Medicines Policy

			POLICY
Reference	CPG-MM-MP		
Approving Body	Joint Drug and Therapeutic and Medicines Optimisation Committee		
Date Approved	28th March 2025		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
		x	
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Author (Position & Name)	Assistant Chief Pharmacist, Joanna Freeman with support from the Medicines Policy Review Group
Lead Division/ Directorate	Clinical Support, Therapies and Outpatients
Lead Specialty/ Service/ Department	Medicines Management/ Pharmacy
Position of Person able to provide Further Guidance/Information	Chief Pharmacist
Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
All related documents are hyperlinked throughout the Policy where applicable	Not applicable
Template control	April 2024

CONTENTS

1.0 INTRODUCTION and POLICY STATEMENT

For all controlled drug (CD) related questions please see the CD Policy available here:
CD Policy and associated SOPs.

The Department of Health requires that all NHS Trusts establish, document and maintain effective systems to ensure that medicines are handled in a safe and secure manner. The document aims to define precisely the roles and responsibilities of all health care professionals involved in any stage of the medicines management process including ordering, storage, prescribing, dispensing and administration of medicines.

All staff dealing with medication must be aware of the Trust Medicine Policy and associated procedures. The general principles within this document are supported by a number of documents produced by the main healthcare regulatory bodies to support their registrants, with which staff should also be familiar:

General Medical Council	Professional standards for doctors
Nursing and Midwifery Council	The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates
General Pharmaceuitcal Council	Standards for pharmacy professionals
Health & Care Professionals Council	Standards of conduct, performance and ethics

There are also a number of Professional Bodies who produce a range of documents to help support their members. The Royal Pharmaceutical Society (RPS) in conjunction with the Royal College of Nursing (RCN) issued a document on the Professional guidance on the safe and secure handling of medicines which sets out additional principles on the safe storage and handling of medication. Other such guidance is available from other Royal Colleges for medical, midwifery and Allied Health Professionals.

The Medicines Policy will be subject to regular monitoring and review to ensure that the principles within are upheld to the highest standards. All staff who engage in actions covered by the policy should give due regard to the individuals ethnicity, age, disability, gender or sexual orientiation, religion and beliefs which might all on occasion be relevent to medicine optimisation and management.

Locums, bank and agency staff are expected to operate to the same standards as permanent staff and therefore should familiarise themselves with the relevant sections of the Medicine Policy

The policy applies to Sherwood Forest Hospitals and other organisations that receive Pharmacy and Medicines Optimisation Services, under contract, from the Sherwood Forest Hospitals' Pharmacy, and have agreed to abide by the Medicines Policy is applicable to the following areas:

- King's Mill Hospital
- Mansfield Community Hospital
- Newark Hospital
- Outpatient Parenteral Antibiotic Therapy services
- Virtual ward

- Community Midwifery Services
- Nottinghamshire Community Health services based at Ashfield and Mansfield Community Hospitals and John Eastwood Hospice

Although the various Sections of this policy may relate to the activities of separate groups of individuals, it is important to view the document as a whole. The potential for error at all stages of the process of administration of medicines should not be underestimated. Maintenance of high standards requires attention to detail from all professionals involved in this process. Staff are asked to use common sense when faced with new situations and to be personally aware of their professional limitations. If unsure about any aspect of a procedure they should seek advice from senior professional staff.

The policy is not a detailed definition of the law. In some areas, in attempting to define safe and good practice, it may go beyond what is expected in law. All topics will not be covered in detail therefore references to other policies and procedures will be incorporated throughout.

The policy has been produced under the auspices of the Sherwood Forest Hospitals NHS Foundation Trust Joint Drug and Therapeutics and Medicines Optimisation Committees. It has the full support and endorsement of the Chief Executive, Chairman and Board. Similarly the document is supported and endorsed by NHS Nottinghamshire County and Nottinghamshire Healthcare NHS Trust. Staff who disregard the principles outlined in this document may run the risk of disciplinary proceeding.

The Medicines Policy is distributed electronically. It is available on the Intranet site; it is intended that staff will access the document via this route. The printing of the Medicines Policy is to be discouraged.

2.0 DEFINITIONS/ ABBREVIATIONS

2.1 NURSING AND MIDWIFERY

Registered Nurse
A nurse who is registered on the appropriate part of the Nursing and Midwifery Council (NMC) register. The nurse must have a field of practice also highlighted either adult, children, learning disability or mental health. They are qualified to have custody of and to administer medicines.

Registered Midwife
A midwife who is registered on the appropriate part of the NMC register. They are qualified to have custody of and to administer medicines.

Nursing Associates
An individual registered on the appropriate part of the NMC register who bridges the role between a Registered Nurse and Healthcare Assistant (HCA). In order for this group of staff to administer medicines from a limited list they are required to attend the Medicines Management lecture, complete the Trust's Medicines Management Pack and demonstrate competence in-line with that for Registered Nurses.

Ward/Department Leader/Nurse-in-Charge/Charge Nurse/Sister
A Registered Nurse, Midwife or Operating Department Practitioner (ODP) with continuing management responsibility for a designated ward/department/caseload.

Shift Co-ordinator
A Registered Nurse, Midwife, ODP or Allied Health Professional (AHP) identified as co-ordinating a shift for a designated ward/department.

Labour Ward Co-ordinator
A Registered Midwife with management responsibility for the co-ordination of the labour ward and birthing unit.

Community Team Leader
A Registered Midwife with management responsibilities for the community midwifery team.

Matron or Divisional Director of Nursing
A senior Registered Nurse or Midwife with management responsibility for a designated group of wards/departments.

Specialist Practitioner
A Registered Nurse, Midwife or AHP who has completed specific specialist training to extend their clinical practice, in order to undertake specific clinical interventions in a defined area of practice.

Nurse or Midwife Consultant
A Registered Nurse or Midwife who has specific responsibility for the leadership and development of a particular aspect of nursing or midwifery care, including the development and implementation of research and audit programmes, and practice development.

Emergency Nurse / Care Practitioner
A registered nurse or AHP who has been specially trained to treat minor injuries within specific healthcare settings. Depending on the practitioner's original qualification they may also be able to prescribe medicines if they have undertaken a prescribing qualification.

Health Care Support Worker
An unregistered Health Care Practitioner who has undertaken, to successful completion, the care certificate, who assists the RN in the delivery of nursing care.

Senior Health Care Support Worker
An unregistered Health Care practitioner who has undertaken the care certificate to completion who assists the RN in the delivery of nursing care and provides additional duties above that of the HCSW such as phlebotomy, insertion of indwelling urinary catheters and completion of ECGs.

Preceptorship nurse or midwife
A preceptorship nurse is a newly registered nurse or midwife, a nurse of midwife returning to practice or a new member of the team moving to a different area of care e.g. community to acute care or an international recruit who undergoes a period of supervised practice and continuous assessment, which generally lasts 12 months, to support the transition from student to registered nurse or from a different area of clinical practice as described.

Tobacco Dependency Advisors
These are HCAs with a specific role in advising patients to stop smoking.

Nursing students
These are students who are affiliated to a university, attending the trust for work placements. There are supervised at all times by a Registered Nurse or Midwife who is responsible for their practice during their placement.

2.2 PHARMACY

Pharmacist
A qualified pharmacist who is registered with the General Pharmaceutical Council (GPhC)

Clinical/Ward Pharmacist
A pharmacist participating in the provision of clinical pharmacy services to a particular ward or department.

Divisional Lead Pharmacist
A pharmacist with responsibility for the provision of advisory and clinical pharmacy services to each of the Trust's Divisions.

Assistant Chief Pharmacist
The pharmacists with management responsibility Trust-wide for:

- Pharmacy clinical services.
- Pharmacy operational services.
- Medication Safety Officer
- Education and training – pharmacy services and medicine management.

Chief Pharmacist
The senior pharmacist with overall management responsibility for operation and delivery of the medicines optimisation agenda and Trust pharmacy services. The Chief Pharmacist is responsible for safe medicines practice within the Trust and is the designated Controlled Drugs Accountable Officer (CDAO)

On-Call Pharmacist
A pharmacist responsible for the provision of pharmacy services when the pharmacy departments are closed. This is an emergency service only.

Community Pharmacist
A pharmacist providing a range of pharmaceutically related services to the community; usually either located within a pharmacy shop or associated with a General Practitioner's (GP) medical practice.

Pharmacy Technician
A qualified technical member of the Pharmacy team, registered with the GPhC, involved in some departmental management roles, dispensing and manufacture of medicines, ward duties, and the supervision of Pharmacy Assistants.

Medicines Management Technician
A qualified Pharmacy technician, registered with the GPhC who has undergone a validated process to allow them to undertake extended ward-based duties working alongside Pharmacists.

Accredited Checking Technician
A Pharmacy Technician, registered with the GPhC, who has undergone additional training to enable them to undertake the final accuracy check of dispensed prescriptions prior to their supply (after the prescription has been professionally 'screened' by a pharmacist).

Stores Management Assistant (SMA)
A member of pharmacy staff, in the receipt and storage of medicines and prescriptions, the provision of the stock 'top-up' service, and the pre-packing of medicines.

Dispensing Assistant
As for SMA, but who has undergone specific training to enable them to dispense medicines under supervision within the dispensary and Aseptic Dispensing Unit (ADU).

Medicines Management Assistant (MMA)
As for SMA, but who has undergone specific training to enable them to dispense medicines under supervision at ward level.

Trainee Pharmacists
A pharmacist who has completed their Master of Pharmacy degree (MPharm), who then joins the Trust for a 12-month accredited training programme prior to registration on the GPhC register as a pharmacist.

Pharmacy Technician Pre-Registration Trainee (PTPT)
A student technician who is undertaking a 2 year, NVQ level 3 qualification prior to registration on the GPhC register as a MMT.

Manufacturing Technician
A technician who has completed a Science Manufacturing Technician Qualification providing additional skills in the aseptic manufacture of medicines.

Quality Control Officer (QC)
The QC Officer is responsible for ensuring compliance with MHRA rules and guidelines and also supporting the manufacturing activities within the Pharmacy production and pre-packing team.

Medicines Information Centre
Located within the Pharmacy Department at King's Mill Hospital, this service is designed to respond to all queries concerning medicine therapy and is available to all staff of the Trust.

2.3 MEDICAL

Doctor
The term Doctor is used throughout this document to describe a qualified Medical Practitioner, and their activities associated with medicine use. In terms of prescribing, it describes all Doctors at Foundation Year (FY) 2 and above in all circumstances. For FY1 doctors this will exclude the prescribing for outpatients and the use of FP10 prescriptions. For convenience, this term also includes Dentists when prescribing or administering medicines.

Medical Student
An undergraduate student with no legal prescribing rights

Consultant Medical Practitioner
For the purposes of this document, the term Consultant is used to describe the senior doctor in charge of an individual patient or group of patients.

2.4 ALLIED HEALTHCARE PROFESSIONAL (AHP)

ODP
An Operating Department Practitioner is a trained and registered with the Health and Care Professions Council (HCPC) and a technical member of the Operating Department staff who has successfully completed training and achieved one of these qualifications; BSc (Hons) in Operating Department Practice, BSc (Hons) Operating Department Practice (Degree Apprenticeship), DipHE in Operating Department Practice, , Certificate NVQ Level 3 in Operating Department Practice or Certificate City & Guilds 752-01 in Operating Department Practice or equivalent qualification.

All the above acknowledge the following competencies:

- store, issue and account for medicines.
- prepare and administer prescribed medicines to patients.
- monitor, assess and respond to the effects of medicines on patients

Surgical First Assistant
Surgical First Assistants are registered healthcare professionals who provide continuous competent and dedicated assistance under the direct supervision of the operating surgeon throughout the procedure, whilst not performing any form of surgical intervention

Surgical Care Practitioner
A non-medical practitioner, working in and out of the operating theatre, who performs surgical intervention under defined levels of supervision by a consultant surgeon.

Optometrist
A trained and registered expert licensed to examine the eyes for visual defects, diagnose problems or impairments, and prescribe corrective lenses or provide other types of treatment. Optometrists may undergo additional training in order to prescribe as independent or supplementary prescribers within their field of competency.

Dietitian
A trained and HCPC registered nutrition expert who has limited 'prescribing' rights to enable the supply and administration of nutritional supplements against an agreed local policy.

Advanced Clinical Practitioners
A registered healthcare professional that has undertaken additional training usually around consultation, assessment diagnosis and therapeutics to practice autonomously. Depending on the practitioner's original qualification they may also be able to prescribe medicines if they have undertaken a prescribing qualification.

Radiographers
A diagnostic radiographer is a healthcare professional registered with the HCPC (Health and Care Professions Council). Diagnostic radiographers provide a range of types of diagnostic imaging to enable screening services and imaging for the diagnoses of diseases and trauma, and forensic investigations.

Imaging assistant
An unregistered Health Care Practitioner who has undertaken, to successful completion, the care certificate and has specific training in Radiology procedures.

Physiotherapist
A trained and HCPC registered healthcare professional, who is trained to assess, diagnose, and facilitate recovery for people affected by illness, injury, or disability. Pain management and prevention of disease are enabled through physical movement, exercise education and advice. Physiotherapists can undergo additional training in order to prescribe as an independent or supplementary prescriber withing their field of competency.

Drug/Medicine/Medication
The terms 'drug', 'medicine' or 'medication' are used interchangeably in this document. Licensed medicines are defined in the Medicines Act 1968 (Part III) as follows:

- GSL – General Sales List
- P – Pharmacy Only
- POM – Prescription Only Medicine

2.5 OTHER

Prescriber
The term Prescriber may refer to a qualified Medical Practitioner, Dentist or an appropriate qualified pharmacist, nurse, midwife or AHP who has successfully completed a period of training as a Supplementary Prescriber or Independent Prescriber and is registered with their respective governing bodies.

Independent Prescribing
Independent prescribing is prescribing by a practitioner, who is responsible and accountable for the assessment of service users with undiagnosed or diagnosed conditions and for decisions about the clinical management required.
An independent prescriber is able to prescribe on their own initiative any medicine within their scope of practice and relevant legislation.

Supplementary Prescribing
A supplementary prescriber is a voluntary partnership between a doctor or dentist and a supplementary prescriber to prescribe within an agreed service user-specific clinical management plan (CMP). This is a written plan agreed between a doctor or dentist and a supplementary prescriber for the treatment of a named service user, with the knowledge and agreement of the service user and/or carer. The plan outlines the illnesses or conditions that may be treated by the supplementary prescriber, the types of medicines they may prescribe any limits to the strength or dose of medicines that they may prescribe.
Once qualified a supplementary prescriber may prescribe any medicine within their clinical competence, within the limits of the CMP.

Controlled Drugs (CD)
As defined in the Misuse of Drugs Act 1971 and subsequent Regulations. In response to a requirement of the National Patient Safety Agency (NPSA), concentrated parenteral potassium products (Policy for the Use and Administration of Parental Potassium) are also now subject to the ordering, storage and record keeping requirements for CDs, even though legally they are not CDs. For all CD related policies and procedures please refer to the new CD Policy available here: CD Policy and associated SOPs

Patients' Own Drugs (PODs)
Although having no specific legal categorisation outside of those specified above, these are medicines belonging to individual patients (either dispensed for or purchased by individual patients for their own use). They can be used for these individual patients whilst in-patients, following the checklist for patient's own drugs (Appendix 2).

COSHH
The Control of Substances Hazardous to Health Regulations (2002).

The Trust
Sherwood Forest Hospitals NHS Foundation Trust, including all services to patients at King's Mill and Newark Hospitals, Mansfield Community and Pharmacy services to the John Eastwood Hospice.

Medicines Management
"Medicines Management in hospitals encompasses the entire way in which medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution that medicines make to produce informed and desired outcomes of patient care" (ref. "A Spoonful of Sugar", The Audit Commission 2001).

Envopak
Plastic, zipped wallet used for the distribution of medicines between Pharmacies and wards/departments. Envopaks are sealed with breakable plastic tags; a traceable numbering system is used for the transport of controlled drugs.

Yellow slip
The yellow order form used by wards and departments to order stock, patient-named medication or to highlight to the Dispensary that there is a TTO to be screened. The yellow slip allows access to medication without a prescription and so must be securely stored at ward level when not in use.

TTO
'To Take Out' medication or discharge prescription.

3.0 ROLES AND RESPONSIBILITIES

All registered professionals have a responsibility for ensuring that prescriptions are appropriate, accurate and legible. All staff must check the accuracy prior to administration of a medicine to a patient. Any member of staff that detects an error on a prescription must take corrective action and document the error on the Trust's electronic reporting system.

Further information on the roles and responsibilities of each staff group can be found throughout this document, please refer to each specific section for additional information.

A Registered Nurse/Midwife and registered Nursing Associate (as defined by the NMC 2002) is personally accountable for their practice and, in exercising professional accountability must

- respect the patient or client as an individual
- obtain consent before giving any treatment or care
- protect confidential information
- co-operate with others in the team
- maintain professional knowledge and competence
- be trustworthy
- act to identify and minimise risk to patients and clients.

The **Ward or Department Leader / Co-ordinator** responsible for a ward/department has accountability for the stock of all medicines held on the ward or department and is responsible for ensuring that medicine procedures are followed correctly.

The **Shift Co-ordinator** in charge of a ward/department for a span of duty.

Community Midwives are responsible for stocks of medicines held and for balancing stocks of CDs with the CD register.

Nurses/Midwives in Training shall be given every opportunity to become proficient in the administration of medicines under appropriate supervision. The Registered Nurse/Midwife who supervises the trainee will be fully responsible for ensuring the correct administration of the medicines.

The Trust **Chief Pharmacist** is responsible for the provision of Pharmacy Services across the organisation, including systems for safe and effective medicines management in all areas.

The **Pharmacy Manager, Operational Services** is responsible for establishing a secure and workable system for the procurement, ordering, storage and distribution of medicines.

The supply of medicines on an FP10 from the Pharmacy Department requires the department to be under the supervision of a Pharmacist, the **Responsible Pharmacist** as defined by the General Pharmaceutical Council**.**

The **Pharmacy Manager, Operational Services** will, at agreed intervals, reconcile the stock levels of medication held within the Pharmacy Departments against the transactions made over the agreed period. Any discrepancies will be investigated and reported to the Chief Pharmacist for appropriate action.

The **Pharmacy Manager, Clinical Services** is responsible for the provision of the Clinical Pharmacy service. The standards by which the clinical pharmacy team will abide are set out in the Clinical Pharmacy Standards, a locally held document available on request.

Doctors and non-medical prescribers are the only staff groups with authority to prescribe within the Trust unless the activity is covered specifically by a Patient Group Direction (PGD)

The prescriber, whenever possible, must ensure that the patient understands and is aware of the purpose of the treatment, and has given their consent. If there is any concern regarding the patient's capacity to understand and retain information regarding the purpose of the treatment then their capacity should be assessed via a 2-stage mental capacity test. Please refer to the Trusts policy on the Mental Capacity Act for more information, available here: Mental Capacity Act Policy).

The Prescriber is responsible for ensuring that all prescriptions written adhere to the basic standards for prescribing as set out in Section 5.6

4.0 APPROVAL

Joint Drug and Therapeutics and Medicines Optimisation Committee

5.0 DOCUMENT REQUIREMENTS

5.1 SUPPLY OF MEDICINES

Medication can be supplied in several ways:

- to wards and departments as stock for use by more than one patient.
- to wards and departments as named-patient supplies, dispensed against an individual patient's prescription.
- to individual patients directly, dispensed against a discharge or outpatient prescription.

For information on the supply of controlled drugs (CDs) please refer to the CD Policy and associated procedures.

5.1.1 Stock supply

Routine stock items are supplied by the pharmacy department by the following methods:

i. Top Up Service

Pharmacy Technicians or Assistants (SMAs or MMAs) visit wards and departments at agreed intervals to check and replace stock items against an agreed stock list. This service covers the ordering and delivery of stock medication. The stores team will also put stock away after it has been delivered to the ward.

ii. Ward Box Service

This is a reduced stock replenishment service and is applicable to areas who do not receive a top up service as described above. A stock requisition order, signed by a Registered Nurse or Midwife, is sent to pharmacy on an agreed day. The stock requisitions forms are supplied by the stores team and can be used for several top ups before they need to be replaced. When not in use the order forms must be securely stored.

iii. Ad hoc stock items.

If stock is required between the agreed top up days, then it may be supplied on the submission of a 'yellow slip' or by writing it into the ward or department diary which will be checked by the pharmacy stores team on a regular basis. In emergencies, it may be necessary to telephone through the order to the stores team on extension 6848. There is a risk of transcription error in this scenario and so both parties must take precautions to minimise this risk. Requests for non-stock items will not be processed via the stores department, these requests must be made via the EPMA system, the ward-based pharmacy team or the dispensary.

Stock lists

Stock lists for wards and departments must be agreed and reviewed at least annually by the Ward or Department Leaders and a member of the Stores Management Team or their representative. The stock lists are held on file within Pharmacy and are available to view on the intranet by searching 'stock'. Items will only be added or removed after agreement by the Divisional Lead Pharmacist for the areas. The quantity of items already listed on the stock list may be authorised by any member of the pharmacy team.

Orders processed via the stock route are monitored for themes and trends in supply. This information is then used to determine future stock levels and lists. Any anomalies in supply of medications are highlighted for investigation to ensure this change is clinically appropriate and not due to unauthorised use or diversion.

5.1.2 Non-stock supply

The supply of non-stock items will be against individual prescriptions for patients, the only exception to this will be a supply against an appropriate Patient Group Direction (PGD). Further information on PGDs can be found on the PGD intranet page.

Checking the prescription
Prior to dispensing a pharmacist will ensure that the prescription is:

- Legal
- Legible
- Unambiguous
- Safe
- Appropriate for the patient
- Clear in terms of directions for administration
- Correctly transcribed (in the case of TTOs)

Any clarification will be escalated to the nurse looking after the patient and / or the doctor.
Any complex calculations must be doubled checked prior to supply of a medication.

Checking the medication
After the product has been processed in the dispensary against the prescription following the relevant pharmacy procedures, the item will be checked against the e-order or original prescription prior to release to the patient directly or to the ward / department. Only individuals who have completed the accuracy checking validation may check medication dispensed.

Stock items do not require a second check. Any pharmacy team member who has completed the appropriate validations in the dispensary or stores department may issue stock items without the need for an additional second check.

Ward based dispensing
Pre-packs may be issued at ward level by a Medicine Management Technician or Pharmacist. These do not need a second check as long as the individual dispensing this has completed their ward validations and accuracy checking validations.

The Medicine Management Assistants (MMAs) may dispense pre-packs for patients at ward level, but these must be checked by an appropriately trained member of the pharmacy team prior to issuing to the patient.

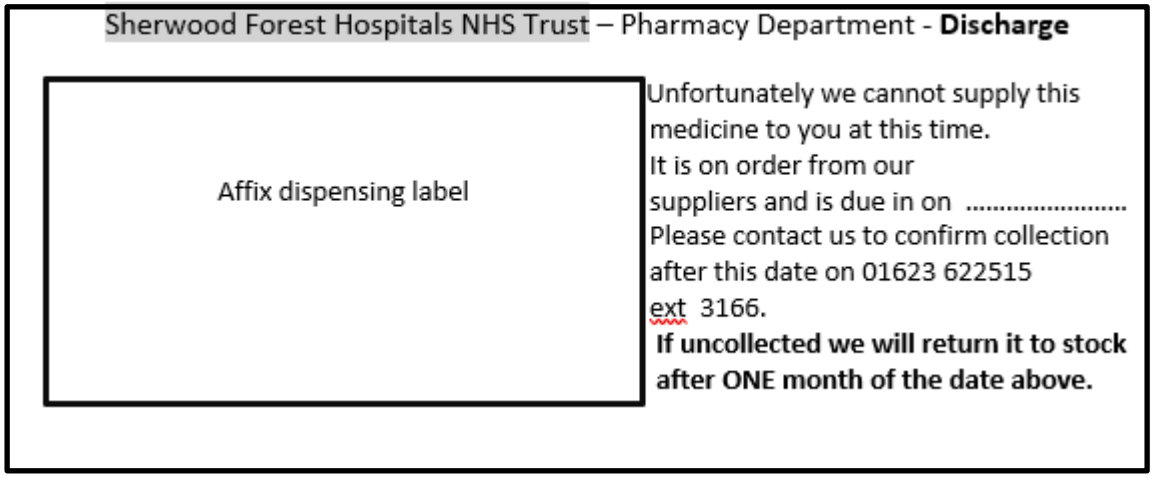
Dispensing must not be undertaken by a nurse, midwife, ODP or doctor unless they have been appropriately trained to 'nurse dispense' according to the Procedure for the dispensing of pre-packed

medication by nursing staff. Please refer to this procedure for more information on nurse or midwife dispensing including the training required, the authorised areas and medication lists. Please note that this procedure is restricted to particular areas and members of staff as outlined in the procedure.

Please note that stock supplies must not be given to patients at the point of discharge. Only appropriately labelled medication with instructions must be provided to patients at this point.

TTO medications will not be issued directly to patients from the dispensary. All supplies for discharge prescriptions will be issued to the wards for onwards supply to the patient. If a patient has left the Trust and is to return for their medication, then it will be to the ward from which they were discharged. The only exception to this is if any items are owing to the patient at the point of discharge due to lack of stock availability, these may be collected from the dispensary. An owing slip will be added to the supply of medication, as shown in figure 1, detailing what is owed and how to contact the department and arrange collection.

Figure 1, an example owing slip for discharge medication



Nicotine Replacement Therapy (NRT)

NRT can be prescribed by nursing and pharmacy staff as well as via the usual prescribing routes. The nurse or midwife can then administer. The patient must be assessed using the Trust Policy and a pre-pack issued from the ward stock. This process is separate to the nurse dispensing processed outlined above and is available to all registered nursing and midwifery staff.

MRSA Prophylaxis

After a patient has been assessed as at higher risk of contracting MRSA based on the Trust Policy, a prescriber, nurse, pharmacist or MMT may prescribe MRSA prophylaxis as outlined in the policy. A prepack may then be issued to the patient from ward stock, this process is separate from the nurse dispensing procedure outlined above and is available to all registered nursing and midwifery staff.

5.1.3 Emergency Supply

Carers and Relatives
The hospital will not supply medicines to patients' carers and relatives without a valid prescription. If a treatment is needed, then the individual must be referred to Primary Care 24 or to the Emergency Department for review. The teams in these areas may supply an FP10 prescription to the individual for dispensing at a Community Pharmacy or in exceptional circumstances prescribe on a white (or pink for ED), prescription for dispensing in the Trust pharmacy.

Hospital staff
There is a separate policy covering the supply of medication in an emergency to hospital staff. This is entitled 'Self-prescribing and prescribing of medicines for family and colleagues policy' and can be found via the hyperlink above.

5.1.4 Supply for visually impaired patients

The dispensary can provide labels in large print if needed, this must be made as a specific request when ordering.

The majority of original packs are now supplied with braille on the carton. Care should be taken when placing labels on the medication boxes so as not to obscure the braille.

5.1.5 Supply of medicine information

The Trust has a database with patient information leaflets which may be accessed at any time to provide further information to patients. It can be accessed via this link: SFHT Patient Information Hub

All original boxes will contain a patient information leaflet. If items need to be packed down, then a printed version of the patient information leaflet will be provided by the pharmacy team. Further copies of all manufacturer issued patient information leaflets can be found on the medicine compendium available via this link: Electronic Medicines Compendium: Browse medicines A-Z

5.1.6 Transport and Receipt

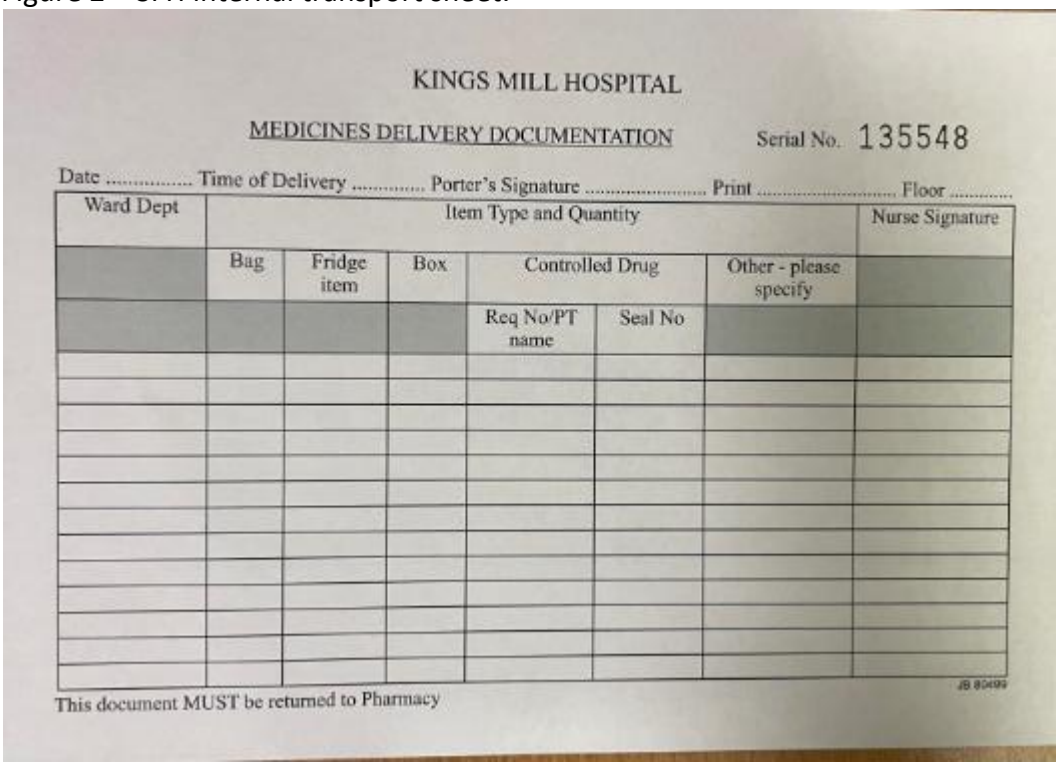
With the exception of bulk fluids, which are delivered directly to the wards by the Baxter ForWards® service, medicine supplies are delivered to wards and departments in locked or sealed containers accompanied by a transport sheet which will need to be signed and returned to the pharmacy team.

Anyone collecting from the pharmacy department must show a valid Trust ID badge. This will be checked not only to confirm identify but also that the individual collecting is working in or on behalf of the area for which they are collecting medicines.

Stock medication Tote boxes
Stock medication will be supplied in sealed Tote boxes. Porters delivering these boxes must ensure that they are placed in a locked room and not left unattended in open areas. The box will be accompanied by the top copy of a carbon copied transport sheet which a nurse on the ward will need to sign to accept the

delivery. Figure 2 shows an example of an internal transport sheet. This top copy is then returned to the pharmacy department to complete the audit cycle.

Figure 2 – SFH internal transport sheet.



KINGS MILL HOSPITAL

MEDICINES DELIVERY DOCUMENTATION Serial No. 135548

Date ..... Time of Delivery ..... Porter's Signature ..... Print ..... Floor .....

Ward Dept	Item Type and Quantity						Nurse Signature
	Bag	Fridge item	Box	Controlled Drug		Other - please specify	
				Req No/PT name	Seal No		

This document MUST be returned to Pharmacy

Envopaks

Medicines may also be delivered in Envopaks if they are being sent to the ward in smaller quantities. These can be collected by a porter or messenger. Any member of staff may collect medication from the pharmacy department as long as they are in possession of a valid Trust ID badge which must be shown on collection. The porter or messenger will be given the top copy of a carbon coped delivery slip. The Envopak must be received by a nurse, midwife or ODP when it is delivered to the ward or department. The receiver must sign to acknowledge the receipt of the Envopak and deal with the contents immediately. If this is not possible then the bag must be securely stored until its contents can be put away securely. If the bag contains a CD, then it must be dealt with immediately by the receiver.

The slip must be returned to pharmacy at the next opportunity, this may be the day after if necessary.

Air Tube

Medication may be sent to wards and departments via the air tube system. The air tube delivery point must be in a secure location. If this is not the case, then it must not be used for the transportation of medication. There are a number of items which will not be transported via this route:

- CDs
- Fridge items
- Glass products e.g. bottles, vials or ampoules
- Pressurised containers

- Fragile products such as Sando K

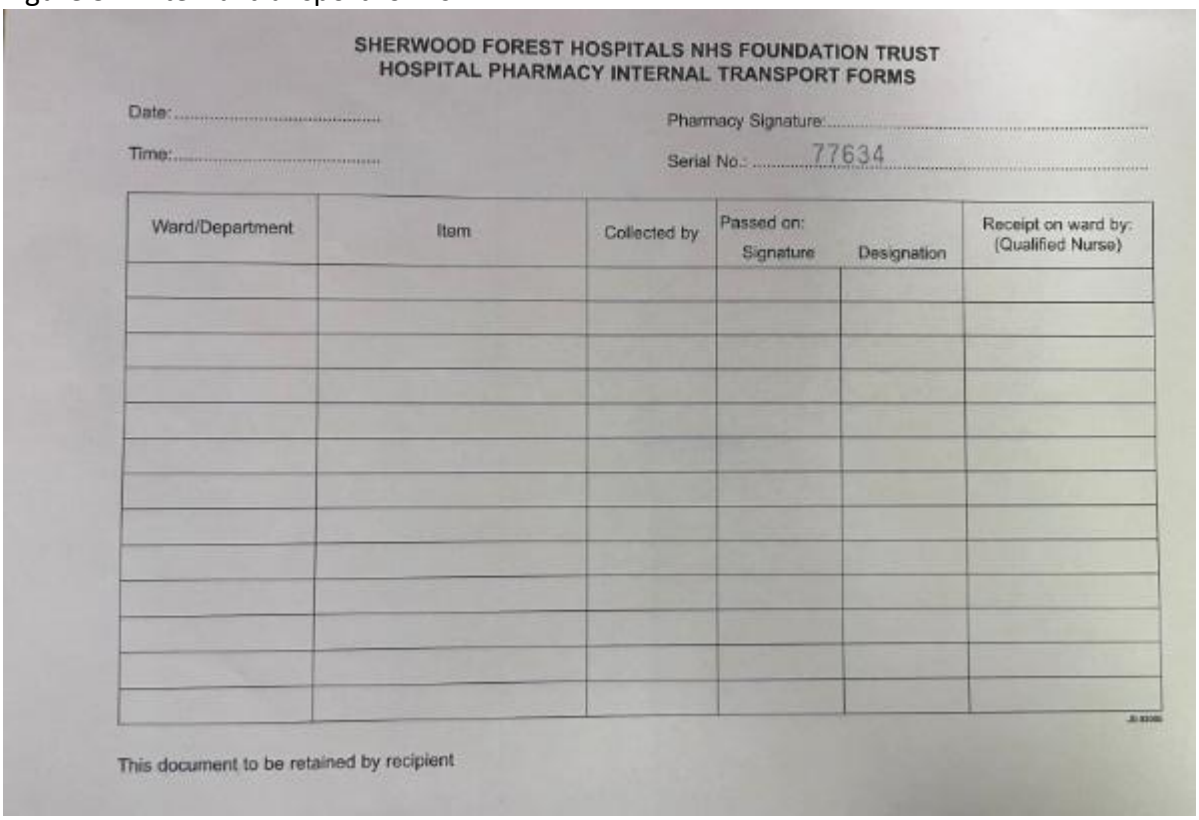
Taxis and transport services

Taxis must not be used to transport medication directly to patients. If a delivery is needed for a patient, then the Royal Voluntary Service should be used. This service is accessible via the 'Flow Room' on extension 6991.

A full procedure on the use of the delivery service can be found on the intranet via this link:
Transport of medicines and other small items using the delivery service.

Deliveries may occur via the Trust transport service or taxi if the destination is another healthcare facility e.g. Mansfield Community Hospital, Newark or another Trust. If the transport or taxi service is used, then a triplicate form will be provided to the driver. If the Trust transport service is used then the form will be that shown in Figure 3, if a taxi is used then the form will be that shown in Figure 4, both triplicate carbon copy forms. One copy will be retained by pharmacy, one by the transport company and one by the receiving ward or department. The ward or department copy must be signed on receipt of the goods and retuned to pharmacy to confirm that the delivery occurred. This completes the audit trail for this transport processes. If the request for an item is made by another facility e.g. another hospital, then it will be their responsibility to organise the transport for that item.

Figure 3 – Internal transport forms



SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST
HOSPITAL PHARMACY INTERNAL TRANSPORT FORMS

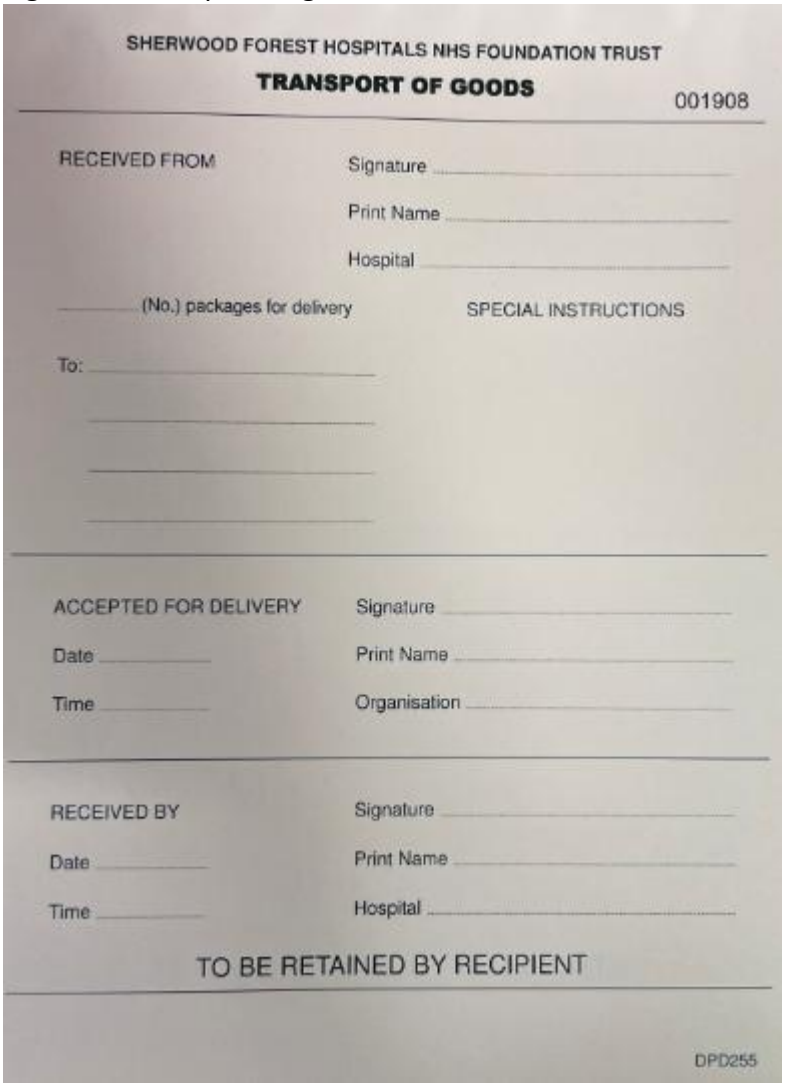
Date:..... Pharmacy Signature:.....

Time:..... Serial No.: 77634

Ward/Department	Item	Collected by	Passed on: Signature	Passed on: Designation	Receipt on ward by: (Qualified Nurse)

This document to be retained by recipient

Figure 4 – transport of goods via taxi forms.



SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST

TRANSPORT OF GOODS 001908

RECEIVED FROM Signature _____

Print Name _____

Hospital _____

_____ (No.) packages for delivery SPECIAL INSTRUCTIONS

To: _____

_____

_____

_____

ACCEPTED FOR DELIVERY Signature _____

Date _____ Print Name _____

Time _____ Organisation _____

RECEIVED BY Signature _____

Date _____ Print Name _____

Time _____ Hospital _____

TO BE RETAINED BY RECIPIENT

DPD255

Deliveries to Mansfield Community Hospital (MCH).

Deliveries to MCH will be via the transport services for the Trust. Any orders which remain at the end of the day or after the scheduled delivery times at weekends will be sent via taxis following the processes laid out in the above section.

Deliveries to Ashfield Health Village

If a delivery to a ward is not directly possible then it may be necessary to delivery to an intermediary point e.g. reception desk. The intermediary recipient must acknowledge the delivery in the same way by signing the transport form (pink copy). There will be no copy kept by this individual as the items, including the delivery note will be passed on to the relevant clinic area. The signed form must be returned to the pharmacy department as outlined above to complete the audit trail of delivery.

5.1.7 Borrowing

During the pharmacy department's opening hours, the transfer or borrowing of medication is discouraged unless there is an emergency, or it has been specifically authorised by the pharmacy team to prevent delay.

Outside pharmacy opening hours, staff should check the intranet stock pages by searching 'stock' on the intranet. This will bring up a link to 'pharmacy stock lists for wards. From here you may search for a specific medication or look at a particular ward stock list. If out of hours, this does not provide an answer then contact the on-call pharmacist via switchboard.

The following guidance must be adhered to when borrowing stock from another area:

i. Ward stock CDs cannot be legally transferred between wards. If a *single* dose is required then it must be booked out of the CD register of the ward that has stock by two nurses and administered immediately to the patient on the other ward. The CD register must contain details of the ward where the patient is at the time of administration to make it clear that the dose has been used elsewhere. Please see the CD Policy and associated procedures for further information.

ii. Non-CD items must be transferred in their original container and not decanted into another container or taken as loose strips. The item borrowed must be returned to the ward immediately after use.

If the medication is available on the ward but was supplied as a named-patient supply for another patient, then it may be used as long as the supply was made during the current inpatient spell. This action will be risk assessed before authorisation is given e.g. if the patient has an infection and medication has been stored in the room, it may be unwise to use for another patient. Contact the Pharmacy team for advice prior to using medication for another patient. Patients' own medication brought in from home must never be used for another patient. Clinical trials medication must also never be used for other patients even when the medication included in the trial is routinely stocked on the ward. A supply must be requested from pharmacy at the earliest opportunity.

5.1.8 Supply of Medicines at Discharge

Generally, discharge medicines will be supplied directly to the patient or their accompanying relative or carer by the discharging nurse.

Please refer to the Trust Discharge Policy for further information on the discharge process.

At the point of discharge the Registered Nurse, Midwife or ACP must check the patient's identity and each medicine, including their own medication that may have been brought in with the patient to ensure:

- The medicine name and strength agree with the medicine on the discharge prescription.
- The form and type agree with the discharge prescription, e.g. modified release or normal release.

- The correct patient's name appears on each container.
- The instructions printed on the container agree with the instructions on the discharge prescription.

The pharmacy team may indicate that a patient has a medicine supply at home and that no supply is needed from the hospital at the point of discharge. The discharging nurse or midwife should confirm with that information is correct, but it is acceptable to discharge the patient in this circumstance.

Patients should not normally be discharged without a full supply of their medicines however, in exceptional circumstances medicines may need to be collected from the hospital after the patient has been discharged. In these circumstances the person collecting should be ideally pre-agreed and the identity of the person collecting should be confirmed at the time.

5.2 STORAGE OF MEDICINES ON WARDS AND DEPARTMENTS

5.2.1 Responsibility

The ward or department leader is responsible for all medicines stored on their ward/department, including those in the bedside Patients' Own Drugs (POD) locker.

5.2.2 Custody and safe keeping of keys

5.2.2.1 – General Principles

Keys are in place for CD cupboards, internal and external medicines cupboards, medicines trolley, medicine refrigerators and POD lockers.

Keys are the responsibility of the Shift Co-ordinator, and may be separated into more than one set, if deemed necessary by the ward or department leader.

CD keys must be separate to all other cupboard keys and must not be on a 'bunch' with other keys except for theatres where each theatre has its own set of keys including the CD key. For further information please see the CD Policy and associated SOPs.

Medicine cupboard keys will be handed over at each shift change to the nurse, midwife or co-ordinator. In areas where there are multiple sets of keys, the shift co-ordinator will collect the keys at the start of the shift and hand out to the relevant staff members e.g. EAU. Theatres have a local guideline for the management of keys including handover protocols, see the local guidance for more information.

Medical staff working in outpatient clinics without a registered nurse, medical staff in Sexual Health Services working in community settings other than on the Kings Mill Hospital site and on call Obstetric Anaesthetists will have access to medicines keys (except CD drug keys) in order to prevent delays in patient treatment.

5.2.2.2 CD Cupboards, Internal Medicines Cupboards, Medicines Trolley, Medicines refrigerator, Patients' Own Drugs Locker Master Keys

These are the responsibility of the nurse, midwife or ODP and must be kept on their person. They must not be removed from the ward/department. The custody of the keys may be passed to another Registered Nurse, Midwife or ODP working within the same ward/department if deemed necessary. The nurse in charge may hand keys to a pharmacist or Medicines Management Technician for legitimate access to these areas. The identification of the individual and reason for requirement of the keys must be checked prior to handing them over which is particularly critical for the CD keys, this will include a physical check of identification.

5.2.2.3 External Medicines Cupboards, Disinfectant and Antiseptic Cupboards, Reagents Cupboards and Other Cupboard Keys.

These are the responsibility of the Shift Co-ordinator and must be kept in a designated secure location to enable access by Health Care Assistants to permitted areas without having access to medicines.

In addition to key locking cupboards, digital combination locks may be used in specifically agreed (with Pharmacy) designated areas to facilitate frequent controlled access during specific clinic sessions. The cupboards must also have the ability to be secured by a standard medicine's cupboard key. An agreed standard operating procedure must be in place for use within the designated area. Best practice requires periodic changing of the lock combination.

5.2.3 Duplicate keys

The Estates Department do not maintain any duplicate keys for ward areas.

The pharmacy department will require duplicate keys for medicine cupboards in order to provide the stock top up services.

The pharmacy team will also require duplicate copies of the POD locker master keys in order to ensure medications are checked and ordered in a timely manner for patients. It is the ward team's responsibility to organise the provision of these keys. These must be provided to the team when locks are replaced so services can be maintained

5.2.4 Lost keys

Urgent effort must be made to locate the keys or retrieve them from off-duty staff.

The Duty Nurse Manager or equivalent must be informed.

The Pharmacist in charge must be contacted the next working day, unless there are serious concerns that CDs have been stolen and there is a risk to patient / public safety. In this case the pharmacist in charge should be contacted immediately. They will inform the Chief Pharmacist as CD accountable officer (CDAO) and advise on any specifics.

If the keys cannot be found/retrieved within 24 hours for cupboard keys or 5 working days for POD locker keys:

- The healthcare professional in charge of the area must make immediate arrangements for the replacement of affected locks by contacting the Estates department, and for new keys to be provided.
- If the lost keys related to the CD cupboard then follow the SOP in the CD Policy available here: CD Policy and associated SOPs
- The Nurse in charge of the ward or department must complete an Incident Report form.

Lost Patients Own Drugs (POD) locker master keys

The general principles set out above should be followed however in addition the following should be applied:

As with the loss of any medicine key extra vigilance must be undertaken during the period that a master key is lost or potentially stolen. All controlled drugs must be removed from patient lockers if stored there for self-administration purposes and stored in the ward CD cupboard as patient's own CDs.

If an individual locker key is lost or the lock is broken and needs replacing Pharmacy must be contacted to ensure that the lock is replaced with a lock of the **same** key suite otherwise master keys will not open the replaced lock.

If the master key is not located the ward must undertake to replace all patient locker keys. The Chief Pharmacist must be contacted for detailed advice for replacement of the locks and new master keys.

5.2.5 Medicine Containers

Within in wards and departments, all medicines must be stored in their original containers, as dispensed or supplied by the Pharmacy Department. Medicines must not be transferred from one container to another or left loose. Strips of blister packs must remain in their original dispensed or supplied box including when stored in medicine trolleys. This is to reduce the risk of mis-selection of medication.

5.2.6 Storage locations and standards

All wards and department who receive a top up service from the Pharmacy department will have a stock location agreement. Stock stored in the approved areas will be topped up regularly by the pharmacy team, this service will also include expiry date checking. Any item stored elsewhere is the responsibility of the ward or department leader, a system for toping up and expiry date checking must be locally agreed for these items stored outside the agreed locations.

5.2.6.1 Intravenous fluids and sterile topical fluids:

Stored in a cupboard or on racking in a clean area approved by the Pharmacy Department. Intravenous fluids and boxes must not be stored on the floor.

Intravenous fluids should not be decanted out of their original boxes into alternative receptacles, with the exception of theatres that use a risk-assessed process.

5.2.6.2 Epidural infusions:

Stored in locked cupboards separate to those areas containing fluids for intravenous and other types of infusions.

5.2.6.3 Potassium:

Additional information on the storage of potassium can be found in the Parental Potassium Use and Administration Policy

5.2.6.4 Midazolam:

There are restrictions on the storage of midazolam within the hospital. Low strength midazolam may be stored in areas where conscious sedation occurs and cannot be stored in other areas. See the Conscious Sedation Guideline for more information. All other inpatient areas will only stock the high strength midazolam 10mg in 2ml for use in palliative care.

5.2.6.5 Temperature monitoring:

It is the responsibility of the ward or department leader to ensure that the medication stored in the ward or department is stored in a way so as to maintain its suitability for administration. One part of this is to ensure the temperature of the storage areas are maintained within an acceptable range. Daily ambient temperature checks must be conducted in each clinical room and recorded on the ambient temperature monitoring form available for download via this link. All forms must be kept for 1 year after completion. If a temperature is logged over 35°C or over 30° on two consecutive days, then the Medication Safety Officer must be contacted to arrange more robust temperature monitoring in that area. Information on how to contact the relevant people is incorporated into the monitoring form.

5.2.6.6 Storage standards

All other medicines must be stored in separate locked cupboards (which comply with the current British Standard for Medicines (BS 2881)) as detailed below. Details of the current guidance for storage cupboard specification and location can be found in the NHS England publication available via this link: NHS England: Health Building Note

Internal Medicines' Cupboard

This may take the form of one large, or several smaller cupboards for tablets, liquids, injections etc. Eye drops and eardrops must be stored in the internal medicine's cupboard (or refrigerator where appropriate) when not in use. The medicines' cupboard should only contain medicines as defined under the Medicines Act 1968.

Electronic Medicines Cabinets

Secure electronic medicines cabinets are in place on the Emergency Admissions Unit and Emergency Department. In these areas all medicines must be stored and accessed via these cabinets. Separate procedures are in place for staff using the cabinets in these areas.

Cupboards for External Medicines, Disinfectants, Antiseptics, Flammables and Reagents

These must be kept separate from medicines for internal use and these cupboards must be locked at all times with the exception of theatres where the cupboard itself is in an access-controlled area. COSHH Regulations must be adhered to.

Waste Medicines for Return to Pharmacy

Hospital or patients' own drugs that are no longer required should be placed in the pharmacy 'green bins' if suitable for reuse or return. If unsuitable for reuse or return, then they should be disposed of in the blue lidded medicine waste bin. CDs must be kept securely stored in the CD cupboard until they can be returned or destroyed by the pharmacy team. Do not place CDs in the green returns or blue waste bins.
Cytotoxic medicines must be disposed of in a cytotoxic waste bin.

Medicines Refrigerators

Medicines requiring refrigeration will be marked 'Store in a Refrigerator' and/or state the exact temperature range suitable for storage. They must be stored in an approved and locked medicine refrigerator running at between 2 and 8 degrees centigrade. **Foodstuffs and pathological specimens must never be stored in a medicine refrigerator.**

Sherwood Birthing Unit has one fridge containing emergency medication which may be left unlocked. All other fridges must be locked.

Refrigerator temperature must be checked at least once daily and recorded on the log sheet in the ward/department. In areas which are not occupied each day e.g. outpatient clinics the temperature can be recorded less frequently according to their working days.

If medicines have been stored outside 2-8^{o}C, Medicines Information on extension 3163 (or the on-call pharmacist via switchboard) must be contacted before using any medicine. They will advise on whether the medicine is safe to use. The medicine must be quarantined, in the fridge, until this can be clarified.

Fridge Monitoring forms can be ordered via forms management and must be stored for 1 year after completion.

Medicines Freezer

Medicines requiring storage below 0^{o}C must be stored in an appropriate freezer. Management of this will be on a case-by-case basis in liaison with the Pharmacy Stores Manager.

Medicines Trolley

This is for the storage of medicines in current use required on the medicines administration round. The Registered Nurse/Midwife conducting the medicine round must be confident of the security of the medicines. If the nurse has to leave the trolley it must be locked and not left with an unregistered member of staff. Medicines no longer in use on the medicines round should be returned to the medicine's cupboard or to the Pharmacy Department. When not in use the medicine trolley must be attached securely to a fixed point or stored, locked, in the treatment room.

Resuscitation Equipment

For clinical emergencies, all wards and clinical departments must have access to a resuscitation trolley, in line with local cardiopulmonary resuscitation guidelines. These trolleys will contain medicines in the form of cardiac arrest boxes. It has been agreed that

they can be stored in the designated areas on wards and in departments to allow emergency access. Please refer to the Resuscitation Policy for more information: Resuscitation Policy

Patients' Own Drugs Locker
These are for the storage of medicines in current use required on the medicines' administration round (which may be patients' own or named-patient dispensed items). They must be kept locked at all times except when accessing medicines.

Patients' bedside cabinet
Medicines listed in Appendix 2 may be stored safely in the bedside cabinet for immediate use by the patient.

5.2.7 Siting of storage accommodation

Storage accommodation should be sited in a lockable room and in a position to allow surveillance and maximum security against unauthorised access.

Medicines must not be stored near major sources of heat or humidity (such as radiators or sinks respectively). Items must never be placed on top of medicines refrigerators as this can affect temperature control.

Patients' own drugs lockers should be located next to each patient bed space, to enable easy access by Nursing or Pharmacy staff, or by patients as part of an agreed local policy. These should generally be attached to patient bedside lockers at such a height to enable patients to sit on their bed and access the medicines, or at an appropriate easily accessible height on the wall.

5.2.8 Access to cupboards

Cupboards Other Than CD Cupboards
In addition to Registered Nurses/Midwives and ODPs, only Pharmacy staff may hold keys and have access to these cupboards. They must ensure that they are known and identified to ward/department staff and notify their presence on each visit.

5.3 STOCK BALANCES, LOSSES and DISCREPANCIES

5.3.1 Medicines other than Controlled Drugs

Ward or departmental stocks will be routinely monitored during the Pharmacy top-up service, and/or formally at least every twelve months by a member of the Pharmacy Department in conjunction with the Shift Co-ordinator/ Nurse-in-Charge.

For the loss of a CD of any schedule please refer to the CD Policy and its associated SOPs

In the event of actual or suspected loss or misappropriation of medicines, the member of staff identifying the issue must inform the Shift Co-ordinator. This also applies to medicines that should be transferred between wards together with the patient i.e. patients' own drugs and those medicines specifically labelled for individual patients. These will be generally stored in the patients' own drugs locker.

The Shift Co-ordinator should undertake the initial investigation. Any discrepancy that is not satisfactorily resolved during that investigation must be reported to the Nurse/Midwifery Manager and a Pharmacy Manager, and an incident form completed.

Out-of-hours, the bleep holder should be informed, with the appropriate Duty Nurse Manager and Pharmacy Manager informed at the earliest opportunity during daytime working hours.

Where there is suspicion of medicine misappropriation or abuse, investigations will be instigated under the direct supervision of the Nurse/Midwifery Manager and a Pharmacy Manager. The appropriate consultant(s) should be informed in the event of medical staff involvement. If there is suspicion of misappropriation, then one course of action could be to make the item subject to CD style restrictions for a period of time. This can be discussed as part of an action plan with the Medication Safety Officer as needed.

5.3.2 Managing Deceased Patients' Medicines

Patients' own medicines of inpatients that have died must be managed sensitively and appropriately.

Under no circumstances must Controlled Drugs be returned to family or carers as this would constitute an illegal supply.

It is the view of the Trust that it is good practice to not return deceased patients' prescribed medicines to relatives/carers. These medicines should be destroyed as per Trust Policy.

Medicines must never be sent to the Trust mortuary.

5.3.3 Donation of Medicines to Other Countries

Medicines returned from patients cannot be sent to other countries for their use.

Medicines will not routinely be donated to other countries from the Trust and requests for this service will be dealt with on a case-by-case basis through the Joint Drug and Therapeutics and Medicines Optimisation Committee.

5.4 WARD AND DEPARTMENT CLOSURES

5.4.1 Intermittent closures (less than 10 days)

This relates to wards that are either operational 24 hours a day, 7 days a week, or open on a 5-day basis each week.

Medicines Other Than Controlled Drugs

Medicines may be left in the locked ward cupboards if the relevant Nurse/Midwifery Manager and Pharmacy Manager are satisfied with the security arrangements in place for the ward/department. If the team are not satisfied with the security during the period of closure, then all medication will be removed by the pharmacy team and resupplied when the ward reopens. Medicine cupboards MUST be checked to ensure that they are securely locked, and that the keys are securely locked on a neighbouring ward. Patients' own drug lockers must be empty of all contents and any medicines locked away.

For the management of CDs please refer to the CD Policy and its associated SOPs.

5.4.2 Long term ward or department closures (longer than 10 days)

ALL medicines must be returned to the Pharmacy Department. Arrangements with Pharmacy for these returns must be made by the appropriate Nursing/Midwifery Manager co-ordinating the closure at the earliest opportunity.

With respect to medicine cupboard keys these should be sent to Pharmacy for secure storage.

5.4.3 Temporary ward or department closures e.g. weekends.

Certain units (e.g. Day Case, X-ray, Outpatient clinics) are routinely closed and therefore without constant supervision. CDs are not routinely stored in the KTC Outpatients and any unused CDs are returned to Pharmacy on a daily basis.

Provided that the relevant Nurse/departmental manager and Pharmacy manager are satisfied that there is adequate security, medicines (including CDs) will NOT be removed, and the once daily CD balance check will be waived.

Where departments or wards shut temporarily e.g. overnight, general medicine keys must be stored in a secure place. This can be either the pharmacy department, an agreed documented adjacent ward or department. In outpatients, the department keys will be stored in a key cupboard which is behind an access-controlled door.

For the management of CD keys during temporary closure please see the CD Policy and associated SOPs.

5.4.4 Ward openings and converting clinical areas into inpatient areas.

If a new ward area is to open or a current clinical area is to convert into an inpatient area, then it is important that the medicine stocks are amended to reflect this change. As much notice as possible would be required whilst appreciating that these decisions are usually time critical.

During usual office hours, any notification of ward openings or clinical area conversions should be directed to the CSTO Leadership Team who will in turn cascade this information to the Assistant Chief Pharmacist - Clinical Services and / or the Assistant Chief Pharmacist – Operational Services. If this occurs out of hours, then this will go to the On-Call Pharmacist.

The Pharmacy Stores team should be notified via email:
sfh-tr.pharmacystoresmanagement@nhs.net

A temporary stock list will be supplied, as advised by the Divisional Lead Pharmacist for that area, based on a location with a similar cohort of patients. If there are no appropriate medicine cupboards available, then this stock will be supplied in a secure medicine trolley from the Pharmacy stores team.

When the area reverts back to its original patient cohort or the area closes, the same people should be notified in order to remove the stocks.

5.5 PATIENTS OWN MEDICINES

The Trust, in agreement with the local ICB, sanctions the use of Patients' Own drugs during their stay within our hospitals. This is nationally accepted practice, provides significant quality and safety advantages for patients and is cost-effective for the health community.

5.5.1 Procedure on admission

The admitting Registered Nurse/Midwife must ascertain whether the patient has brought any medicines into the Trust and inform the admitting Doctor in order for them to be prescribed accurately

Medicines brought in by patients remain legally their property and should not therefore be destroyed or otherwise disposed of without their or, if this is not possible, their relative's/carer's consent.

As with any medicines, patients' own medicines must be stored securely during their stay. It is the responsibility of the Nurse or Midwifery managers for the shift to ensure that patients' own medicines are stored securely within bedside medicines lockers (or other secure system e.g. specific patient medicines trolleys). Patients own medicines must not be left unattended on ward nursing stations or other unsecured areas with the exception of those listed in Appendix 3.

Medicines brought into hospital by patients should be reviewed by the clerking clinician in conjunction with any written communication from the GP or other referring practitioner and electronic systems. The process for medicines reconciliation is outlined in Chapter 5.18.

It is the duty of the admitting Doctor to decide whether or not to continue the prescription of the existing medication as appropriate.

Medicines that are stopped on admission should be documented in the clinical notes and on the appropriate section on the Medicine Prescription and Administration Chart or on the 'arrival meds' tab of the electronic prescribing system. Reason(s) for discontinuation should be stated.

Medicines brought into the hospital may, with the patients' permission, continue to be used provided:

- they have been prescribed for the patient
- they are deemed suitable for use as specified by the **Checklist for the use of Patients' Own Drugs (PODs)** – see appendix 2

Medication supplied in a mediwallet may not routinely be used for administration of medication as identification of individual medications is often difficult. In order to prevent a delay in the administration of critical medicines it is permissible for individual doses of medication to be administered from a patient's own mediwallet if the medication can be identified, until suitable supply of that medication can be sourced from Pharmacy. The patient must be recorded as having 'self-administered' that dose with an explanation documented in the nurses Kardex to that effect.

As with other medicines, Patients' Own medicines must be stored within a secure cupboard when not in direct control of a practitioner.

Patients own medication must not be used for other patients under any circumstances.

5.5.2 Procedure on Discharge

The discharge prescription and inpatient chart, either electronic or paper based, must be checked by Pharmacy staff prior to discharge.

The TTO will be endorsed by Pharmacy staff to indicate.

- whether patients' own supply is available (endorsed as: ON WARD)
- a pre-labelled supply from the Trust is available at ward level (endorsed as: ON WARD
- or a new supply is made for that TTO (endorsed as: DISPENSARY)
- if the patient has a further supply at home (endorsed as: AT HOME)

TTOs are processed electronically. Paper TTOs are only used in a Business Continuity scenario if the electronic systems are down. For this refer to the relevant procedure.

At discharge the Nurse and / or midwife MUST check all medicines, including patients' own, against the discharge prescription prior to issuing to the patient to take home.

5.5.3 Transfer of PODs between locations

As with any other patient property, medicines must be transferred with the patient should they move between wards or hospitals. The transfer applies to all medicines that have been labelled for that patient, including those dispensed within the Trust.

It is important that the patient's medicines are removed from their Patients' Own Drugs locker when the patient is transferred and moved with the patient to the new location. Medication must be transferred and not put into the pharmacy returns bin.

Portering staff are permitted to transfer non-CD medications which are either in the patient's bag or a green opaque pharmacy bag to their new area of care. For the transfer of CDs, please refer to the CD Policy and its associated SOPs.

Healthcare Assistants are permitted to transfer medications with patients between ward areas.

5.5.4 Disposal of PODs

Patients' own medicines that are no longer needed or are unsuitable for use should ideally be placed into the blue medicine waste bins on the ward. This may only take place provided the patient or representative agrees to disposal.

Should the patient or patient's representative insist that the medicines be returned, they should be advised if the medicines are not safe for use or no longer required. A decision to not return the medicines to the patient may be taken if there is reasonable concern that the patient may come to harm if this takes place. The decision and reasons must be documented in the Clinical notes.

5.6 PRESCRIBING

This section applies to all prescribers working at SFH or working in the community on behalf of SFH prescribing medicines. Prescribers must act within their sphere of competence at all times and be accountable for their practice in accordance with the standards of their professional body and within the requirements of the SFH Medicine Policy.

The Trust is using various electronic prescribing systems. The same principles as outlined in this section will apply, but the electronic system should enforce much of this practice.

All patients admitted to hospital must have a prescription written as part of the admission process. Care should be taken to ensure medicine reconciliation has taken place. More information on the medicine reconciliation process can be found in Section 5.18.

5.6.1 The Hospital Formulary.

Only those medicine listed as part of the Nottinghamshire Joint Formulary can be newly prescribed to a patient receiving treatment at SFH, whether this is as an inpatient or outpatient. The Joint Drug and Therapeutics and Medicine Optimisation Committee (DTC), approve medicine for inclusion on the SFH formulary and the ICS will approve medicines for use across Nottinghamshire.

A medicine not included in the formulary can be used under the following conditions:

- A patient has brought in a useable supply from home of a medication prescribed elsewhere.
- A medicine as part of a medicine trial
- A medicine used for an individual patient after approval by DTC.

A prescriber may request a medication be added to the formulary by submitting a request via the Professional Secretary to DTC. This can be done by contacting the Pharmacy Administration Team via switchboard. Medication will not be ordered until approval has been gained through DTC for formulary inclusion and funding approved by the Division for items with significant cost.

Free samples must not be accepted (see section on dealing with pharmaceutical reps for more information, Section 5.19). A written agreement must be provided by DTC for the use of free samples in any area.

5.6.2 Authority to prescribe.

Only legally authorised prescribers can prescribe medication for hospital inpatients and those attending clinics at the Trust.

Staff who are authorised within individual PGDs may themselves administer the medicine(s) within that PGD but not prescribe for others to administer. Midwives may administer certain medicines on their exemption list but not prescribe for others to administer on their behalf unless they are a designated prescriber.

Staff who are not authorised prescribers must not prescribe medication. This includes transcribing, preparing outpatients prescriptions or discharge prescriptions before a signature from the prescriber.

Non-Medical Prescribers must adhere to the principles set out in this section and overarching Medicine Policy. Please see the separate Policy for more information on this entitled Non-Medical Prescribers Policy which is available via the intranet or by clicking the link above.

Dietitians - Although sip feeds are not medicines and so do not legally require a prescription, the Trust allows for Dietitians to write sip feeds on the inpatient prescription administration chart.

Medical Students cannot prescribe medication.

Tissue Viability Nurses may prescribe wound care products.

Tobacco Dependence Treatment
The Tobacco Dependency Advisors will attend the ward to review adult inpatients and offer advice to nursing and medical staff on suggested interventions. These will be documented in the medical notes. The prescribing of the nicotine replacement therapy will then be the responsibility of the nursing staff or a prescriber. Please see the Smoke Free Policy for more information.

Tobacco dependence treatment in maternity is provided by the Phoenix Team who are an in-house team. Nicotine Replacement Therapy is issued as per Trust GSL protocol to those on the treatment plan. Maternity inpatient treatment of nicotine withdrawal symptoms is facilitated by the prescribing of Nicotine Replacement Therapy that is the responsibility of the midwives and prescribers.

5.6.3 Prescriptions

Treatment may only be administered on the authorisation of a prescriber.

There are several ways in which medication may be prescribed in the Trust and in this Policy the word ‘prescription’ can refer to any of the methods below:

1. On the electronic prescribing and administration record (EPMA) which is used for in patient prescriptions and discharge prescriptions
2. On the Medicine Prescription and Administration Chart (inpatient paper prescription chart)
3. Orion electronic discharges
4. Green paper TTO prescriptions
5. White outpatient prescription forms which can only be dispensed via the Trust Pharmacy Department. These are only used for RED (hospital restricted) medication according to the Traffic Light System on the formulary or items which need to be started urgently after consultation.

6. FP10 NC forms. These are then dispensed in the patient's local community pharmacy and are the preferred method for outpatient prescribing.
7. Approved electronic prescribing systems in addition to the EPMA system such as Chemocare (oncology, haematology, CRIS (radiology), Inform (Sexual Health) and BadgerNet (maternity).
8. Additional specialist prescription and supplementary charts as approved by the DTC.

For all in-patients a prescription must be written by the Practitioner on the official Trust 'Medicine Prescription and Administration Record' chart or the electronic prescribing and administration system (EPMA). This applies to all areas of the Trust where nurses are administering medicines to patients including day case patients and 'ward attendees'. Where day case patients stay for longer than 48 hours, they must have a prescription written to include all their regular medicines. In some clinical areas, alternative documentation may be used, provided that they have been given specific approval for use from the DTC.

For in patients, care must be taken to ensure that there is only one prescription or one set of prescriptions in use for a patient at any one time.

For areas where a patient may transfer between EPMA and paper charts, local procedures are in place to aid staff in how to deal with this transition.

5.6.4 Verbal Orders

Trust policy is that verbal orders for medicines are not permitted except in a medical emergency where the doctor is not available to attend as described below. A remote prescription by a doctor who then attends as soon as possible to review the patient, is preferable to a verbal order.

In an emergency situation, it is acceptable for a doctor to give a verbal order providing two nurses independently take the order and repeat the intended medicine and dose back to the doctor. The name and dose of the required medicine, along with the full name of the prescriber issuing the verbal order must be written down in the medical notes by the nurses receiving the verbal order. Both nurses must countersign the entry in the medical notes to confirm that the name and dose of medicine written down is what the prescriber has ordered.

All occurrences of administration of a medicine on the basis of a verbal order must be reported as a clinical incident, clearly stating that it was a medical emergency and why the doctor could not attend to prescribe the medicine in writing before administration.

The doctor must attend to write the prescription as soon as the situation with which they are dealing with is resolved. There is the facility to write an EPMA prescription remotely, but best practise is that the prescriber attends the patient in person to write the prescription for the medicine. If a nurse has given a medicine in an emergency on a verbal order, this must be recorded in the nursing notes and then transcribed onto either the paper medicine chart or the EPMA system as soon as a valid prescription is written.

If a Doctor is unable to write a prescription before the administration of a medicine, the Registered Nurse/Midwife/ACP should record the prescription in **red** in the 'once only' section of the prescription chart if using a paper chart.

If the patient is using an electronic prescription, then the doctor may be able to prescribe the required medication remotely, ensuring a thorough review in person as soon as possible.

The Prescriber's name, the date, time, medicine, dose and route of administration must be recorded.

The verbal message should be repeated to a second Registered Nurse/Midwife/ACP that will act as witness. Both Nurses should sign the prescription.

The Doctor must counter-sign (if paper) the prescription within:

- 12 hours on the acute sites, i.e. King's Mill and Newark Hospitals.
- 24 hours non-acute sites, e.g. community hospitals, John Eastwood Hospice.

It is the responsibility of the prescriber giving the verbal order to sign the prescription or in **rare circumstances** ensure that a colleague signs on their behalf within the stated time period. This may mean contacting a colleague to ensure they are willing to take this responsibility; otherwise, the prescriber will be required to attend and sign the prescription personally within the above timeframe.

A single dose maybe administered within the time periods stated above and after this period it is best practice to ensure that the patient is reviewed by a doctor before additional doses are administered.

The following types of medicines are permitted to be prescribed via a verbal order:

- Intravenous or subcutaneous fluids
- Analgesics (except Schedule 2 or 3 CDs)
- Anti-emetics
- Anti-diarrhoea drugs
- Laxatives (oral and PR)
- Antacids
- Cough mixtures
- Drugs for excessive respiratory secretions

No cytotoxic medicines or schedule 2 CDs can be prescribed via verbal order.

5.6.5 Prescribing Procedures

5.6.5.1 General Instructions

It is the responsibility of the Prescriber to:

Ensure that the correct patient identification label ("Addressograph sticker") is affixed, or that relevant patient identification information is fully completed, on ALL in-use sections of the prescribing documentation. This information MUST include a minimum of at least the patients' NAME and DATE OF BIRTH, WARD/UNIT and NHS or D number. In situations where there are patients with similar or the same name on the ward/unit a "Similar Name Sticker" must also be attached to every prescription chart including supplementary charts such as those used for warfarin and insulin.

Where the dose of the medicine is prescribed in accordance with BODY SURFACE AREA (BSA) actual body weight or ideal body weight then BSA, weight and height should be included as appropriate. The inclusion of patient weight on paediatric prescriptions should be routine.

List any known allergies, hypersensitivities or known serious adverse effects from medicines or components of medicines on the appropriate section of the Medicine Prescription and Administration Chart. This must be signed and dated by the Prescriber (Pharmacists, MMTs and nurses/midwives may also complete this information to this standard). If there are no known drug allergies or hypersensitivities, tick against 'no known drug allergy', date and sign. If prescribing on the EPMA system, then the allergies must be listed or 'verified' prior to any prescribing actions taking place.
Confirmation of a patient's allergy status may be obtained from several sources. Ideally at least two sources should be used to increase the likelihood that the information obtained Is accurate. Where appropriate one of these sources should be the patient or their carer. A list of possible information sources can be found in Appendix 5 with advantages and disadvantages for each.

Prescribers must review the patient's allergy statues prior to any prescribing activity.

Inform relevant Nursing/Midwifery staff of any changes to the prescription.

5.6.6 Prescribing Medicines

Prescriptions MUST be written LEGIBLY in INDELIBLE black or blue ink, be computer generated as part of the EPMA / Chemocare system or be on DTC approved stickers. Pharmacists may add prescriptions under the Trust's Enabling Policy and if handwritten, these medicines must be written in green.

The Prescriber MUST ALWAYS complete:

The **NAME** (using the Recommended International Non-proprietary Name (rINN), e.g. furosemide or bendroflumethiazide) of the medicine written in CAPITAL LETTERS. Abbreviations (e.g. 'ISMN' or 'DF118') or chemical formulae (e.g. FeSO4) are not acceptable and must not be used.

GENERIC names must be used EXCEPT when:

- a preparation with specific pharmacokinetic properties is required, such as modified release theophylline, lithium which must be prescribed by BRAND, e.g. as *Uniphyllin,* or *Priadel* respectively.

- a compound preparation is required (although most compound preparations generally have a generic name, e.g. *Frumil 5/40* must be prescribed as co-amilofruse 5/40). Where no formal 'co-' name exists then the Trade name should be used.

- Oral MORPHINE preparations should be prescribed by brand name in order to clarify the exact product required (e.g. Zomorph).

- The FORM of the medicine (if not a tablet or capsule).

The **DOSE**

Calculating the dose.
Where the dose requires a complex calculation, the calculation must be double checked by either another qualified healthcare professional (doctor, nurse, pharmacist) or by use of an appropriate calculation aid, for example those available via the online formulary and intranet.

A single dose MUST be specified

- Doses of **1 gram** or more must be written using the abbreviation '**g**' or **gram**, and a decimal point if required. A trailing zero after a decimal point (e.g. 1.0g) must not be used as this can easily be misread as ten times the prescribed dose.

- Doses of **1 milligram** or more must be written using the abbreviation '**mg**'.

- Doses less than 1mg must be prescribed as **micrograms** or **nanograms**, both WRITTEN IN FULL to prevent confusion (abbreviations µg and ng are easily confused with mg)

- Doses of liquids for oral administration must be prescribed as **g**, **mg** etc., NOT as volumes, so that confusion is avoided where more than one strength of the liquid is available.

- Liquids for oral use without a specific strength (e.g. Simple Linctus) must be prescribed in **millilitres**, written as '**ml**'. Volumes less than 1ml must be written as e.g. '0.25ml'.

- Doses of **insulin** and other relevant agents such as **unfractionated heparin** must be written in full as **'units'** to prevent confusion or misinterpretation (abbreviations 'U' or 'IU' are easily misread as a zero).

The **ROUTE** of administration. This must be specified in full, or by using the following permitted abbreviations:

IV	-	intravenous
IM	-	intramuscular
ID	-	intradermal
IP	-	intraperitoneal
SC	-	subcutaneous
PR	-	per (by) rectum
PV	-	per (by) vagina
O, PO, ORAL	-	by mouth
SL	-	sublingual
BUC	-	buccal
Intrathecal	-	intrathecal must always be written in full
NG	-	by nasogastric tube
PEG	-	by percutaneous endogastric tube
INH	-	inhalation
NEB	-	nebuliser
TOP	-	Topical
PATCH	-	by transdermal patch
EYE, EAR	-	into the eye(s), ear(s) (specify which as necessary)
INTRANASAL	-	into the nostril

The prescribing of multiple routes of administration for a medicine should be discouraged.

The **TIMES** of administration. The Prescriber must select the times at which the medicine is to be given. EPMA will default to 'morning', 'afternoon', 'night' etc, if a specific time is required then the prescriber must select this when prescribing the medication. If prescribing on a paper chart, then the default times will be 0600, 0800, 1200, 1400, 1800 and 2200 and again the prescriber must clearly document if times outside of these standard times are required by writing this on the chart or circling the appropriate time if pre-printed.

A continuous infusion should have a circle around all administration times if prescribing on a paper chart. Infusions with additives cannot currently be prescribed on EPMA and must be prescribed on supplementary paper chart. If this occurs then a placeholder must be prescribed on the EPMA system to ensure staff are aware there is an additional prescription in use.

The **STARTING DATE** for administration. If there is a period of time between the date of writing the prescription and the date of commencement of treatment, the Prescriber must block out all intervening squares on the administration record, where doses are not required, with a bold '**X**'. The original starting date must be carried forward if the prescription is rewritten onto a new chart. When prescribing on EPMA, the system will default to the next administration time, if this is not appropriate then this must be manually changed at the point of prescribing or the administration times blocked out manually on the EPMA system to prevent inappropriate doses being given.

The **STOP/REVIEW DATE** box on the chart should be completed when appropriate for defined courses of therapy or highlighted as part of the initial prescribing process on EPMA

The **PRESCRIBER'S SIGNATURE**. A specimen signature of all Practitioners must be obtained as part of the appointing procedure and must be forwarded to the Pharmacy Department. All such

signatures must be easily identifiable as belonging to a specific Prescriber. Nursing/Midwifery staff should not administer medicines against unsigned prescriptions. All practitioners will be enabled on EPMA to allow prescribing

For a patient with a known allergy or adverse drug reaction to a medication where prescribing of that medication is deemed appropriate, ensure there is a discussion with the patient or their representative in advance of initiation and that the rationale is clearly documented in the patients' medical notes. Add a note to the prescription either handwritten or electronically to say 'Potential Allergy – monitor carefully'.

5.6.7 The Administration Record (paper charts)

The Prescriber should not normally need to write on the administration record section of the paper prescription sheet, except:

To indicate that an individual dose, or sequence of doses, must be OMITTED, by blocking the appropriate square(s) with a bold '**X**'.

To terminate treatment – see Section 5.6.19. Other lines drawn across the administration record may cause confusion.

To sign for an administered dose

5.6.8 Intravenous Medication

IV fluids must be prescribed on the infusion section of the Medicine Prescription and Administration Chart ONLY, stating the nature, strength and volume of the fluid, any additives required, the DURATION or RATE of administration and be signed by the Prescriber. If the patient is in an area with EPMA then fluids *without* additives may be prescribed on the EPMA system. Any infusion with an additive must be prescribed on an infusion chart and a placeholder prescribed on the electronic prescribing system to alert other healthcare professionals that there is a paper chart in existence.

When prescribing IV medicines that need to be diluted in an infusion fluid the prescriber must prescribe the IV medicine and in the section provided beneath the IV medicine add details of the fluid in which it is to be administered including:

- the IV fluid name,
- volume to be diluted.
- infusion rate.

Medicines to be given by IV bolus injection must be written in the appropriate section of the main prescription sheet or prescribed on EPMA.

It is the responsibility of the person prescribing the IV medicines to ensure that there are no incompatibilities between multiple IV medicines if they are to be administered via the same lumen.

5.6.9 'Once-only' Prescriptions

The TIME of administration must be specified. If a once only or 'stat' dose is prescribed then the individual responsible for administration must be informed.

5.6.10 'As required' Prescriptions

Such prescriptions should state the actual dose, preferably as a SINGLE route of administration. It is good practice to prescribe a specific dose rather than a dose range. If a range is prescribed then the actual dose given needs to be recorded on the administration sheet.

The MINIMUM INTERVAL between doses, and the MAXIMUM number of doses to be given in a specified period of time must be stated. A maximum dose is required if the dose is different to that allowed with the minimum interval.

The indication for the medicine should be stated in the appropriate box on the prescription.

5.6.11 'Variable dose' Prescriptions

All such doses must be prescribed individually.

5.6.12 Use of Specialised Prescribing Charts, e.g. Insulin, Anticoagulation, Acute Pain etc.

The Prescriber must:

- Enter the name of the medicine in the 'regular' section of the paper prescription chart.
- Write, "see……chart", or "as per……chart" in the 'regular' section of the prescription chart.
- Write the full prescription on the specialised chart.
- When prescribing using EPMA, then a placeholder must be prescribed for the corresponding specialist chart.

5.6.13 Duration of Treatment

Treatment duration MUST be regularly reviewed (usually daily) for specific courses (e.g. for oral antibiotics (usually for 5-7 days) and particularly parental antibiotics (whose use must be reviewed after 36-48 hours).

5.6.14 Combination (sequential) Packs

For such multi-drug, sequence-dependant packs (e.g. Did Ronel-PMO), each stage of treatment should be prescribed separately, with a stop date specified to indicate the change in medicine (e.g. etidronate daily for 14 days then Cacit daily for 76 days).

5.6.15 Unclear, Ambiguous, Illegible or Incomplete Prescriptions

A prescription that is deemed to be unclear, ambiguous, illegible or incomplete MUST be clarified with an appropriate Prescriber and addressed BEFORE administration of the medicine(s) in question.

Pharmacists may make minor clarifying amendments to prescriptions but must consult the Prescriber if the original intention is unclear. Any Pharmacist annotation must be written clearly in green ink, signed, dated if on the paper chart. If amending on the EPMA system, then this must be documented in the pharmacy notes section of the arrival tab and / or in the medical notes. Pharmacists must only amend prescriptions based on the Enabling Policy unless they are an independent prescriber.

Other than pharmacists, only staff who are independent prescribers may amend prescriptions

Prescriptions should not be written using 'as directed' as the only instruction to the patient. Precise directions should be recorded on the prescription.

5.6.16 Supplementary Prescription Charts

There are a number of medications which are not currently prescribed directly onto the EPMA system for example those currently prescribed using auto-prescriptions, syringe drivers or infusions with additives. In this scenario a placeholder must be prescribed on the system to show that this additional paper chart is in use. The supplementary charts are then kept in the patient's bedside folder for use.

If prescribing on paper charts, then this cross referencing must also occur to prevent missed and delayed doses.

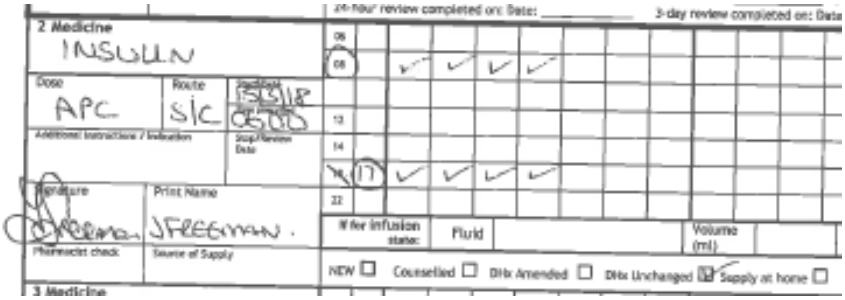
The following process is advised. Insulin has been used as an example.

Refer to the additional chart on the front of the main 'Medicine Prescription and Administration Record' as shown in figure 5.

Figure 5: 'Other medicines charts / sections in use (TICK)'

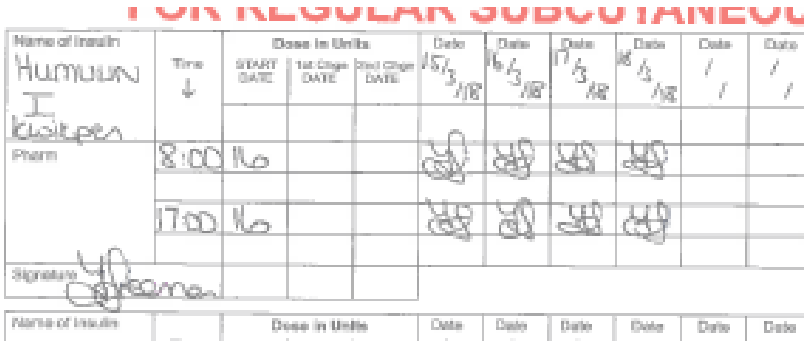
Prescribe the medication on the regular section of the 'Medicine Prescription and Administration Record' as shown in figure 6. This is to reduce the chance of a missed dose and to keep track of the doses given. The administration section here can be ticked to show the dose has been given. The administration occurs on the specialist chart which is where the signature and additional information will appear, see figure 7.

Figure 6: Regular Prescription Administration Record example.



The signature for administration should appear on the specialist / additional prescription chart as shown in Figure 7.

Figure 7: Signature record of the administered dose.



5.6.17 Patient Group Directions (PGDs)

For information on the use of PGDs please refer to the PGD Policy on the intranet**.** The supply of medication via a PGD must be appropriately document but the medication is not prescribed for others to administer if supplying medication via this route.

5.6.18 Cancellations and Alternations to Prescriptions on Paper Charts

To cancel a prescription

A bold '**X**' must be drawn across the whole of the prescription section for the medicine in question. A vertical **line** must be drawn at the end of the last day on which the medicine is required to be administered, and a bold '**X**' drawn across the remainder of the administration section.

If some of the prescribed doses are NOT to be given (for whatever reason), they must each be cancelled by filling the specific administration boxes with a bold '**X**'.
All cancellations MUST be signed and dated by the Prescriber making the cancellation.
A medicine may be discontinued by a pharmacist or Registered Nurse/Midwife at the request of a Doctor, and MUST be signed and dated by that Pharmacist or Nurse/Midwife, with specific reference to the Prescriber authorising the discontinuation.

To amend a prescription on a paper chart

Where alterations to doses, routes, frequencies etc. of any prescribed medicines are required, the original prescription for the item(s) MUST BE CANCELLED, and a NEW one written. Changes to existing doses and frequencies are not acceptable as this causes ambiguity, mistakes and does not provide a reliable audit trail for dose administration.

5.6.19 When the prescription chart is full (paper charts only)

Generally, no more than one prescription chart should be in use for each patient, UNLESS there are too many concurrently prescribed medicines to fit one chart.
A new prescription sheet MUST be written, and all continuing treatment transferred to it, when:

- No further space is available for the required prescription, or
- The administration record is full, or
- The clarity of the prescription sheet is impaired by soiling or other damage, or
- The prescription chart has torn or separated despite being legible.

When two prescription sheets are legitimately required to be in use at once, the Prescriber MUST:

- Annotate the charts as, e.g. "1 of 2", "2 of 2" charts etc.
- Securely attach ALL active prescription sheets together (e.g. with a 'treasury tag').
- Return to the use of a single prescription sheet as soon as possible.
- Prescribers must not alter the established sequence of dates on the administration record in order to prolong the life of a prescription sheet.

5.6.20 Transferred Patient

The prescription sheet must accompany the patient and their notes during transfer if the prescription is paper. If this is to an external organisation, then a photocopy must be sent of the paper chart.

Any unusual, non-stock or patients' own or medicines specifically labelled for that patient MUST also be transferred with the patient to the new location.

For transfers external to the Trust, a 5-day administration chart or MAR chart may be printed from the EPMA system which must accompany the patient. If it is likely that the patient will need treatment enroute, then the prescription sheet and an adequate supply of medicines must accompany them. If the patient is transferred to another organisation and is unlikely to return to SFH then a full TTO must be completed for the GP describing the onwards provision of care. If the patient will be repatriated, then a TTO can be completed at the end of the treatment spell e.g. at the point of discharge from SFH following their repatriation.

5.6.21 Medicines to Take Out / Home (TTO)

For full information on the standards and requirements for discharge prescriptions please refer to the Area Prescribing Committee (APC) Policy, available via this link:
https://www.nottsapc.nhs.uk/media/yj1hc4u3/apc-prescribing-policy.pdf

A prescription must be written for ALL medicines (including all dressings) to be dispensed for use after discharge or transfer outside the hospital for all patients who have been in hospital for over 48 hours, using the specific TTO prescription. This prescription must include all medicines, whether or not they are required for dispensing (e.g. if appropriate patients' own drugs are available), as this prescription also provides a complete discharge drug history for the patient, their GP or the receiving unit.

For patients who have been in hospital less than 48 hours only the new and changed items need to be included on the TTO. This is unless the patient requires a new mediwallet to be prepared or has informed the team looking after them that they require additional supplies on discharge.

Changes to a patient's prescription during their hospital admission or visit must be conveyed to their GP. The specific section on the electronic TTO should be completed.

Patients that are self-discharging should be provided with TTO medicines and a discharge summary completed for communication with the GP. If a patient refuses to wait for TTO medicines this should be documented in the case notes and communicated to the GP. Outside Pharmacy opening hours the TTO will be dispensed at the next opening hours and the patient or representative will be invited back to collect the discharge medication. Refer to the Trust's discharge policy for further information.

For Day Case patients that are not admitted as an inpatient the regular medicines need not be prescribed on the 'discharge' prescription. However, if a Day Case patient stays for more than 48 hours, they would then require a full TTO including the patients existing regular medication to communicate to the GP even if no medicines need to be dispensed.

It is important that the patient understands his/her discharge treatment, particularly where changes have been made.

Prescribers should seek Pharmacist assistance if necessary, to ensure that the advice given to patients about their discharge medication is clear and appropriate.

5.6.22 Outpatients

Prescriptions must be written on the appropriate outpatient and Emergency Department (ED) prescription forms or FP10NC forms.

Normally a maximum of **28 days' treatment** is supplied.

Any changes to a patient's prescription should be conveyed promptly to the GP.
Prescribing in outpatient settings must align to the local formulary.

Security of Outpatient Prescriptions

All prescriptions must be locked away securely when not in use. Please refer to the FP10 Policy for further information on the safe storage and use of FP10s available here: FP10 prescription pad policy

5.6.23 Requirements for Prescribing of Specific Medications

There are a number of medications with additional requirements to consider when prescribing.

Medications with a narrow therapeutic window e.g. lithium.

It is important when prescribing a medication with a narrow therapeutic window that appropriate monitoring is in place.

If a patient is admitted on a medication and there are any concerns about underdosing or toxicity, then a level should be obtained as soon as possible after admission.

In the case of lithium, a level should be obtained for all patients if there has not been a level taken within 3 months of admission.

Opioids

Please refer to the CD Policy and Associated SOPs for more information on the prescribing of opioids and controlled drugs.

Teratogenic medication.

When prescribing a medication which could have detrimental effects to the unborn child, please ensure that the required Pregnancy Prevention Programmes are in place and that all prescribing requirements are adhered to. If the medication is to be newly prescribed then the patient must be appropriately counselled so as to understand the implications of the medication.

For more information on specific medications then go to the following webpages.

Valproate products: Valproate safety measures - GOV.UK (www.gov.uk)

Topiramate: Topiramate (Topamax): introduction of new safety measures, including a Pregnancy Prevention Programme - GOV.UK (www.gov.uk)

Isotretinoin: Isotretinoin (Roaccutane▼): introduction of new safety measures, including additional oversight of the initiation of treatment for patients under 18 years of age - GOV.UK (www.gov.uk)
Alitretinoin and Acitretin will also be subject to restrictions as outlined in the isotretinoin guidance.

Potassium products.

When prescribing potassium containing products, please refer to the separate policy detailing information on this.
Parental potassium use and administration policy

Midazolam

When prescribing midazolam products for conscious sedation please refer to the conscious sedation policy

Epidurals

When prescribing epidurals please refer to the Patient Controlled Epidural Analgesia Policy

Dosifusers
When prescribing Dosifusers please refer to the relevant procedure available here:
Bupivacaine 0.25% continuous local wound infiltration for post laparotomy incision (dosifuser) procedure

Intrathecal

Intrathecal administration of medication, including chemotherapy is no longer conducted at SFH.

Oral methotrexate

Methotrexate will only be initiated by the relevant specialist teams. Information on the risks and benefits of oral methotrexate should be given to the patient. Confirmation of the patient's understanding and consent should be sought, baseline tests conducted, monitoring schedule explained, and patient-held monitoring booklet issued.

The use of 'as directed' on prescriptions for methotrexate is not accepted.

The quantity **and** frequency of tablets must be regularly discussed with the patient.

Prescribers must be aware of patients that attend with symptoms that may be indicative of methotrexate toxicity e.g. breathlessness, dry persistent cough, vomiting or diarrhœa.

Patients admitted to wards taking methotrexate must be referred to a pharmacist at the earliest opportunity for a full medication review. The prescriber must review all new medications prescribed to ensure suitability to be taken concurrently with methotrexate.

The prescriber must make the nursing staff aware of the fact that the patient is taking methotrexate and that there are specific requirements for administration and monitoring.

For inpatients the decision to continue a patient's methotrexate must be made by the consultant (or consultant colleagues, prescribing nurse specialists or registrars) under whom the patient has been admitted (preferably in conjunction with the patient's initiating consultant e.g. rheumatologist, dermatologist, gastroenterologist).

Oral methotrexate for inpatient administration must only be prescribed by an F2 doctor or above.

The prescriber must ensure that methotrexate is prescribed weekly and that the other six days are scored out on the prescription chart, if paper, to prevent inadvertent administration. In rare instances the weekly dose may be split into two separate doses during the stated day of the week. The scoring out of the days will automatically occur when methotrexate is prescribed on the electronic prescribing system using the required dose sentence.

Methotrexate prescriptions for outpatients and discharge must be legible and include the form, strength, dose and directions in full an example might be "Methotrexate 2.5mg tablets SIX tablets ONCE a week on Wednesdays".

Oxygen

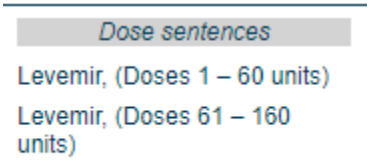
Oxygen therapy must be prescribed in the appropriate section on the patient's inpatient prescription chart if using a paper chart or using the relevant dose sentence if prescribing on the electronic prescribing system.
Staff should refer to the Trust Policy for the prescribing of oxygen: Oxygen Policy – prescription, administration and monitoring of oxygen therapy in adults
Oxygen may be given without a prescription in an emergency situation if necessary to save a life.

Insulin

Paper charts (in areas without EPMA):
Insulin products (clearly specifying the full name and device/presentation) should be written in the 'regular' and/or 'PRN' section of the main prescription chart as appropriate.
Doses should be indicated "see insulin chart", or "as per insulin chart".
The full prescription (specifying doses in 'units', the abbreviation U or IU must NOT be used) should be written on the specialised insulin prescription, and the box indicating an insulin chart in-use ticked on the main prescription chart.

Electronic Prescribing System:
The electronic prescribing system has been developed with 'dose sentences' to ensure the safe prescribing of insulin and to prevent large doses being prescribed in error. When selecting a dose

sentence to use, select the most appropriate for the dose you would like to prescribe. An example is shown in the diagram below



When selecting the dose sentence please note that this is not the dose to be prescribed but the range to choose a dose from, 1-60 units must not be prescribed as the dose for the patient.

Medicines that must be withheld until review on admission

Many medicines may have undesired effects if continued in the acutely ill and it is therefore essential that these be reviewed or withheld on admission. The following should not be continued without first ideally consulting the original prescribing consultant (or a consultant colleague, prescribing nurse specialists or registrars):

- Methotrexate
- Biologic treatments e.g. for rheumatoid arthritis
- Cancer chemotherapy must not be prescribed until reviewed by an oncologist or haematologist.

5.6.24 Reducing harm from omitted medicines in hospital

Medicine doses are often omitted or delayed in hospital for a variety of reasons. Ideally, all medicines should be administered at the prescribed time; for most medicines, administration +/- 1 to 2 hours from the time prescribed on the in-patient prescription chart is acceptable; for some critical medicines/conditions, such delays or dose omissions can cause serious harm or death. In response to a NPSA alert, an agreed list of 'critical' medicines/conditions has been compiled, where timeliness of administration is crucial. For more information on this see the critical medicine poster available here: Critical Medicine Poster and the associated guidance on reducing harm to patients from missed and delayed doses, available here: Reducing the harm to patients from missed and delayed medicines in hospital

Prescribers should be aware of the 'critical' medicines to ensure that all such medicines are appropriately prescribed to minimise the risk of delay/omission, particularly on admission.

Reasons for intentional dose/medicine omissions MUST be clearly documented in the medical notes (and in-patient prescription chart as necessary) and communicated to nursing/midwifery staff.

Prescribers should liaise closely with nursing/midwifery staff when prescribing critical medicine 'stat' doses.

When reviewing prescriptions, prescribers should check the administration section of the in-patient prescription chart in order to identify dose omissions/delays and reasons (from the use of non-administration code numbers), or documentation gaps. Such gaps should be queried with nursing/midwifery staff in an attempt to clarify whether or not dose(s) had in fact been administered.

Significant delay/omission of 'critical' medicine administration must be recorded as a patient safety incident on Datix.

5.7 ADMINISTRATION

Professional conduct and responsibility

All registered professionals administering and checking medicines must be competent to do so. They are accountable for their action, non-action and omissions and must exercise professionalism and professional judgement at all times.
The registered professional who administers and / or checks the medicine must understand the prescription and have knowledge of the common indications, side effects and dosage of the medicine prescribed and the reason that it has been prescribed for the patient.
If the registered professional is not familiar with the medicine, they must check that both medicine and dose are appropriate, referring to the current BNF, BNF for children or other appropriate up to date reference sources. If there is any doubt, then they must confirm the prescription with the original prescriber or a pharmacist. If there is still any doubt, then the medicine must not be administered and the original prescriber contacted.

Whilst carrying out medicine related activities, registered and non-registered professionals will encounter a number of abbreviations. These are explained in Section 5.6.6.

The Ward/Department Leader is responsible for ensuring the competence of any registered professional involved in medicines administration in their clinical area, and that all prescribed medicines are administered as prescribed.

5.7.1 Authorisation to administer medicines

Medicines may be administered to a patient under the authorisation of a:

- Prescription by an authorised prescriber
- Verbal Order (in exceptional circumstances – see section 5.6.4)
- Patient Group Direction. Please note a PGD does not give authorisation for the administration of a medication by another individual, the person issuing the medication must be the person to administer.
- An in-date local agreement ratified by the Joint Drug and Therapeutic and Medicines Optimisation Committee (DTC/MOC)
- An in-date written instruction ratified by the DTC/MOC
- An in-date national protocol.

A registered Midwife may administer a medicine within the course of their professional practice without the need for a prescription including a number of prescription only medicines included on the Midwives exemption list on the NMC website. Other prescription only medicines will require an authorised prescription or PGD.

5.7.2 Staff authorised to administer medication at SFH

The following practitioners are permitted to administer medicines, providing they have the relevant underpinning knowledge, training, and competency to do so.

- Registered nurses and midwives including student midwives

- Agency nurses and midwifery staff who have completed the relevant induction programme to work at SFH

- Registered Nursing Associates can administer certain medications as described below but have certain restrictions to their practices, also described below.

  Qualified, Registered Nursing Associates can:
  - Order and receive medicines, with the exception of Controlled Drugs.
  - Be second checker for patients' TTOs.
  - Administer insulin only if the second checker is a Registered Nurse.
  - Administer warfarin, direct acting anti-coagulants (DOACs), and oral cytotoxic medicines
  - Administer medicines via subcutaneous or intramuscular injection
  - Intravenous medication as long as the relevant competency packages and training have been completed.

  Qualified, registered Nursing Associates **cannot:**
  - Administer as required (PRN) medicines administration – due to the fact that they are not allowed to do initial assessments.
  - Administer or second check any medicine that is being administered via a PGD.
  - Dispense or second check any medicine as part of a pre-packed TTO (nurse dispensing).
  - Be involved in the ordering, receiving, checking or administering any schedule 2 or 3 CDs.
  - Administer methotrexate.
  - Administer or check any medicine via a verbal order.

- Registered paramedics who are working within the Trust as Advanced Clinical Practitioners.

- Registered orthoptists working within their scope of practice

- Registered optometrists working within their scope of practice

- Registered physiotherapists working within their scope of practice

- Registered radiographers working within their scope of practice

- Advanced Clinical Practitioners, once fully qualified.

- Registered ODPs. In the theatre environment, a registered ODP can administer medication as per their professional scope and competency. After completion of the medicine management

training package and IV training competency packages, they can also act as a second checker for intravenous medication. The individual must be familiar with the medication they are beings asked to second check.

- Student ODPs can draw up medication when on the scrub side, whilst they are under direct supervision from a registered practitioner. They can run free flow fluids, so long as they are under direct supervision of a registered practitioner who has undergone the relevant training. The student ODP can also be involved in the preparation of intravenous medication but must not then administer to the patient, this must be done by the registered professional supervising this activity.

- Student nurses may administer medication under the direct supervision of a Registered Nurse.

- Preceptorship nurses may administer all medication once the relevant competency packages and training modules have been completed.

- Speech and Language Therapists may administer food and water with or without thickener in order to conduct swallowing assessments.

- Registered doctors including foundation year doctors and locum doctors, ensuring the practice is within their competence.

- Medical students: The table below, Table 1, summarises the administration process for medical students and the required supervision for each activity.

Table 1: Guidance for Medical Students Administering Medication			
Route	Checking	Accountability	Supervision
Oral	1 Registered HCP	1st Registered HCP	Direct
Subcutaneous (Not Insulin)	1 Registered HCP	1st Registered HCP	Direct
Subcutaneous (Insulins)	2 Registered HCPs	1st Registered HCP	Direct
Intra-Muscular	1 Registered HCP	1st Registered HCP	Direct
Peripheral IV Infusion – further info below**	2 Registered HCPs	1st Registered HCP	Direct
Peripheral IV Injection (Bolus) (Push)	2 Registered HCPs	1st Registered HCP	Direct
Under NO circumstances can Medical Students Administer IVs Through Central Venous Access			

** Undergraduate Medical Students and Administration of IV Medication

Medical students are expected to gain competency in the administration of IV medication, as part of their medical training. In their 5th Year of Medical School students will attend theoretical and simulated practical training where they are assessed, and their clinical passports are signed. This will be delivered by a clinical skills trainer or someone who is qualified to teach and assess the skill. This is substantiated and corroborated by the Practical Skills and Procedures outlined in the General Medical Council (GMC) (2023) practical_skills_and_procedures_a4_july_2023.pdf (gmc-uk.org) originating from the GMC (2018) Outcomes for Graduates Outcomes for graduates (gmc-uk.org).

For the administration of IV medication, medical students can only be supervised and signed off by two members of staff who have completed their training according to Trust processes and have been deemed competent and up to date with current practice to perform the skill of IV administration (N.B. Agency nurses and bank staff are not permitted to supervise and sign off students in this area of practice). Prior to undertaking any of the above skills, the HCP supervising the medical student must confirm they have completed their theoretical and simulated practical training by checking their clinical passport. The supervising HCP is responsible for the correct administration and documentation of IV medication administered.

Except for controlled drugs, medical students are permitted, under the direct supervision of two HCPs who are competent to administer IV medications, to undertake the following in the clinical environment.

- Preparing medication for parenteral administration.
- Setting up a fluid or medication infusion.
- Administering an IV bolus.

In the event that the HCP has any concerns regarding the safe practice/competency of a medical student administering an IV medication whilst under their supervision they should undertake the following:

- Complete the procedure themselves with another competent HCP to ensure that the patient has safely received the prescribed medication.
  (The student can observe the procedure if appropriate to do so).
- Discuss with the student the concerns they have with their practice and explain that they should refrain from undertaking the skill until they have been contacted by their Clinical Skills Educator from the Undergraduate Medical Education department, who will formulate a plan of action.
- If an error or near miss has occurred, a DATIX must be completed.
- Contact the undergraduate medical education department, explain their concerns to the appropriate Clinical Educator.
- The HCP will also be asked to write a brief statement.
- The Clinical Skills Educator will contact the student and discuss a plan of action to support them with their practice.

All staff must be working within the scope of their job description and professional practice and competence and have appropriate training.

All staff should have completed appropriate records of administration.

Administration and prescribing should be done by separate registered professional wherever possible.

If a group of individuals is not listed above, then they must have a local guideline ratified by the DTC/MOC prior to administering medication.

5.7.3 Non-registered staff administering medication.

Non-registered staff such as clinical support workers or healthcare assistants may assist in the administration of dressings and emollient based topical treatments which have been prescribed. The delegation of administration duties cannot be made to non-registered staff however, they may assist an individual to take medication. The registered professional is responsible for all aspects of the administration of medicinal products and they are accountable to ensure that the person assisting in the administration of the medicine has a recognised competency to carry out the task.

Where there is a ratified local agreement in place, specific groups of non-registered staff may administer specific medications within limited criteria.
Healthcare assistants working in Ophthalmology may administer a limited number of eye drops when following a Patient Specific Directive or working as part of the diabetic retinopathy pathway.

5.7.4 General points to consider

Carers may administer medication to patients after they have been assessed as part of the Trusts Self-Administration Procedure which is available via this link:
Self-administration of medicines by patients or carers procedure

Specifically authorised adult patients may administer their own medication if assessed and competent to do so, after having completed all the relevant paperwork as highlighted in the Self Administration Procedure above.

The administration of intravenous radio-diagnostic agents is the subject of local departmental arrangements and regulations concerning radiological protection. The Registered Nurse or Radiographer must have specific enabling certification and will have completed a Radiation Protection Certification Course.

The Trust uses Medusa, the online injectable guide for detailed guidance on the preparation, reconstitution and specific guidance on the administration of intravenous injections and infusions. A link to this guidance is available via the electronic prescribing system and the intranet.

Registered Nurses/Midwives must have completed IV training in accordance with the specific 'role development' before administering injections via peripheral cannula.

Compliance aids (e.g. *Mediwallets*) are intended for use by patients once discharged or for self-administration while in hospital. These should not routinely be used by healthcare professionals for administration to patients. Medicines dispensed into compliance aids must NOT be altered by Medical, Nursing/Midwifery staff or patients if a dose change is prescribed. In such cases, the container must be re-dispensed by Pharmacy to take into account the prescription changes. In an acute setting, such as just after admission to hospital, where a patient is prescribed a critical medication which is unavailable, the mediwallet may be used if the medication is easily identifiable. This is to ensure a dose is not missed until a further supply can be obtained.

5.7.5 Checking Medicines

Any medicine may be administered by a single Registered Practitioner, deemed competent to administer medicines, with the following exceptions:

- Preceptorship nurses who have not completed the required number of supervised medicines assessments and their medicines and oxygen questions within the preceptorship pack.

- Intravenous injections and infusions – the procedure must be undertaken by TWO registered practitioners throughout the procedure.
    - For a nurse/midwife they must have completed the Scope of Practice for Intravenous Therapy.
    - To act as the second checker preceptorship nurses or midwives must have completed the intravenous calculation test.
    - Note that within the Radiology department (under specific PGDs) the second check of the intravenous medicine is not required.
    - Note that for "OPAT" (Outpatient Parenteral Antimicrobial Therapy) where injections are administered within a patient's home, a lone nurse will be required to administer the injection. The patient may wish to check the injection to be administered with the nurse as a matter of good practice, but they are not acting in the same capacity as a healthcare professional providing a second check and will not be asked to sign checking paperwork. The medications to be administered via the OPAT service are second checked prior to the nurse leaving for the visit by a second registered professional.

      When using the patient as the second check in this situation then they can be asked to confirm the following:
        - That they are the correct patient
        - That they are expecting that medication intended
        - That they are not allergic to the prescribed item.

- Intramuscular injections – two registered practitioners.

- Spinal, epidural – two registered practitioners.

- Syringe drivers and all infusions, including subcutaneous infusions – two registered practitioners.

- Subcutaneous injections of insulin – all insulin injections require two registered practitioners unless the patient is authorised to self-administer their own insulin

- There are specific exceptions to the checking process for IM injections:
    - Midwives administering injectable medicines on the Midwives' exemption list. It is good practice to check the medicine with two qualified individuals, unless a Midwife is present at a birth alone then it is accepted that the Midwife can check and administer alone.
    - Staff working within Sexual Health Services administering IM and SC contraception.
    - Registered Nurses working in Occupational Health administering single dose IM or SC vaccinations.

- Vaccinations as defined in the specific PGD

- ALL schedule 2 CDs by any route must be checked by TWO registered practitioners throughout the procedure, one of whom must be the administering Doctor or Registered Nurse/Midwife/ODP. The two-registrant check should include all stages up to and including the administration of the medicine to the patient.

- ALL oral cytotoxic medicines must be checked by TWO registered practitioners, one of whom must be the administering Doctor or Registered Nurse/Midwife. The electronic prescribing system will identify cytotoxic medication. Refer to Section 5.11 for use of cytotoxic medicines.

5.7.6 Second Check Standards

There are a number of registered professionals who can act as a second checker. This will ordinarily be another registered nurse or midwife but in some circumstances other registered professionals may be called upon to complete this task.

These staff may be asked to second check medication. Please note that to check intravenous medication the second checker must have completed the IV competency pack and training:

- Nurse – all medications if competent and completed all the relevant training packages
- Midwife – as above
- Preceptorship Nurse after completing the relevant training packages and the other checker is a Registered Nurse.
- Doctor – if the other checker is a Registered Nurse
- Pharmacist or Medicine Management Technician – not for intravenous preparations.
- Nursing Associate (not CDs), the other checker must be a registered nurse or midwife.
- ODPs in the theatre environment only but may act as a checker for intravenous medication recovery after completion of the relevant training and competency packages.

The expectations of a second check

The second check must be independent, this means it is conducted in ‘isolation’ and not under the influence of another professional.

All aspects of the process must be included in a second check from the selection of the product against the prescription, the calculations if applicable, the appropriateness and timing of the dose, parameters needed to determine the safety of the dose e.g. weight of the patient.

The second check will also include the administration to the patient at their bed side including an independent check of the patient’s identity, the route of administration.

Both practitioners will sign the administration section on either the paper chart or electronic prescribing system to show that this process has been completed after the medication has been administered. The

prescribing system will provide an additional box for an electronic signature for those medications that require this additional check.

5.7.7 Preparing injections and other sterile fluids for administration

In order to minimise the risk of infection, injections should be ideally prepared under aseptic conditions within aseptic purpose-built suite in Pharmacy. Where this is not possible injections should be prepared in clean utility rooms using appropriate 'aseptic non-touch' technique. The preparation of injections in other areas should only occur in exceptional circumstance such as emergency situations where this is in the best interest of the patient.

5.7.8 Administering injections via infusion devices

The Trust is using administration safety software to help reduce errors around administration of injections via syringe drivers and volumetric pumps. Guardrails® is being used in some areas of the Trust and must be used for administering injections where available.

5.7.9 Use of single and multidose injections

Serious infection and fatalities have been reported due to the inappropriate use of a single container to prepare more than one dose of injection especially for more than one patient.

The following guidance aims to minimise the risk to patients.

Single Use Container

Single use containers of injectable products are for the use in ONE patient only on one occasion. Single use products must not be retained for use at a later date or time. The formulation does not contain a preservative. Any volume remaining must be discarded after a single use.

This guidance applies regardless of the presentation (ampoule, vial, syringe, infusion bag) and also includes situations where a single use injectable product is given non-parenterally such as for diluting nebuliser solutions or flushing nasogastric tubes.

Devices that facilitate multiple access into bags or bottles of infusions such as multidose adaptors or needles with three-way taps must not be used.

Where an exception to this policy is deemed necessary then a local procedure must be authorised by the Joint DTC/MOC

Multidose Containers

Multidose containers are products which contain both a medicine and a preservative. They will always be labelled for multidose use. Examples include insulin vials and cartridges. Multidose containers of injectable products may be used to prepare more than one dose but are for use in a

single patient only. Multidose containers must be labelled with the following information when first used:

- Patients name
- D number or NHS number
- Expiry date (depends on product but usually 4 weeks or less)

Once opened multidose vials should be stored at room temperature and not in the fridge. Low temperature prevents the preservative from working effectively. Where possible products in use should be stored in the medicine's drawer within the bedside locker.

Part used vials must be discarded once the expiry date is reached. Any part-used vials found that are not labelled with the patient's name and expiry date must be discarded.

Where an exception to this policy is deemed necessary, then a local procedure must be authorised by the Joint DTC / MOC

5.7.10 Process for Safe Administration of Medicines

There are a number of steps to follow to ensure the safe administration of a medication to a patient, these are commonly referred to as the '5 Rights', and this process is also followed on the EPMA system. It is important before any administration that the prescription is clear and unambiguous, if there is any question as to what should be administered then refer back to the prescriber for clarification.

It is also essential to check the suitability of the medication for administration e.g. if the package has tamper evident seal, is this intact, is the product discoloured and has it been stored appropriately.

Right patient, this is ascertained using the steps highlighted in the Positive Patient Identification Policy available here: Positive Patient Identification Policy. The registered professional must also check, using the same methodology that they have the **right prescription.**

Allergy status must be checked prior to the administration of any medication. Allergy status must be checked against the prescribing records and if possible, the patients or against the red wrist band (if in situ) prior to the administration of any medication. If this is not documented then this information can be obtained from several sources, the advantages and disadvantages of which are listed in Appendix 5. Ideally two sources should be checked to increase the likelihood that the information is correct. Where possible one of these sources should be the patient. If using the EPMA system, then the allergies must be document AND verified prior administration.

Right medication, this should also encompass a check to ensure it is appropriate to administer the medication e.g. is the blood pressure appropriate for antihypertensives. Pay attention to the preparation prescribed for example is it a modified release preparation, dispersible or liquid.

Right time, is the administration appropriate for the patient at this time, some patients may have specific requirements e.g. Parkinson's medication or insulin with food. Ensure there is an appropriate length of

time between doses if they are multiple times a day or when required. Does this time of administration match that prescribed?

Right dose, if the prescription needs to be checked then use appropriate reference sources. Also ensure that the medication you are about to administer matches that prescribed. Any **calculations** should also be doubled checked prior to administration.

When measuring and/or administering oral doses less than 10ml in volume, an appropriate sized graduated purple **oral syringe** must be used. 1ml, 3ml, 5ml and 10ml oral syringes are available. For volumes greater than 10ml and incremental to volumes of 5ml, a measuring pot can be used. In addition, oral syringes should be used for administration via enteral feeding lines e.g. PEGs, NG tubes. A separate policy covers the use of syringes to administer flushes, feeds and medication via the oral and enteral route (link).

Right route, check that the route by which you are about to administer the medication is correct. If the route is not available then liaise with the prescriber to ensure doses are not missed.

Check the **expiry date** for all medication prior to administration.
Check whether two registered professionals need to check the medication in question.

Ensure the patient has taken the medication after administration. It is good practice to remain with the patient until all medicines have been taken.

Do not leave medication unattended with the patient. If the patient refuses then remove the medication and dispose of it appropriately. This should be appropriately documented. On going refusal of treatment will require a review by the prescriber to understand the reasons behind the refusal, more appropriate treatments may be required.

Sign the chart either physically or electronically immediately after administration has occurred

It is good practice to check if there is enough stock left for subsequent doses, order if not.

If a nurse or other member of staff has grounds to believe that the medication selected is incorrect or that something is wrong with the medicine then the following action should be taken in conjunction with a pharmacist:

- use the BNF to confirm the description of the medicine.
- contact the Medicines Information Centre on 3163 (9am-5:30pm Monday to Friday) or the on-call Pharmacist via switchboard at other times.

Where there is still concern regarding the medicine, a new supply will be issued by the Pharmacy department. The problem medicine must be isolated in a locked cupboard until it can be collected by a member of the pharmacy team.

5.7.11 Breaking, crushing or cutting tablets

When administering tablets that need to be split into half or quarters via a score mark the remainder of the tablet must be discarded unless the tablets have been supplied pre-cut in a bottle by Pharmacy or where Pharmacy have advised that it is safe to keep the remainder of the tablet for administration at the next dose.

Crushing or cutting tablets

- Before tablets are crushed it must be confirmed that it is safe and appropriate to do so. Refer to the ward pharmacist in the first instance. If they are unavailable, then check the medicines formulary for advice or contact Medicines Information.
- Where tablets need to be cut or crushed before administration tablet crushers or cutters may be used. These must be washed in soapy water, rinsed and left to air dry to remove tablet residue after use.
- Tablet cutters and crushers are available from Pharmacy.

5.7.12 Administering medicines to 'off-site' patients

Scenarios arise where patients will be visiting other organisations for one-off treatments, investigations or where medicines may be administered by Trust staff in the patient's home. In circumstances where the patient may require medicines to be administered by a healthcare professional whilst off-site this should be undertaken in-line with the Medicines Policy: the patient's medicines and prescription chart should accompany the patient or the nurse. If the prescription is electronic then a printout must be taken with the patient to allow administration to be recorded. If the patient requires a controlled drug to be administered whilst off-site a TTO supply must be requested. In these scenarios a single nurse administration of the patient's own CD is acceptable if the patient cannot self-administer e.g. injections.

5.7.13 Administration of specific medicines and via specific routes

Enteral administration

For the administration of liquid medication via the oral or enteral route please refer to the policy for more detail available here:
Syringe use to administer flushes, feeds and medication via the oral and enteral routes policy
Purple oral syringes, 5mL medicine spoons or measuring pots are the only permitted ways to measure oral liquid medication.

Rectal or bladder

If the medication is not supplied with an appropriate device for administration, then a bladder syringe and rectal tube must be used to administer.

Spinal, epidural administration.

In line with the recent patient safety alert, NatPSA/2024/002/NHSPS, entitled 'Transition to NR-Fit connectors for intrathecal and epidural procedures and delivery of regional blocks'. All procedures which access the cerebrospinal space will use NR Fit compatible, non-luer spinal needles.

Transdermal patches.

When applying transdermal patches, it is important to ensure that the previous patch is removed. The site of the patch should also be rotated, unless the patch is lidocaine, in which case this is placed specifically for local pain relief.

Infiltration vs irrigation

Infiltration is the deposition of a solution directly into tissue often during surgical procedures. The same standards for the IV preparation of medication should apply due to the risk of infection with this process. Irrigation is the washing or filling of an organ, body cavity or wound by a stream of fluid. The same standards for the IV preparation of medication should apply due to the risk of infection with this process.

Intravitreal administration should only be undertaken by appropriately trained and competent staff in line with local procedures.

Oral methotrexate

The administration of oral methotrexate must be checked and witnessed by a second registered professional. Both professionals should sign the administration record on either paper charts or the electronic prescribing system.

Low-dose methotrexate is always given weekly and must NEVER be given on a daily basis. In rare instances the weekly dose may be split into two separate doses during the stated day of the week.

Record the administration of methotrexate immediately on the medicine chart i.e. at the time of administration; a delay in recording can result in one or more additional doses being given.

Administering opioid medicines – please refer to the Controlled Drugs Policy available here:
Controlled Drug policy and associated standard operating procedures

Administering insulins

All regular and single insulin (bolus) doses are measured and administered using an insulin syringe or commercial insulin pen device. Intravenous syringes must never be used for insulin administration.

Insulin doses must be written in 'units' and this must not be abbreviated.

An insulin syringe must always be used to measure and prepare insulin for an intravenous infusion. Insulin infusions are administered in 50ml intravenous syringes or larger infusion bags.

Insulin cartridges must not be used to withdraw insulin with a needle, they must only be used in conjunction with the appropriate pen device.

5.7.14 Preparation of medicines for administration by medical staff

Where a medicine is prepared by a Registered Nurse or Midwife, but administered by a doctor, the following must be undertaken:

- The medicine **must** be prepared in the presence of the Doctor unless already prepared within the Pharmacy department.
- If, for any reason it is not possible to prepare the medicine in the presence of the doctor, the vial/container from which the medicine was taken must be retained and shown to the Doctor before administration.
- The Doctor and Registered Nurse/Midwife/ACP must follow the procedure for checking and administering medicines as described above.

5.7.15 Administration of parenteral medicines in life saving emergencies

A prescription is usually required to allow the administration of a parenteral medicine, however in life-saving emergencies the following medicines may be administered without a prescription if competent to do so:

- Adrenaline 1:1000 up to 1mg for intramuscular use in anaphylaxis
- Atropine sulphate and obidoxime chloride injection
- Atropine sulphate and pralidoxime chloride injection
- Atropine sulphate injection
- Atropine sulphate, pralidoxime mesilate and avizafone injection
- Chlorphenamine injection
- Dicobalt edetate injection
- Glucagon injection
- Glucose injection
- Hydrocortisone injection
- Naloxone hydrochloride
- Pralidoxime chloride injection
- Pralidoxime mesilate injection
- Promethazine hydrochloride injection
- Snake venom antiserum
- Sodium nitrate injection
- Sodium thiosulphate injection
- Sterile pralidoxime

5.7.16 Covert administration of medicines

The covert administration of medicines is now covered under a separate Trust Policy.
For more information please refer to the specific guidance available here: Covert Administration of Medicines Policy

5.7.17 Swallowing difficulties

If the patient is unable to swallow medication then please seek advice from the pharmacy or speech and langue therapy teams.
Crushing tablets will place the medicine outside of its product licence, there is more information on this in the following policy:
Syringe use to administer flushes, feeds and medication via the oral and enteral routes policy

5.7.18 Vomiting of medicines

If the patient vomits within 30 minutes of the administration of a medication then the doctor must be contacted to determine which medications may be readministered. If they are to be given again then they must be prescribed as stat or 'once only' doses.
If the patient vomits more than 30 minutes after administration, then it may be that they have absorbed some or part of the dose and so further administration is not advised.

5.8 PRESCRIBING AND ADMINISTRATION OF MEDICINES IN CHILDREN

For the purposes of this Section, a child is defined as in The Children Act 2002 as under the age of sixteen years.

5.8.1 General Considerations

Since children are particularly vulnerable, the Pharmacist and/or Medicines Information Service should be consulted whenever necessary for advice and information on dose and formulation when prescribing for children.

A high proportion of medicines used in children are not licensed specifically for children *i.e.* they are used "off-label".

It is essential that all staff involved in the prescription and administration of medicines to children familiarise themselves with the various problems and potential hazards of this situation.

If, in exceptional circumstances, children are being cared for on an adult ward, it is the responsibility of the caring team to seek advice from paediatric specialists where doubt exists concerning medicine dosages.

5.8.2 Specific Measures relating to Children

The following measures are an important addition to earlier sections

All medicines administered to children must be checked by TWO MEMBERS OF STAFF *i.e.* two Registered Nurses/Midwives or a Doctor and a Registered Nurse/Midwife. When two Nurses are required to administer medicines to babies and children, the senior registered Nurse on duty would normally be a Registered Sick Children's Nurse (RSCN) or a Senior Registered Nurse.

Ensure correct positive patient identification via wristband prior to medication administration, this should be a two-nurse check.

The prescription should be read aloud before proceeding to administer the medicine. The second member of staff (Registered Nurse/Midwife/ACP or Doctor) must check both the calculation, route, dose of the medicine and time of last dose before administration. All intravenous fluids should be checked by two Registered Nurses/Midwives.

The dose of the medicine should ALWAYS be checked against a reference. Specific paediatric guides are available; the "BNF for Children" should normally be used to check doses of medicines and further dosing advice may be sought from other recognised national references such as and "Medicines for Children" or by contacting the Medicines Information Centre. NICU will refer to Nottingham medication monographs.

Attention must be paid as to whether the reference relates to the single or total daily dose. If the medicine is not included in the above, reference should be made to the BNF which usually contains childhood dosage information or contact the Ward Pharmacist or Medicines Information Centre.

The dose of the medicine should always be calculated using weight or surface area and child's age. **CALCULATE THE DOSE AND CHECK IT AGAIN - particular attention should be paid to decimal places**.

The date of birth, age and weight, and where appropriate height and surface area MUST be written on the prescription charts. The date on which these calculations were made must also be included and signed for.

The parent may administer the medicine under the supervision of a Registered Nurse/Midwife. Where the parent is administering the medicine, Nurses MUST:

- check the medicine as above.
- observe the administration of the medicine.
- record the administration in the appropriate records.

When measuring and/or administering oral doses less than 10ml in volume, an appropriate sized graduated purple **oral syringe** must be used. 1ml, 3ml, 5ml and 10ml oral syringes are available. Volumes greater than 10ml and incremental to volumes of 5ml, a measuring pot can be used. Additional oral syringes are available from Pharmacy. In addition, oral syringes should be used for administration via enteral feeding lines e.g. PEGs, ng tubes.

Paediatric formulations must be used when these are available. Where they are not available and multi-dose or adult strength preparations have to be used, particular vigilance should be exercised when calculating and preparing the dose. The Ward Pharmacist should be consulted regarding the preparation of medicines in suitable dosage forms and concentrations for administration to children.

Children and infants should wear identity bracelets, these must be checked prior to the administration of each medicine. Oral preparations should be sugar free wherever possible.

5.9 PRESCRIBING, DISPENSING AND ADMINISTRATION OF TRIAL MEDICINES

This section sets out the standards required for the management of Investigational Medicinal Products (IMPs).

5.9.1 Key messages

Investigators must:

- Delegate defined aspects of IMP management to SFH pharmacy.
- Consult with Lead Trials and Medicines Information Pharmacist as part of the study feasibility and approval process.
- Investigational medicinal products (IMPs) are controlled through the Pharmacy at KMH.

5.9.2 Administration of medicines.

- SFH Pharmacy trials team will control IMP management via internal SOPs in accordance with relevant legislation and guidance.
- The Trust supports the safe use of Investigational Medicinal Products (IMPs) where appropriate. All staff involved with the research process must be aware of their research responsibilities with respect to the relevant legislation and guidance, and SFH policies, and act in accordance with these.

5.9.3 Definitions

- **Advanced Therapy Investigational Medicinal Product (ATIMP)** - An investigational medicinal product used within a clinical trial. The medicine, for human use, is a gene therapy, somatic cellular therapy or tissue engineering product or a combination of the three.
- **Clinical Trial of an Investigational Medicinal Product (CTIMP)** - Any investigation in human subjects intended to discover or verify the clinical, pharmacological, and/or other pharmacodynamic effects of an investigational product(s), and/or to identify any adverse reactions to an investigational product(s), and/or to study absorption, distribution, metabolism, and excretion of an investigational product(s) with the object of ascertaining its safety and/or efficacy.
- **Clinical Trial Authorisation (CTA)** - Authorisation given by the competent authority (MHRA in UK) to conduct a clinical trial.
- **Disposal** - The removal of investigational products from the research site either by return to the trial sponsor or by destruction according to local policy. Destruction is usually performed by an external waste contractor.
- **Good Clinical Practice (GCP)** - A standard for the design, conduct, performance, monitoring, auditing, recording, analyses, and reporting of clinical trials that provides assurance that the data

and reported results are credible and accurate, and that the rights, integrity, and confidentiality of trial subjects are protected.

- **Good Manufacturing Practice (GMP)** - The part of quality assurance which ensures that medicinal products are consistently produced and controlled to the quality standards appropriate to their intended use and as required by the marketing authorisation (MA) or product specification. GMP is concerned with both production and quality control.
- **Health Research Authority** - the government department responsible for the approvals process for research projects in the NHS in England.
- **Investigational Medicinal Product (IMP)** - A pharmaceutical form of an active ingredient or placebo being tested or used as a reference in a clinical trial, including a product with a marketing authorisation when used or assembled (formulated or packaged) in a way different from the approved form, or when used for an unapproved indication, or when used to gain further information about an approved use.
- **Investigator** - A person responsible for the conduct of the clinical trial at a trial site. If a trial is conducted by a team of individuals at a trial site, the investigator is the responsible leader of the team and may be called the principal investigator.
- **Medicines and Healthcare products Regulatory Agency (MHRA)** - The government agency which is responsible for ensuring that medicines and medical devices work, and are acceptably safe.
- **Research Ethics Committee (REC)** - An independent body, constituted of medical / scientific professionals and nonmedical / non-scientific (lay) members, whose responsibility it is to ensure the protection of the rights, safety, and well-being of human subjects involved in a trial by, among other things, reviewing and providing a favourable opinion on the trial protocol, the suitability of the investigator(s), facilities, and the methods and material to be used in obtaining and documenting informed consent of the trial subjects.
- **Sponsor** - An individual, company, institution, or organisation that takes responsibility for the initiation, management, and/or financing of a clinical trial.
- **Standard Operating Procedures (SOPs)** - Detailed, written instructions to achieve uniformity of the performance of a specific function.

5.9.4 Roles and responsibilities

- **Committees Medicines Management Committee** - authors of policy
- **Individual officers** - All staff involved with the research process must be aware of their research responsibilities in accordance with relevant legislation and guidance.
- **The pharmacy service** - their role in relation to clinical trials is to safeguard the patients, healthcare professionals and the Trust by ensuring that the medicines are appropriate for use and are procured, handled, stored, used safely and correctly, and disposed of appropriately.

5.9.5 Introduction

While some clinical trials will involve the use of existing marketed products used within their licensed indications, others will use new medicines, formulations or methods of administration unfamiliar to staff handling them. IMPs may also be coded to prevent ready identification by investigator or patient. Extra precautions need to be taken to ensure safety and security in their use. Each clinical trial must have a sponsor responsible for the initiation, management and financial arrangements of the trial. The sponsor may be a pharmaceutical company, a research organisation, the Trust, an academic institution, or a combination of these. The sponsor may delegate responsibility for defined and agreed trial duties.

5.9.6 Regulatory Authorisation and Other Approvals

The use of medicines in a trial must be supported by a Clinical Trials Authorisation (CTA) issued by the Medicine and Healthcare Products Regulatory Agency (MHRA). All trials not conforming to all of the following conditions are considered to be interventional and will require a CTA.
A non-interventional study is defined as a study of one or more medicinal products which have a marketing authorisation (i.e. are licensed products), where the following conditions are met:

- the products are prescribed in the usual manner in accordance with the terms of the authorisation.
- the assignment of any patient involved in the study to a particular therapeutic strategy is not decided in advance by a protocol but falls within current practice.
- the decision to prescribe a particular medicinal product is clearly separated from the decision to include the patient in the study.
- no diagnostic or monitoring procedures are applied to patients included in the study, other than those that are normally applied in the course of the particular therapeutic strategy in question and
- epidemiological methods are to be used for the analysis of the data arising from the study.

The trial sponsor is responsible for CTA application. This may be formally delegated to the investigator for protocols which are sponsored by the Trust.

5.9.6.1 HRA approval

HRA Approval is the process for the NHS in England that brings together the assessment of governance and legal compliance, undertaken by dedicated HRA staff, with the independent REC opinion provided through the UK research ethics service. It replaces the need for local checks of legal compliance and related matters by each participating organisation in England. A favourable opinion from the main REC is given on the condition that HRA approval is obtained and that local sites confirm capacity and capability. All approvals and confirmations need to be in place before an activity on a research project begins. Further information available at http://www.hra.nhs.uk

5.9.6.2 Research and Innovation (R and I) Approval

At SFH the R and I team will engage with investigators and study teams in the Trust to ensure that the correct arrangements are in place, confirm capacity and capability and offer support throughout the lifecycle of the research project.

5.9.7 Final pharmacy sign off

This will be required before IMPs can be dispensed and will occur when all IMP's related procedures are in place.

5.9.8 Responsibilities of designated research staff in the research process

Investigator responsibilities
These are detailed in the Good Clinical Practice (GCP) regulations European Commission Directive on Good Clinical Practice 2005/28/EC. April 2005. Particular vigilance is needed when operating protocols which are sponsored by the Trust or an academic institution in which Trust patients are to be recruited.
In summary, the investigator should:

- be qualified by education, training and experience, including evidence of GCP awareness, to assume responsibility for proper conduct of the trial.
- demonstrate adequate resources e.g. time, support staff and facilities to conduct the trial properly and safely within an agreed time period.
- ensure before the study begins that it has a favourable opinion from an Ethics committee.
- obtain and document informed subject consent, or if the subject is unable to provide informed consent, the subject's legally acceptable representative, before any trial related procedures are performed. Subjects should have a clear understanding of the proposed treatments, the potential for harmful effects and any available alternative treatment, information and instructions which has Ethics committee approval, should be provided and the subject must have ample time to ask questions and decide whether or not to participate.
- ensure that all persons assisting with the study are adequately informed about the protocol, the investigational medicinal products and their trial related duties and functions.
- be responsible for reporting serious adverse events to the sponsor in accordance with the protocol.
- be responsible for all trial related medical decisions during and following a subject's participation in the study;
- be responsible for investigational product accountability at the trial site and delegate this responsibility to the pharmacy department.
- follow trial randomisation procedure if applicable and ensure that in blinded studies, the treatment code is broken only in accordance with the protocol.
- ensure the accuracy, completeness, legibility and timeliness of trial data and ensure that all other persons who have delegated responsibility for data collection are adequately trained in trial procedures and are aware of those responsibilities.

Pharmacy responsibilities

The Pharmacy clinical trials coordinator has overall responsibility for the pharmacy clinical trial service. The designated lead clinical trials pharmacist for a study should:

- before the commencement of a clinical trial involving IMPs, ensure that the pharmacy department has copies of all essential regulatory and technical documents, a copy of the protocol, an investigator brochure or Summary of Product Characteristics, if applicable and randomisation codes, if relevant.
- carry out risk assessments for each clinical trial and put procedures in place to minimise the predictable risks from trial medication to patients and staff.
- ensure that all medicines provided or procured for use in a clinical trial are of suitable quality and fit for purpose, i.e. are manufactured in accordance with Good Manufacturing Practice, by a holder of a relevant manufacturing authorisation.
- ensure that packaging and labelling of clinical trial medication is acceptable for use within the Trust and complies with applicable legislation.
- be responsible for management of IMP stock, including IMP accountability and any other duties as delegated by the investigator. A written agreement or contract, detailing these delegated duties and pharmacy fees, should be in place for each clinical trial.

5.9.9 IMP Management

All medicines used in clinical trials at SFH must be stored and dispensed by the pharmacy department and managed to the same standards as other medicines used therapeutically.
All organisations supplying medicines and related products for use in clinical trials must do so through the SFH Pharmacy Department.

The investigators must delegate responsibilities to the pharmacy department for the:

- correct receipt and recording of deliveries of trial medicines.
- safe handling, storage and dispensing of trial medicines.
- maintenance of accurate accountability records for all clinical trial medicines.
- return of unused products to the trial sponsor or their disposal according to SFH policy.
- reconciliation of delivery records with usage and return of unused stock.
- safe keeping of randomisation information including emergency code breaks.
- provision of medicine information to trial subjects on administration of study medication.
- where necessary, the manufacture and/or assembly of study medication.

5.9.9.1 Prescribing of IMPs

IMP prescribing must be by study specific authorised prescribers only. A record of prescribers will be kept in the study specific pharmacy file. IMP prescribing must be on an authorised, study specific prescription form or a clearly annotated SFH prescription chart. The pharmacy department can assist in the design and production of a suitable prescription.

Prescriptions must include:

- Trial name
- visit number
- patient identifying details, name, address, date of birth, hospital number and trial subject number if relevant.
- dose, frequency, duration and route of administration.
- quantity of IMP required for the prescribed treatment period (this should correspond with prepacks designed to meet the requirements of the treatment protocol wherever possible).

5.9.9.2 Storage of IMPs

All IMPs must be managed in a temperature-controlled storage facility in the pharmacy department. It is inappropriate for separate stocks to be kept in wards, clinics or private offices. In some circumstances investigators may need to store IMPs in a clinical area. The designated lead clinical trials pharmacist for the study must authorise the storage. Alternative storage facilities should be designated for IMP storage only with appropriate security and temperature monitoring methods approved by the trial sponsor. IMPs will be delivered to the pharmacy department. Issue to and return from the alternative storage facility will be documented as part of the IMP accountability records in the pharmacy file.

5.9.9.3 Dispensing of IMPs

The pharmacy department must have a study-specific dispensing procedure for all trials. Labelling should comply with the requirements of the clinical trials directive and UK dispensed medicines and will include patient name and study number (if applicable), dosage instructions, treatment period, batch number, expiry date, investigator name and contact details, hospital address, study identifier and sponsor details.

5.9.9.4 IMP accountability

The pharmacy department must have study specific accountability documents for each trial, where applicable.

5.9.9.5 IMP Administration

Ward staff should be given reasonable notice of pending studies and provided with copies of all relevant documentation, including a protocol summary, information on IMP administration, study specific medication administration records, if applicable and any available information concerning possible adverse drug reactions. Ward staff must be informed of their responsibilities with respect to the confidentiality of study information.

5.9.9.6 Return of used and unused IMPs to pharmacy

These processes are under pharmacy control and governed by pharmacy Standard Operating Procedures (SOPs).

5.9.9.7 Disposal of IMPs

These processes are under pharmacy control and governed by pharmacy SOPs.

5.9.10 Treatment code breaking in blinded studies

- Emergency code break information must be accessible 24 hours a day.
- Codes must only be broken in accordance with the procedures contained in the protocol.
- Out of hours the contact with pharmacy will be via the oncall pharmacist.
- The mechanism for code breaking will be detailed in the Pharmacy Trials spreadsheet

5.10 UNLICENSED MEDICINES

Please refer to the Policy for the procurement and use of medicines without marketing authorisation and medicines used outside their marketing authorisation.

5.11 PRESCRIBING, DISPENSING AND ADMINISTRATION OF SACTs (Systemic anticancer Treatments) and Cytotoxics and monoclonal antibodies for none-cancer indications

This section outlines the requirements and responsibilities of staff who are involved in the prescribing, administration (by any route), supply, storage and disposal of all licensed and unlicensed SACTs, cytotoxics, SACTs and cytotoxics and monoclonal antibodies for none-cancer indications.

All staff working in areas involved in the prescribing, dispensing, administration and disposal of these medicines must be aware of the risks and hazards associated with their use and adhere to the principles set out in this section and the overarching principles set out in the Medicine Policy as a whole. Prescribers and practitioners who administer these medicines must be aware of both the immediate and long-term side effects of any SACT administered.

This section also applies to prescriptions generated by SFH for Homecare services. SFH does not provide any SACT for Paediatric patients.

5.11.1 Definitions relating to Section 5.11

SACT – Systemic Anti-Cancer Treatment refers to any medicine used as an anticancer agent. This can include chemotherapy, immune therapy and monoclonal antibodies.

Chemotherapy – the treatment of disease by a chemical substance, particularly the treatment of cancer with cytotoxic and other agents.

Cytotoxic – an agent that I toxic to cells

Cytostatic – an agent that inhibits cell growth.

Immunotherapy – a type of cancer treatment which helps the immune system fight cancer.

Monoclonal antibodies (mABs) – immune system proteins created into medicines that can be used for a variety of cancer and non-cancers indications.

Antibody – Drug conjugates (ACDs) – cytotoxic chemotherapy linked to a monoclonal antibody.

Immunomodulating drugs – drug which modify the response of the immune system.

Chemocare – an electronic chemotherapy prescribing, and patient management system hosted by NUH and used at SFH.

5.11.2 Prescribing

Prescribers must adhere to the principles of prescribing as detailed in Section 5.6 of the Medicines Policy.

All prescribing should be undertaken by appropriately trained staff as defined below:

Prescribers should follow any additional guidelines or procedures in place in their areas, including SACT prescriber training.

Intrathecal chemotherapy is no longer provided at SFH, and all patients will be referred to Nottingham University Hospitals if they require medication via this route.

Parenteral SACT and intravesical Cancer treatments

All parenteral SACT are prescribed on Chemocare ONLY, by haematology prescribers at SFT and oncology at NUH with prescribing access to Chemocare. **Intravesical** treatments for cancer e.g. intravesical mitomycin and BCG are prescribed on Chemocare ONLY, by urology prescribers at SFH and NUH.

Only prescribers who have received the required training of SACT prescribing within these teams have the required level of access to prescribe on Chemocare.

If required, any queries with regards to the authorisation of a particular prescriber can be verified by contacting the pharmacy cancer services team at NUH or haematology clinical lead at SFH directly or via senior pharmacist team at SFH ADU pharmacy.

These treatments are NEVER prescribed on any other system e.g. EPMA even when patients are admitted to the hospital.

Oral SACTs:

All Oral SACTs when initiated are prescribed on Chemocare ONLY, by haematology prescribers at SFT and oncology prescribers at NUH with prescribing access to Chemocare. Hydroxycarbamide is an exception and can be prescribed on paper outpatient forms or FP10s.

Only prescribers who have received the required level of SACT prescribing training within these teams have the required level of access to prescribe on Chemocare.

If required, any queries with regards to the authorisation of a particular prescriber can be verified by contacting the pharmacy cancer services team at NUH or haematology clinical lead at SFH directly or via senior pharmacist team at SFH ADU pharmacy.

No NEW cycle of ANY oral SACT can be prescribed by anyone other than the relevant haematology or oncology teams on any system other than Chemocare even when patients are admitted to the hospital (except for hydroxycarbamide as explained above which can always be prescribed on EPMA). If a patient is admitted to a ward, once the oral SACT is prescribed on Chemocare and patient assessed to be fit to receive it, the prescription can be transcribed on to EPMA by ST3 or above or an appropriate authorised none medical prescriber covering the ward.

For continuation of a "current" cycle of an oral SACT already prescribed on Chemocare, firstly the SACT medical history must be verified by the medical and pharmacist teams as part of their drug history process and by checking Chemocare. Once the decision has been made by the senior consultant in charge of the patient care on the ward for the treatment to continue, the oral SACT can then be transcribed on to EPMA by ST3 or above or an appropriately authorised nonmedical prescriber covering the ward. The consultant must consider contacting the relevant specialist teams for review of the patient if unsure about the appropriateness of continuation of the SACT. This is considered to be the best practice. The decision to continue the SACT and all relevant discussions must clearly be documented in the notes. (No supply of any SACT medicines for any cycle of ANY SACT can happen per EPMA. All supplies for any cycle occur only as per Chemocare)

Any Oral SACT and supportive meds transcribed from Chemocare on to EPMA and "still on EPMA at the time of discharge", must be correctly listed on TTO with appropriate explanations in the body of the discharge document. For information with regards to supply of these medicines see the following relevant section. There is no need to mention the details of any parenteral SACT on the TTO as they are documented and communicated to the patient via the haematology clinic letters and are never prescribed on EPMA.

Paediatric patients: Paediatric patients who are prescribed SACT will be admitted to NUH only or transferred at the earliest opportunity. Contact the specialist team prior to prescribing in all circumstances.
Chemotherapy of any sort will not be initiated in paediatrics at SFH, all patients will be referred to NUH.

Topical cytotoxics in ophthalmology: These drugs are prescribed by ophthalmology consultants and senior registrars on inpatient white charts. They are not prescribed on Chemocare**.**

Topical cytotoxics in dermatology: These drugs are initiated and prescribed ONLY by dermatology specialist consultants and doctors (ST3 or above (including clinical fellows) who have received special training. When patients are admitted on the ward, these medicines can be prescribed by ST3 or above or an appropriate authorised nonmedical prescriber

Cytotoxics and monoclonal antibodies for non-cancer indications

All cytotoxics and Mabs for non-cancer indications in adults and paediatrics are initiated (first cycle) and continued on designated CYTOTOXIC (purple), white inpatient charts, or most up-to-date pre-printed cytotoxic prescription charts (**never** Chemocare) by specialist consultants. In their absence specialty registrars and appropriately trained non-medical prescribers, can prescribe all cycles.

When patients are admitted to the hospital, they must be assessed by the senior consultant in charge of the patient care on the ward for the treatment to continue. The consultant must consider contacting the

relevant specialist teams for review of the patient if unsure about the appropriateness of continuation of the treatment. The decision to continue the treatment and all relevant discussions must clearly be documented in the notes. Once it is decided that treatment can continue, the medicines can then be transcribed on to EPMA by ST3 or above or an appropriate authorised non-medical prescriber covering the ward. Some Mabs with complicated infusion rate schedule e.g. rituximab cannot be transcribed on nerve centre (rituximab is almost always put on hold for rheumatology patients admitted to the hospital).

5.11.2.1 New therapy in an established indication

Examples include the initiation of a cytotoxic e.g. oral methotrexate for the treatment of Rheumatoid Arthritis by a specialist, IV cyclophosphamide for the treatment of SLE, topical or subconjunctival injections of 5-fluouroucail (5FU). Any medical prescriber of ST3 level or above, or an approved nonmedical prescriber, may prescribe new or continuation treatment of a cytotoxic medication where the cytotoxic drug is established therapy in their specialist area. Medical prescribers below this grade may prescribe new or continuation treatment of cytotoxic chemotherapy if permitted to do so in accordance with local procedures. No specialist list of authorised prescribers is kept.

5.11.2.2 New therapy for a novel / non-established indication.

All drugs for novel indications should be considered by the Joint Drug and Therapeutics and Medicines Optimisation Committee including those for 'one off' requests.

5.11.2.3 Continuation therapy in an established condition, including by non-specialists.

Examples may include patients admitted on established oral methotrexate or hydroxycarbamide treatment etc. for non-cancer indications. Any grade of medical staff, or a non-medical prescriber may prescribe oral cytotoxics for adult/paediatric patients as a continuation of a patient's treatment. Unless details of the dosing regime and protocol are available in the notes or a patient hand-held record, the prescriber must contact the supervising team to clarify the regime and protocol for that individual patient and the plan must be documented in the medical notes before it is prescribed.

5.11.2.4 Prescribing of Cytotoxics/ chemotherapy for Continuation on TTOs on Discharge.

Cancer indications:
Medical staff writing discharge prescriptions for patients who have been receiving Anti-Cancer Therapy for cancer indications which should continue at home should reference these on the TTO. Supply will NOT be made against this by Pharmacy as the patient will have received an appropriate course length already, but it serves as a complete description of the patient's discharge medication for the purposes of the discharging nurse and the GP. Pharmacy staff should ensure that the TTO clearly states that anticancer agents will be supplied only from the hospital.

Non-cancer indications:
Cytotoxics for non-cancer indications that are to be continued on discharge can be prescribed on the TTO and supplies made against this if the patient does not have their own supply.

5.11.2.5 Non-Medical and Supplementary Prescribers:

Non-medical prescribers are only permitted to prescribe cytotoxic medicines under independent prescribing provided they are competent to do so.
A register must be kept of approved doctors or approved nonmedical prescribers competent to prescribe oral and parenteral SACT and must be updated at each staff change.
A named practitioner within each specialty is responsible for keeping this register up to date.

5.11.3 Consent for SACTs, Cytotoxics and Monoclonal antibodies (Mabs) for non-cancer indications

Treatments must always be discussed with patients and their relatives/carers to avoid confusion and anxiety. Written informed consent must always be obtained before the initial treatment course for the relevant treatment protocol and filed in the medical notes. Information about treatment protocols must be available to patients and carers as well as information regarding the intent of treatment, anticipated side effects and how to contact the relevant department for advice.

All patients must be given verbal and written information about their treatment and possible side-effects. They must also be given a list of contact telephone numbers to call with any queries and if they are feeling unwell during a course of their treatment.

Patients will be issued with a Rapid Response Alert Card (for SACTs) or an arthritis immunosuppressive card for non-cancer indications as part of their initiation by the relevant prescribing team. The card should provide them with the list of symptoms to look out for and the contact number for whom they should contact.

Information for Primary Care:
The medical team will provide written information for the GPs of patients undergoing chemotherapy regarding side-effects and possible complications of treatment, such as neutropenic sepsis, extravasation, nausea and vomiting.

5.11.4 Timeliness of requests for products to be prepared in Pharmacy

The timely prescribing, authorisation and pharmacist screening (clinical verification) of SACT to be manufactured is critical to avoid patient delays and to ensure treatment is manufactured and prepared safely. Prescribing, authorisation and pharmacist screening of routine day case SACT should be completed no later than 4pm the working day prior to treatment administration. Clinically urgent and inpatient SACT (Monday to Friday) should be prescribed, authorised and screened by a pharmacist as soon as possible, ideally by 4pm the day before administration. If the final decision to prepare and administer chemotherapy depends on the results of patient investigations, pharmacy must still be informed in advance of the intention to treat. Failure to prescribe planned chemotherapy in advance may lead to treatment delays.

5.11.5 Pharmacist professional screen of SACTs (Systemic Anticancer Treatments) and cytotoxic and monoclonal antibodies (Mabs) for non cancer indications

Working within their sphere of competence, only pharmacists who have successfully completed separate required training and validations provided under the supervision of the senior ADU/ oncology pharmacist, can clinically screen oral and parenteral SACTs. This is in an addition to the general training and validation required for professional screen of ALL medicines in the Trust. The list of these pharmacists is kept locally in pharmacy ADU.

Pharmacists must refrain from professionally screening these prescriptions until they have passed their validations. Only pharmacists who have successfully completed their validations are given the appropriate access to prescriptions on Chemocare by the senior ADU pharmacist. Pharmacist must follow local procedures when screening prescriptions.

The professional screen of all cytotoxic and Mabs for non-cancer indications can be done by any pharmacist who has completed the general training and validation required for professional screen of ALL medicines in the Trust.

5.11.6 Dispensing, Handling, Preparation and Final check and release of SACTs (Systemic Anticancer Treatments) and cytotoxic and monoclonal antibodies (Mabs) for non-cancer indications

Parenteral products:

Preparation of parenteral products in this category follows local pharmacy SOPs and must be carried out in our dedicated aseptic dispensing unit (ADU) unless a risk assessment has been completed and agreed by the Joint DTC/MOC or regional guidelines have been issued approving their safety for preparation on the ward (ward preparation can only apply to Mabs used for cancer or non-cancer indications). Use of pre-made preparations when available must always be considered and encouraged.

No cytotoxic for topical, oral or other routes are prepared at SFH. In the absence of a licenced product or stock unavailability, the preparation of oral cytotoxic medicine in ADU can be considered after assessment and approval of the ADU senior pharmacist and lab manager if an injection can be given orally.

Bladder instillations such as mitomycin that are provided as a closed system may be prepared on the ward or clinic.

Oral products and prefilled syringes appropriate for self-administration:

The products are supplied via pharmacy in-patient dispensary in line with local dispensing procedures.

5.11.7 Transport of SACTs (Systemic Anticancer Treatments) and cytotoxic and monoclonal antibodies (Mabs) for non-cancer indications:

Reconstituted cytotoxics

Cytotoxics prepared by the pharmacy aseptic production units must be supplied in chemotherapy transport bags. Staff transporting these items must be aware of what they are carrying and of the cytotoxic spillage policy. The items must be signed out from pharmacy when collected.

Liquid oral or topical therapy (including eye and ENT preparations)

Cytotoxic liquids, and topical and subconjunctival eye preparations will be sealed in a bag by pharmacy staff. Staff transporting these items must be aware of what they are carrying and of the Pharmacy cytotoxic spillage policy.

Oral therapy (solid dosage form, i.e. tablets)

Oral cytotoxic tablets will be placed in a designated purple printed cytotoxic bag for delivery to wards.

5.11.8 Returning of SACTs (Systemic Anticancer Treatments) and cytotoxic and monoclonal antibodies (Mabs) for non -cancer indications

The transport requirements stated above also apply to returning unused chemotherapy back to the pharmacy department. Under no circumstances should cytotoxics be returned to pharmacy in ward tins, boxes or envopaks, or via the Pharmacy Returns Units on wards.

5.11.9 Administration of Cytotoxic Chemotherapy

The principles in Section 5.7 of the Medicines Policy apply to staff administering cytotoxic medication.

Staff responsibilities

The person in charge of the ward or department is responsible for ensuring that all staff involved in the handling of cytotoxic chemotherapy are aware of the relevant procedures and have completed the SACT training package. All staff involved with cytotoxics must familiarise themselves with these procedures and to make themselves aware of the hazards of exposure to cytotoxic medicines.

Spillage

Medical and nursing staff must familiarise themselves with the procedure for spillage of cytotoxics. A spillage kit must be readily available in any clinical areas where cytotoxic bladder instillations and parenteral or liquid preparations of cytotoxics are to be administered.
This poster summarises the main points: Cytotoxic spillage poster

A spillage kit is supplied to WTC to the required clinics and wards stated and as per ADU SP.05.07- Procedure for filling and issuing out of hours and spillage and extravasation kits from pharmacy ADU (local Pharmacy procedure, available on request).

Handling of waste and bodily fluids

Waste must be disposed of in designated bags & bins in accordance with the Waste Policy available here: Waste Policy. Bodily fluids and contaminated linen must be disposed of in accordance with relevant local policies and procedures.

Extravasation

Extravasation of cytotoxic medication is an emergency and must be treated immediately. All clinical areas where parenteral cytotoxic administration takes place must have appropriate extravasation kits and a copy of the current extravasation guideline.

Medical and nursing staff must familiarise themselves with the local policy and procedure, the use of the kits and the management of patients who have experienced extravasation of cytotoxic chemotherapy.

Administration of parenteral cytotoxics/ chemotherapy/SACT in designated areas:

Administration via a parenteral route must only occur in designated areas of the Trust, the Welcome Treatment Centre (WTC), which is used regularly for this purpose and equipped to deal with any emergency that may arise from this treatment (see local procedures). This includes the availability of extravasation kits, spillage kits, protective masks, aprons and gloves and appropriate cytotoxic waste disposal facilities.

In exceptional circumstances, i.e. only when it is not possible to transfer a patient to the Welcome Treatment Centre for medical reasons, parenteral chemotherapy may be administered to a patient at ward level.

In these instances, the following must occur:

- Consultant decision that chemotherapy cannot be delayed until patient can be transferred to the WTC
- Discussion and agreement between pharmacy, doctors and nurse in charge of non-designated ward.
- Administration of chemotherapy only by a nurse or doctor trained in administration of cytotoxics (requires liaison with the Welcome Treatment Centre team).
- Chemotherapy is stored on designated ward/ Pharmacy and taken to non-designated ward at time of administration only, by trained nurse or doctor.
- Cytotoxic bin, extravasation kit and cytotoxic spillage kit must be made available.
- Details of all the above must be documented in the patient notes with details of all the practitioners involved in the discussion e.g. oncology, haematology, production or senior pharmacist, doctor, nurse.

Subcutaneous methotrexate may be administered on any ward where this a continuation of their regular treatment and the patient/ carer are self-administering the medication. Access to a spillage kit and cytotoxic disposal bin should be made available before administration. If it is required for a nurse to give the dose, then all steps as above should be undertaken.

Authorisation of personnel to administer parenteral cytotoxics/ chemotherapy

Parenteral cytotoxics must be administered by a practitioner who has received the necessary training and been assessed as being competent in the procedure for administration of cytotoxics.

Any member of nursing staff who is unsure about any detail of the administration must not proceed but must seek help and advice from a more senior and/or experienced colleague.
Any ambiguity in the prescription must be discussed with the prescriber before administration takes place.

Normal working hours for administration.
Wherever possible all inpatient and outpatient parenteral SACT/ cytotoxics administered to patients will be within 'normal working hours'. These are defined as Monday to Friday 8am to 6pm i.e. when the usual complement of trained medical and nursing staff are on duty.

Intrathecal cytotoxic chemotherapy

Intrathecal administration of chemotherapy will no longer occur at SFH. Any patient requiring medication via this route must be refeed to NUH for this.

Oral cytotoxics and SACT must be checked by two practitioners who are aware of the hazards of administering oral cytotoxic preparations or self-administered by the patient in line with the self-administration policy. Any concerns over a prescription must be checked with the prescriber. If there are still concerns the nurses must check with a pharmacist before any oral cytotoxic medicines are administered. A patient's own medication must be checked for its suitability for use by a pharmacist or pharmacy technician before it is administered to that patient. There is no restriction on the areas in which oral cytotoxics and oral SACT can be administered.

Administration of bladder instillations

Administration must occur in designated areas of the Trust. Cytotoxic bladder instillations must be administered by a senior doctor or nurse who has been trained and assessed as competent in the procedure for administration. Administration should have a two-person check.

Other routes of administration

Eye subconjunctival and topical and laryngeal/pharyngeal topical cytotoxics may only be administered by eye/ ENT surgeons of ST3 and above who are competent in the procedure for administration of cytotoxic medicine by that route. The administration must be second checked by a competent registered practitioner. An exception to this is that a nurse assessed as competent can administer Mitomycin C eye drops to patients on a ward. The administration must be second checked by another registered competent practitioner.

5.11.10 Storage of Cytotoxic Chemotherapy in Clinical Areas

Some cytotoxics may be stored in the WTC if the expiry allows. However, some drugs deteriorate rapidly after reconstitution, and so must be used as soon as possible after receipt.

All preparations will have storage instructions on the pharmacy label.

Storage conditions must be checked on receipt onto the ward. It is the responsibility of the ward staff to ensure that the prepared cytotoxics are correctly stored and used in the correct order.

Parenteral cytotoxics for storage at room temperature must be locked in a designated cupboard.

Parenteral cytotoxics to be refrigerated must be locked in a designated cytotoxics drugs refrigerator, where the temperature is in the range of 2°C - 8°C. Refrigerated products should be warmed to room temperature before they are administered to the patient.
Oral and topical cytotoxics may be stored in the patient's medicine locker or in the normal medicines fridge if they need to be stored at 2°C – 8°C.

Oral liquid chemotherapy that requires refrigeration may be stored in the normal ward medicines fridge segregated from other medicines, if no separate designated cytotoxic fridge is available. Oral liquid chemotherapy that does not require refrigeration may be stored in the patient's bedside locker.

Out of Hours supply of injectable SACTs and cytotoxics and Mabs for none cancer indications From Pharmacy ADU

For detailed information with regards to pharmacy ADU working hours and cut-off for requests for work please contact the ADU via switchboard.

No injectable SACTs are currently supplied or administered out of hours at SFH. Pharmacy ADU only operates during normal working hours 8:30-17:15. Exceptions to this scenario are:

- WTC is running late during the week due to treatments taking longer than expected or patients becoming poorly during the treatment hence prolonging the administration time to late evening. (Supply has been made during normal hours)

- Mabs requested as urgent from on call pharmacist and by gastroenterology team for patients on ward 22 during weekend and Bank Holidays. Under these circumstances supply is only possible if a premade bag for the required dose is available in ADU. Any other scenario must be discussed with the ADU senior pharmacist if they are contactable for possible options to be considered and discussed.

- Some Subcutaneous SACTs can be considered necessary by the relevant haematology consultant for their patient on ward 24. The situation has to be discussed and assessed during the week between the haematology team, WTC nurses and ADU. This can only be considered if ADU can make the product during the week (expiry allowing) and two experienced chemotherapy nurses are happy to attend the ward during weekend for administration.

For all situations above medical staff must be available in case of queries by nursing staff and patient complications with side effects

Out of Hours supply of Oral SACTs and cytotoxics for non-cancer indications:

As per detailed information under 5.11, oral SACTs are only supplied according to Chemocare prescriptions never EPMA or outpatient prescriptions. Hydroxycarbamide is an exception and can be prescribed on paper outpatient forms or FP10s. These prescriptions are only produced by relevant specialists at the clinics which are usually open only during normal working hours. Pharmacy IPD should be able to clinically screen any oral SACT prescriptions and make a supply during its opening hours including late afternoons, weekends or Bank Holidays.

Cytotoxics for non-cancer indications can be prescribed on EPMA or outpatients prescriptions. Pharmacy IPD should be able to clinically screen any of these prescriptions and make a supply during its opening hours including late afternoons, weekends or BHs.

5.12 SELF ADMNISTRATION OF MEDICINES BY PATIENTS

The Trust wishes to actively encourage patients to self-administer their prescribed medicines whilst in our hospitals. This should only be undertaken on wards where staff have been trained for self-administration. A separate procedure governs the self-administration of medicines.

5.13 MEDICINES IN OPERATING THEATRES, RECOVERY, ENDOSCOPY AND X-RAY DEPARTMENTS.

5.13.1 Introduction

Practices involved in the prescribing and administration of medicines in operating theatres, recovery, X-Ray and endoscopy differ substantially from those followed on hospital wards.
The contents of other sections of the Medicines Policy still apply to these areas, subject to the special provisions detailed below.

Anaesthetists
All anaesthetists **must** be aware of the content of this theatre-specific section in addition to Trust-wide sections of the Medicines Policy. It includes differences in second checking and labelling of medicines during the anaesthetic.
Anaesthetists must document all medicines administered during the anaesthetic on the anaesthetic record and must adhere to CD requirements as outlined in this document and the SFH Controlled Drug policy.

Surgeons
Verbal instructions to prepare medicines are necessary in a theatre environment when the scrubbed surgeon cannot prescribe or handle non-sterile medicine containers intra-operatively.
The policy outlines the roles of theatre practitioners to support preparation and checking of medicines intra-operatively.
The surgeon **must** provide verbal confirmation of the same details expected in a written prescription. The surgeon **must** provide a second check of all medicines requested and **must** document their administration in the operation notes

5.13.2 Definitions

Doctor: The term ‘doctor’ is applied to any medically trained professional who may administer medicines. In this section, this is usually an anaesthetist or surgeon, but the term encompasses all doctors using the theatre facilities.

ODP: Operating Department Practitioner

SCP: Surgical Care practitioner

SFA: Surgical First Assistant

AA: Anaesthesia Associate

Registered practitioner - A registered ODP or Nurse

TAP: Theatre Assistant Practitioner

The **Divisional Director or Nursing** in collaboration with the **Chief Pharmacist**, is ultimately accountable for ensuring secure systems for the ordering, custody and availability of medicines (including Controlled Drugs (CDs)). The implementation of these systems may be delegated by the theatre department leaders or theatre coordinators to appropriately registered theatre practitioners on a day-to-day basis.

Theatres and Recovery staff have varying responsibilities for the management of medicines in theatre (including CDs) according to their professional registration and grade. The Matron for Surgery must ensure that each member of staff is aware of their responsibilities as part of the preceptorship process. There is a theatre specific medicine pack which must be completed by all new appointees who are to work in theatre.

Operating department practitioners (ODPs) must be registered with the Health and Care Professions Council (HCPC). ODPs will be included under the term 'registered practitioner' throughout this procedure.

A registered ODP may be given the same responsibilities as a registered nurse regarding the management of medicines in theatre.

A registered ODP who has received the appropriate training and assessment may undertake an expanded role in medicine administration.

Surgical Care practitioners (SCP)/Surgical First Assistants (SFA) are registered non-medical healthcare professionals who have extended the scope of their practice by completing an accredited training programme. They work as members of the surgical team and perform surgical interventions and pre-operative and post-operative care under the supervision of a senior surgeon. Medicines cannot be administered unless specifically prescribed by an authorised prescriber on an approved prescription.

Anaesthesia Associates (AA) are practitioners trained to care for patients undergoing anaesthesia under the supervision of a Consultant Anaesthetist. They have a Postgraduate Diploma in Anaesthetic Practice and are voluntarily registered with the Royal College of Anaesthetists.

They administer medication under the Local Agreement for the Patient Specific Direction for the Administration of Medicines by a named Anaesthesia Associate (AA)
The supervising consultant anaesthetist must prescribe medication for each patient using the locally developed Patient Specific Directions that allow AAs to check and administer drugs within appropriate limits. Patient Specific Direction for the Administration of Medicines by a named Anaesthesia Associate

(AA) is on the authority of a named Consultant Anaesthetist. The formulary outlining the drugs, doses, routes and indications that the AA can administer is listed in the Local Agreement.

All drugs administered to a patient by an AA will be recorded by the AA on the anaesthetic chart and countersigned by the supervising consultant.

Theatre Assistant Practitioner (TAP) are non-registered theatre staff who have been trained to handle or prepare medicines, may do so under the direct supervision of the registered practitioner. The registered practitioner retains responsibility for second checking medicines with the doctor prior to entering the sterile field and administration.

5.13.3 Prescribing and administration of medicines

Responsibility for preparing and administering medicines in theatre by Anaesthetists

The anaesthetist who is responsible for the conduct of an anaesthetic, is responsible for the preparation and administration of all medicines that they administer (by any route) during the course of that anaesthetic. The anaesthetist is also responsible for the preparation and administration of medicines by a supernumerary anaesthetist, AA, theatre practitioner or medical student within their sight and under their direct supervision.

All doctors remain responsible for the drugs that they prepare and administer. Trainees are actively encouraged to check drug preparation with their supervisor should there be unfamiliarity or any similar concern.

It is recognised that it is impractical for anaesthetists to have a formal two-person check for each individual administration of medicines (by whatever route) during the course of an anaesthetic.

However, a two-person check should be considered under the following circumstances:

- When dilution regularly occurs (e.g. paediatrics)
- When there is a critical or unusual dilution of drugs
- When the anaesthetist is unfamiliar with the medicine.

Ultimately, administration of any drug remains the anaesthetist's responsibility.

Preparation of medicines in theatres by anaesthetists

If possible, all medicines should be drawn up, prepared, and labelled in an environment where disturbance of the anaesthetist is unlikely to occur.
Sharing of any medicine vials between patients is not permitted at SFH as this will compound any potential drug errors; refer to use of single dose and multiple dose vials policy, see Section 5.7.9

The following principles apply:

i. Following medicine preparation, the attending anaesthetist must ensure that all syringes are labelled and placed on a clean tray.

ii. Syringes containing medicine which has been administered to a patient should follow the patient as they are moved around the hospital, e.g. anaesthetic room to theatre, ED to CT scan. Emergency medicines should only move to the operating theatre if they have been administered to a patient in the anaesthetic room, or if they are subsequently required during surgery.

iii. Any medicine drawn up in advance e.g. immediately before the patient's arrival, must be labelled and placed on a clean tray, although this practice is discouraged.

iv. Medicine preparation in advance for several patients on an operating list must be avoided.

v. Upon receipt of any CD, the attending anaesthetist must ensure that it remains under their supervision at all times. In the event that this is not possible, the CD must be securely stored pending its administration or safe disposal. In practice, any drawn-up CD that is unsupervised should be labelled and locked in the CD cupboard in the anaesthetic room.

vi. Each vial or bottle of medicine is for single patient use only. Drawing up of medicines from a single vial/bottle for more than one patient is not permitted, as this practice could result in repeated errors. Sodium chloride bags (using bag spikes) can be used to make up syringe drivers multiple times for the same patient but must not be used for multiple patients, a new bag would be required.

vii. Any emergency medicines drawn up can be kept for the duration of the list, observing aseptic techniques and storage. These prepared medicines must be labelled, signed and dated, and discarded at the end of the list.

viii. Any used syringes containing medicine will be disposed of during the clean sweep, after the patient leaves the operating theatre.

Security of anaesthetist-prepared medicines in theatres

A medicine should not be used when the identity of who has drawn it up cannot be established, this is done verbally, or if the medicine has not been held (prepared and labelled) under the direct supervision of the attending anaesthetist, as sterility, tampering and batch origin cannot be guaranteed.

At all times, anaesthetists need to ensure that they know what medicines are contained within each drawn up syringe, and this can only be established if these medicines are kept under direct supervision or stored securely, even if prepared for a pending theatre case. All syringes will be labelled with the product it contains.

Administering and recording medicines administration by the anaesthetist

The practice of retaining opened ampoules to keep them for inspection (in a controlled and safe manner, away from medicines in current use) until the end of the anaesthetic can be recommended. This practice provides an additional opportunity to confirm which medicines have been prepared and administered. This can help in the follow-up of medicine-related incidents, e.g. anaphylaxis. Disposal of open ampoules should occur at the end of each case after confirmation with the attending anaesthetist, unless they are required for inspection.
In order to minimise adverse events from residual IV agents, all lines and cannulas must be flushed with 0.9% sodium chloride before the patient leaves theatre, as per the WHO Time Out.

The attending anaesthetist/AA must ensure that all medicines given during the course of an anaesthetic are recorded on the anaesthetic chart and on EPMA where applicable as described below.

Any medicines that may be continued into the post-operative period or have been given in theatre which affects the subsequent dose of the same (or another) medicine must be documented on the electronic prescribing system where available or on a paper chart if this is not available. This may include (but is not limited to) agents such as paracetamol, anticoagulants, antibiotics, antiemetics.

Roles of registered and non-registered theatre practitioners in assembling and preparing medicines for administration

The surgeon's preference sheet may be used as a prompt to assemble routine medicines which are likely to be required during a case. However, the preparation (including decanting, dilution, mixing, connecting with sets/ pumps) should be supplemented with a verbal order from the doctor to ensure the formulation is appropriate for the individual patient. The verbal order will be agreed prior to the list commencing at the Team Brief in collaboration with the surgeon and the anaesthetist.

TAPs and non-registered theatre staff who have been trained to handle or prepare medicines, may do so under the direct supervision of the registered practitioner. The registered practitioner retains responsibility for second checking medicines with the doctor prior to administration.

Delegated administration of medicines to an appropriate registered practitioner

A doctor using the operating theatre facilities, is responsible for ensuring the appropriateness of any medicine (including the dose/concentration/route) given by themselves or at their request.

In extreme circumstances they may delegate the administration of medicines to a registered practitioner by means of a written prescription or verbal instruction.

Any registered practitioner administering a medicine under this type of direction is responsible for ensuring that the medicine is administered in the correct manner, especially confirming patients' possible allergies with the theatre team before administration to an unconscious patient.

Where a verbal instruction is given to administer, the registered practitioner must repeat the verbal order back to the doctor to confirm the correct drug, dose, concentration/ dilution and route, and ask the doctor to second check.

In these situations, the usual rules for training and second checking apply.

Infiltration and irrigation are considered to need a second check, similar to intravenous medication, in this case it may be the scrub practitioner and the circulator who make this additional check.

For all medicines administered by all theatre staff groups, confirmation in writing must be made as soon as possible by the doctor either in the surgical notes or anaesthetic chart; irrigation administration should be documented in the Perioperative Care Pathway.

Responsibility for preparing and administering opioids in Recovery

Patients are frequently prescribed opioids in the form of boluses or aliquots for post-operative pain relief in Recovery.

Two practitioners are required for the initial preparation and positive patient identification checks. Two practitioners are required for the disposal, denaturing and documentation of the syringe in line with the guideline/ SOP.

Where dose titration is used and multiple aliquots given, these may be administered by a single practitioner.

5.13.4 Issue and supply of medicines (other than Controlled drugs) in theatres, recovery, endoscopy and X-Ray

Ordering of medicines

Pharmacy staff provide a regular top-up service for all stock medicines against agreed stock levels in the approved areas on the stock location agreement signed by the Stores Manager and the Department Lead. Further emergency supplies can be obtained from pharmacy by ringing the department on extension 6848. Any medication stored outside this authorised location are the responsibility of the theatre staff and there must be a system for routine stock topping up and expiry date checking.

Transport and receipt

Orders will be sent to theatres in sealed containers. These medicines must be put away securely in a timely fashion to prevent any unauthorised access to them. (Refer to local procedures).

5.13.5 Security of Medicines in theatres and recovery

Security of Medicines in theatres

i. The medicine cabinets in the anaesthetic room should only be unlocked when there is a registered practitioner in attendance for a theatre list. The cupboards should be locked at the end of the theatre session and during breaks in the list.
ii. Part-used ampoules and syringes must be disposed of correctly at the end of each case as part of the clean sweep.

Below exceptions apply due to accessibility requirements:

- Emergency theatres- Medicines (with the exception of CDs) must be accessible at all times unless there is a planned break in operating where no practitioner will be directly supervising the theatre. At these times the medicines must be put away in a locked cupboard or fridge and local arrangements exist to ensure the emergency theatre key-holder is contactable at all times.

- Sherwood Birthing Unit (SBU) Anaesthetic Room Fridge and SBU TH2 fridge are to remain unlocked at all times to allow access to the emergency intubation boxes.

- Surgeon-only list, e.g. LA cases, injection lists – the local anaesthetic cupboard may remain unlocked for the duration of the list if required. The main anaesthetic medicine cupboard should only be unlocked on a case-by-case basis in the event that the attending surgeon requests medicines contained within it, e.g. cortico-steroid, contrast media. Otherwise, the main anaesthetic drug cupboard should remain locked. In the event of an emergency, e.g. LA toxicity, cardiac arrest, emergency drug boxes should be used in the first instance.

- Using theatre as a recovery area – the CD register should be checked before handover of the CD cabinet keys from the attending ODP/ anaesthetic nurse to the attending recovery nurse/ODP. The keys to the anaesthetic cupboard should also be handed over to the attending recovery nurse/ODP at this time. The anaesthetic cupboard should remain locked, and only accessed by the attending recovery nurse/ODP on an ‘as required’ basis. Usual standards of practice in recovery are expected with respect to access of controlled-drugs stored in the anaesthetic controlled-drugs cabinet.

- Warming cabinets - do not need to be locked. Write on the fluid bag or bottle the date when the item was placed in the cabinet. This should be checked when removing to ensure it is within the altered expiry for that product following warming. The Pharmacy Medicines Information department maintain an updated document outlining any expiry modifications needed for agreed warmed fluids, this will be displayed by the fluid warmer.

Security of medicines in recovery areas

All medicines must be stored securely in locked cupboards. When recovery is in use, a tray of emergency drugs may be kept outside the cupboard providing a registered practitioner is present.

5.13.6 Disposal of unused medicines

Any medicines that are opened but not required must be disposed of according to Trust policy. All blue topped medicines bins in theatres should have absorbent pads in the bottom. They will be supplied with this from the provider. It is the responsibility of the doctor or registered practitioner administering the medicines to ensure that waste medicines, ampoules, needles and syringes are disposed of safely and appropriately. Particular attention should be given to removing the remainder of any infusions from syringe drivers into blue-lidded bins.

If a CD liquid is to be disposed of in a volume over 10mL then refer to the CD Policy and associated SOPs for more information. An CD denaturing kit may be required.
CD Policy and Associated SOPs

5.13.7 Management of controlled drugs in theatres and recovery

Refer to the CD Policy and Associated SOPs via the link above.

5.13.8 Transfer of patients with infusions from the theatre suite

If a patient is transferred from theatres to another clinical area with any medicine(s) by infusion (including infusions of controlled drugs), the syringe/infusion must be clearly labelled with the name of the medicine(s) and strength/concentration thereof. The patient must also have a prescription written for the ongoing treatment.

The volume of any infusion containing a controlled drug must be checked and documented by two practitioners on handover to the receiving ward.

5.13.9 Key Security

The Matron for Surgery must ensure that every registered practitioner who is an authorised key holder has submitted a sample signature, that this list is current, and that practitioners who no longer work in SFH Theatres/Recovery have this authorisation removed from the list.

Theatres

Registered practitioners must follow the local theatre procedure entitled 'formal handover and safe storage of main theatre house keys. This includes management of CD keys.
Each operating theatre has its own set of keys which provide access to medicines and controlled drugs. This set of keys must not be divided.

Recovery

Keys for both Main Theatre Recovery and Day Case Theatre Recovery should be signed out on the daily key log when removing from the Key safe in the Theatre Coordinators office and signed back in when the keys are returned at the end of a session.

Radiology keys are signed in and out from pharmacy at the start and end of the shift.

Endoscopy keys are locked in an access controlled key cupboard behind two access-controlled doors.

5.14 MEDICINE DEFECT REPORTING including adverse drug reactions.

5.14.1 Defective medicines

All suspected medicine defects should be reported to the stores department by ringing extension 8484 during normal office hours. The defective medicine should be removed from circulation, labelled as defective and sent to the pharmacy stores team for processing. This can be done via any of the pharmacy team. Do not put defective medicines into the Pharmacy Returns Bin.

If in doubt, report the suspected defect. The following action should be taken in all cases:

- If a patient is involved still receiving the suspected medicine, its use must be immediately discontinued.

- The Consultant's team in charge of the patient should be notified at once. It is the responsibility of the team to inform the patient or carer about the suspected reaction.

- If further medication is required, this should be taken from a different batch. If an intravenous infusion has been set up, both the administration set and the infusion fluid should be replaced from a different batch.

- The defective medicine and any equipment involved in administration should be labelled clearly, isolated and retained for safekeeping. The Pharmacy Department will need to know the name of the product (including strength and presentation), batch number, expiry date, manufacturer, product licence number and full details of the suspected defect. If possible, the affected item should be sent to the pharmacy department.

The following are examples of possible medicine defects:

- Particulate matter or growth in IV fluids,
- Cracks in IV bottles or ampoules,
- Labelling and packaging defects, i.e. label or container which does not correspond with the outer wrap,
- Unusual appearance or odour,
- Unexplained Clinical reaction (e.g. pyrexia).

Anomalous clinical responses, which are unlikely to have been caused by a defective medicinal product, should be reported by using the yellow cards provided by the Medicines and Healthcare Products Regulatory Agency (MHRA) for monitoring adverse drug reactions. In some cases, it may be necessary to report the incident both as a suspected defect in a medicinal product and as a suspected adverse drug reaction.

5.14.2 Adverse Drug Reactions (ADRs)

Suspected ADRs and certain medicine defects should be reported on the MHRA yellow card system. This can be found via this link:
Yellow Card Reporting

All reactions relating to 'black triangle' or new medicines should be reported along with series adverse reactions noted in other medicine groups.

The yellow card site has information on all reactions and defects which should be reported.

5.15 OUTPATIENTS

This section contains specific exceptions for how medicines are used within outpatient areas.

5.15.1 Key holding

At bases where a number of designated practitioners may require access to the medicine cupboards a digilock key cupboard may be used to hold the keys in a secured clean utility room. In the event of CDs within the KTC please refer to the CD Policy for further information. This has been risk assessed specifically for the outpatient environment and is not recommended practice in other areas of the Trust. The number and nature of medication stored in the outpatient clinics is low in risk and quantity.

No CDs are routinely to be stocked in Outpatients and will be ordered on the day in the rare occasions that they are needed. CDs are not to be stored in Outpatients overnight.

5.15.2 Control of paper prescriptions

The Trust will maintain clear records on FP10 prescription stationery stock received and distributed, both when prescriptions are received into the Trust and distributed on to authorised prescribers. It is the responsibility of the prescriber and the clinic staff to ensure the safe and secure handling of FP10 prescription forms are maintained at all times.

A separate policy outlines the safe use of FP10 prescriptions and can be found on the Trust intranet or by following this link: FP10 Policy

5.15.3 Administration of specific eye drops

Healthcare Assistants in Ophthalmology Outpatients and on Minster ward, can administer a limited range of prescribed eye drops within an agreed protocol.

5.15.4 Resuscitation

It is the responsibility of staff in departments where the trolleys are located, to ensure, on a daily basis, that these remain sealed and in date and that arrangements are made for the replacement of trolleys after use or in the event of breakage of the seal.

5.16 ERRORS IN PRESCRIBING, ADMINISTRATION AND DISPENISNG OF MEDICINES

The reporting and investigation of medication related incidents will be dealt with in line with the Trust Incident reporting policy which is available via this link: Trust's Incident reporting Policy and Procedures.

The Medicines Safety Group will maintain an overview of all medicine related incidents. This is a multidisciplinary group, Chaired by the Medication Safety Officer. The group will provide regular updates to the Joint DTC/MOC and Patient Safety Committee.

5.17 MIDWIVES

5.17.1 Introduction

Midwives may in the course of their professional practice supply and administer substances specified in medicines legislation under midwives' exemptions. This includes all medicinal products on the general sale list and pharmacy (P) medicines providing they are used within the course of their professional practice. In addition to this, midwives practising within the Trust may supply and administer medicines on the Trust's agreed list. This list can be found in Appendix 4.

Registered Midwives may also supply and administer on their own initiative, substances that are specified under medicines legislation under midwives' exemptions providing this is within the course of their professional practice. This can be done without the need for a prescription or a patient group directive (PGD). A list of the current medications covered under the current exemption can be found in Annexe A of the Nursing and Midwifery Council guidance entitled 'Practicing as a Midwife in the UK'

A hard copy of this list may be displayed in the Maternity Unit but must be reviewed annually to ensure it is up to date and in line with national guidance.

Midwives can dispense pre-packed medicines from the maternity ward, providing they are medicines that they are entitled to supply. A record of this should be made on the electronic maternity care pathway and supply must be in line with the current Trusts guidance entitled 'Procedure for the dispensing of pre-packed medication by nursing and midwifery staff (Obstetrics and Gynaecology).'

Midwives will make records of medicines administered under exemption on the medicine chart, electronic or paper, when in hospital.

In the home, Midwives should make a record of any medication administration within the maternity records on BadgerNet. BadgerNet is an online portal allowing maternity notes to be visible to all healthcare professionals and patients. It is a live system, and all notes will be made on these records when visiting a patient outside the hospital. When the patient is in hospital, the medical notes will be used to document.

Student Midwives can administer medicines on the midwife's exemption list, except controlled drugs, under the direct supervision of a midwife. The Medicines and Healthcare products Regulatory Authority (MHRA) requires that the midwife supervising the administration of medicines by a student midwife must have undertaken an approved mentorship programme and be a practice supervisor.

Midwives must ensure their practice is evidence based and be familiar with current BNF guidance for any medicine they are supplying or administering.

A Registered Midwife may, in emergency situations or during an imminent birth, administer parenteral medicines that are under midwives' exemption without a 2nd registered practitioner check. It is the Midwife's responsibility to check the medicine prior to administration. In hospital it is advisable to have

a 2nd practitioner check wherever possible. If this is required in an emergency situation then administration may be signed retrospectively on the electronic prescribing system.

The community midwives are employed by the trust and so work within the trust guidelines and policies.

5.17.2 Community Midwives

The Midwifery Management Team, the Senior Leadership team and Chief Pharmacist should decide a list of medicines and stock levels, which may be carried by Community Midwives. Whenever new medicines permitted in law are notified by the Midwifery Committee of the NMC there will be further consultation before these are added to the list.

The current list for Community Midwives is as follows:

- Entonox
- Oxytocin
- Ergometrine
- Vitamin K
- Lignocaine

Any additions to this list can only be done after consultation as described above.

Nicotine replacement therapies may be supplied and recorded on BadgerNet within the community setting and the electronic prescribing system for in patients.

These are GSL products and are not required to be labelled with patient-specific directions.

5.18 MEDICINES RECONCILIATION

The aim of medicines reconciliation is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission, unless the multi-disciplinary team deems them to be clinically inappropriate.

5.18.1 Responsibilities for medicine reconciliation

It is the responsibility of the admitting doctor to ensure that complete and accurate information regarding the patient's usual medicines is collected and documented. Any omissions should be communicated to the pharmacist or MMT, and the medical team responsible for that patient's ongoing care, so that they can be followed up. All elective patients who have their drug history documented in pre-admission clinic must have the drug history rechecked by the admitting doctor to ensure that there have been no recent changes in medication.

All changes to medicines should be clearly documented in the patient's medical record and communicated to the GP on discharge. It is the responsibility of the medical team caring for a patient to check the discharge prescription against the documented drug history for that admission and inform the GP of all changes in medication with the reasons for those changes.

It is the responsibility of the pharmacist or MMT to ensure that the hospital prescription is checked against the appropriate resources including the patient, primary care records and acute trust correspondence such as clinic letters and that any discrepancies are deliberate and clearly documented in the patient's medical record. This should ideally take place within 24 hours of admission in accordance with the Department of Health's Medicines Management framework.

5.18.2 Reconciling medication

An accurate account of a patient's medication history is essential on admission to hospital for a number of reasons:

- To allow medicines to continue during the patient's stay in hospital
- To identify drug related adverse effects which may or may not have contributed to admission
- To ensure appropriate monitoring is carried out
- To ensure medicine interactions which could lead to harm are avoided
- To allow medication review and ensure the patient is receiving optimum treatment for their condition(s)
- To support the patient in taking their medicines reliably and effectively and educate the patient on how to get the most out of their medication

This process of medicines reconciliation should take place within 24 hours of admission wherever possible.

All patients should have their allergy status documented on the front of their medicine/ EPMA chart and in the medical record. If the patient has no medication allergies, then the box labelled 'No Known Drug Allergy' should be ticked. For all known allergies, the medication and reaction (if known) should be recorded. All allergy information should be signed and dated and endorsed with the source of the information.

If the patient has a history of any serious adverse drug reaction (ADRs) it is helpful to document these also even though they are not true allergies. The medicine/ EPMA chart should be endorsed 'Adverse Drug Reaction' followed by the medicine or group of medicines and then the reaction. The information should be signed and dated, and the source of the information recorded.

Confirmation of a patient's current medication may be obtained from a number of sources. Ideally at least two information sources should be used to increase the likelihood that the information obtained is complete and accurate. Where appropriate, one of these sources should be the patient or their carer as information regarding how the patient actually takes their medication is essential.

Possible information sources are listed in Appendix 5 with advantages and disadvantages of each.

Information should be obtained about all medication that the patient is currently taking on a regular and as required basis. This should include:

- Oral medication
- Inhalers/Nebules
- Eye drops/ointment
- Injections e.g. insulin
- Weekly, monthly or 3 monthly medications e.g. bisphosphonates, hydroxocobalamin, depot antipsychotics, including the date the medicine was last taken/given
- Topical preparations e.g. creams/ointments including area of application
- Sprays e.g. glyceryl trinitrate (GTN) spray, nasal sprays
- Patches
- Contraception or hormone replacement therapy (HRT)
- Herbal products, vitamins and supplements
- Over the counter products
- As required medication – clarify how often the patient normally takes it
- Oxygen

As a minimum the medicine name, form, strength, dose and frequency should be confirmed for each medication taken. It may be appropriate to ascertain the indication and date started for certain medicines particularly if there is concern about adverse effects.

If the patient is on oxygen the following should be clarified: what type of oxygen e.g. short bursts, long term, ambulatory, whether cylinders or concentrator and what the flow rate and duration is.

A complete list of the patient's current medication should be recorded on the 'arrival' tab of the electronic prescribing system or in the clerking notes for those areas where electronic prescribing is not yet available. The admitting doctor will usually do this but in some areas such as pre-op or ED, this task may be delegated to a nurse. The doctor or nurse should also record the source of such information and the date that the information was obtained along with their signature. This prevents duplication.

If any medication is altered on admission this must be clearly documented in the medical notes and on the mandated EPMA box with the reason for such changes, to ensure that this information is communicated to the GP when the patient is discharged from hospital.

Any discrepancies should be clearly documented in the medical notes with a date and signature. The source of such information should also be documented. Where appropriate this documentation should request a review by the medical team listing the discrepancies requiring action. Any significant errors or omissions that could lead to patient harm, should be discussed directly with the doctor looking after the patient. The pharmacist or MMT should record on the EPMA system that they have confirmed the medication history.

When the TTO is written the doctor responsible for the patient's care should compare the documented drug history with the current medication prescribed and ensure that all changes are communicated to the GP along with reasons for those changes, and any monitoring required. The pre-populated TTO changes box is insufficient as this is usually highly inaccurate.

5.19 MEETING AND DEALING WITH SUPPLIER REPRESENTATIVES - medicinal and wound care products

Supplier representatives are active throughout the Trust promoting both pharmaceutical and wound management products to a range of medical, nursing, pharmacy and allied health care professionals.

This section supplements detailed guidance given in the 'Code of Practice for the Pharmaceutical Industry', published annually in the Association of the British Pharmaceutical Industry (ABPI) Medicines Compendium. The ABPI Code relates to pharmaceutical products, but its principles should also be enforced locally to manage the activities of representatives.
The code should be referred to directly for detailed information on appropriate interactions and behavior.
ABPI 2024 Code of Practice

Supplier representatives are expected to fully comply with the ABPI Code of Practice, AND with the local regulations indicated below (even if they represent non-ABPI member companies).

5.19.1 Appointments

If an appointment is required with a member of the Pharmacy team, an enquiry should be made via the pharmacy admin team.

Supplier representatives must ONLY be seen by hospital staff (i.e. doctors, nurses and allied health care professionals) after making a prior appointment, at which time the subject(s) for discussion must be identified. Drop in visits are not allowed.

Supplier representatives must not promote products to hospital staff, unless explicit prior arrangements have been made with the individuals concerned.

5.19.2 Formulary

Only those medicines that are listed in the Joint Formulary are routinely available for prescribing.

Requests for products not included in the Joint Formulary (including new chemical entities) can only be made by a consultant, this can be a Consultant Physician, Nurse, Pharmacist or AHP. If the product is to be used by GPs as well as hospital physicians, then the request for the product must be submitted to the Area Prescribing Committee. If the product is for use in hospital only then the application must be made via the Joint Drug and Therapeutics and Medicine Optimisation Committee. In both instances contact the Medicines Information team for support. Such applications do not infer automatic inclusion in the Formulary.

Such restriction will also apply to wound management products.

5.19.3 Samples

NO samples of products (including wound management products) are to be offered or supplied to any hospital staff on any ward or department.

Samples will only be accepted by pharmacy after the assessment of potential costs (after use of any samples) and an application made by a Consultant through the Joint DTC/MOC. Any subsequent use will be strictly controlled and monitored by pharmacy and does not infer automatic inclusion in the Formulary.

Non-pharmaceutical samples must be deposited with the Supplies or Medical Equipment Management Department. Non-medicines may only be accepted with specific approval of the Supplies department to ensure liability cover.

5.19.4 Gifts or Inducements

Gifts in the form of promotional aids (whether related to a particular product or of general utility) may be distributed to hospital staff provided that the gift is inexpensive for example pens, post-its and miscellaneous stationary.

Gifts for personal benefit or of significant monetary value must not be accepted and are prohibited under the ABPI code of practice.

5.19.5 Hospitality

Hospitality offered to hospital staff for the purpose of product sales promotion must be secondary to the main purpose of the meeting.

The level of hospitality offered must be appropriate and not out of proportion to the occasion. Its cost should not exceed the level that the recipients would normally adopt when paying for themselves.

Medical and group educational meetings are desirable and are to be encouraged. Both the BMA and the ABPI consider that such meetings should only occur if the advertising content is supported by a clear educational content relevant to the target audience.

Hospitality that becomes little more than pure entertainment has limited value in terms of the provision of information and promotion. Such hospitality can, therefore, only be regarded as irrelevant and wasteful, and should be discouraged.

5.20 THE PREPARATION AND ADMINISTRATION OF INTRAVENOUS BOLUS MEDICINES AND INFUSIONS.

5.20.1 Introduction

The use of injectable medications is essential in the care of many patients but the use of this type of medication is not without risk at all stages of the process. There are complexities around prescribing, preparation and administration which mean that use of medication via the injectable route carries a greater potential risk to patients than other routes of administration. It is important to have safe and rigorous operating systems and processes to ensure the risks of this route of delivery are minimised.

Medications administered via the intrathecal route are no longer administered at SFH and therefore are not covered in this Policy.

In order to minimise the risks of injectable medicines it is important that these risks fully understood so that staff are able to mitigate these more effectively.

The main risks with injectable treatments are as follows:

i. An incomplete prescription which does not contain all of the information that defines how the medicine is to be injected or infused such as details of the reconstitution and dilution instructions, final volume of the product, final concentration and intended rate of administration, can lead to inaccuracies in the preparation and administration of the medication resulting in patient harm.
ii. Calculations can be complex due to the dilutions, and manipulations required to get the final required dose. Calculation errors lead to the wrong dose or concentration being administered or the right dose at the wrong rate which can cause significant patient harm.
iii. Appropriate resources are required, and these must be readily available to staff
iv. Increased risk if the medication, diluent or infusion bag are used when past their expiry date.
v. Poor aseptic procedures will increase the risk of infection for the patient
vi. Complexities around diluent and infusion compatibility, increase the risk especially if multiple infusions are required.

These risks are mitigated by:

1) Provision of guidance on the preparation of injectable medicines via the Medusa guide, including risk scores and appropriate diluents and concentration ranges,
2) Provision of a catalogue of products available ready to administer from the pharmacy department, either made in the pharmacy Aseptic Dispensing Unit or sourced from commercial aseptic providers.
3) Provision of training for staff required to make injectable products in clinical areas.

All clinical areas will have access to technical information to assist in the prescription, preparation and administration of injectable medications which includes:

- ADU medicine catalogue

- BNF (and BNFc for paediatric departments) which will be available in hard copy and also online: BNF British National Formulary - NICE
- Summary of Product Characteristics which is supplied in the original container for all products and is also available online: Home - electronic medicines compendium (emc)
- Medusa which is available via the embedded link in the electronic prescribing system or via the intrant (log on required this way): Medusa log in page
- Medicines Information extension 3163 during normal office hours Monday – Friday
- Oncall Pharmacist out of hours via switchboard.
- Formulary intranet pages for individual medications may also contain information.

The following information sets the expected standards for all stages of prescribing, preparation and administration for injectable medications.

5.20.2 Prescribing

Medications must only be given by injection when all other routes have been excluded. The use of this route should be regularly reviewed in favour of switching to oral administration as soon as possible.

It is the responsibility of the prescriber to ensure that the medications to be prescribed are appropriate for the intended route and the vehicle for administration is chosen taking into account stability and compatibility of the products.

It is the prescriber's responsibility to ensure that the patient has appropriate intravenous access where required.

All prescribing standards are applicable as described in Section 10 above.

Prescriptions for injections or infusions must be legal, legible and signed and include the following information:

- Medication name
- Dose
- Frequency
- Route of administration
- Review date for treatment

Where dilution is required for administration by infusion, the prescription should also state:

- The name and volume of the diluent to be used
- The concentration of the final infusion
- Rate of administration
- Duration of the infusion

Any flushes which will be required before or after the injection must also be prescribed.

It is essential that if an additional chart is used that it is cross referenced on the main paper prescription or electronic prescription.

5.20.3 Supply and storage

Where available ready to administer preparations should be used. A ready to administer product is one supplied in a format that does not require further manipulation prior to administration. Risks assessment of all high risk injectables is conducted and frequently revisited to assess if safer products have become available. If a product is required, please discuss with the pharmacy team.

An up-to-date risk assessment for all injectable medication can be found on individual monographs on the internet based injectable medicines guide, Medusa. Access to this guide can be via the internet home page via this link (requires a password) Medusa log in page, or via the embedded electronic prescribing system link. Products with high-risk scores are added to the ADU catalogue and should be available as ready to administer preparations, capacity permitting.

Certain injectable products are not suitable for preparation in clinical areas due to level of manipulation required or the risk to individuals in their preparation. These include parenteral nutrition infusions and cytotoxic medications. Further information on this may be obtained from the Aseptic Dispensing Unit.

Multiple use of unpreserved injectable medicines should be eliminated. Most injectable products do not contain a preservative and are licensed for 'once only' administration to a single patient. Unless the manufacturer's label specifically indicates that the injection contains a preservative, the container should only be used for a single dose for a single patient. Any deviation from this should be risk assessed and logged on the department risk register. Approval for this deviation must be gained from the Drugs and Therapeutics / Medicines Optimisation Committee prior to administration.

Epidural solutions should be stored separately from those intended for intravenous use.

High strength opioids should be stored in the red bag provided by the Pharmacy department.

The risk assessment of products includes the following elements:

1. Does the product carry a therapeutic risk to the patient?
2. Does the preparation include the manipulation of a concentrated product?
3. Is there a complex calculation involved in the process?
4. Does the preparation process involved the reconstitution of a vial?
5. Is the dose usually obtained from a part of or multiple containers?
6. Does the administration requite a pump or infusion device?
7. Is a non-standard infusion set required?
8. Is there a ready to administer product available – if so, this must be used wherever possible.

5.20.4 Preparation

Injections should only be prepared by healthcare professionals who are trained in the safe procedures, aware of the risks involved and have demonstrated their competence as part of a training package.

Aseptic (non-touch) technique should be used during the preparation and administration of the injectable medication. Injectable medications prepared in clinical areas must be administered immediately and not stored prior to use. The administration of products prepared in clinical areas should be completed within 24 hours. If this is not possible then a risk assessment must be completed and the rationale for this deviation recorded in the patient's medical notes. In this case the infusion must have been prepared from a single container to minimise the risk.

All syringes, flushes and infusions must be labelled immediately after preparation by the person preparing. The only exception to this is if the preparation and bolus administration is one uninterrupted process. Any infusion must be labelled in accordance with the Medicines Policy.

If preparing multiple medicines for administration, each one must be labelled with the contents before preparing the next.

It is current Trust policy that all injectable medications require a two person check of the whole process from preparation to administration at the patient's bedside.

5.20.5 Administration

A registered nurse/midwife operating department practitioner (ODP) or doctor must only administer a medication against a legal prescription, patient group direction (if applicable) or other written instruction which contains essential information about the product and the processes needed for safe preparation and administration.

The only exception to this is in a theatre environment where the administration of medication will be documented as part of the theatre record. This record must include the details of the medication administered, dose given and route as a minimum. In this case the medication may only be administered by the Anaesthetist.

The person who administers the medication must make a record of the administration as soon as possible after the event.

An individual must only administer a medication that they have prepared themselves and never a medication prepared by someone else.

The registered nurse/midwife, ODP or doctor must have completed the appropriate training in accordance with the Trust's Scope of Professional Practice, before being able to administer medication or fluids via the intravenous route. The administering nurses / midwife or ODP must have attended the Trust's Intravenous Study Day (or have received an accredited priory experiential learning (A.P.E.L) competency form) and completed their competency assessment.

All infusions should be monitored in accordance with the policy 'Intravenous (IV) Medication and Fluid Therapy Administration Through a Peripheral Venous Cannula Policy' available via this link: Infusion Policy

The patient and the paperwork must have been positively identified using the processes outlined in the 'Positive identification of patient policy' available here: PPI Policy, before any medication is administered.

Previous administration episodes must be reviewed to ensure that no medication is omitted unnecessarily and that there are no duplicate doses.

Do not administer any medication unless the allergy status has been documented. Check that the patient is not allergic to the medication which is about to be administered prior to administration. If the patient has a documented allergy to a medication prescribed, check the patients' medical notes or within the EPMA system to ensure that the prescription is intentional. If there is no documentation or there are further concerns, then query this with the prescriber or ward pharmacist prior to administration.

Allergy status must be checked against the prescribing record and if possible with the patient or red wrist band (if in situ) prior to the administration of any medication.

Ensure calculations are double checked as part of the two-person checking process.

Prior to administration the healthcare professional who is to administer the medication must be familiar with or take account of the following:

1. the equipment required
2. the therapeutic class of medication
3. the appropriateness of the medication for the patient
4. reconstitution process if required
5. administration process e.g. bolus or infusion
6. the infusion rate
7. whether peripheral or central administration is appropriate.
8. side effects and appropriate action to take in the event that these occur

The administration of an injectable product requires a two person check from start to finish i.e. up to the start of administration by the bedside.

In addition to checks highlighted in Section 5.7, the following steps apply to the preparation and administration of injectable medications.

1. Write out an additive label if required.

2. Wash hands and put on a pair of gloves

3. Wipe down the bench and swab the tops of any ampoules or vials with a wipe containing alcohol. If you are adding to a bag of fluid swab the additive port also.

4. Draw up the required medication and dose into an appropriate syringe (using a filter needle or orange needle). A filter needle should be used if drawing out of a glass ampoule. If an ampoule/vial needs to be reconstituted, first draw up the diluent and then mix with the medication ensuring all the dry powder is dissolved. Ensure the correct amount of diluent is used (see package insert guide). If the medication is being added to an infusion bag only use a green or filter needle and invert the bag several times to ensure adequate mixing.

5. Check the final injection/infusion for particles.

6. Make sure an additive label is completed and signed and applied to the infusion bag/syringe taking care not to obscure any details on the syringe or infusion bag

7. Both nurses / midwives, ODP or doctor should take the fluid/injection/infusion to the patient in a suitable receiver.

8. Check the patient's identity following the Trust's positive identification policy and the patient's allergy status.

9. Inform the patient of the procedure and the medication you are administering

10. Check the cannula site for signs of inflammation

11. Clean the needle free device (bionector) hub attached to the cannula hub with a Chlorotrip swab and leave to air dry for 30 seconds

12. Pre-flush the cannula with 5-10ml of 0.9% sodium chloride by attaching the syringe to the needle free device (bionector) hub, observe the cannula site throughout the procedure

13. Administer the medication at the prescribed rate by attaching the syringe to the needle free device (bionector) hub. If an infusion device is involved in the administration, then the administering nurse / midwife, ODP or doctor must have completed an assessment of competency to use the equipment. The infusion rate must be checked by the two nurses / midwives, ODP's or doctors. Once the pump or the bolus is commenced then the second nurse / midwife, ODP or doctor procedure is complete. The administering nurse / midwife, ODP or doctor must observe the patient for any signs of reaction to the medication throughout the procedure.

14. Repeat the 0.9% sodium chloride flush

15. Dispose of equipment safely according to Trust Policy

16. Sign and date the drug administration record and ensure the second nurse, midwife, ODP or doctor signs the appropriate documentation

17. If more than one medication is being given then flush the cannula via the needle free device (bionector) hub with 5-10ml of 0.9% sodium chloride between each medication to avoid issues with incompatibility. If more than one bolus is to be administered, then the above procedure needs to be followed and the syringes labelled with the name of the medication. The second checker is not required to return to observe the administration of multiple bolus administrations. If each bolus is not given consecutively and there is a time delay, then the medication should be disposed of and the procedure must be followed as above.

18. There are a limited number of medications which are incompatible with 0.9% sodium chloride, if you are unsure then please consult the Medicines Information Centre on 3163 or the on-call pharmacist out of hours.

5.21 THE MENTAL HEALTH ACT 1983

There are some important issues to be aware of in relation to medicines prescribing and administration in patients that fall under the Mental Health Act (MHA). Patients under this act may be admitted, detained and treated in hospital against their wishes. These patients may be referred to as 'being sectioned' or 'under a section'. There are a number of different sections of the MHA that can be applied according to the particulars of a patient's case. The most common sections that apply to patients are Section 2 and Section 3 of the MHA:

Section 2 – patients under this section are detained to a named location for up to 28 days for a period of assessment and treatment. Treatment of their mental health problems should be with their consent, where possible. Compulsory treatment (without the person's consent or against their will) can be pursued where it is deemed to be proportionate to the need. Any medicines prescribed for the treatment of mental health problems must be given by, or under the direction of the approved clinician in charge of the patient's treatment (usually the Consultant Psychiatrist).

Section 3 – patients under this section are detained to a named location for up to 6 months for a period of treatment. Section 3 can be renewed and the detention prolonged subject to certain safeguards. Treatment of their mental health problems should be with their consent, where possible. Compulsory treatment (without the person's consent or against their will) can be pursued where it is deemed to be proportionate to the need. Any medicines prescribed for the treatment of mental health problems must be given by, or under the direction of the approved clinician in charge of the patient's treatment (usually the Consultant Psychiatrist).

When a patient has been treated under detention for more than 3 months, there are safeguards in place to ensure that the treatment is reasonable and proportionate. The patient will be asked if they consent to the treatment that they are receiving or not. The 3-month period starts from the first day that the treatment is administered to the patient, not the date that the patient was detained.

Where they do give their consent, a form called 'T2' will be completed by the approved clinician in charge of the patient's treatment (usually the Consultant Psychiatrist). The patient may only be prescribed and administered medicines listed on this form for the treatment of their mental health problem. This includes treatments for any side-effects that result, for example, the use of hyoscine for clozapine-induced hypersalivation must be included.

Where they do not give their consent, a second opinion is requested from a specially trained medical doctor from the Care Quality Commission, called a Second Opinion Appointed Doctor (SOAD). The SOAD will consider the treatment plan in use, and assuming agreement that it is reasonable and proportionate,

they will complete a form called 'T3'. The patient may only be prescribed and administered medicines listed on this form for the treatment of their mental health problem. As above, this includes treatments for any side effects that result, for example, the use of hyoscine for clozapine induced hypersalivation must be included.

Sometimes there is a delay until a SOAD can review the patient. It is acceptable for the approved clinician in charge of the patient's treatment to complete a Section 62 form to cover treatment that is urgent, or immediately necessary in the intervening period. The same rules around prescribing and administering medicines that are stated on the form apply.

The prescription and administration of medicines other than those approved and stated on the relevant form may be considered as assault against the patient. It is therefore essential that advise if sought from a specialist mental health pharmacist where necessary, or in the case of a section that is not listed above.

When a patient is deemed to have the capacity to agree to and agrees to a new treatment for their mental health problem, or a side effect thereof, the form must be updated by the approved clinician to include this, or a further review by a SOAD requested. In some rare cases a patient may have both a Form T2 and T3 in place.

It is worth noting that a detained patient has the same rights as any other patient in the hospital with respect to treatment of any other health problems that they have and are treated in the same way. This means that they retain the right to refuse or accept treatment of any other health problems (see Mental Capacity and the Trusts' Covert Administration of Medicines Policy may be relevant).

6.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
The safe storage and security of medicines	Medication Safety officer	Audit	Every 2 years	Joint DTC / MOC
Reducing harm from missed and delayed medication	Medication Safety Officer with support from nursing colleagues	Audit and QI work	Audit monthly – QI as required	Joint DTC / MOC, Medication Safety group, Nursing, Midwifery and AHP Committee.
Incident review	Medication Safety Officer	Ad hoc – as needed	As needed	Investigation managed by the Divisions as needed

7.0 TRAINING AND IMPLEMENTATION

Elements of the Policy will be covered on an annual basis in the Medicines Management mandatory training e-learning package and booklet.

All staff will be informed on the Policy and a brief outline of its content at Trust induction including medical staff.

All preceptorship nurses, Nursing Associates and registered healthcare professionals who are required to administer medication, will be required to complete a medicine management competency-based booklet covering various elements of the Medicine Policy.

8.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix 6
- This document has been subject to an Environmental Impact Assessment, see completed form at Appendix 7

9.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- Health Building Note: 14-02 Medicine storage in clinical areas. NHS England Publications approval reference: PAR38. Issued 28 May 2021, updated 31 January 2024
- Royal Pharmaceutical Society of Great Britain; Professional guidance on the safe and secure handling of medicines. Issued December 2018
- ABPI 2024 Code of Practice

Related SFHFT Documents:

- Policy for the Use and Administration of Parental Potassium
- CD Policy and associated SOPs
- Mental Capacity Act Policy
- Smoking Cessation Policy
- MRSA Treatment and Prophylaxis Policy
- Self-prescribing and prescribing of medicines for family and colleagues policy
- Procedure for the dispensing of pre-packed medication by nursing staff
- Transport of medicines and other small items using the delivery service.
- PGD intranet page.
- Discharge Policy
- Conscious Sedation Guideline
- Non-Medical Prescribers Policy
- FP10 prescription pad policy
- Patient Controlled Epidural Analgesia Policy
- Oxygen Policy – prescription, administration and monitoring of oxygen therapy in adults

- Reducing the harm to patients from missed and delayed medicines in hospital
- Self-administration of medicines by patients or carers procedure
- Syringe use to administer flushes, feeds and medication via the oral and enteral routes policy
- Positive Patient Identification Policy
- Covert Administration of Medicines Policy
- Policy for the procurement and use of medicines without marketing authorisation and medicines used outside their marketing authorisation
- Waste Policy
- Trust's Incident reporting Policy and Procedures
- Procedure for the dispensing of pre-packed medication by nursing and midwifery staff (Obstetrics and Gynaecology).'
- Infusion Policy

10.0 KEYWORDS

medication, medicines, potassium, reconciliation, nurse, doctor, AHP, theatre, drug, cytotoxic, chemotherapy, prescribing, administration, supply, storage, children,

11.0 APPENDICES

Appendix 1 – Consultation for 2024 Medicine Policy Update

A task and finish group was set up to review the main body of the Medicine Policy and consisted of the following people:

Assistant Chief Pharmacist – Medication Safety Officer (Chair)
Assistant Chief Pharmacist – Education and Training
Assistant Chief Pharmacist – Clinical Services
Clinical Pharmacist – Surgery and ICCU
Corporate Head of Nursing
Consultant Nurse – Pain
Clinical Governance and patient Safety Lead – Theatres
Medication Safety Technician
Practice Development Matron – Medicine Management
Discharge Lounge Lead Nurse
Deputy Director of Nursing – CSTO
OPD Matron
Saving Babies Lives Lead

There were also several specialists who inputted in addition to the core group, into the relevant sections as follows:

Advanced Clinical Practitioner Lead
Nurse Educator – Medical Training
Specialist Pharmacist – Medical Education
Dispensary Manager
Stores Manager
Radiography Services Manager
Welcome Treatment Centre Lead
Oncology / Haematology Lead Pharmacist
Formulary, MI and Trials Lead Pharmacist
Safeguarding Adults Lead
Mental Health Lead Nurse
Deputy Director of Nursing – Quality and Governance
Tobacco Lead – Maternity
Chief Allied Healthcare Professional
Lead Operating Department Practitioner.

Appendix 2 – Checklist for Patients Own Drugs (PODs)

When to use PODs

- They are the property of that particular patient.
- They comply with all conditions below:

Labels

- A label is present;
- The label must be typed and legible;
- The label must clearly state the **patients' name,** the **medicine name**, the **medicine strength** (if applicable), plus the **name and address of the Pharmacy** dispensing the medicine;
- Where possible cross check the medicine name on the label with the contents e.g. original pack items e.g. creams, inhalers, eye drops etc. and blister-packed medicines. NB Trade names and the generic medicine names may be used and interchanged on the labels and contents and the prescription, if unsure check in the BNF, check with your ward Pharmacist or contact Medicines Information x3163;
- The medicine must have been dispensed in the last SIX months.

Original Pack Items e.g. creams, inhalers, eye drops etc. and blister-packed medicines may not always be in the original labelled container. These may be used if:

- The medicine has been dispensed in the last SIX months – check with the patient;
- They medicine is the property of that particular patient – check with the patient;
- The patient is definite and clear that they are using them.
- *Discretion is required here having to balance retaining the patients' respect and confidence in the process against concerns that these medicines are the correct ones for the patient. If in doubt then Pharmacy will dispense to replace those medicines.*

Container

- For medicines in bottles, the patient must not have transferred or swapped around any of their medicines to or between bottles;
- The medicine has a container (excluding blister packaging);
- There is only one product within the container.

Expiry

- The medicines are still in date (if an expiry date is present). Note that some items may have a reduced expiry date once opened e.g. eye drops.

Product Integrity

- The medicines should be clean, whole if tablet or capsule, if opaque liquid then consistent in colour, if a transparent liquid then clear.

General

- Ensure all the medicines the patient takes are handed over, prescription medicines from Doctor and ones purchased from a shop/supermarket or Community Pharmacy (Retail Chemist);
- Any doubts clarify with Pharmacy or do not use.

Appendix 3 – Medicines that need to be accessible by patients

The Trust understands that it may be in patients' best interest to have ready access to certain medicines and permits these to be stored at the patient's bedside as long as these are stored out of sight and not readily accessible by other patients and visitors. These medicines are listed below:

- Glyceryl trinitrate (GTN) spray and sublingual tablets.
- Emollients.
- Inhalers.
- Epi-Pen emergency adrenaline injection (and equivalents)
- Eye lubricants or tear deficiency preparations
- Artificial saliva products.
- Medicinal shampoos and washes.
- Nicotine replacement therapies

In addition, the Trust permits insulin pen devices to be stored at the patient's bedside under the following circumstances:

1. The patient must be self-administering their insulin.
2. Specific self-administration paperwork including patient consent must be completed and filed in the patients' case notes.
3. Needles must never be left attached to the device and must be disposed of after every dose.
4. The patient must have a sharps bin provided for safe needle disposal following each dose.
5. The insulin must be stored in the patient's bedside locker or within their personal possessions, out of sight of other patients and visitors.

Appendix 4 – Medicines that may be administered or supplied by midwives.

The following medicines are those that the Trust has agreed that Midwives may administer or supply to patients as part of their midwifery practice. These medicines appear on the General Sales List or are Pharmacy medicines. All medicine supplies must be labelled as a dispensed medicine and will have been pre-packed by Pharmacy for that purpose.

- Clotrimazole cream
- Clotrimazole pessary
- Chlorphenamine
- Docusate capsules
- Ferrous fumarate
- Ferrous sulfate
- Ibuprofen
- Ispaghula (Fybogel®)
- Lactulose
- Peppermint oil capsules
- Paracetamol tablets
- Peptac® liquid

The list below is an approved list that we have on Maternity Ward and some of these are nurse dispensed from the Maternity Ward as TTO's

- Algopedol (Sucrose 24%)
- Amoxicillin x
- Anusol
- Cefalexin x
- Co-Amoxiclav x
- Codeine Phosphate
- Diclofenac Suppositories
- Depo-Provera
- Enoxaparin (10 days Course and 6 weeks Course)
- GlucoBoost
- Glycerol Suppositories
- Labetalol
- Laxido
- Metoclopramide
- Morphine Oral Solution
- Nicorette
- Nicotinell Patch
- Octenisan Nasal Gel
- Octenisan Wash Lotion
- Omeprazole
- Phosphate Enema

Appendix 5 - The sources which may be used for medicine reconciliation

Source	Advantages	Disadvantages	Further information and documentation required
Patient/carer recall and verification	**Must be part of all medication histories where possible.** • Likely most up-to-date with recent changes in regime • Likely best source for allergy status • Information on OTC purchase • Information on whether patient is using certain PRN medications (e.g. creams, eye drops etc.) • Information about how medication is taken including indications, day of patch change etc. • Can gain information about compliance / concordance. • Find out where their medication comes from in the case of specialist treatments, this may not be via the GP	• Patient may not be a reliable historian or may mixed up names of medications • Not always possible to speak to patient due to individual circumstances (e.g. dementia, acute confusion, sedated)	• Clarify any additional information gained from other sources with the patient/carer
Patients own medication	• Information to confirm formulation and strength • Issue dates are useful	• Ensure up to date and still relevant • The presence of a medication does not mean this is current • May not be representative of a	• Document the date the medicine was dispensed. • Medications over 3 months old may not represent an accurate source so

	• A way to find out if patient uses a mediwallet • Has label with instructions on • Serve as prompt for patient • A source for non-English speaking patients	full list (e.g. insulin will be in the fridge, weekly injections may not have been brought in etc.)	a further source should be checked. • Old medications may suggest compliance issues. • Brief POD check alongside DHx check may be helpful to ensure correct medicine had been issued to the patient (instead of relying on just the label)
Repeat prescription lists from GP surgery.	• Clear • Can see issue dates • Supplementary information to act as patient's prompt	• May be out of date - a conversation with patient will be needed to confirm if the list is current • Repeat medication is often managed by the community pharmacy meaning unnecessary medication is continually ordered. • Won't include medicines prescribed by other centres such as hospital, mental health services, substance misuse • Does not have allergy status • Not always complete – patient may have only 3 pages out of 4, so SCR may be more appropriate	• Document the date on the repeat prescription used. • This will have similar information to the GP letter and SCR and so may not class as an 'additional' source.
GP referral letter	• May or may not contain dosing information • Up to date • Clear	• May or may not contain dosing information • Patients not always sent to hospital with	• Document the date the list or letter was written if possible.

	• May include information on recent consultations leading up to the admission	a list of medicines alongside the referral letter	• This will have similar information to the repeat prescription and SCR and so may not class as an 'additional' source.
Telephoning GP surgery	• Current repeat and acute medication • Issues dates available • GP receptionist sometimes have access to clinic consultation's documentation hence able to provide clarity on medication details • Possible to find out warfarin dosing information • Can discuss with GP if further clarification is required • Possible to contact to district nurses	• Information given is determined by the GP receptionist and may not be complete • Pronunciation issues • Time constraints for both parties • Long delays	• Confirm who spoke to e.g. nurse, receptionist • SCR is preferable to this source and telephoning a GP surgery should only occur if there is no SCR available or issues need to be clarified. Document date prescription was last issued
Nursing / Residential home administration sheets (MAR charts)	• Useful for assessing compliance • Likely to be up-to-date and accurate if was used appropriately • Likely to be a full list of current medications (except where patient has separate community insulin charts)	• Take note of annotations that are used by care home (e.g. some care home signed 'NN' as 'not needed' but may be mistaken as a signature of administration instead) • Need to ensure we have the full MAR chart, and the chart	• Ensure all sheets are present and that the MARS is current. • Information from the home should be used in conjunction to ascertain any issues with taking medication e.g. covert administration etc.

	• Contains information on recent changes (e.g. certain medication may have been crossed off and indicative that they have been stopped)	for the correct patient • Not always scanned properly or some MAR charts are handwritten which can be inaccurate • Allergy information commonly not up to date or accurate.	
Telephoning Nursing / Residential home	• Information on allergy status, feeding requirement (e.g. thickened fluids requirement), and source of supply of regular medications • Able to clarify details on MAR chart • Information on specifics (e.g. who administers insulin etc.)	• Person on the phone may not be the main carer hence documented information may not provide level of detail required	• Confirm who spoke to e.g. nurse, receptionist
Patients own reminder lists	• Will show the patient's preferred way to take medication	• May not be up to date or complete	
Dosing booklets – e.g. warfarin, insulin, methotrexate	• Useful for specialist dosing information	• Only a second source for specific medication and should only be used as an additional source • Not every patient has them, and information hand-written	
Medical notes – medicine charts, clinic letters, previous admission information, charts, clinic visits	• Clinic letters are useful for specialist conditions • Outpatient and ED prescriptions	• Clinic letters often specify medication but list may not be complete. • Clinic letters are often dictated and	• Document date of letter, previous chart etc. if used as a source

	• Previous clerking information – previous medication history information.	not checked by the doctor. • Not always available hence not always practical unless deemed necessary	
Dragon Medical Workflow Manager	• Contains information on clinic consultation and recent medication changes • Useful for specialist information such as outpatient clinics	• Does not always have dosing information • Medication list on clinic letters are unlikely to be complete nor accurate • Access not always reliable	
Community Pharmacy	• Provides information on issue, or new medication that are awaiting pick-up at the chemist • Provide mediwallet details (things that are kept in or out of MW) • Provide issue and delivery date, which allow discharge planning • Communication between primary and secondary care • Methadone and Buprenorphine information (or we can contact local ADLT as they have access to information on key worker etc. if	• May not always have all medicines on record as patient may collect acute prescriptions from other community pharmacy's	• Document date medicines were last dispensed • Time-consuming • If patient does not use mediwallet, the primary difference between community pharmacy and SCR will be on whether the prescribed medications had been issued

	patient had been in hospital)		
Specialist community services e.g. CPN, community substance misuse team)	• Specialist information that might not be available other GP related sources	• Can be difficult to find contact details or find relevant key workers etc.	• Confirm which service the patient is under and any relevant professionals and contact details
District nurses	• Information on insulin doses • Information on dressings	• Time-consuming, and most provide a call-back service instead	
Alcohol & Drug Liaison Team (ADLT)	• Medicines to support substance misuse management • Community based team contact details such as key workers	• Referral is required • Answerphone – team not always available in the time frame required	• Referral via ext. 3935 or on vocera using 'Drug & Alcohol Liaison Nurse.' It is sufficient to leave a message
Summary Care Record. Accessible via the National Care Records Service (NCRS) portal.	• Includes allergy information • Has dates of issue, which provide information such as if patient gets supply as weekly issue, or occasionally, indicative of mediwallet patient • Includes acute, repeat and discontinued medications. and sometimes with reasons stated • Provide information on nominated chemist and surgery • Available out of hours. • Consent to access has been agreed nationally therefore	• Insufficient as single source for complex patient (i.e. lack information such as insulin doses) and only provides information medications prescribed by GP • Acute issue list can be overwhelming long, will require judgement to identify critical ones (e.g. steroids course over the year may be relevant, but creams may not be as critical etc.) • All issues included – need to make sure only relevant ones are documented. • May not always be up-to-date in particular if the	• Document the date the SCR was last updated. • This will have similar information to the GP letter and repeat prescription and so may not class as an 'additional' source

	individual patient consultation not required	patient has moved GP surgery	
MIG (Notts Health and Care Portal) Via Orion (Amadeus)	• Discharge information and clinic letters from multiple secondary care providers in Nottinghamshire including NUH	• Log in on own username – doesn't work if computer log in is generic	• Document date of letter, previous chart etc. if used as a source
Orion (Amadeus) GP record	• Easily accessible, time effective, useful for patient with few co-morbidities • Has medical history too which helps in medicine reconciliation • Up to date information on medication issues • Includes all acute, repeat and discontinued medications • Allergy information	• Not available for every patient • Has three tabs: current, past and medication issue – will need to flick through all three tabs to obtain accurate list • Like SCR, insufficient as the only source for complex patient	• This will have similar information to the GP letter, repeat prescription and SCR and so may not class as an 'additional' source.
Notts Care record	• Includes allergy information * • Has dates of issue, which provide information such as if patient gets supply as weekly issue, or occasionally, indicative of mediwallet patient • Includes acute, repeat and discontinued medications. and sometimes with reasons stated	• Acute issue list can be overwhelming long, will require judgement to identify critical ones (e.g. steroids course over the year may be relevant, but creams may not be as critical etc.) • All issues included – need to make sure only relevant ones are documented.	• * allergy information is documented in 3 places on this record. Take care to check all three.

	• Available out of hours. • Consent to access has been agreed nationally therefore individual patient consultation not required • Discharge information and clinic letters from multiple secondary care providers in Nottinghamshire including NUH • Includes basic information on GP consultations so can be used for insulin doses		
Previous EPMA admission records	• Easily accessible and time effective • Allergy information • Useful source if recent admission, likely to be accurate and highlight any changes from previous admissions • Likely to be complete list including specialist information • Useful source to identify if patient is mediwallet patient • Available out of hours • Easily transferable onto current admission on EPMA	• Not to be used if DHx had not been done in hospital • May not be accurate beyond certain timeframe (e.g. 3 months)	•
Orion (Amadeus) SFH TTO	• Useful source if TTO is recent, likely to	• Not to be used if DHx had not been	• Document the date of the TTO

	be accurate and highlight any changes from previous admissions • Likely to be complete list including specialist information • Useful source to identify if patient is mediwallet patient • Available out of hours	done in hospital – rely on TTO-screening person to document this info • Will require attention on "medication changes box" which likely to have info on PRN medications that were not used whilst inpatient • May not be accurate beyond certain timeframe (e.g. 3 months)	
Hospital discharge (other than SFH)	• Useful for patients who had been transferred from other hospitals • Likely most accurate and recent (as patient unlikely to be a useful source due to recent changes that may not have been communicated through)	• Other Trusts may not have the same medication history taking procedure and validation process in place. If it is not clear that the medication history process has taken place then this process must be repeated on admission to SFH • May be difficult to navigate due to unfamiliarity of the layout • May not always be available (sometimes hospital send medicine charts instead)	• Document the date of the TTO and which hospital patient was discharged from
SFH JAC record	• Identifies specialist "hospital only" medicines • Provides information on issue	• Require a phone call to dispensary pharmacist which may can be an	

	date and dosing information (including homecare prescription) • Provides information on recent ED or outpatient prescriptions	interruption if it's busy	
ChemoCare	• Has information on recent chemo regime and medical notes entry along with info on next cycle that is due • Provides a list of oral supportive medications	• Time-consuming • Not everyone has access • Training required on the usage/navigation	
Homecare prescription / High cost medicines	• Useful for specialist medicine, dosing information and indication, and for deducing if patient is likely to have supply	• Require a phone call to dispensary pharmacist which may can be an interruption if it's busy	
SystmOne  SystmONE Guide and Training .pdf	• Useful source to identify insulin dose (by district nurse), warfarin dose (by GP) and record of injection administered • Provides the list of repeat and acute medications prescribed • Contain GP consultation notes, discharge letter and clinic letter • Can be used to identify details of NOK as needed	• May take longer to load SystmONE as compared to other sources • Contain comprehensive details. To look out for the relevant information • If using the search button, take note of the date of entry. (Entry >3 months may not be accurate)	• Document the date of the injection and if any due in the future. • Record the type of document (i.e clinic letter or discharge information) and the date of the document

APPENDIX 6 - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Medicine Policy			
New or existing service/policy/procedure: Existing			
Date of Assessment: 30.12.24			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	NA	NA	NA
Gender	NA	NA	NA
Age	NA	NA	NA
Religion / Belief	NA	NA	NA
Disability	NA	NA	NA
Sexuality	NA	NA	NA
Pregnancy and Maternity	NA	NA	NA
Gender Reassignment	NA	NA	NA
Marriage and Civil Partnership	NA	NA	NA
Socio-Economic Factors	NA	NA	NA

(i.e. living in a poorer neighbourhood / social deprivation)			

What consultation with protected characteristic groups including patient groups have you carried out?

- Not applicable

What data or information did you use in support of this EqIA?

- Not applicable

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- No

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment:
Joanna Freeman, Assistant Chief Pharmacist

Signature:

Date:
30.12.24

APPENDIX 7 – ENVIRONMENTAL IMPACT ASSESSMENT

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

Area of impact	Environmental Risk/Impacts to consider	Yes/No	Action Taken (where necessary)
Waste and materials	• Is the policy encouraging using more materials/supplies? • Is the policy likely to increase the waste produced? • Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled?	N	
Soil/Land	• Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals) • Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.)	N	
Water	• Is the policy likely to result in an increase of water usage? (estimate quantities) • Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water) • Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal)	N	
Air	• Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.) • Does the policy fail to include a procedure to mitigate the effects? • Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations?	N	
Energy	• Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities)	N	
Nuisances	• Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)?	N	