aseptic conditions within the Pharmacy Department.
    - A specific extension to the life of the medication has been approved in advance by Drug and Therapeutics in consultation with a Consultant Microbiologist for the ward or department, in which case the medication will be given an expiry date not exceeding this time.

Where a medicine is not administered for any reason, the administration record shall be marked with the reason for non-administration. Where the reason is other than a refusal by the patient an explanation will be made in the record; in the case of an electronic prescription this may take the form of a note. This explanation will contain as a minimum the following information:

- Date.
- Time.
- Reason for omission.
- Any action taken
- Signature, recognised abbreviation) or electronic signature of the person responsible of the person responsible for administration.

All approved prescription forms or electronic administration records will form part of the medical record and be preserved in accordance with the Trust's policies for maintenance of patient notes.

6.3 Timeliness of Administration

It is expected that medicines be normally administered within two hours of their prescribed time.

There are circumstances where the timeliness is more critical and medicines should be administered as close to the prescribed time as possible; for example

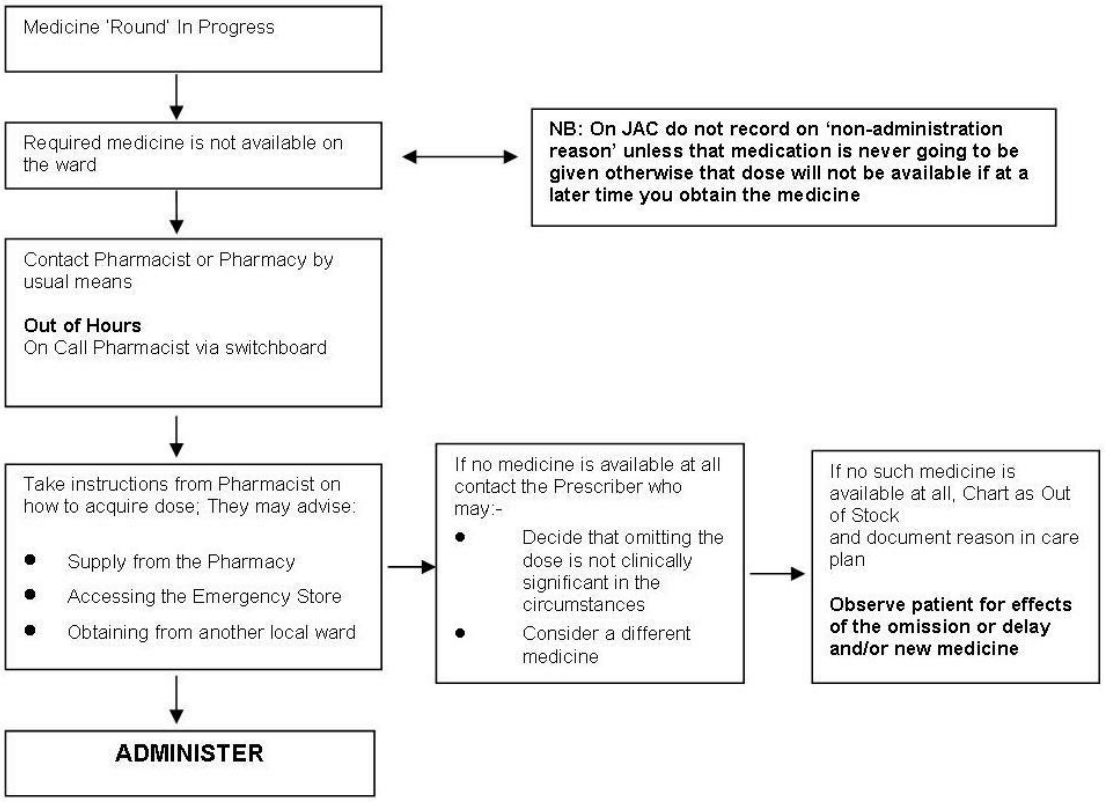
- STAT dose medicines required before the regular prescription starts
- First Doses of injectable medicines such as
    - Anti-infectives
    - Anticoagulants
    - Anticonvulsants
- Medicines for Parkinson disease
- Strong Analgesics
- Any other medicine as determined by the Drug and Therapeutics Committee

In other circumstances, whilst timeliness may not be critical the omission of the medicine may be, for example but not exclusively:

- Anticoagulants
- Anti- psychotics
- Anticonvulsants
- Any other medicine as determined by the Drug and Therapeutics Committee

6.3.1 Actions a Nurse should take to ensure medicines are administered in a timely manner

1. Be aware of the stock medicines held on the ward.
2. If necessary order stock medicine in advance of the regular supply arrangements.
3. Assess the non-stock medicines on admission; assess quality and quantity. Where the patient's own medicines do not meet the quality criteria or there are insufficient for the patient's predicted length of stay order **all** medicines required from the pharmacy at the first opportunity.
4. Alert the Pharmacist or Pharmacy where critical medicines are required for timely administrations before routine deliveries.
5. Be aware of the local arrangements to access the Emergency Store.
6. Understand the arrangements to contact the Out Of Hours Pharmacist which is via switchboard.



6.4 Self Administration

Patients may only undertake routine self-administration of their medicines where a ward has in place the Self Administration of Medicines Policy Pat MM9 as approved by the Drug and Therapeutics Committees. The decision to use self administration policy is agreed with Management of the clinical area.

The benefits of such an approach include:

- Helping patients achieve/maintain a greater degree of independence during their stay.
- Identifying compliance issues prior to discharge.
- Improving patients' knowledge of prescribed medicines.
- Promoting drug administration at the most appropriate time.
- Reducing wastage of primary care derived medication.
- Preventing medicine hoarding and consequent inappropriate resumption of discontinued treatment.
- Minimising delay at discharge.

Refer to PAT MM Self Administration of Medicines Policy for further details

6.5 Unused Medication

Any medication dispensed or prepared **for administration** will not be returned to its original stock container, but disposed of in accordance with the Trust Waste Disposal Policy.

6.6 The Role of Students Nurses

This policy recognises that a registered nurse is expected to facilitate students to develop their competence in the administration of medicines. Where a student is involved in medicines administration the registered nurse must ensure that the student is supervised at all times. Where a student signs the prescription, the record is clearly countersigned by the registered nurse. A student may not check the administration of a medicine. Where a medicine requires a check this must be undertaken by a person authorised to administer medicines. In all cases the registered nurse is responsible for the correct administration of the medicine.

6.7 The Role of Other Staff

Unless specifically authorised otherwise by the Drug and Therapeutics Committee the role of support staff in administering medicines is described below

The Individual Authorised to administer medicines retains the responsibility to ensure that a medicine has been administered correctly; that cannot be delegated. However in certain circumstances support staff may aid in the administration of medicines.

The Individual Authorised to administer will identify the correct medicine and correct patient to whom the medicine is to be administered

In this context the following are considered a support staff who may aid administration of medicines; Health Care support Workers or Health Care Assistant trained to NVQ level 2; Nursery Nurses, Play Leaders, and Hospital Play Specialist working in Children's Service.

Support staff may not be involved in the administration of Controlled Drugs.

The Individual Authorised to administer medicines will ensure that the support staff has sufficient information to aid the administration of the medicines safely.

The following situations are suitable for support staff to aid in the administration:

- The application of emollient creams and ointments
- Nursing a child who is using a nebuliser
- The supervision of a dependent patient to ensure their medicines are taken effectively

If in the course their duties visiting wards, Pharmacy Staff observe circumstances where the safety of ward preparation and administration medicines are compromised they should bring this to attention of the Individual in Charge who will resolve the potential problem. Where they find this on repeated occasions they should bring it to the attention of the Individual in Charge and an untoward incident form completed; a copy will be sent to the Appointed Person for action.

7 STANDARDS FOR THE USE OF PATIENTS' OWN MEDICINES

7.1 Introduction

The Trust has a duty of care to ensure that any patients' own medicines used while the patient is under the inpatient care of the Trust are both safe and fit for purpose. It acknowledges that medicines brought in by patients are the patient's property and staff require the permission of patient to dispose of their medicines.

7.2 Responsibility and Storage

Once a patient has been clerked in, agreement should be sought with the patient or their carer to use any of patient's medicines that are suitable during their stay. Agreement should also be sought that if the medicines are no longer prescribed we have permission to destroy them otherwise they should be returned home with a responsible adult.

If the decision is taken to retain patients' own medicine they become the responsibility of the Assigned Individual in Charge, who must ensure they are stored as securely as any other medicine in the hospital. This means they must be in a locked medicine cupboard, a locked individual patient cabinet or locked medicines trolley. Patients must be advised that they must not retain medicines in the personal belongings as this represents a security risk and safety risk to visitors and other patients.

7.3 Use of Patients' Own Medicines

Patients' own medicines are only administered or supplied to the individual patient to whom they belong and in accordance with a valid direction or prescription.

7.4 Assessment of Patients' Own Medicines before use

7.4.1 Use of Patient's Own Medicines for Administration

Provided a valid authorisation to administer exists, medicines brought into hospital by a patient may be administered to that patient following an assessment by the individual authorised to administer medicines undertaken immediately prior to each administration.

The individual authorised to administer medicines will assess the patient's own medicines against the following criteria.

- Has this medicine been prescribed (or purchased) for the specific use of this patient?

- Can the medicine (name, pharmaceutical form and strength) be positively identified, other than from the pharmacist's dispensing labels if present?

- Where a pharmacist's dispensing label is present do the product details (name, pharmaceutical form and strength) agree with the product as identified?

- Is all the medicine in the container the same (consistent colour, size, markings, etc.)?

- Is all the medicine in date (as identified by the manufacturer's expiry date) **OR** has it been dispensed in the last 3 months (as identified by the date on the pharmacist's dispensing label).

- Has the patient (to whom the medicines belong) given verbal consent for them to be used?

Where the answers to **ALL** these questions is yes, the medicines used for that specific patient.

In all other circumstances, a pharmacist is contacted. The pharmacist will either approve the patient's own medicines for use or arrange a hospital supply.

7.4.2 Use of Patient's Own Medicines at Discharge

It is normal practice to involve a pharmacist in checking medicines at discharge, even when there is no requirement for items to be dispensed. However there may be occasions when patients' own medicines are available and a individual authorised to administer medicines decides it is not in the patient's best interests to delay discharge until a pharmacist is available. In these circumstances, in addition to ensuring the medicines meet the above criteria, **the individual authorised to administer medicines must take individual responsibility for the safety and appropriateness of the medicines prescribed at discharge** and for ensuring:

- A discharge prescription / interim discharge summary has been completed by a prescriber.
- There is a patients' own supply of all the medicines prescribed on the discharge prescription/interim discharge summary.
- All the patients' own medicines are labelled in accordance with the prescribers instructions on the discharge prescription
- The quantities of medicines are sufficient to last 14 days. Except where a course of treatment is prescribed for a period less than 14 days, when quantities must be sufficient to fulfil the course.
- Where a medicine brought in by a patient has not been prescribed at discharge and it is not intended for the patient to take those medicines on discharge, the individual authorised to administer medicines must advised the patient

accordingly, and offer to have the medicines sent to the pharmacy for destruction.

The medicines are in date for the prospective period of use

- A record of the supply is made, signed and dated on the discharge prescription/pharmacy copy of the interim discharge summary

In all other circumstances or if the nurse is unhappy to take responsibility for the use of the patients' own medicines or is unable to take responsibility for the safety and appropriateness of the medicines prescribed at discharge, a pharmacist is involved in the patient's discharge.

7.5 The Use of Patients' Own Controlled Drugs

Refer to the Policy for the Safe and Secure Handling of Medicines Part B Controlled Drugs.

For this purpose the following are classified as Controlled Drugs:

- Morphine Sulphate Oral Solution 10mg/5ml
- Schedule 3 Controlled Drugs such as barbiturates

Temazepam preparations may be stored in the Individual Patient Cabinet, if available. No record of administration need be maintained.

7.6 The Use of Medicines in Monitored Dosage System

Where a monitored dosage system (MDS) tray has been prepared by a community pharmacist for a patient this may be used to administered medicines to the patient provided:

1. The tray is labelled with the contents and direction for use
2. The contents of the tray and their directions for use agree with the patient current prescription.
3. The future days supplies are all intact
4. The past days supplies have been removed
5. The nurse at the point of each administration confirms that the content of the current unit matches the patient current medicines due for that medicine round

Where a medicine which is in the tray is changed or discontinued the tray must not be used.

Other devices prepared outside of a pharmacy must not be used

8 RISK MANAGEMENT

The Appointed Person is responsible for carrying out local risk assessment with respect to medicines used in their area. Risk assessments for injectable medicines should be reviewed annually.

These should be carried out whenever a high risk product is introduced into an area or following a significant untoward incident.

8.1 Errors in the Prescribing, Administration, and Dispensing Of Medicines

Error and near misses involving medication shall be reported on an Incident Reporting form.

8.1.1 Prescribing Errors

The appropriate prescriber should be contacted, and when necessary remedial action taken to ensure the safety of the patient.

The Consultant in Charge is responsible for dealing with prescribing errors concerning his patients. Minor errors discovered by a doctor or other colleague should be pointed out to the Prescriber. More serious or unresolved errors must be discussed with the Consultant with the knowledge of the Prescriber. The Consultant should discuss significant prescribing errors with the Prescriber and the Clinical Pharmacist. Supporting statements may be required from all staff concerned; these are essential if there is any possibility of serious injury to the patient or of litigation.

An Adverse Incident Report Form must be completed on all occasions. A copy of this report will be sent to the Chief Pharmacist.

8.1.2 Administration Errors

As soon as it is realised that there has been an administration error the following action should be taken:

The appropriate prescriber should be contacted and, when necessary, remedial action taken to ensure the safety of the patient.

The incident should immediately be reported to and investigated by the Line Manager or a person delegated to act on his/her behalf.

Supporting statements may be required from all staff concerned; these are essential if there is any possibility of serious injury to the patient or of litigation.

An Incident Report Form must be completed on all occasions. . A copy of this report will be sent to the Chief Pharmacist.

8.1.3 Dispensing Errors

If the patient has received the wrong medicine through a dispensing error the appropriate prescriber should be contacted and, when necessary, remedial action taken to ensure the safety of the patient.

The Chief Pharmacist or nominated deputy will investigate the error.

Supporting statements may be required from all staff concerned; these are essential if there is any possibility of serious injury to the patient or of litigation.

An Incident Report Form must be completed on all occasions.

8.2 Sharing Learning from Incidents

Incidents relating to medicines shall be discussed in the first instance at the Division's Clinical Governance meeting. Outcomes of investigations and action plans should be shared via the Drug and Therapeutics Committee to ensure that Trust wide learning may be gained. In addition the Drug and Therapeutic Committee will review retrospective medicines related incidents to look for trends and emerging problems.

9 TRAINING AND COMPETENCE

Training and development in relation to the safe and secure handling of medicines can be achieved in a number of ways including but not exclusively

- Inclusion in the nurse basic training
- Inclusion in the Newly Qualified Nurse Development Program
- Completion of the medicines administration competency assessment that forms part of the Preceptorship Guidance for Healthcare Professionals
- Inclusion in the Junior Hospital Doctor Induction Program
- The F1 F2 junior hospital doctor training program
- PRESCRIBING SAFETY ASSESSMENT for new Foundation doctors
- Completion of specific training module; for examples those national modules published in relation to National Patient Safety Alerts
- Specific JAC prescribing and administration training
- Publication on the intranet of this and other medicine related policies
- Publication of the Medicines Management Bulletin

At annual Personal Development Reviews staff who prescribe or administer medicines should identify any areas of training required to ensure they maintain their competence in those areas.

With respect to prescribing Clinical Supervisors in discussion with the prescriber shall identify any areas that require development. Where the Clinical Supervisor identifies an area where the prescriber is unsafe to prescribe the Clinical Supervisor will refer the prescriber the Clinical Director who will take appropriate action, for example restricting prescribing. A standard tool is available to support the process.

9.1 Role of the Clinical Director

The Clinical Director (supported by their , Heads of Nursing, Matron and Clinical Governance and Audit leads) is responsible for ensuring full implementation of this and the other associated medicines management policies within their DIVISION. This includes:

- Ensuring all staff undergo appropriate training and maintain their required competencies in the areas of medicines management required by their role.
- Actively monitoring medicine management within their areas and taking actions to improve practice where required
- Participating in Trust wide audits of medicines management, including the development and implementation of resulting action plans for any required improvement within their areas

9.2 Personnel

The Management Team of each clinical area will be responsible for ensuring appropriate selection and vetting procedures are in place to account for Safe and Secure Handling of Medicines issues during the recruitment process.

The Appointed Person will be responsible for monitoring and reporting any signs that individuals may be abusing or diverting medicines from the ward or department.

10 MEDICINES DEFECT AND ADVERSE DRUG REACTION REPORTING

10.1 Definitions

10.1.1 Defective Medicines

Medicines may be considered defective for two principal reasons.

- Physical defects caused by damage or contamination noted by an individual handling the medicine at any point in the Medicines Trail.

- Efficacy defects caused by reactions that in the judgement of a professional caring for the patient(s) concerned indicate a non-response or an unexpected response outside that normally experienced with the medicine in question.

10.1.2 Adverse Drug Reactions

An event that is noxious and unintended and occurs at doses in humans for prophylaxis, diagnosis, therapy or modification of physiological function. It is not due to defect in the product.

10.2 Reporting a Defective Medicine

Where a physical defect is identified the following action will be taken by the individual noting it.

- The Chief Pharmacist is immediately informed of the occurrence. This will take during published department opening hours directly via the appropriate telephone extension. Out-of-hours via contact with the Pharmacist on-call.
- The defective dose unit is retained together with all others in the container concerned and any original packaging from which it was taken.
- The medicine is marked "*Defective: not for use*" and returned to the Pharmacy Department according to the specific instructions given at the time.
- The patient is given the required medicine from a different container following inspection that has confirmed it is unaffected.

Where an efficacy defect is identified the professional noting it will be responsible for taking the following action:

- The Chief Pharmacist is immediately informed of the occurrence. This will take place during published department opening hours directly via the appropriate telephone extension. Out-of-hours via contact with the Pharmacist on-call.
- The defective dose unit is retained together with all others in the container concerned and any original packaging from which it was taken.
- A Medical Practitioner in the team caring for the patient(s) is immediately informed of the occurrence.

- The medicine is marked "*Defective: not for use*" and returned to the Pharmacy Department according to the specific instructions given at the time.

10.2.1 Formal Reporting

The Chief Pharmacist will be solely responsible for formally reporting all defective medicines to the authorities, the manufacturer concerned, and other wards and departments as necessary.

The Chief Pharmacist will be responsible for ensuring procedures are in place for the following issues relating to medicines defects.

- The retention of suspected defective medicines for analysis, return or impounding.

- Recall to the Pharmacy Department of all potentially defective medicines.

- Dissemination of information relating to potentially defective medicines to all potential users supplied by the Pharmacy Department.

10.3 Reporting of an Adverse Drug Reaction

The MHRA run the Yellow Card Scheme for reporting adverse drug reactions. Reports can be made by all healthcare professionals and patients.

- Online at www.yellowcard.gov.uk
- By completing the paper Yellow Card form found in the back of the BNF.

10.3.1 What should be reported?

- All suspected adverse drug reactions for new medicines. These are identified in the BNF or medicine's Summary of Product Characteristics by the black triangle ▼symbol.
- All suspected adverse drug reactions occurring in children, even if a medicine has been used off label.
- All serious suspected adverse drug reactions for established vaccines and medicines, including unlicensed medicines, herbal medicines and medicines used off label.

Serious reactions are those reactions that are fatal, life threatening, disabling, or incapacitating, result in or prolong hospitalisation, or medically significant.

For further advice, contact the Trust Medicine Information Service within the Pharmacy.

11 MONITORING AND COMPLIANCE

To ensure that the guidance set out in the policy is followed and to provide feedback on the continued appropriateness of this document a program of audit is recommended and agreed with the Clinical Audit department.

Responsible Person	Audit Subject	Method	Frequency
Chief Pharmacist	Security & storage on wards & departments	Physical Checks	Top Up areas 6/12
The Accountable Officer for Controlled Drugs	Controlled Drugs stored on wards and department	Physical check, Balance and record keeping	6/12
Clinical Site Manager	Controlled Drugs stored on wards and department	Physical check, Balance and record keeping	6/12
The Principal Author of a PGD	Patient Group Directions	Examination of sample administration or supply record	12/12
Clinical Director (with the support of their Matron and Clinical Governance and Audit Lead)	Compliance with PAT MM1	As a minimum Self Declaration – Exceptions are reported to D&T	12/12 or where there is a change of ward or department manager
Chair Drug and Therapeutics Committee	Other audits as necessary which may be a required to comply with national alerts or guidance such as the NPSA rapid responses	Devolution to the appropriate Clinical Service Unit	As required

12 EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Impact Assessment Policy and the Fair Treatment For All Policy – CORP/EMP 27.

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified.

A copy of the EIA is available on request from the HR Department.

13 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Policy for the Safe and Secure Handling of Medicines - Controlled Drugs - Part B – PAT/MM1 Part B

Policy and Procedure for the Use of Unlicensed Medicines – PAT/MM4

Paediatric Acute Pain Policy - Assessment and management of pain in children and young people (previously PAT/T 27 - Acute Paediatric Pain Guidelines) – PAT/MM6

Policy for the Management of Intravenous Patient Controlled Analgesia (IV-PCA) – PAT/MM7

Self Administration of Medicines Policy – PAT/MM9

Mental Capacity Act 2005 Policy and Guidance - PAT/PA 19

Privacy and Dignity Policy - PAT/PA 28].

14 REFERENCES

Medicine Management Strategy 2012-2013 - Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

The Safe and Secure Handling of Medicines: A Team Approach. RSPGB 2005

Guidelines for the Administration of Medicines, NMC 2004
Accommodation for Pharmaceutical Services Health Building Note 29 HMSO 1997
Cupboards for the Storage of Medicines in Health Care Premise BS 288:1989

NPSA Alerts, Rapid Responses and Safety Guidance

NPSA Reference	NPSA Description
NPSA/2007/18	Actions that can make anticoagulant therapy safer:
NPSA/2007/20	Promoting safer use of injectable medicines
NPSA/2010/RRR013	Safer administration of insulin
NPSA/2007/19	Promoting safer measurement and administration of liquid medicines via oral and other enteral routes
NPSA/2010/RRR018	Preventing fatalities from medication loading doses
PSG001	NICE NPSA medicines reconciliation adults hospital
NPSA/2006/13	Improving compliance with oral methotrexate guidelines
NPSA/2008/RRR011	Reducing risk of overdose with midazolam injection in adults
NPSA/2010/RRR009	Reducing harm from omitted and delayed medicines in hospital
NPSA/2009/RRR006	Oxygen safety in hospitals | Rapid Response Report
NPSA/PSA 2002/001	Potassium solutions: risks to patients from errors occurring during intravenous administration
NPSA/2010/RRR008	Vaccine cold storage

15 APPENDIX I: PATIENT GROUP DIRECTIONS FOR THE SUPPLY AND ADMINISTRATION OF MEDICINES

15.1 Introduction

A *Patient Group Direction (PGD)* is a specific written instruction to enable the supply or administration of a medicine to groups of patients who may not be individually identified before presentation for treatment. The majority of clinical care should be provided on an individual patient specific basis. The supply and administration of medicines under patient group directions should be reserved for those limited situations where this offers an advantage for patient care.

The following qualified health care professionals may supply or administer medicines under patient group directions; nurses; midwives; health visitors; optometrists; pharmacists; chiropodists; radiographers; orthoptists; physiotherapists; and ambulance paramedics**. They may only do so as named individual.**

15.2 Completing the PGD

All PGD's must be written by a multidisciplinary team consisting of senior doctor, senior pharmacist, and a senior member of the profession expected to supply or administer medicines under the PGD. The PGD must state their names and be signed by them.

To ensure consistency of approach all PGD's must be completed using the Trust approved PGD template; this is available in electronic format.

15.3 Approval

All PGD's will be reviewed by the PGD Review Group that is a sub group of the Drug and Therapeutics Committee, Following approval of the Drug and Therapeutic Committee, its Chair will request the approval of the Trust Lead Clinician for Clinical Governance.

A PGD is only approved when it is complete with the signatures of the authors, the Chair of the D&T, and the Lead Clinician Clinical Governance.
PGD's will normally be approved for two years.

Each PGD will be allocated a unique reference number on approval.

15.4 Named Individuals

Healthcare professionals may only act under a PDG as named individuals. Persons may be named in the PGD individually, and this is appropriate where the numbers of staff involved are small, or they may be named as part of a list held by an identified clinical manager. Matrons or their equivalents are appropriate persons in the

organisation to hold these lists. They have the responsibility to ensure that those persons named meet the criteria of the PGD.
In all cases the named individuals must sign the copy of the PGD held by the Matron or Head of Department or equivalent.

15.5 Storage & Handling of Medicines

All medicines described in a PGD must be stored and handled accordance with the general principles of the Trust Policy for the Safe and Secure Handling of Medicines.

Where medicines are supplied, rather than administered under a PGD, the Trust Pharmacy Service will provide pre-labelled packs, complete with appropriate patient information sheets.

15.6 Controlled Drugs

Except for diamorphine to relieve cardiac pain by specialist cardiac nurses and midazolam, Schedule 2 and Schedule 3 Controlled Drugs may not form part of a PGD.

15.7 Antimicrobial Agents

A Consultant Microbiologist of the Trust must, in addition to the signatories above, also sign any PGD that contains an antimicrobial agent.

15.8 Black Triangle, Off License and Unlicensed Medicines

Black Triangle and medicines used off licence may exceptionally form part of a PGD. Where a black triangle medicine is used reporting arrangements for adverse incidents must be stated. Where an off license use is specified supporting evidence must form part of the PGD to justify its use. In each case the PGD must clearly show the status of the medicine.
Unlicensed medicines may not be form part of a PGD.

15.9 Audit

The PGD must state what arrangements have been made to audit the policy. PGD will only be re-approved following confirmation a successful audit that demonstrates that the medicine stated in the PGD has been used safely and effectively. The PGD must identify the person responsible for carrying out the audit.
REF: HSC 2000/026.

16 APPENDIX II - MEDICINES RECONCILIATION

16.1 Introduction

In December 2007, the National Institute for Health and Clinical Excellence, in conjunction with the National Patient Safety Agency, issued a Patient safety guidance alert requiring acute hospitals to ensure that all medicines prescribed on admission to hospital correspond to those that the patient was taking before admission.

Medicines reconciliation will help ensure that all intended medication is given, all unintended medication is avoided and the information transferred is accurate and contemporaneous.

The policy applies to all patients over the age of 16 years, admitted as inpatients, whether elective or emergency.

16.2 Aims of the Medicines Reconciliation Process

- To obtain, and verify, an accurate medication history for all adults on admission to hospital.
- To maintain a contemporaneous record of current medicines and the reasons for addition, discontinuation or alteration of the patient's medicines during the inpatient stay.
- To provide accurate information of current medicines prescribed, including any changes, upon transfer of care e.g. to the GP upon discharge.

16.3 Definition of Medicines Reconciliation

The National Prescribing Centre defines Medicines Reconciliation as:

- Collecting information on medication history (prior to admission) using the most recent and accurate sources of information to create a full and current list of medicines (for example, GP repeat prescribing record supplemented by information from the patient and / or carer), and
- Checking or verifying this list against the current inpatient prescription and administration record in the hospital, ensuring any discrepancies are accounted for and actioned appropriately, and
- Communicating through appropriate documentation, any changes, omissions and discrepancies

16.4 Summary of Roles and Responsibilities

16.4.1 Role of the prescriber (to include medical staff and non-medical prescribers)

1. To take a full, accurate medication history at the point of medical assessment on admission. Ideally more than one source should be used to obtain an accurate medication history. Where more than one source is available they should all be considered and reasons for any discrepancies sought. The reliability of the sources used should also be taken account of when deciding if further clarification is needed (see section 19.5.2 for further information).
2. To communicate with the patient/carer when possible with regard to their usual medicines to ensure there are no discrepancies between the information obtained from the information sources and the patient/carer.
3. To ensure the medication history appears complete and clinically consistent in relation to the patient's medical history.
4. To ensure that the medication that is prescribed for the patient is consistent with the patients past medical history and presenting complaint.
5. To establish an allergy status and record this on the medication record and on the alert sheet in the medical notes as per Trust policy.
6. To document the full list of medications the patient was taking in the clinical record. This should be either in the medication history pathway when an IPOC is in use or directly into the clinical record.
7. Only prescribe once the medication history is complete and accurate as doing so without this information is potentially hazardous unless risk outweighs benefit and measures have been put in place to ensure the task is completed in its entirety.
8. Where it is known that a medication history is incomplete the prescriber should ensure this is clearly documented in the clinical records and measures should be put in place to clearly handover this information to the team responsible for ongoing care
9. To prescribe all medication taken prior to admission onto the medication record clearly stopping /suspending all those items that are not currently appropriate(This will ensure a clear audit trail with respect to prescribing decisions regarding medicines the patient was taking prior to admission). A record should also be made in the clinical records detailing the reasons why these medicines have been suspended/discontinued (This should be either in the medication history pathway when an IPOC is in use or directly into the clinical record).
10. When stopping medication it is essential that the correct discontinued order reason is selected. In the case of items from the medication history that are no longer required this will usually be-'No longer clinically indicated' or 'adverse reaction'. Do not select prescribed in error unless this is the case as this will not appear in the audit trail
11. To document, in the same place, the reason(s) for any alteration in dose/frequency or for discontinuation of medication.

12. To maintain, in the same place, an accurate, contemporaneous record for the addition/discontinuation/alteration of any medicines during the patient's inpatient stay.
13. To document any changes/discontinuations/additions of medicines on the patient's discharge summary.

16.4.2 Role of the pharmacist

1. To verify that the medicines reconciliation process has been undertaken by the prescriber as soon as possible after the patient's admission to hospital. This is nominally within the first working day following admission
2. To ensure the medication prescribed appears complete and clinically coherent in relation to the past medical history, presenting complaint and current medical problems
3. Where a medication history has been recorded in the clinical record ensuring this is not contradictory to the medicines currently prescribed and any discrepancies are clarified
4. To refer to the pharmacy technician for a full medication history, where the history does not appear clinically coherent (or if appropriate take a full medication history) and to act upon the information received. The medication history should be documented either in the clinical record or on the medication history pathway within the IPOC as appropriate.
5. To communicate and handover to the appropriate pharmacy team members where any of this process is incomplete.
6. To ensure any discrepancies are documented appropriately in the medication history pathway within the IPOC or in the clinical record.
7. To clarify any undocumented discrepancies with the prescriber.
8. Where a medication history pathway document has been used to record the medication history the pharmacist should ensure it is filed in the medical records after all outstanding issues have been resolved.
9. To endorse the appropriate record that the medication history is complete and clinically coherent.
10. To confirm and document allergy status, where appropriate.

16.4.3 Role of the pharmacy technician

1. To facilitate the medicines reconciliation process by establishing a medication history using appropriate resources in collaboration with a pharmacist.
2. To record any information obtained on a medication history pathway document.
3. To inform the pharmacist , of any discrepancies detected.
4. To communicate and handover to the appropriate pharmacy team members where any of this process is incomplete.
5. To confirm and document allergy status, where appropriate.

16.4.4 Role of the nursing staff

1. To highlight to a member of the medical or pharmacy team if they recognise any discrepancies between the inpatient prescription and administration record and the patient's regular medication.
2. To ensure any information obtained is documented in either the medication history pathway within the IPOC or the patient's clinical record.
3. To ensure allergy status has been confirmed and documented on the front of the inpatient prescription and administration record prior to administration of any medicines (unless in an emergency situation).
4. To ensure any medicines prescribed are appropriate, after considering any allergy status.

16.5 The Medicines Reconciliation Process

16.5.1 Allergy status

The prescriber retains the principal responsibility for ascertaining allergy status of any patient for whom they prescribe. However, it is the responsibility of every person involved in the medication process – prescribing, dispensing or administration – to take every practical step to establish the allergy status of the patient.

The only exception to this is in an emergency situation where this information is unobtainable and the risk of not treating the patient outweighs the risk of having the information needed to make a fully informed decision.

It must be recognised that prescribing/administering medicines without establishing allergy status is potentially hazardous. Further guidance can be found in the medicines policy, appendix VII.

16.5.2 Sources of information

Obtaining a full, accurate medication history requires access to one or more of the following sources:

- Referral letter from primary care
- Repeat prescription sheet from the patient
- Electronic medication record from the GP practice
- GP surgery
- Community pharmacy
- Nursing Home Medication Administration Record (MAR sheet) / care home / residential home
- Patient's relative / carer
- Transfer information from another unit / hospital
- Recent hospital discharge letter / prescription chart
- Patient's Own Drugs
- Patient

Thought should be given to the reliability of the source of information used and further clarification sought when appropriate. It is best practice to use more than one source when taking a medication history and when more than one source is available all should be considered and reasons for any discrepancies sought.

In addition to using the sources listed above to identify prescribed medicines, the patient, relative or carer should be questioned when possible with regards to over the counter medicines and alternative therapies they may be taking.

It is important to establish if there are any discrepancies between the information obtained independently to the patient and the information that the patient delivers. Ideally, more than one information source should be used to obtain an accurate medication history.
The medication history should always be considered in light of the patients past medical history.

16.5.3 Recording the medication history

Once the medication history has been established, all of this information must be transferred into the medication history pathway within the IPOC or where an IPOC does not exist into the patients clinical record; the information must be recorded regardless of whether the medicine will be continued during the admission. All the medication that the patient was taking prior to admission must be prescribed on the medication chart (electronic or paper) and the medication no longer required either suspended or discontinued as appropriate (This will ensure a clear audit trail of prescribing decisions regarding the patients usual medication is made)

16.5.3.1 Recording the medication history on admission

Irrespective of how the medication history is recorded the following information must be recorded:

- Date of admission
- Source of information
- Full name of the medicine and the formulation (e.g. tablet, capsule, modified release preparation)
- Dose, frequency and route
- Sign and date the entry and enter your bleep number.
- If any of the patient's current medication is to be discontinued or altered on admission (for example, if the reason for admission is medication related), this should be entered in the "additional information" column with the reason for discontinuation/alteration and the entry signed and dated if a medication history pathway document is in use or directly into the clinical record when not.

16.5.3.2 Recording the medication changes during a patient episode

Patients who have a written Medicine Prescription and Administration record and do not have a history recorded in a pathway in the IPOC:

- Any medication started, stopped, or amended during a patients stay should be recorded contemporaneously in the clinical record with a reason for the change

Patients who have a written Medicine Prescription and Administration record and the medication history recorded in the pathway in the IPOC:

- All medicines that are started on the admission must also be entered onto the Medication History Pathway document and the indication for treatment should be stated in the "additional information" column
- All medicines that are discontinued/altered during the course of the patient's episode should have the reason for this recorded in the "additional information" column adjacent to the medicine in question and the entry signed and dated

16.5.3.2.1 Patients who have an electronic prescriptions:

As described above all changes to medication must be recorded in the clinical record or on the pathway depending on the situation. However in those with an electronic prescription in order to improve communication to the GP further information must be added to the electronic prescription record.

In order to track medication changes that will automatically form part of the discharge letter the prescriber must track medication changes in the following way:

- All medicines that are started on admission must have the 'Admitted on drug' check box ticked in the Medication order Entry screen.
- All new medicines prescribed that are expected to be taken by the patient after discharge should a have a 'Note to appear in the Discharge Letter' note attached by the prescriber in the Medication Order Entry screen.
- All medicines discontinued during a patient's stay require a reason for discontinuation to be selected from the drop down menu in the Discontinue Medication Order screen.

16.5.4 Communicating medication changes at discharge or transfer

All significant changes to the medication that have occurred during a patient's stay, including medicines stopped on admission, must be recorded on the discharge summary with reasons for those changes. This information is obtained from the patient's clinical record, the medication history pathway and, where applicable, the electronic prescribing system.

17 APPENDIX III: SELF DECLARATION FOR WARD BASED SERVICES

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

WARD

17.1 Introduction

The purpose of this document is to enable the Ward Manager who has overall responsibility for the safe and secure handling of medicines, to provide assurance to the Trust that the ward handles medicines in accordance with the Policy for the Safe and Secure Handling of Medicines Pat MM1, now referred within this declaration as the ***Medicines Policy.***

The document refers to each of the main chapters of the policy and is written as a declaration that the policy is followed. In some cases additional information is required, and this should be completed. In other cases, some of the declarations will not be applicable and this can be stated.

If the declaration cannot be made the Ward Manager should discuss this with their Matron in the first instance to seek clarification or further advice.

17.2 Responsibility

The Ward Manager will act as the Appointed Person and is responsible for ensuring the policy is followed and that the safe and secure handling of medicines in the area concerned is maintained.

The Ward Manager may delegate some of the duties described, but the responsibility always remains with the Ward Manager.

The Nurse in Charge of the shift will act as the Assigned Individual in Charge.

17.3 Medicines Security

The security of medicines is maintained in accordance with the ***Medicines Policy - Section 3 – Medicines Security.***

Medicines are stored in separate locked cupboards in accordance with the ***Medicines Policy Section 3.4 - The Storage of Medicine*** for:

- Controlled Drugs
- Medicines for Internal Use
- Medicines for External Use
- Medicines for individual patients in lockable bedside lockers

Medicines are stored in a locked refrigerator monitored accordance with the ***Medicines Policy Section 3.4 - The Storage of Medicine.***

Medicines are also stored in a lockable medicines trolley, which is secured or immobilised when not in use.

The trolley is secured by:
Delete as applicable.

Being locked with a chain to a wall	Yes / No
Storage in a locked room whose access is restricted to person authorised to hold the medicines keys	Yes / No
Other (specify)	

Ward medicines cupboards are locked by means of:

Keys	Yes / No
Electronic / Computer Controlled Locks	Yes / No

In the case of electronic / computer controlled locks the Ward Manager is responsible for controlling access to the PIN numbers and / or access fobs in accordance with the ***Medicines Policy Section 3.3 - Physical Security.***

The ward holds the following sets of keys

Controlled Drug Cupboard	X	Keys
Medicines Refrigerator	X	Keys
Internal Medicines Cupboards	X	Keys
External Medicines Cupboards	X	Keys
Bedside Master Locker Keys	X	Keys

Other Keys Held, please specify

	X Keys
	X Keys
	X Keys

The following spare keys are held securely by

……..

Controlled Drug Cupboard	X Keys
Medicines Refrigerator	X Keys
Internal Medicines Cupboards	X Keys
External Medicines Cupboards	X Keys
Bedside Master Locker Keys	X Keys

Other keys held, please specify

	X Keys
	X Keys

When the ward is closed, temporarily or routinely, the keys are held by:

……..

The Ward Manager will ensure that Controlled Stationery is held securely at all times.

With the exception of large volume fluids, medicines are delivered to the ward in lockable or tamper evident containers.

17.4 Stock Management and Control

17.4.1 Ordering Medicines

Stock medicines are routinely supplied by

Pharmacy Department Bassetlaw DGH	Yes / No
Pharmacy Store, Doncaster Royal Infirmary	Yes / No

Medicines held as stock are ordered by a Pharmacy Assistant and supplied on an agreed day once each week.

At other times, the Nurse in Charge is responsible for ordering any stock medicines required from the Pharmacy. This is done by written or telephone requisition where the name and designation of the person ordering will be given.

Non Stock medicines are supplied in one of three ways

- The nurse identifies the need for a non stock medicine and contacts their clinical pharmacist or presents a requisition to the Pharmacy department.
- The clinical pharmacist identifies the need for a non stock medicines and orders it on behalf of the Nurse in Charge.
- The ward services technician identifies the need for a non stock medicine and following authorisation by the clinical pharmacist, and orders it on behalf of the Nurse in Charge.

Non Stock medicines are routinely ordered from:

Pharmacy Department Bassetlaw DGH	Yes / No
Main Dispensary, Doncaster Royal Infirmary	Yes / No

The Nurse in Charge is responsible for ordering Controlled Drugs, by completing a Controlled Drug Requisition and sending the requisition to the supplying dispensary.

Controlled Drugs are routinely ordered from:

Pharmacy Department Bassetlaw DGH	Yes / No
Main Dispensary Doncaster Royal Infirmary	Yes / No

When the Pharmacy department is closed, and for clinically urgent items stock can be accessed from the Emergency Store or the On Call Pharmacist.

17.4.2 The Receipt of Medicines

Medicines are received in accordance with the ***Medicines Policy Section 4.4***
Controlled Drugs are received in accordance with the ***Medicines Policy Part B Appendix 2 Section 6.***

Any discrepancies are in receipt are brought to the attention of the supplying Pharmacy.

17.5 Return of Unwanted Medicine

Medicines that are no longer required are returned to the Pharmacy in accordance with the ***Medicines Policy Section 4.7 Return of Unwanted Medicines.***

Controlled Drugs that are no longer required are returned in accordance with the **Medicines Policy Part B Appendix 2 Section 11.**

The Ward Manager will ensure that all medicines awaiting return are stored securely the ward in either a locked cupboard or locked medicine transit box.

17.6 Prescribing, Prescriptions and Authorisations to Administer or Supply Medicines

Prescribing and authorisation to administer medicines is undertaken on the ward in accordance with the ***Medicines Policy Section 5 Standards for Prescribing, Prescriptions and Authorisations to Administer and Supply.***

Authorisation is required before any medicine is administered on the ward or supplied to a patient. It is obtained in one of five ways.

1. An indelible instruction, signed and dated by a Prescriber written: a. on a prescription form and/or label approved by Drug and Therapeutics Committee; where the instruction is in the form of a pre-printed label, the label shall be non-peelable	Yes
2. A computerised prescription held on a Trust approved computerised prescribing system, entered by a Prescriber and validated by password controlled electronic signature.	Yes
3. A Patient Group Direction approved by the Trust Drug and Therapeutics Committee and Trust Clinical Governance Lead.	Yes
4. Under **exceptional** circumstances the Nurse in Charge may accept a verbal order from a Prescriber to administer a medicine. See the ***Medicines' Policy Section 5.1.1***	Yes
5. By an individual authorised to administer medicines who is exempted from the requirements of a prescription under the Medicines Act 1968 / Human Medicines Regulations 2012, who initiates and administers treatment themselves. **N.B. This exemption and the associated lists of medicines has been previously approved by the Drug and Therapeutics Committee** Please Specify: Healthcare Professional exempt	YES / Not Applicable **YES / NO**

In an emergency situation, for example when a Crash Team responds to the sudden collapse of a patient, a qualified nurse may act on the verbal instructions of a doctor to administer a medicine.

Immediately after the incident the doctor makes an entry in the patient's notes detailing the drugs and doses administered which is countersigned by the qualified nurse administering them.

17.7 Administration of Medicines to Patients

The administration of medicines is undertaken in accordance with the ***Medicines Policy Section 6 – Standards for Administration.***

The administration of medicines may be undertaken by the following persons.

Class of Person	Delete as Applicable
A person whose name appears on Sub Part 1 of the Nurses part of the NMC register	Yes / No
A person whose name appears on Sub Part 2 of the Nurses part of the NMC register and who has undergone approved additional training and who has been awarded a medicines proficiency certificate. There are two levels of the certificate which allow: Administration of medicines excluding Controlled Drugs. Administration of Controlled Drugs.	Yes / No
A person whose name appears on the Midwives part of the NMC register	Yes / No
A person whose name appears on the Specialist community public health nurses part of the NMC register	Yes / No
A medical practitioner.	Yes / No

Other Healthcare Staff authorised to administer medicines:	
The following staff group have been specifically authorised by the Drug and Therapeutic Committee to administer medicines Please Specify	**YES / NO**

The following medicines or classes of medicines on this ward are checked by a second person authorised to administer medicines.

- Any cytotoxic medicines, by any route
- Controlled Drugs.
- Any medicines where the dose is expressed by weight or surface area.
- Injectable medicines unless exempted by the Drug and Therapeutics Committee

Medicines Policy Section 6.2 – Administration of Medicines
Medicines Policy Appendix IX Checking Injectable Medicines

In making the check they are checking:

1. The right medicines has been prepared
2. The right dose has been prepared
3. The medicines is due to be given
4. With the person giving the medicine the intended route
5. With the person giving the medicines the right patient has been identified

In the case of Controlled Drugs the second person witnesses the administration of the medicine.

17.8 Self Administration

An approved Self Administration Policy is in place and used on this ward	YES / NO / Not Applicable

17.9 Supply of Medicines at Discharge

Supply of medicines at discharge is undertaken in accordance with the ***Medicines Policy Section 4.6 Supply of Medicines for Discharge or to Outpatients or Patients Attending A&E.***

The patient may receive their medicines by one or more of the methods.

1) Dispensed by the Pharmacy Service against discharge prescription.
2) The patient's own medicine that are suitable for re-use.
3) From dispensed for discharge medicines.
4) From pre-labelled stock medicines.

Before the medicines are given to the patient, the nurse will check the medicines to ensure they are correct against the copy discharge prescription and current inpatient prescription and those medicines supplied through Method 2 & 4 will not expire before the supply is exhausted. The nurse will ensure the patient understands how they should take their medicines.

Supply outside normal Pharmacy Opening Hours (restricted to wards at Bassetlaw Hospital).

Outside of normal Pharmacy opening hours where no pharmacist is available to authorise a prescription and no suitably labelled medication is available. The nurse and the doctor may supply essential medicines from ward stock. This is undertaken in accordance with the ***Medicines Policy Section 4.6.6 Supply of Medicines at Discharge by Dispensing From Ward Stock***	Yes /No

17.10 Disposal of Medicines

All medicines are disposed of in accordance with the Trust Waste Disposal Policy.

17.11 Medicines Supplied Through Clinical Trial

Unless arrangements specific to the clinical trial concerned have been made, all medicines supplied through clinical trial will follow the requirements of non-stock medicines specified in this procedure. In accordance with the ***Medicines Policy Section 4.9 – Medicines Supplied Through Clinical Trials***.

17.12 Medicines Supplied as Free Samples

Free samples are not accepted onto the ward under any circumstance other than through the normal supply mechanism.

17.13 The Use of Patients' Own Medicines

Patient's Own Medicines are used in accordance with the ***Medicines Policy Section 7 Standards for the Use of Patients' Own Medicines.***

17.14 Medicines Defect Reporting and Adverse Drug Reaction Reporting

Medicines thought to be defective will be handled in accordance with the ***Medicines Policy Section 10 Medicines Defect and Adverse Drug Reaction Reporting.***

17.15 Risk Management

The Appointed Nurse in Charge is responsible for carrying out local risk assessment with respect to medicines used in their area. Risk assessments for injectable medicines should be reviewed annually.

These should be carried out whenever a high risk product is introduced into an area or following a significant untoward incident.

17.16 Declaration

I declare that medicines held on this ward are handling in accordance with the PAT MM 1 Policy for the Safe and Secure Handling of Medicines.

Signed _____
Ward Manager

Date_____

Acknowledged by _____ Matron

18 APPENDIX IV: SELF DECLARATION FOR DEPARTMENT BASED SERVICES

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

DEPARTMENT

18.1 Introduction

The purpose of this document is to enable the Departmental Manager who has overall responsibility for the safe and secure handling of medicines, to provide assurance to the Trust that the department handles medicines in accordance with the Policy for the Safe and Secure Handling of Medicines Pat MM1, now referred within this declaration as the ***Medicines Policy.***

The document refers to each of the main chapters of the policy and is written as a declaration that the policy is followed. In some cases additional information is required, and this should be completed. In other cases, some of the declarations will not be applicable and this can be stated.

If the declaration cannot be made the Departmental Manager should discuss this with their Line Manager/Matron in the first instance to seek clarification or further advice.

18.2 Responsibility

The Departmental Manager will act as the Appointed Person and is responsible for ensuring the policy is followed and that the safe and secure handling of medicines in the area concerned is maintained.

The Appointed Person is: (Job Title)

The Departmental Manager may delegate some of the duties described, but the responsibility always remains with the Departmental Manager.

In the absence of the Departmental Manager the Individual in Charge of the shift will act as the Assigned Individual in Charge.

The Individual in Charge of the Shift is: (Job Title)

18.3 Medicines Security

The security of medicines is maintained in accordance with the ***Medicines Policy - Section 3 – Medicines Security.***

Medicines are stored in separate locked cupboards in accordance with the ***Medicines Policy Section 3.4 - The Storage of Medicine*** for:

- Controlled Drugs
- Medicines for Internal Use
- Medicines for External Use

Medicines are stored in a locked refrigerator monitored accordance with the ***Medicines Policy Section 3.4 - The Storage of Medicine.***

Medicines cupboards are locked by means of:

Keys	Yes / No
Electronic / Computer Controlled Locks	Yes / No

In the case of electronic / computer controlled locks the Departmental Manager is responsible for controlling access to the PIN numbers and / or access fobs in accordance with the ***Medicines Policy Section 3.3 - Physical Security.***

The department holds the following sets of keys

Controlled Drug Cupboard	X	Keys
Medicines Refrigerator	X	Keys
Internal Medicines Cupboards	X	Keys
External Medicines Cupboards	X	Keys
Bedside Master Locker Keys	X	Keys

Other Keys Held, please specify

	X Keys
	X Keys
	X Keys

The following spare keys are held securely by

……..

Controlled Drug Cupboard	X	Keys
Medicines Refrigerator	X	Keys
Internal Medicines Cupboards	X	Keys
External Medicines Cupboards	X	Keys

Other Keys Held, please specify

	X Keys
	X Keys

When the department is closed temporarily or routinely the keys are held by:

……..

The Appointed Person will ensure that Controlled Stationery is held securely at all times and process are in place to account for their use..

Controlled Stationery includes:

Outpatient Prescription forms to be dispensed by the hospital pharmacy	Yes / No
FP10HNC prescription forms to be dispensed by community pharmacies	Yes / No

With the exception of large volume fluids, medicines are delivered to the department in lockable or tamper evident containers.

18.4 Stock Management and Control

18.4.1 Stock Medicines

For those areas not Topped Up by the Pharmacy Service:

The range and quantities of medicines available in the department are in accordance with the agreed stock list	Yes / No Not Applicable (in the case of an area topped up by pharmacy staff)

18.4.2 Ordering Medicines

Stock medicines are routinely supplied by:

Pharmacy Department Bassetlaw DGH	Yes / No
Pharmacy Store, Doncaster Royal Infirmary	Yes / No

Routine stock medicines are ordered from a stock list:

The Person responsible for ordering is:

By a Pharmacy Assistant	Other:

Frequency of ordering is:

Weekly	Other:

At other times, the person responsible for ordering any stock medicines required from the Pharmacy is:

Specify:

This is done by written or telephone requisition where the name and designation of the person ordering will be given.

Non Stock medicines are supplied by the person responsible for ordering identifying the need for a non stock medicine and contacting or presenting a requisition to the Pharmacy department. Non stock request are authorised by a pharmacist before supply.

Non Stock medicines are routinely ordered from:

Pharmacy Department Bassetlaw DGH	Yes / No
Main Dispensary Store, Doncaster Royal Infirmary	Yes / No

The Person responsible for ordering Controlled Drugs is:

Specify:

Controlled Drugs are ordered by completing a Controlled Drug Requisition and sending the requisition to the supplying dispensary.

Controlled Drugs are routinely ordered from:

Pharmacy Department Bassetlaw DGH	Yes / No
Main Dispensary, Doncaster Royal Infirmary	Yes / No

When the Pharmacy department is closed, and for clinically urgent items stock can be accessed from the Emergency Store or the On Call Pharmacist.

18.4.3 The Receipt of Medicines

Medicines are received in accordance with the ***Medicines Policy Section 4.4***
Controlled Drugs are received in accordance with the ***Medicines Policy Part B Appendix 2 Section 6.***

Any discrepancies are in receipt are brought to the attention of the supplying Pharmacy.

18.5 Return of Unwanted Medicine

Medicines are no longer required are returned to the Pharmacy in accordance with the ***Medicines Policy Section 4.7 Return of Unwanted Medicines***
Controlled Drugs that are no longer required are returned in accordance with the **Medicines Policy Part B Appendix 2 Section 11.**

The Appointed Person will ensure that all medicines awaiting return are stored securely the ward in either a locked cupboard or locked medicine transit box.

18.6 Prescribing, Prescriptions and Authorisations to Administer or Supply Medicines

Prescribing is undertaken on the department in accordance with the ***Medicines Policy Section 5 Standards for Prescribing, Prescriptions and Authorisations to Administer and Supply.***

Authorisation is required before any medicine is administered on the ward or supplied to a patient. It is obtained in one of five ways.

1. An indelible instruction, signed and dated by a Prescriber written: a. on a prescription form and/or label approved by Drug and Therapeutics Committee; where the instruction is in the form of a pre-printed label, the label shall be non-peelable	Yes
2. A computerised prescription held on a Trust approved computerised prescribing system, entered by a Prescriber and validated by password controlled electronic signature.	Yes
3. A Patient Group Direction approved by the Trust Drug and Therapeutics Committee and Trust Clinical Governance Lead.	Yes
4. Under **exceptional** circumstances the Nurse in Charge may accept a verbal order from a Prescriber to administer a medicine. See the ***Medicines' Policy Section 5.1.1***	Yes
5. By an individual authorised to administer medicines who is exempted from the requirements of a prescription under the Medicines Act 1968 / Human Medicines Regulations 2012, who initiates and administers treatment themselves.	YES / Not Applicable

N.B. This exemption and the associated lists of medicines has been previously approved by the Drug and Therapeutics Committee Please Specify: Healthcare Professional exempt	**Yes / No**

In an emergency situation, for example when a Crash Team responds to the sudden collapse of a patient, a qualified nurse may act on the verbal instructions of a doctor to administer a medicine.

Immediately after the incident the doctor makes an entry in the patient's notes detailing the drugs and doses administered which is countersigned by the person administering them.

18.7 Administration of Medicines to Patients

The administration of medicines is undertaken in accordance with the ***Medicines Policy Section 6 – Standards for Administration.***

Class of Person	Delete as Applicable
A person whose name appears on Sub Part 1 of the Nurses part of the NMC register	Yes / No
A person whose name appears on Sub Part 2 of the Nurses part of the NMC register and who has undergone approved additional training and who has been awarded a medicines proficiency certificate. There are two levels of the certificate which allow: Administration of medicines excluding Controlled Drugs. Administration of Controlled Drugs.	Yes / No
A person whose name appears on the Midwives part of the NMC register	Yes / No
A person whose name appears on the Specialist community public health nurses part of the NMC register	Yes / No
A medical practitioner.	Yes / No

Other Healthcare Staff authorised to administer medicines:	
The following staff group have been specifically authorised by the Drug and Therapeutic Committee to administer medicines Please Specify	**YES / NO**

The following medicines or classes of medicines on this ward are checked by a second person authorised to administer medicines.

- Any cytotoxic medicines, by any route.
- Controlled Drugs.
- Any medicines administered to children under 16 years of age.
- Any medicines where the dose is expressed by weight or surface area.
- Injectable medicines unless exempted by the Drug and Therapeutics Committee.

Medicines Policy Section 6.2 – Administration of Medicines
Medicines Policy Appendix IX Checking Injectable Medicines

In making the check they are checking:

1. The right medicines has been prepared.
2. The right dose has been prepared.
3. The medicines is due to be given.
4. With the person giving the medicine the intended route.

In the case of Controlled Drugs the second person witnesses the administration of the medicine.

18.8 Supply of Medicines to Patients

Supply of medicines to patients is undertaken in accordance with the ***Medicines Policy Section 4.6 Supply of Medicines for Discharge or to Outpatients or Patients Attending A&E.***

The patient may receive their medicines by one or more of the methods.

1) Dispensed by the Pharmacy Service against prescription.
2) The patient's own medicine that are suitable for re-use.
3) From dispensed for discharge medicines.
4) From pre-labelled stock medicines.

18.9 Disposal of Medicines

All medicines are disposed of in accordance with the Trust Waste Disposal Policy.

18.10 Medicines Supplied Through Clinical Trial

Unless arrangements specific to the clinical trial concerned have been made, all medicines supplied through clinical trial will follow the requirements of non-stock medicines specified in this procedure. In accordance with the ***Medicines Policy Section 4.9 – Medicines Supplied Through Clinical Trials.***

18.11 Medicines Supplied as Free Samples

Free samples are not accepted onto the department under any circumstances other than through the normal supply mechanism.

18.12 The Use of Patients' Own Medicines

Patient's Own Medicines are used in accordance with the ***Medicine Policy Section 7 Standards for the Use of Patients' Own Medicines.***

18.13 Medicines Defect Reporting and Adverse Drug Reaction Reporting

Medicines thought to be defective will be handled in accordance with the ***Medicines Policy Section 10 Medicines Defect Reporting.***

18.14 Risk Management

The Appointed Person is responsible for carrying out local risk assessment with respect to medicines used in their area. Risk assessments for injectable medicines should be reviewed annually.

These should be carried out whenever a high risk product is introduced into an area or following a significant untoward incident.

18.15 Declaration

I declare that medicines held on this ward are handling in accordance with the PAT MM 1 Policy for the Safe and Secure Handling of Medicines.

Signed _____

Appointed Person/ Department Manager (Designation) _____

Date _____

Acknowledged by _____ Line Manager/ Matron

19 APPENDIX V: POLICY ON THE USE OF STRONG MAGNESIUM AND POTASSIUM SOLUTIONS

19.1 Aim

To reduce the risk of accidental overdose of intravenous magnesium sulphate, potassium chloride concentrate solutions and other strong potassium solutions.

These include:
- Magnesium Sulphate 50% inj (5g in 10mL
- Potassium Chloride 15% inj (1.5g in 10mL)
- Potassium Chloride 10% inj (1g in 10mL)
- Potassium Chloride 20% inj (2g in 10mL)
- Potassium Phosphate 17.42% inj
- Potassium Acid Phosphate 13.6% inj

To ensure that seriously ill patients in critical care units who urgently require intravenous potassium as part of their treatment can continue to receive it promptly.

NOTE: Commercially available ready to use preparations containing potassium will be used wherever possible.

19.2 Storage and Handling

Strong potassium solutions are only routinely stocked in critical care areas where the concentrated solutions are needed for urgent use and the clinical needs of the patient group cannot be met by any commercially available preparation.

Authorisation will only be given after review by the Drug and Therapeutics Committee.

The authorised areas are: -

BASSETLAW DISTRICT GENERAL HOSPITAL	CCU,ITU, Theatre Recovery, SCBU
DONCASTER ROYAL INFIRMARY	CCU, NNU, Critical Care, Theatre Recovery
MEXBOROUGH MONTAGU HOSPITAL	Nil
TICKHILL ROAD HOSPITAL	Nil

1. Strong potassium solutions are stored in the Controlled Drugs cupboard and documentation should follow the pattern for controlled drugs i.e. they are ordered using the Controlled Drugs requisition book, all administration is documented in the Controlled Drugs Record Book which is signed by 2 members staff.

2. Wards authorised to stock strong potassium solutions are not allowed to transfer the product to other clinical areas. Wards requesting supplies are referred to the pharmacist.

3. In areas where potassium strong solutions is not authorised to be stocked requests will be authorised by a pharmacist for individual patients. The pharmacist must countersign the order for the preparation before a supply is made. The pharmacist will authorise sufficient supply to cover immediate use only, which will dispensed and labelled for the particular patient.

19.3 Prescribing of Solutions containing Potassium

See Trust Formulary for further guidance.

20 APPENDIX VI GUIDANCE FOR THE COMPLETION OF MEDICATION ALLERGY STATUS AND SENSITIVITIES

20.1 Introduction

This guidance is primarily concerned with the identification and recording allergic reactions to medicines. These reactions are an immunological response where the reaction can vary from rash, serum sickness and angio-oedema to life threatening bronchospasm and hypotension associated with anaphylaxis. However the principles involved are equally applicable in identifying other idiosyncratic reactions to medicines that should also be recorded.

20.2 Responsibility

The prescriber retains the principal responsibility for ascertaining allergy status of any patient for whom they prescribe. However it is the responsibility of every person involved in the medication process - prescribing, dispensing, or administering medicines - to take every practical step to establish the allergy status of the patient. This can be done at various points in the patient journey and should be considered to be an on going process.

20.3 Sources of Information

1. Ask the patient whilst taking the medication history
2. Ask the patient whilst ordering or approving the supply of medicines
3. Ask the patient before administering medicines
4. The referring GP's Letter
5. The medicine charts from a previous admission
6. The Alert / Hazard Notification Card in the case notes
7. The case notes from a previous admission

20.4 Practical Steps

It is recognised that in many cases not all the sources of information are available. Where an allergy is identified a record must be made (see 4).

20.4.1 For Prescribers

Before prescribing any **new** medicine check all available sources for the allergy status, and where the patient is competent ask the patient.

Where the patient cannot communicate - and where none of the above sources are available to indicate an allergy status - weigh the risk and benefit of the therapy carefully, and only prescribe where necessary and record in the clinical record.

20.4.2 For those Approving the Supply of Medicines

Before approving the supply any **new** medicine check all available sources for the allergy status, and where the patient is competent ask the patient.

Where the patient cannot communicate - and where none of the above sources are available or indicate an allergy status - weigh the risk and benefit of the therapy carefully, and only authorise where necessary. Where appropriate discuss with the prescriber.

20.4.3 For those Ordering Medicines

Check the allergy status on the prescription chart or electronic record
Where this is not recorded ask the patient

20.4.4 For those Administering Medicines

Check the allergy status on the prescription chart and where possible ask the patient. Where no allergy status is identified the other sources of information must be consulted. If in doubt refer to the prescriber and record actions

20.5 Unconfirmed Allergy Status

All patients must have their allergy status recorded. If it is not possible to establish the allergy/ADR status on admission the 'Allergy status unconfirmed' row must be signed by the prescriber. Nursing staff may administer medication until the end of the next weekday. The prescriber must confirm the allergy/ADR status (e.g. by telephoning the patient's GP) and signed the relevant row before further doses can be administered.

20.6 Recording the Allergy Status

20.6.1 Inpatients

All staff involved in the medication process – prescribing, authorising supply of, ordering, and administering medicines -are authorised to record the allergy status on the medication chart. Whenever an allergy is identified the Alert / Hazard Notification Card must also be updated following Trust procedure CORP/REC 1.

20.6.1.1 When an allergy is identified the following must be recorded on the inpatient medication chart.

i) The (approved) name of the medication
ii) The reaction experienced
iii) The date
iv) Signature of the person making the record

20.6.1.2 Where no known allergies are identified record the following information

i) "No Known Drug Allergies"
ii) The date
iii) Signature of the person making the record

20.6.2 Outpatients

When an allergy is identified at an outpatient consultation a record must be made on the Alert / Hazard Notification Card of the patient's notes. The patient's general practitioner must be informed in the follow up letter.
When an allergy is identified at the point of dispensing the Pharmacist must contact the prescriber and inform them of this information. It is the prescribers responsibility to update the Alert / Hazard Notification Card.

20.7 Transferring Information

When a medicine chart is re-written the allergy status must be transcribed to the new chart.

The allergy status must be routinely provided on and discharge letter or inter-hospital transfer.

20.8 Penicillins – Special Note

Patients with penicillin allergy may exhibit cross sensitivity to other antibiotics containing beta-lactam rings. These include cephalosporins, imipenem (Primaxin), and meropenem. Aztreonam appears to show little cross sensitivity but the SPC advises caution in patients with hypersensitivity to penicillins.

Some products also contain penicillin but it is not obvious from their name, e.g Tazocin and Augmentin, these must also be avoided.

21 APPENDIX VII- NON MEDICAL PRESCRIBING MODEL OPERATIONAL POLICY

21.1 Scope of Service

The prescribers identified in this policy will follow the prescribing principle set out in the Trust Medicines Management Policies which are prefixed PAT/MM. This operational policy details the specific roles, responsibility, and operational method for this service and it should be read in conjunction with the Policy for Non-Medical Prescribing.

Describe the scope of the service
Specify whether the prescribing is Independent, Supplementary or both

The Non Medical Prescriber shall prescribe within the following legal framework:

Practice	**Independent Prescribing**	**Supplementary Prescribing (Within a Clinical Management Plan CMP)**
Lawful	• Licensed Medicines • Off-label (prescribing outside the terms of the Manufacturer's Product License) • Specific Controlled Drugs for specific medical conditions in DH Guidance (Nurses only, not applicable to Pharmacists) • Prescribing requiring the mixing of a licensed drug with a vehicle/diluent in a syringe • Unlicensed medicines prescribing medicines with no Product License) • Prescribing requiring the mixing of two licensed drugs in a syringe	• Licensed Medicines • Off-label (prescribing outside the terms of the Manufacturer's Product License) • Controlled Drugs • Prescribing requiring the mixing of a licensed drug with a vehicle/diluent in a syringe • Prescribing requiring the mixing of two licensed drugs in a syringe • Unlicensed medicines
Unlawful	• All other Controlled Drugs not in DH Guidance	

21.2 Prescribing of unlicensed medicines

All unlicensed medicines prescribed will be subject to adherence to the unlicensed medicines policy PAT/MM 4.

The non-medical prescriber will be able to initiate or continue unlicensed medicines that are categorised as risk level 1 within the policy that is within the non-medical prescriber's clinical competency.

The non-medical prescriber will be able to initiate treatment with UK licensed products used outside of their license indications (level 2) providing they are being used within recognised clinical guidelines / as part of established practice and it is within the non-medical prescriber's clinical competency.

Any other unlicensed products that are categorised as risk level 2 or above will be initiated with the agreement of the patient's consultant following PAT/MM 4.

21.3 Clinical Service Unit Management Responsibility

The Clinical Director through the Management Team of the clinical area is responsible for

1. Agreeing the need for the non medical prescribing service.
2. For evaluating the impact of the non-medical prescribing service.
3. Ensuring the competence of the non medical prescriber and appropriateness of the individual prescriber in the specific prescribing environment.
4. Providing professional development opportunities to support personal and service development.
5. Ensuring that the consultants within the directorates affected are aware of the NMP prescribing service and this operational policy, and that they have had an opportunity to opt out. It is assumed that once consultants are informed patients will be eligible for non medical prescribing unless otherwise indicated by the individual consultant.

21.4 Clinical Responsibility

Where a service provides both independent and supplementary prescribing, it is the responsibility of the referring Independent Medical Prescriber will decide which model of prescribing is appropriate for the individual patient and non medical prescriber.

21.4.1 Independent Non Medical Prescribing

21.4.1.1 For Patients Under the Care of a Consultant

Where a patient is referred to a Consultant, the ultimate responsibility for the patient's care remains with that consultant. The Consultant's role is to lead the care of the patient and to provide clinical support to the non medical prescriber.
The Non Medical Prescriber will prescribe on behalf of the consultant by following the formulary choice of that consultant. They remain personally accountable for the prescribing action.

21.4.1.2 The Patient Not Under the Direct Care of a Consultant

Where the service is not consultant led the responsibility lies with the non medical prescriber. The Non medical prescriber will follow the Trust Formulary.

21.4.2 Supplementary Non Medical Prescribing

The Consultant's role is to lead the care of the patient and to provide clinical support to the non medical prescriber.

21.4.2.1 The Role of the Independent Medical Prescriber

The Independent Medical Prescriber will

1. Undertake the initial assessment and diagnosis of the patient.
2. Lead the development of the Clinical Management Plan in partnership with the Supplementary Prescriber.
3. Define the limits of supplementary prescribing.
4. Resuming full responsibility at the request of the Supplementary Prescriber.

21.4.2.2 The Role of the Supplementary Non Medical Prescriber

The Supplementary Prescriber will

1. Monitor the patient's progress against their clinical management plan.
2. Prescribe in accordance with clinical management plan.
3. Maintain contemporaneous records.
4. Accept responsibility for their prescribing decisions.
5. Refer back to the Independent Medical prescriber when indicated.

21.5 Clinical Management Plans and Clinical Guidelines

All patients prescribed under supplementary prescribing arrangements require an individual clinical management documented in their clinical records. The clinical management plan is an agreement with the patient that is signed by the independent and supplementary prescribers. It details the treatment aims, plan, and monitoring arrangements; it includes criteria for referral back to the independent prescriber.

The following guidelines approved by the Drug and Therapeutics Committee are used to support individual clinical management plans.

21.5.1 National Guidelines

1. *Specify applicable national guidelines.*

21.5.2 Local Guidelines

1. *Specify applicable local guideline.*

21.6 Operational Detail

1. *Describe the referral process to the non medical prescriber.*
2. *Describe the inclusion criteria for patients.*
3. *Describe the referral process from the independent non medical prescriber to another prescriber e.g. for inappropriate referrals.*
4. *Describe the circumstances of prescribing being undertaken; e.g. inpatient, TTO, Outpatients.*
5. *Describe the communications required following prescribing. Eg. Documentation in notes, communication with GP following clinic visits.*
6. *If necessary describe the security arrangements for Controlled Stationery. Eg. Where clinics are held in non Trust premises.*

21.7 Prescription Forms

Prescription forms, including FP10 forms, are Controlled Stationery. The Non Medical Prescriber will ensure that all Controlled Stationery under their control is held securely at all times.

Any loss or theft of any item of Controlled Stationery will be reported to their Line Manager and to the Chief Pharmacist at the earliest opportunity.

All prescriptions are authorised by the signature (or electronic signature) of the Non Medical Prescriber. Non Medical Prescribers will identify themselves by a legible signature, bleep number, or printed name. For internal prescriptions the non medical prescriber will use the abbreviation NMP after the signature. For prescription written on FP10 the Non Medical Prescriber will add their professional registration number to the form to enable the Community Pharmacist to identify them.

21.8 Audit

Add any arrangements in place to audit the service.

22 APPENDIX VIII – INFORMATION RESOURCES

To enable medicines to be prescribed and administered in a safe manner the following minimum information resources must be available.

22.1 Ward and Departments

The appointed person in charge is responsible for ensuring the following are available and their staff are familiar with how to access them.

1) The current edition of the British National Formulary (BNF).
2) The current edition of the Children's BNF - where medicines are prescribed for children.
3) The Medusa the Online injectable medicines guide, accessible via the intranet.
4) The University College Hospitals London injectable Medicines Guide.
5) The Trust Hospital Formulary accessible via the intranet.

The Appointed Person in Charge is responsible for ensuring that any other locally held policies, protocols or other information is relevant to their area is up to date.

22.2 Prescribers

1) The current edition of the British National Formulary.
2) The current edition of the Children's BNF -where medicines are prescribed for children.
3) The Trust Hospital Formulary accessible via the intranet.

22.3 Distribution of BNFs

The Chief Pharmacist is responsible for ensuring a system is in place to distribute new and retrieve superseded BNFs from ward and departments.

Prescribers are responsible for ensuring they obtain a copy of the latest BNF which are available from the local Pharmacy Departments or gain access to the online version or mobile application.

23 APPENDIX IX – CHECKING INJECTABLE MEDICINES

23.1 Checking the Administration following the written directions of another person

Single person administration system is the normal method of administration **except** where the following types of medicines are involved.

- Any cytotoxic medicines, by any route.
- Controlled Drugs.

- Any medicines where the dose is expressed by weight or surface area.
- Injectable medicines unless exempted by the Drug and Therapeutics Committee.

In these cases a second individual authorised to administer medicines needs to check the administration as described below.

23.2 Injectable Medicines

The following injectable medicines are exempted by the Drug and Therapeutics Committee from the need for a check by a second individual authorised to administer medicines;

1) Subcutaneous bolus injections
2) Intramuscular injections
3) Intravenous bolus injections

4) Crystalloid Infusions
   a) Sodium Chloride 0.9%, Glucose 5%, Glucose 4% with Sodium Chloride 0.18% Infusion.
   b) Hartmann's Solution, Plasmalyte.
5) Plasma expanders
   a) Volulyte, Gelaspan
6) Ready made infusions
   a) Ciprofloxacin
   b) Linezolid
   c) Metronidazole 500mg in 100ml
   d) Paracetamol
7) Antibiotics given in a small volume Minibag Plus system or prepared using an approved reconstitution device

All other injectable medicines, including infusions require a check by a second person authorised to administer medicines before administration.

The second authorised individual checks the administration, although the responsibility remains with the administering individual.

The checking person's role includes verification of the following:

- The medication is prescribed and it is due for administration.
- The correct medication is selected.
- Any calculations made are correct.
- The medication and dose are prepared for use correctly.
- The patient to whom it is being administered is correct.
- The route is correct.
- In the case of a Controlled Drug witnessing the actual administration

The process of double checking involves two people working together, but staff should be aware that this can present dangers where staff prompt each other to reach the same conclusion.

The following medicines shall also be considered as Controlled Drugs for the purpose of administration:

- Schedule 3 Controlled Drugs such as barbiturate
- Strong Potassium Injections such as Potassium Chloride 15%

24 APPENDIX X – Providing Information on Medicines to Patients

24.1 Introduction

Patients understanding of their medicines has a major impact on their compliance with treatment regimes. The NICE Clinical Guideline on Medicines Adherence (CG76 http://guidance.nice.org.uk/CG76/NICEGuidance/pdf/English) recommends that patients should be provided with the following information about their medicines, particularly those newly prescribed:

- what the medicine is
- how the medicine is likely to affect their condition (that is, its benefits)
- likely or significant adverse effects and what to do if they think they are experiencing them
- how to use the medicine
- what to do if they miss a dose
- whether further courses of the medicine will be needed after the first prescription
- how to get further supplies of medicines.

Provision of this information is a requirement for compliance with CQC (Outcome 9 Regulation 13);which states 'wherever possible [people using the service] will have information about the medicine being prescribed made available to them or others acting on their behalf'.

24.2 Prescriber's Responsibilities

The prime responsibility for provision of this information remains with the prescriber at the point new medication is initiated.

It is essential in order for the patient to give informed consent that basic information is given by the person responsible for initiating the new medicine, such as:

- what the medicine is.
- its benefits.
- significant adverse effects
- alternative treatments.

Where patients require more in depth information it may be appropriate for the prescriber to make a referral to a pharmacist.

24.3 Nursing Responsibilities

The key role of Nursing staff is to ensure the patient has all the information they require about their medicines. This may involve supplementing and/or reinforcing the information provided by the prescriber. Where more in depth information required patients should be referred to a pharmacist by for medication counselling.

As part of the discharge process nursing staff should, as a minimum, ensure patients understand:

- how to use the medicine
- what to do if they miss a dose
- whether further courses of the medicine will be needed after the first prescription
- If required, how to get further supply after discharge.

The provision of this information should be documented in the clinical record and, ideally, if appropriate on the electronic prescribing system (JAC).

24.4 Pharmacy Responsibilities

Members of Pharmacy staff are responsible for counselling patients in the following specific groups:

- Patients newly prescribed particular groups of generally higher risk medicines:
  - medicines that have specific counselling points (e.g., bisphosphonates, immunosuppressants, sulphasalazine, phosphate binders, TB medications),
  - medicines that require patient-held monitoring booklets (e.g. lithium, warfarin, methotrexate)
  - Patients where the reason for admission is related to medicines (e.g. NSAID's and gastric bleeding)
  - Patients who are on high strength opioids
  - Patients on unlicensed medicines (e.g. N-acetylcysteine)

- Patients newly prescribed medicines requiring the use complicated administration devices.
- Patients where there is a history of poor compliance, or where compliance is considered to present a potential risk.
- Patients referred by medical and nursing colleagues.

Consideration of patients future needs for information should be considered and if required communicated with the patients GP via the discharge summary. Appropriate patients may be referred to their community pharmacist for Medication Utilisation Review (under the 'new medicines' and/or 'hospital discharge' aspects of the Targeted MUR Programme).

Any counselling undertaken, or other actions taken, should be documented in the clinical record and, ideally, if appropriate on the electronic prescribing system (JAC).

25 APPENDIX XI – The Handling of Medicines in Theatre Environments

It is acknowledged by the Drug and Therapeutics Committee that the handling of medicines takes place in a wide variety of settings, and whilst there is an expectation that the policy will be followed as written, in some settings this may require some further interpretation. Thus in Theatre environments the handling of medicines is also subject to a memorandum of understanding, agreed by the Drug and Therapeutics Committee, which has been written to provide that interpretation. The memorandum of understanding covers both the handling of both Controlled Drugs and non- Controlled Drugs.

26 APPENDIX XII – Controlled Stationery Register for Prescription Forms

Controlled Stationery Register

FP10 / Outpatient Prescriptions

Prescription starting number: _____ Received from Pharmacy: _____ _____ _____

Name Signature Date

Date	Clinic	Lead Consultant	Signing Out			Signing In		
			Prescription ID#*	Name	Signature	Prescription ID#*	Name	Signature

*The Prescription ID# is unique identifying number for the prescription at the top of the pad

Controlled Stationery Register

FP10 / Outpatient Prescriptions

Prescription starting number: _____ Received from Pharmacy: _____ _____ _____

Name Signature Date

Date	Clinic	Lead Consultant	Signing Out			Signing In		
			Prescription ID#*	Name	Signature	Prescription ID#*	Name	Signature

*The Prescription ID# is unique identifying number for the prescription at the top of the pad

27 APPENDIX XIII – Missing/Lost/Stolen NHS prescription form(s) notification form

Missing/lost/stolen NHS prescription form(s) notification form

Organisation:	Date reported:
Contact name:	Contact telephone number:
Contact address:	
The following numbered NHS prescriptions forms have been identified to us as lost or stolen:	
Date of theft/loss	
Name of person reporting (GP, practice manager, nurse, trust pharmacist)	
Telephone number	
Full details of theft/loss (please fill in details below)	
Include the following information: • date and time of loss/theft • date and time of reporting loss/theft • place where loss/theft occurred • type of prescription stationery • serial numbers • quantity • details of the LSMS or nominated security management specialist to whom the incident has been reported.	
Details of doctor/department/dentist/nurse etc from whom prescription form(s) have been stolen or lost	
Name	
Personal dispensing or identification code/number	
Address	
Serial number(s) lost or stolen **From** **To**	
Details of NHS prescription form type lost or stolen (tick appropriate box)	

Issue	Colour	Please indicate type lost/stolen
FP10NC	Green	
FP10HNC	Green	
FP10SS	Green	
FP10MDAS	Blue	
FP10HMDAS	Blue	
FP10MDASP	Blue	
FP10MDASS	Blue	

FP10PN	Lilac	
FP10CDF	Buff/pale yellow	
FP10SP	Lilac	
FP10P	Lilac	
FP10D	Yellow	
FP10PCDSS	Pink	
FP10PCDNC	Pink	

* updated current forms in use October 2006

	Yes	No
Has this incident been reported to the police?		
Name and police station of investigating police officer (please fill in details below)		

	Yes	No
Has an alert and warning been issued to all local pharmacies and GP surgeries within the area? (please tick box)		

Please give details of any ink change or security measures and the effective dates of these measures (please fill in details below)

Name:	
Position:	
Signed:	
Dated:	

Return this completed form by email to prescription@nhsprotect.gsi.gov.uk

28 APPENDIX XIV – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	DIVISION/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Pharmacy and Medicines Management	Diagnostics & Pharmacy	John Bane	Existing Policy	January 2019

1) Who is responsible for this policy? Drug and Therapeutics Committee

2) Describe the purpose of the service / function / policy / project/ strategy? To ensure the safe and secure handling of medicines

3) Are there any associated objectives? Ensure compliance with national legislation, CQC standards, and national best practice guidelines

4) What factors contribute or detract from achieving intended outcomes? Non-compliance with policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation]

6) Is there any scope for new measures which would promote equality? Na

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

Date for next review: January 2022

Checked by: John Bane **Date: January 2019**