

Medicines Policy

POLICY	
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	Date Associated Documents/ Information was reviewed
Not Applicable	Not Applicable

MEDICINES POLICY

Version 1.182

November 2019

[Click here for a list of recent changes](#)

Disclaimer

- Overarching policy statements **must** be adhered to in practice.
- Clinical guidelines are for guidance only. The interpretation and application of them remains the responsibility of the individual clinician. If in doubt contact a senior colleague or expert.
- The Author of this clinical document has ultimate responsibility for the information within it.
- This clinical document is not controlled once printed. Please refer to the most up-to-date version on the intranet.
- Caution is advised when using clinical documents once the review date has passed.

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INTRODUCTION

This Policy document is the culmination of an extensive process of review following the creation of the Sherwood Forest Hospitals NHS Foundation Trust; significant input and help has been provided by many members of staff, including those from Nottinghamshire Community Health and Nottinghamshire Healthcare NHS Trust, to whom the Sherwood Forest Trust is very grateful. The document aims to define precisely the roles and responsibilities of all health care professionals involved in any stage of the Medicines Optimisation process including ordering, storage, prescribing, dispensing and administration of medicines.

The policy follows the general principles set out in the 'Professional guidance on the safe and secure handling of medicines' document published by the Royal Pharmaceutical Society in December 2018. This updated report was based on a set of principles originally published as the "Guidelines for the Safe and Secure Handling of Medicines" a report to, and commended by, the Department of Health in 1988 and updated in 2006, produced by a Joint Subcommittee of the Standing Medical, Nursing and Midwifery, and Pharmaceutical Advisory Committees, and chaired by Professor R B Duthie (and known as 'The Duthie Report'). The report charges the Trust senior leadership team with the overall accountability for the safe and secure handling of medicines in the organisation and states these process should be regularly monitored through corporate governance processes and regularly reviewed.

The policy is applicable to the following areas:

- *King's Mill Hospital*
- *Mansfield Community Hospital*
- *Newark Hospital*
- *John Eastwood Hospice*
- *Critical Care Teams*
- *Community Midwifery Services*

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. However, no excuse is made for identifying good practice and making it part of the policy document.

The policy has been produced under the auspices of the Sherwood Forest 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. In this way the document will be simpler to maintain. However, we recognise that a small number of copies will be printed and kept within specific locations in the Trust.

This policy will be reviewed on at least an annual basis. Any constructive comments should be directed to:

Steve May,
Chief Pharmacist & Clinical Director for Medicines Optimisation
Sherwood Forest Hospitals

Tel: 01623 622515 ext. 3173 or email steve.may@nhs.net

SCOPE OF THE POLICY

This clinical document applies to:

Staff groups

- The Policy applies to registered practitioners such as Doctors, Nurses, Radiographers, Operating Department Practitioners, Pharmacy staff, and unregistered healthcare workers such as Porters and Healthcare Support Workers and any other member of staff that handles medicines.
- The Policy also applies to staff employed via other agencies on a temporary basis.

Clinical areas

- 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. These include
 - Nottinghamshire Healthcare NHS Trust
 - Nottinghamshire Community Health services based at Ashfield and Mansfield Community Hospitals and John Eastwood Hospice

Patient groups

- This Policy applies to all patients.

Exclusions

- None

Related Trust policies and guidelines and/or other Trust documents

- Self-administration of medicines
- Intrathecal
- Enabling policy
- Policy for the use and administration of parenteral potassium
- IV Policy

EVIDENCE BASE

Medicines act and subsequent

Controlled drugs legislation

Duthie report - removed from circulation December 2018 and replaced with the guidance listed below.

NPSA/NHS Improvement alerts

Professional guidance on the safe and secure handling of medicines, Royal Pharmaceutical Society. Published December 2018. Accessed 30th Jan 2019.

Professional guidance on the administration of medicines in healthcare settings, Royal Pharmaceutical Society and Royal College of Nursing. Published January 2019. Accessed 30th Jan 19

KEYWORDS

CONTROLLED DRUGS

MEDICATION

MEDICINES

DRUGS

POTASSIUM

RECONCILIATION

MONITORING COMPLIANCE

Compliance with and effectiveness of the Medicines Policy is monitored by a number of means.

Audits

The following audits are completed on an annual basis:

- safe storage of medicines at ward/department level
- completion of required allergy statements on prescription charts
- quality of prescribing against standards within the Medicines Policy

Other audits are completed on an ad-hoc basis under the direction of the Trust's Medicines Optimisation Committee or the Drug & Therapeutics Committee as appropriate.

Incident monitoring

Incidents involving medicines within the sites under the remit of this policy and that are reported into the Trust are reviewed by the Medicines Safety Group, which instigates any required action.

Pharmacist Intervention Monitoring

Pharmacists undertake biannual intervention monitoring over a week period, which is recorded in a database and reported to the Joint Drug & Therapeutics Committee/Medicines Optimisation Committee. Significant issues of concern are escalated to the Clinical Governance Committee.

Other Monitoring

On-going monitoring of prescribing, administration and safe storage is performed by Pharmacy staff as a prerequisite of their role.

Specific audit of controlled drugs is undertaken at 3-6 monthly intervals according to usage within individual units.

A monitoring table is given below.

NHSLA Criterion		Method of Monitoring	Timescale	Lead
1.5.10a	How medicines are prescribed	Pharmacist review of prescriptions and pharmacist contribution monitoring audit. Clinical incidents.	On-going and biannually for audit. Incidents are dealt with individually.	Chief Pharmacist & Clinical Director for Medicines Optimisation.
1.5.10b	How the organisation makes sure that all prescription charts are accurate	Pharmacist review of prescriptions. Electronic prescribing where installed. Review by pharmacists.	On-going review by pharmacists.	Chief Pharmacist & Clinical Director for Medicines Optimisation.
1.5.10c	How medication errors are reported	Significant medication errors – generally prescribing, administration and dispensing are reported as clinical incidents via Datix.	On-going.	Chief Pharmacist & Clinical Director for Medicines Optimisation.
1.5.10d	How the organisation learns from medication errors	Direct feedback to the individual concerned. A subgroup of the MMO reviews all Medicines Optimisation Clinical incidents and implements communication and learning for policy changes, immediate action or other via other means of communication e.g. newsletters.	On-going	Chief Pharmacist & Clinical Director for Medicines Optimisation.
1.5.10e	How the patient's medicines are managed on handover between care settings	Medicines reconciliation on admission to the Trust is covered in chapter 21. Detailed changes to medication is included within the Trust's discharge communication.	On-going.	Chief Pharmacist & Clinical Director for Medicines Optimisation.
1.5.10f	How the organisation trains staff in line with the training needs analysis	Training needs are identified via multiple pathways including analysis of incidents, pharmacy contribution audits and changes to the Medicines Policy. Pharmacy input into undergraduate medical training, junior doctor training and nurse medicines management training.	On-going	Chief Pharmacist & Clinical Director for Medicines Optimisation/Training, Education & Development Manager.
1.5.10g	How the organisation monitors compliance with all of the above.	Compliance is monitored via reporting to divisions and via the Medicines Optimisation Committee	On-going with biannual reporting to the committee via contribution audits.	Chief Pharmacist & Clinical Director for Medicines Optimisation.

TRAINING

It is important that staff are trained against the areas of the Medicines Policy that are relevant to their work. It is expected that staff attend training sessions, provided by appropriate Trust staff for Medical, Nursing and Pharmacy staff at induction and on an on-going basis. Reference should be made to Sherwood Forest Hospitals' Mandatory Training Policy for training needs analysis.

EQUALITY IMPACT ASSESSMENT (EIA)

The Trust is committed to ensuring that none of its policies, procedures and guidelines discriminate against individuals directly or indirectly on the basis of gender, colour, race, nationality, ethnic or national origins, age, sexual orientation, marital status, disability, religion, beliefs, political affiliation, trade union membership, and social and employment status. An EIA of this policy has been conducted by the author using the EIA tool developed by the Diversity and Inclusivity Committee. See appendix 12 for the completed EIA proforma.

GLOSSARY OF TERMS USED

1.1 Nursing and Midwifery

1.1.1 Registered Nurse

A Nurse who is registered on the appropriate part of the Nursing and Midwifery Council (NMC) register. They are qualified to have custody of, or administer medicines.

1.1.2 Registered Midwife

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

1.1.3 Registered Sick Children's Nurse

A Paediatric Nurse who is registered on the appropriate part of the NMC register. They are qualified to have custody of or administer medicines.

1.1.4 Nursing Associates

A registered Band 4 individual that bridges the role between a Registered Nurse and Healthcare Assistant. Nursing associates are registered with the Nursing and Midwifery Council (NMC) and in order for this group of staff to administer medicines they are required to complete the Trust's Medicines Optimisation Pack and demonstrate competence in-line with that for Registered Nurses. At present Nursing Associates may administer a limited number of medicines via defined routes as described in section 11.1.4 of this Policy.

1.1.5 Ward/Department Leader/Nurse-in-Charge/Charge Nurse/Sister

A Registered Nurse/Midwife with continuing management responsibility for a designated ward/department/caseload.

1.1.6 Shift Co-ordinator

A Registered Nurse/Midwife identified as co-ordinating a shift for a designated ward/department.

1.1.7 Midwifery Co-ordinator

A Registered Midwife with management responsibility for the co-ordination of hospital or Community Midwifery services.

1.1.8 Supervisor of Midwives

A Registered Midwife appointed in accordance with section 16(3) of The Nurses, Midwives and Health Visitors Act, by a Local Supervising Authority, to offer statutory supervision to Midwives.

1.1.9 Midwifery Manager/Modern Matron/Heads of Nursing

A senior Registered Nurse/Midwife with management responsibility for a designated group of wards/departments.

1.1.10 Nurse Specialist/Practitioner

A Registered Nurse/Midwife who has completed specific specialist training to extend their Clinical practice, in order to undertake specific Clinical interventions in a defined area of practice.

1.1.11 Nurse Consultant

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

1.1.12 Nurse prescriber

A Nurse who has undergone additional training and is registered on the appropriate part of the Nursing and Midwifery Council (NMC) register as a prescriber. They may be qualified as a supplementary prescriber or as an independent prescriber.

1.1.13 Health Care Assistant

An unregistered Health Care Practitioner who has undertaken, to successful completion, non-vocational studies in health care that are specific to role and work area and who works under the direct supervision of a registered Nurse at all times.

1.1.14 Preceptorship nurse

A preceptorship nurse is a newly registered nurse who undergoes a period of supervised practice and continuous assessment, which generally lasts 22 weeks, to support the transition from student to registered nurse.

1.2 Pharmacy

1.2.1 Pharmacist

A qualified person who is registered with the Royal Pharmaceutical Society of Great Britain.

1.2.2 Pharmacist prescriber

A pharmacist who has undergone additional training to enable their registration with the Royal Pharmaceutical Society of Great Britain as a prescriber.

1.2.3 Clinical/Ward Pharmacist

A Pharmacist participating in the provision of Clinical Pharmacy services on a daily basis to a particular ward or department.

1.2.4 Divisional Lead Pharmacist

A Pharmacist with responsibility for the provision of advisory and Clinical Pharmacy services to each of the Trust's Clinical Divisions.

1.2.5 Pharmacy Manager

The Pharmacists with management responsibility Trust-wide for:

- Clinical services;
- Operational services.
- Medication Safety Officer

1.2.6 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.

1.2.7 On-Call Pharmacist

A Pharmacist responsible for the provision of Pharmacy services when the Pharmacy Departments are closed. This is an emergency service only.

1.2.8 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 Medical practice.

1.2.9 Pharmacy Technician

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

1.2.10 Medicines Management Technician

A qualified Pharmacy technician who has undergone a validated process to allow them to undertake extended ward-based duties working alongside Pharmacists.

1.2.11 Accredited Checking Technician

A Pharmacy Technician who has undergone significant 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).

1.2.12 Pharmacy Assistant

An unqualified member of staff trained in the receipt and storage of drugs and prescriptions, the provision of the stock 'top-up' service, and the pre-packing of medicines.

1.2.13 Dispensing Assistant

As for 1.2.12, but who has undergone specific training to enable them to dispense medicines under supervision.

1.2.14 Medicines Information Centre

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

1.3 Medical

1.3.1 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.

1.3.2 Medical or Dental Practitioner

A Doctor or Dentist as used in the Medicines Act 1968.

1.3.3 Doctor

The term Doctor is used throughout this document to describe a qualified Medical Practitioner and their activities associated with drug use. In terms of prescribing, it describes all Doctors at F2 and above in all circumstances. For F1 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 drugs.

1.3.4 Medical Student

An undergraduate student with no legal prescribing rights.

1.4 Other terms

1.4.1 Drug/Medicine/Medication

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

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

1.4.2 Authorised Prescriber

The term Authorised Prescriber may refer to a qualified Medical Practitioner or Dentist. An authorised prescriber may also include a Pharmacist or Nurse that has successfully completed a period of training as a Supplementary Prescriber or Independent Prescriber and is registered with their respective governing bodies.

1.4.3 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.

1.4.4 Accountable Officer for Controlled Drugs

The Chief Pharmacist is the Trust's nominated Accountable Officer for Controlled drugs and takes legal responsibility for ensuring safe prescribing, storage, dispensing, administration, transport and auditing of CDs. If any member of staff should have **any** concerns regarding CDs they must inform the Accountable Officer of their concerns. Concerns regarding CDs will be taken seriously and investigated.

1.4.5 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 1).

1.4.6 ODP

An Operating Department Practitioner is a trained technical member of the Operating Department staff who has successfully completed training and achieved one of these qualifications:

- Certificate NVQ Level 3 for , or Certificate City & Guilds 752-01 plus Unit 4 of NVQ Level 3 for, or equivalent qualification, e.g. Diploma in Operating Department Practice,

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.

1.4.7 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.

1.4.8 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.

1.4.9 Dietician

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

1.4.10 Advanced Clinical Practitioners

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

1.4.11 Medical Support Workers and other band 3 practitioners

This term incorporates suitably trained practitioners who provide a supporting role to clinical staff and whose competency is checked in specific duties that allow routine functions to be undertaken.

1.4.12 Imaging assistant (Cath to get definition)

1.4.13 COSHH

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

1.4.14 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.

1.4.15 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).

1.4.16 Envopak

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

1.5 Abbreviations

The following brings together a list of abbreviations found within this document, some of which will have been explained elsewhere.

ABPI	-	Association of the British Pharmaceutical Industry
ACH	-	Ashfield Community Hospital
ACP	-	Acute Care Practitioners
BMA	-	British Medical Association
CD	-	Controlled Drug
COSHH	-	Control of Substances Hazardous to Health
ED	-	Emergency Department
F1/F2	-	Trainee doctors are now required to complete a two-year Foundation Programme in an NHS hospital. Foundation Year 1 (F1) is equivalent to the old PRHO year, and Foundation Year 2 (F2) is equivalent to the first year as a SHO. The learning objectives for F1 are set by the GMC at the end of their F1 year, based on the achievement of specific competencies.
GMC	-	General Medical Council
GP	-	General Practitioner
GSL	-	General Sales List
ID	-	Intradermal
IM	-	Intramuscular
IP	-	Intraperitoneal
Intrathecal	-	Intrathecal (intrathecal must always be written in full and is included here to emphasise that abbreviation is not accepted)
IV	-	Intravenous
MCH	-	Mansfield Community Hospital
NG	-	by nasogastric tube
NMC	-	Nursing and Midwifery Council
NPSA	-	National Patient Safety Agency
NVQ	-	National Vocational Qualification
ODP	-	Operating Department Practitioner
P	-	Pharmacy (Medicine)
PEG	-	Percutaneous Endoscopic Gastrostomy

PO	-	by mouth
POD	-	Patient's or Patients' Own Drug
POM	-	Prescription Only Medicine
PR	-	per (by) rectum
PRHO	-	Pre-registration House Officer
PV	-	per (by) vagina
RPS	– Royal Pharmaceutical Society	
SC	-	Subcutaneous (not included in the BNF but accepted by the Trust)
SHO	-	Senior House Officer
SL	-	sublingual

2 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 detail on the reporting of errors can be found in chapter 19.

2.1 Nurses

A **Registered Nurse/Midwife** (as defined by the Nursing and Midwifery Council 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.

2.1.1 The **Ward/Department Leader/Nurse-in-Charge** responsible for a ward/department has accountability for the stock of all drugs held on the ward/department, and is responsible for ensuring that drug procedures are followed correctly.

2.1.2 The **Shift Co-ordinator** in charge of a ward/department for a span of duty, and **Community Midwives** are responsible for stocks of drugs held and for balancing stocks of CDs with the CD register.

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

2.1.4 Nursing and midwifery staff also have responsibilities for medicines reconciliation as outlined in chapter 21.

2.2 Pharmacists

The roles and responsibilities of Pharmacists are clearly defined in the 'Duthie Report' ("Guidelines for the Safe and Secure Handling of Medicines", Department of Health 1988) and "Medicines, Ethics & Practice – A guide for Pharmacists" (Royal Pharmaceutical Society of Great Britain, biannual publication).

2.2.1 The Trust Chief Pharmacist is responsible for the provision of Pharmacy Services across the organisation, including systems for safe and effective Medicines Management.

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

- 2.2.3** The **Pharmacy Manager(s)** in consultation with appropriate members of Medical, Nursing and administrative staff will draw up all procedures concerning medicines management.
- 2.2.4** Once instigated, the **Pharmacy Manager(s)** will monitor such procedures and systems. Existing procedures shall be reviewed at least annually and amended where necessary.
- 2.2.5** The distribution of medicines from the Pharmacy Department will be under the supervision of a Pharmacist.
- 2.2.6** Stock levels of medicines on wards/departments will be determined by an appropriate member of Pharmacy staff after consultation with the ward/department leader and, if appropriate, with Medical staff.
- 2.2.7** Security of stocks of medication held on wards/departments will be checked periodically (at least every 3 months) by a Pharmacist or their representative.
- 2.2.8** The security of CDs on wards/departments **MUST** be checked by a Pharmacist, with audit and reconciliation, at least every 3 months, **AND** when there is any change in overall responsibility for drugs on a ward/department (e.g. change in appointment). These checks must be made in conjunction with the ward/department leader.
- 2.2.9** 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.
- 2.2.10** The **Pharmacy Manager, Clinical Services** is responsible for the provision of the Clinical Pharmacy service. This service is wide ranging; however, the following minimum standards will be observed by the ward/Clinical Pharmacists:
- 2.2.10.1** The Pharmacist should confirm that all sections of the prescription in use are written correctly and legibly, so as to reduce the risk of misunderstanding or error, and that it is signed by an authorised Prescriber.
- 2.2.10.2** The Pharmacist should be satisfied that any newly prescribed medicines will not pose a risk to patients/clients from significant interactions with other medicines being taken concurrently.
- 2.2.10.3** The Pharmacist should ensure that medicines are provided in a form appropriate and relevant for the administration to the particular patient, provided in an appropriate container giving the relevant information, and that the ward staff and/or patient advised appropriately on storage and security conditions.
- 2.2.10.4** Where the prescription for a specific item falls outside the terms of the Product Licence (whether as to its route of administration, dosage or other key factor), the Pharmacist will have taken steps to ensure that the Prescriber is aware and has chosen to exceed that licence.

2.2.10.5 If the prescription bears any written amendments made and signed by the Pharmacist, the Prescriber has been consulted and advised, and the amendments have been accepted.

2.2.10.6 The Pharmacist will monitor the effectiveness and the adverse side effects of medicines, and will report any adverse variance to the Prescriber.

2.2.10.7 The Pharmacist will, where possible, endeavour to ensure the safe, effective and cost-effective use of medicines that achieve the desired outcome(s) for the individual patient. Once satisfied that this is the case, the prescription must be annotated accordingly.

2.2.11 All medicines will be supplied in containers that are appropriate and suitably labelled. Labels **MUST** not be altered or otherwise defaced once they have been issued. If a label becomes damaged or obliterated, the container and medicine must be returned to the Pharmacy Department for replacement.

2.2.12 Pharmacy staff also have responsibilities for medicines reconciliation as outlined in chapter 21.

2.3 Doctors

2.3.1 Apart from specific exceptions within Patient Group Directions, only a registered Doctor or Nurse Prescriber has the authority to prescribe drugs for patients attending the Trust. Medical students are **NOT** allowed to prescribe. Section 10 of this policy gives further detail on prescribing.

2.3.2 Whenever possible, the Prescriber must ensure that the patient understands and is aware of the purpose of the treatment, and has given their consent (commonly implicit). 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. This should be available via individual Trust's intranets (SFH version is [here](#)).

2.3.3 The Prescriber is responsible for ensuring that the prescription includes:

2.3.3.1 The **NAME** and **ADDRESS** (or patient identifier for Genitourinary Medicine Outpatients) of the patient (on **ALL** relevant sections of the prescription).

2.3.3.2 The **DATE OF BIRTH** of the patient (on **ALL** relevant sections of the prescription).

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

2.3.3.4 The name of the **WARD/DEPARTMENT**.

- 2.3.3.5** The STARTING DATE of the drug treatment (which must also be BROUGHT FORWARD if the prescription is rewritten).
- 2.3.3.6** The GENERIC NAME of the drug (unless it is an approved exception such as theophylline preparations) and the ROUTE of administration, written CLEARLY and in BLOCK CAPITALS.
- 2.3.3.7** The TIME of administration, clearly indicated on the prescription. The frequency of administration of 'as required' medicines must be indicated by clear and definitely stated intervals.
- 2.3.3.8** The Prescriber's SIGNATURE, to authorise its dispensing or administration. If the signature is unclear, the Prescriber must print their name alongside in order to be identifiable.
- 2.3.3.9** The DURATION OF TREATMENT (as appropriate). Where such duration is predictable (such as for antibiotics), the number of days for which the prescription is valid must be indicated.
- 2.3.3.10** Clear and unambiguous CANCELLATION (as appropriate), which is signed and dated by the Prescriber. The cancellation must enable the easy identification of the cancelled item. This also includes prescription AMENDMENTS where the whole prescription line must be cancelled and re-written.
- 2.3.3.11** Details of any known DRUG ALLERGIES or HYPERSENSITIVITIES (see Section 10.2.1.2).
- 2.3.4** The admitting doctor has responsibilities to ensure that medicines reconciliation is undertaken as outlined in chapter 21. Nottinghamshire Healthcare Trust should refer to their own medicines reconciliation policy.

3 SUPPLY OF MEDICINES BY PHARMACY

Medicines are supplied by the Pharmacy Departments in several ways:

- to wards/departments as STOCK for use by more than one patient.
- to wards/departments as NAMED-PATIENT supplies, dispensed against an individual patients' prescription. This includes supplies provided as part of the 'One-Stop' dispensing service, where discharge-labelled supplies are dispensed to in-patients, used during the in-patient stay and issued on discharge as appropriate.
- to individual patients directly, dispensed against a discharge or outpatient prescription.

Individual prescriptions must fulfil legal requirements and be in accordance with procedures outlined in this policy.

3.1 Medicines other than Controlled Drugs

3.1.1 Stock Items

Routine items are supplied by the Pharmacy Departments by the following methods:

3.1.1.1 'Topping-Up' Service

Pharmacy Technicians or Assistants visit wards/departments at agreed intervals to check and replace stock items against an agreed stock list. The appropriate Pharmacy Technician/Assistant signs requisitions for replacement stock.

3.1.1.2 Ward Box Service (applicable only to those wards/departments NOT receiving a 'top-up' service).

A requisition signed by a Registered Nurse/Midwife is sent to the Pharmacy on an agreed day. Stock requisition documents must be securely stored when not in use.

Signatures of Registered Nurses/Midwives eligible to sign ward stock requisitions must be deposited with Pharmacy.

3.1.1.3 Stock Items Requested between 'Top-Up'/Requisition Days

Such items will be supplied by Pharmacy on submission of a stock requisition signed by a Registered Nurse/Midwife. In emergencies only, a telephone request for stock medicines will be accepted, but special care MUST be taken by Pharmacy staff to minimise the risk of TRANSCRIPTION ERRORS, and to ensure the identity of the requestor. Telephone requests for non-stock medicines are not accepted.

3.1.1.4 Storage of Stock Requisition books

Stock requisition books MUST be stored in a locked cupboard under the control of the Nurse in Charge of the ward department. Stock requisition books are used to order medicines outside the normal top-up supply process and as such provide a means for medicine supply direct to individuals for transport back to the ward/department or via the Envopak delivery system. Although identity checks are carried prior to issue of medicine these books do give easy access to medicine supply without a prescription.

3.1.2 Named-Patient Medicines (Non-stock)

These are those medicines that are not held as part of ward stock. These medicines are therefore supplied against the patients' prescription chart, which must either be sent to Pharmacy with the request for supply or will be ordered at ward level by a member of the Pharmacy staff.

3.1.3 Named-Patient Medicines (Non-stock) – faxed requests

Ordering prescribed drugs via a fax is inherently unsafe and under current Royal Pharmaceutical Society of Great Britain should be used only in exceptional circumstances and guidance requires the original prescription to be endorsed within 24 hours of the medicine supply. Hence, faxing of prescriptions on sites where a dispensary is present can only be accepted in **extreme circumstances** e.g. for the John Eastwood Hospice where the patient's pain control would be unacceptably compromised.

A separate procedure is available for those areas that are permitted to fax prescriptions for requesting medicine supplies.

3.1.4 Stock Lists

Stock lists for wards/departments must be agreed and reviewed at least annually between the Ward/Department Leader and the Ward Pharmacist or their representatives.

Each stock list is held on file in Pharmacy and no item is available for issue as ward stock without the specific authorisation of the Ward Pharmacist (unless on an agreed 'exception' list).

3.1.5 Transport and Receipt

With the exception of bulk fluids, medicine supplies are delivered to wards/departments in locked or otherwise sealed containers.

3.1.5.1 Delivery of stock medicines boxes

Stock medicines are supplied to wards and departments in sealed Tote boxes. Porters delivering these boxes must ensure that these are placed in a locked room and never left unattended in open areas.

3.1.5.2 Transport of medicines in Envopaks

Medicines that are delivered by a porter or messenger e.g. HCA, will be accompanied by a duplicate requisition or delivery note. The Envopak must be received by a qualified nurse/midwife at ward/department level. The nurse will sign for receipt of the Envopak and ensure that the Envopak is either stored securely or emptied immediately.

3.1.5.3 Transport of medicines via air tube

Some medicines are delivered to wards and departments via the air tube system. The delivery point cupboard should be kept locked to maintain security of medicines. Controlled drugs and fridge items are not to be transported via the air tube system.

3.1.5.4 Deliveries by transport services and taxis

Deliveries of medicines via the transport service or by taxis are accompanied by a triplicate form signed by the driver. One copy is retained by Pharmacy, one by transport and one by the receiving ward/department. The ward/department copy is signed on receipt of the goods and returned to Pharmacy to confirm that fact.

3.1.5.5 Deliveries to MCH/ACH

3.1.5.5.1 Where a medicine delivery is not made directly to a ward and transport use an intermediary delivery point e.g. reception desk, the intermediary recipient acknowledges receipt by signing the top (pink) copy. Thus, there is no record kept by the intermediary recipient.

3.1.5.5.2 Where a locked box is in use, one key for the locked box is held in Pharmacy; the second is held by the Shift Co-ordinator (see Section 5.2).

3.2 Controlled Drugs (CDs)

The responsibility for the ordering, receipt and proper storage of CDs lies with the Ward Sister or Charge Nurse. On receipt of CDs from Pharmacy, he/she is lawfully in possession of them and is accountable for their custody.

3.2.1 Ordering

All Schedule 2 CDs must be ordered using a standard CD Order Book. All Schedule 3 CDs must be ordered in a Schedule 3 CD Requisition Book. A listing of Schedule 2 and 3 CDs is given in Appendix 5.

3.2.1.1 CDs for stock will ONLY be supplied by the Pharmacy against a correctly completed order written in the official appropriate CD requisition or order book, and signed by a Registered Nurse/Midwife/ODP.

3.2.1.2 A list of signatures of Registered Nurses/Midwives/ODPs authorised to sign CD requisitions will be held centrally in Pharmacy. This list will be used to check the validity of the individual requesting CDs. The authorisation sheet can be seen in Appendix 6. All signatures must be countersigned by the Ward Sister, Charge Nurse or nominated Deputy. This Deputy must be Band 6 or above and be the operational Deputy for the ward or department. Exceptions to this will be made for the following areas where the authoriser may be the designated pharmacist for the area: Emergency Department, All Newark wards and departments, All MCH wards and departments and the Hospice. It is expected that if an individual starts work in an area where they will be expected to order CDs then they must present at the Pharmacy department alongside the authoriser and sign the centrally held signature log, for the above mentioned exceptions, this may be done locally by the designated pharmacist. Identification of both parties will be checked by the Pharmacy team at this point. If a CD order book is received and the signature is not on this central log then the CD book will be returned to the area and no supplies will be made. This is to ensure the security of CDs is maintained at all times.

3.2.1.3 Only ONE of each type of CD order/requisition book will be in use in a clinical area at one time.

3.2.1.4 The sample signature list will be kept in Pharmacy. Each signature will be countersigned by the ward/department leader or Pharmacist to verify the authenticity of the signature. The ward/department leader's signature will be authorised by a Nurse Manager or a Pharmacist.

3.2.1.5 CD registers AND order/requisition books must be stored in a locked cupboard or drawer.

A faxed order for CDs from an outside unit will be accepted to enable the preparation of the item(s), but the dispensed CD(s) will NOT be released until the original order has been received. In order to prevent duplication, the original requisition must be endorsed with the fact that it has been transmitted by fax. All areas have a designated CD stock list. If items are required which are not on the stock list then a current prescription for an individual patient will be required before a 7 day temporary stock supply will be made.

3.2.2 Transport and Receipt

3.2.2.1 The dispensing process will follow the procedure for CDs. All documentation and registers will be completed. A Pharmacist/Technician will sign the CD order book and the top copy of the order retained in Pharmacy.

3.2.2.2 Dispensed CDs and the order book will be placed into an Envopak, which will then be sealed with a unique, tamper-evident numbered clip. The duplicate CD delivery document will then be completed by a Pharmacist, dispensing assistant or Technicians including details of the destination ward/department and the clip number.

3.2.2.3 On completion of 3.2.2.2, the Envopaks will be transferred to a designated storage area until collected for delivery.

3.2.2.4 CDs will be delivered to on-site wards/departments by a Pharmacist or a designated messenger at agreed time(s), as a CD-specific delivery run. They may be delivered to outside units in a sealed container by an authorised person (e.g. Hospital transport) or by the use of taxis.

3.2.2.5 The authorised messenger will sign the delivery document against each line for CDs, after first checking that the delivery bag is sealed and the number is correct. The top copy of the delivery document will remain in Pharmacy; the bottom copy will accompany the authorised messenger on the delivery run.

3.2.2.6 Upon receipt of the CD delivery, the Registered Nurse/Midwife will sign the delivery document after confirming the number on the sealed bag is correct, in the presence of the authorised messenger.

3.2.2.7 The sealed bag will be opened by two Registered Nurses/Midwives/ODPs or a Registered Nurse/Midwife/ODPs with a Pharmacist or accredited checking Technician, and the supply checked against the CD order, which will be signed to confirm receipt. Any discrepancies will be reported to Pharmacy immediately.

3.2.2.8 Two Registered Nurses/Midwives/ODPs or a Registered Nurse/Midwife/ODP with a Pharmacist will record receipt in the ward/department CD register without delay, and secure the supply in the CD cupboard immediately. The amount received and the running total must be recorded in the CD register – in red ink - see example under section 6.1.2.5.

3.2.2.9 The authorised messenger will return the signed copy of the delivery document to Pharmacy at the next available opportunity.

3.2.3 Patients' Own CDs

3.2.3.1 Patients own CDs may be kept securely within the ward/department CD cupboard following the procedure below.

3.2.3.1.1 Patients' CDs should be logged in a 'CD log book' *i.e.* 'Record of Controlled Drugs Brought into Hospital by Individual Patients'. These are available from Pharmacy.

3.2.3.1.2 Patients own CDs should be received by a registered nurse/midwife, counted and checked by another registered nurse/midwife. An entry for each CD medicine should be made on a separate page of the 'CD log book'

3.2.3.1.3 Generally the nurse in charge will order CDs for administration to the patient; however there is a facility to use the CD log book to record administration of doses to that patient. The same 2 nurse process must be used for administration of the CD as would be used for any other CD administration. **Patient's own CDs must never be administered to another patient.**

3.2.3.1.4 As with hospital stock CDs a stock level check of patient's own CDs must be undertaken at least ONCE daily.

3.2.3.2 Patients may only keep their own CDs in their locked bedside medicines locker when that patient has been approved for self-administration and the patient is self-administering the CD. Further detail regarding the procedure is contained within the Trust's Self-Administration policy.

3.2.4 CDs to Take Home

3.2.4.1 Once dispensed CDs will either be delivered to the ward by a Pharmacist or designated messenger, or will be collected from Pharmacy by a designated messenger, who will be required to show official Trust identification.

3.2.4.2 On delivery to the ward, a Registered Nurse/Midwife will sign the delivery document to confirm that receipt has taken place. Unless the CDs are given to the patient immediately on receipt onto the ward they must be logged into the Patients' Own CD Log Book. The drugs will be stored in the ward CD cupboard until handed to the patient or their representative on discharge by a Registered Nurse/Midwife. When the controlled drugs are handed to the

patient/representative on discharge they must sign the Patients' Own CD log book.

3.3 Borrowing of Medicines

During the Pharmacy Department's opening hours, the transfer, or 'borrowing' of medicines between wards/departments is **DISCOURAGED**, unless in an emergency or specifically authorised by a Pharmacist. Such uncontrolled borrowing creates further subsequent medicine availability problems.

Outside normal Pharmacy Department's opening hours, all staff have access to an 'On-Call' Pharmacist and Emergency Medicine Cupboards if medicine supplies are urgently required. In some circumstances, the 'On-Call' Pharmacist will arrange for stock transfers between wards/departments.

The following guidelines must be followed when borrowing medicine from another ward/department:

- 3.3.1** Ward/department stock CDs **CANNOT** be legally transferred between wards or departments, and must **NEVER** be borrowed.
- 3.3.2** **SINGLE** doses of CDs may be administered to a patient on one ward/department from stocks on another. The necessary CD records must be made in the CD register of the ward making the supply (to whom the stock belongs).
- 3.3.3** Other (non-CD) drugs must only be transferred in the original container. Medicines must **NEVER** be decanted from one container to another.
- 3.3.4** The borrowed pack must be returned to the 'lending' ward immediately after administration to the patient, or arrangements made with the Pharmacy to provide a replacement supply.
- 3.3.5** If a medicine is available for a named-patient on a ward and a second patient is prescribed that medicine, the Registered Nurse/Midwife may use a dose of that medicine for the second patient, but a named-patient supply for the second patient should be obtained from Pharmacy as soon as possible. Please note the following exceptions:
 - Patients' own medicines that are not dispensed by the Sherwood Forest Hospitals during that hospital stay are the property of the individual patient and therefore **MUST NOT** be used for other patients.
 - Patients on clinical trial medicines: clinical trial medicines must never be used for administration to another patient.

3.4 Emergency supply of medicines to patients' relatives and carers

- 3.4.1** The hospital will not normally supply medicines to patients' relatives or carers. In the first instance they should be directed to Primary Care 24 who may issue them with a supply or a prescription. The prescription may be dispensed at a community Pharmacy or in exceptional circumstances within the Trust's Pharmacy.

- 3.4.2** In emergency situations e.g. where the person cannot get a prescription in adequate time an emergency supply may be supplied by a pharmacist from the Trust's dispensary following General Pharmaceutical Council guidelines.

3.5 Emergency supply of medicines to hospital staff

There is a separate policy covering these supplies – see Policy for self-prescribing and the prescribing of medicines for family members and colleagues

4 DISPENSING OF INDIVIDUAL PRESCRIPTIONS

4.1 General

- 4.1.1 Individual prescriptions must fulfil legal requirements and be in accordance with procedures outlined in this document.
- 4.1.2 Dispensing must NOT be undertaken by Nursing, Midwifery or Medical staff, EXCEPT for the process of issuing a pre-labelled pre-pack medicine specifically prepared by Pharmacy for a purpose of timely patient care. In order to supply medication in this way, there must be a procedure in place that has been agreed by a Head of Nursing and a Pharmacy Manager. To meet legal requirements, the pre-printed label on the pre-pack must be clearly endorsed with:
- the NAME (or unique patient identifier for Genitourinary Medicine Outpatients) of the patient
 - the DATE at the time of supply.

Supply in this manner may be against a Patient Group Direction (PGD), or against a written prescription by a Practitioner. The prescribing Consultant's team retains accountability for any supply made under these circumstances.

For supply of oral contraceptive tablets under PGDs within Contraception and Sexual Health (CaSH) services the nursing staff will select the appropriate pre-printed label for attaching to the tablet box. The patient's name and date are then written on the box as above.

- 4.1.3 Ward stocks and medicines dispensed for in-patients must NOT be given to patients against a discharge prescription unless authorised by the Pharmacy and labelled for an individual patient with full directions. Pharmacy will request that these medicines are given to the patient at discharge.
- 4.1.4 Trust staff collecting medicines from Pharmacy must carry official Trust identification.

It is the responsibility of Pharmacy staff to ensure that medicines are collected by authorised individuals only.

- 4.1.5 The identity of patients collecting outpatient medicines from Pharmacy must be checked by matching outpatient ticket numbers and confirming the name and address and/or date of birth. If there is any doubt then an issue will NOT be made without further checks.
- 4.1.6 In exceptional circumstances where patients or their representatives are collecting discharge medicines from Pharmacy this must be previously agreed with Pharmacy. The identity of patients collecting discharge medicines from Pharmacy must be checked by confirming the name and address of the patient and/or date of birth. If there is any doubt then an issue will NOT be made without further checks.

4.2 Discharge dispensing by nurses/midwives

The dispensing of medicines for patient discharge should take place only in pre-approved areas.

- 4.2.1 The NMC allows for nurses/midwives to dispense medicines to patients in **exceptional circumstances** and states that the process to be to the same standards ('reasonable skill and care') as provided by a pharmacist.
- 4.2.2 Dispensing performed by nurses/midwives should be undertaken in accordance with the standard operating procedure 'Procedure for the Dispensing of Pre-packed Medication at Discharge by Nursing Staff'.
- 4.2.3 For the purpose of nurse/midwife dispensing exceptional circumstances apply when the dispensaries are closed or with specific prior local agreement for that ward/department.
- 4.2.4 Nurse dispensing is permitted only in agreed (with Pharmacy) areas where specific pre-labelled stocks are available.
- 4.2.5 Two nurses/midwives must perform the dispensing process.
- 4.2.6 Ideally the nurse/midwife undertaking the dispensing process should not be the prescriber, but this may not always be achievable.
- 4.2.7 Part of the dispensing process requires the nurse to check that:
 - a. Each medicine is suitable for that patient
 - b. The dose is appropriate (taking into account the patient's age, weight, renal function, hepatic function and any specific disease factors)
 - c. There are no clinically significant interactions with other new or existing medicines that the patient may be taking
 - d. No contra-indications exist for the prescribed medicine
 - e. The patient has no allergies to the prescribed medicine
- 4.2.7.1 Should the nurse/midwife have any concerns regarding the prescription these should be queried with the prescriber and/or discussed with the on-call pharmacist.
- 4.2.7.2 Nicotine replace therapies are available as GSL products and are readily available for the public to purchase. The Trust allows these to be supplied by nursing & midwifery staff that have received smoking cessation training directly to patients for use during their inpatient stay and at discharge. No prescription is needed for these products.

4.3 Dispensing Without a Written Prescription

- 4.3.1** Pharmacists will NOT dispense medicines for individual patients (as opposed to supplying stock items) without a prescription written by a Practitioner except in an emergency when the clinical condition requires urgent medication and:
- a Doctor cannot leave a patient
 - no other Doctor is available to write the prescription
 - a Pharmacist cannot go to the Doctor to check the prescription prior to dispensing.

Inconvenience to the Prescriber would NEVER constitute an emergency.

- 4.3.2** Prescription of the dispensed medicine must be confirmed in writing at the earliest possible opportunity after the emergency (within 24 hours).

4.4 Checking of Dispensed Prescriptions

4.4.1 Dispensing Medicines

Prior to supply, a Pharmacist must ensure that the prescription is:

- legal
- legible
- unambiguous
- safe (the clinical check for correct dose, interactions *etc.*)
- appropriate for that patient
- having clear directions for administration.
- correctly transcribed from the in-patient prescription (for discharge prescriptions)

Any identified concerns will require clarification from the Prescriber and/or Nursing/Midwifery/ODP staff prior to dispensing.

For complex calculations of doses the pharmacist must ensure that a double check is employed by use of a colleague to subsequently check the initial calculation or by use of another dose calculation aid, for example those available via the medicine formulary and intranet.

The dispensed item(s) will then be checked against the prescription itself, for the accuracy of dispensing, and completeness of labelling by a Pharmacist or an Accredited Checking Technician.

Specific sections refer to dispensing of trial, unlicensed medicines and cytotoxic medicines – see chapters 13, 14 and 15.

4.5 Dispensing and Pharmacy review of specific medicines

4.5.1 Oral methotrexate

- 4.5.1.1** Patients should be asked to provide their patient's monitoring booklet to enable a check of dose changes, if any, since the last prescription issued. This check should take place for both inpatients and outpatients.

- 4.5.1.2** Patients should be assessed on an individual basis to ensure that they are able to take methotrexate (and other prescribed medicines) and alternative aids supplied where appropriate to reduce the likelihood of decanting of methotrexate into other containers at home.
- 4.5.1.3** The strength of tablet supplied to the patient must stay consistent to prevent any confusion about the number of tablets they need to take, and the patient's monitoring document and Patient Medication Record should be checked to confirm the previous supply.
- 4.5.1.4** The patient must be told their dose in terms of **quantity** of tablets and **weekly** frequency.
- 4.5.1.5** Patients that do not already have a monitoring booklet should be given one.
- 4.5.1.6** Show the patient how to differentiate between the oral methotrexate and folic acid packaging. If they take both medicines at the same time, they will need to know how to distinguish between them, given that both may be round yellow tablets of similar size.
- 4.5.1.7** Be aware of patients who attend with symptoms such as breathlessness, dry persistent cough, vomiting or diarrhoea, as these can be signs of oral methotrexate toxicity or intolerance. If any signs are apparent contact the prescriber immediately in person.

4.5.2 Opioid Medicines

In response to an NPSA alert there are specific processes that must be undertaken to help reduce patient risk at the dispensing stage – this applies to the checking of a prescription by a pharmacist in any location e.g. wards and dispensaries:

- 4.5.2.1** When an individual prescription for an opioid medicine is dispensed the pharmacist that approves the prescription must ensure that they are familiar with the therapeutic characteristics of the opioid to be dispensed. The pharmacist should be familiar with the usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose and common side-effects.
- 4.5.2.2** If the opioid is not prescribed at the expected starting dose and the opioid is not already being taken by the patient the pharmacist must contact the prescriber to confirm the dose.
- 4.5.2.3** The pharmacist should ensure that any dosage increases of the opioid are within accepted limits before allowing dispensing.
- 4.5.2.4** Refer to Appendix 7 for a pictorial representation for safe dispensing of opioid medicines.

4.6 Drug Alerts or Recall Notices

- 4.6.1** When an error/defect occurs in the manufacture of a commercially available medicinal product, the Medicines and Healthcare products Regulatory Agency (MHRA) will issue a Drug Alert. This will be received in Pharmacy, where the appropriate action will be taken according to the standard NHS Drug Alert procedure, and if necessary the drug recall procedure instigated:
- 4.6.2** Pharmacy staff will check computer records to assess whether the affected product has been received by the Trust, and to which wards/departments it may have been distributed. If wards/departments have been identified as having received the affected product, the Senior Pharmacy Technician (Stores and Distribution) or the Pharmacy Quality Control Section will contact them, giving details of the product concerned, and requesting that a Registered Nurse/Midwife take the appropriate action as specified in the Drug Alert.
- 4.6.3** If a product is recalled, it should be removed from stock and placed in a bag/box clearly labelled NOT FOR USE. This should be returned to Pharmacy for the attention of the Senior Pharmacy Technician (Stores and Distribution). It should also be clearly marked so as to identify from which ward/department it came.

4.7 National Patient Safety Agency (NPSA) Alerts

- 4.7.1** The NPSA is a Special Health Authority created in July 2001 to co-ordinate the efforts of the entire country to report, and more importantly to learn from mistakes and problems that affect patient safety. Safety alerts are implemented under the auspices of the Drug & Therapeutics Committee/ Medicines Optimisation Committee as appropriate. A list of alerts is outlined in appendix 4.

5 STORAGE OF MEDICINES ON WARDS AND IN DEPARTMENTS

5.1 Responsibility

The Nurse-in-Charge is responsible at all times for all medicines stored on their ward/department, including those in the bedside Patients' Own Drugs locker.

5.2 Custody and Safe Keeping of Keys

Keys are in place for CD cupboards, internal and external medicines cupboards, medicines trolley, medicine refrigerators, 'air tube' and patients' own drugs locker (master and locker-specific keys).

Keys are the responsibility of the Shift Co-ordinator, and may be separated into two sets, if deemed necessary by the Nurse-in-Charge.

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

5.2.1 CD Cupboards, Internal Medicines Cupboards, Medicines Trolley, Medicines refrigerator, Air Tube, Patients' Own Drugs Locker Master Keys

These are the responsibility of the Shift Co-ordinator 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 working within the same ward/department if deemed necessary by the Shift Co-ordinator. The nurse in charge may hand keys to a Pharmacist or Medicines Management Technician for legitimate access to these areas.

5.2.2 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 drugs.

5.2.3 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 medicines cupboard key. A standard agreed operating procedure must be in place for use within the designated area. Best practice requires periodic changing of the lock combination.

5.3 Duplicate Keys

The Trust does not maintain any duplicate keys for ward areas.

5.4 Patients' Own Drugs (POD) Locker Keys

Each patient's own drugs locker has its own specific key, and such keys must be locked in a specified lockable key cabinet, or the ward CD cupboard, or in the actual locker itself, unless their issue is authorised by local Self-Administration and/or reuse of patients' own drugs policy.

Master keys, which can access all such lockers, may be retained as part of the ward keys, and/or held by the Ward Pharmacist/Pharmacy Technician to enable access to check Patients' Own drugs.

5.5 Procedure If Keys Are Lost

5.5.1 Controlled Drugs Cupboard Keys

Lost or misplaced CD keys must be taken as a potentially serious situation that can give unauthorised individuals access to CDs. **The security of CDs at ward/department level is the responsibility of the nurse/midwife/ODP in charge of the area.**

- 5.5.1.1** Extra vigilance must be undertaken during the period that CD keys are lost or potentially stolen to ensure that there is no unauthorised access to the CD cupboard.
- 5.5.1.2** If CDs are needed before staff have access to the CD cupboard then staff must administer CDs using stock from a nearby ward or department, making a record in the other ward's or department's CD register.
- 5.5.1.3** There are no duplicate keys held for CD cupboards on SFHT sites. For operational reasons a local policy is in place for the storage of a duplicate CD cupboard key on the John Eastwood Hospice site.
- 5.5.1.4 Locating keys**
 - 5.5.1.4.1** **Urgent** effort must be made to locate the keys, or retrieve them from off-duty staff.
 - 5.5.1.4.2** The Duty Nurse Manager or equivalent must be informed.
 - 5.5.1.4.3** The Pharmacist in charge must be contacted the next working day, unless there are serious concerns that CDs have been stolen and there is risk to patient/public safety which case the Pharmacist in charge should be contacted immediately. They will inform the Chief Pharmacist as CD Accountable Officer (CDAO) and advise of any specific actions.
 - 5.5.1.4.4** It is expected that lost CD keys should be located and returned by the end of the shift in which they are noted to be lost (this will generally be within a 12 hour period). In exceptional circumstances extension to this period can be agreed with the CDAO
- 5.5.1.5** If the keys cannot be found/retrieved:
 - 5.5.1.5.1** The CDAO should already have been informed. The CDAO will advise if the Police need to be contacted.

5.5.1.5.2 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.

5.5.1.5.3 Once the CD cupboard has been accessed by Estates a check of all stock must be undertaken, all controlled drugs must be removed from and stored temporarily within a local ward's CD cupboard or in a temporary locked cupboard on the ward. Records of CDs transferred should be recorded and witness by 2 healthcare professionals i.e. the healthcare professional in charge of the area plus another registered nurse/midwife/ODP/ pharmacist or Pharmacy Technician.

5.5.1.6 On fitting of a new lock to the CD cupboard any spare keys must be handed to a pharmacist for destruction.

5.5.1.7 The Nurse in charge of the ward or department must complete an Incident Report form.

5.5.2 Ward/Department Medicine Cupboard Keys

5.5.2.1 Follow the process outlined under CD cupboard keys; however there may be less urgency and duplicate keys may exist within the ward area.

5.5.2.2 Local arrangements exist for storage of duplicates in areas outside Sherwood Forest Hospitals and the Pharmacist will advise.

5.5.2.3 Ensure that a copy of the key is passed to Pharmacy for topping-up of medicines.

5.5.2.4 Every step must be taken to resolve the situation as quickly as possible and extra vigilance must be observed during the interim period.

5.5.3 Patients' Own Drugs (POD) Locker Master Keys

5.5.3.1 The general principles under 5.5.1 should be followed however in addition the following should be applied:

5.5.3.2 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 and stored within the ward CD cupboard as patient's own CDs.**

5.5.3.3 **Until the master key is relocated CDs must not be stored within patients' lockers.**

5.5.3.4 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.

5.5.3.5 If the master key is not located within 5 working days of the loss of the master key 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.

5.6 Containers

Within 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.

5.7 Storage Locations

Intravenous fluids and sterile topical fluids are 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.

All other medicines must be stored in separate locked cupboards (which comply with the current British Standard for Medicines (BS 2881)) as detailed below.

5.7.1 Controlled Drugs Cupboard

The CD cupboard is reserved **solely** for the storage of

- the CD order book;
- schedule 2 CDs;
- schedule 3 CDs (those requiring safe storage - see appendix 5);
- patient's own CDs
- unknown or potentially illicit substances;
- a CD key held for safe storage for another ward/department.

Schedule 2 CDs and those schedule 3 CDs requiring safe custody e.g. *temazepam*, *buprenorphine* are legally required to be stored within the **inner** section of the CD cupboard. Other Schedule 3 CDs should be stored in the **outer** section of the CD cupboard this includes *midazolam*, *phenobarbital*, *tramadol*, *gabapentin* and *pregabalin*.

Access to the CD cupboard should be restricted and only for the purpose of accessing schedule 2 and 3 CDs or high strength potassium injections.

The CD cupboard must comply with the Misuse of Drugs (Safe Custody) Regulations. It must be within an internal medicine cupboard, secured to the wall and ideally connected to a red light to identify when the outer door is open.

Storage of CDs should comply with the criteria listed in Appendix 5, whether they be ward stock or patients' own, unless the patient is self-administering as described below.

If a patient is self-administering under the Trust's Self-administration Policy they may store their own CDs within their patient's own drugs cabinet if this is their own CDs from home or a specific TTO supply is made to them.

5.7.2 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 medicines cupboard (or refrigerator where appropriate) when not in use. The medicines' cupboard should only contain medicines as defined under the Medicines Act 1968.

5.7.3 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.

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

These must be locked at all times and COSHH Regulations must be adhered to.

5.7.5 Waste Medicines for Return to Pharmacy

Hospital or patients' own drugs that are no longer required e.g. expired or prescription stopped should be placed in a ward stock box, which should be kept locked if containing medicines. For those areas that do not have stock boxes waste medicines should be secured within a locked cupboard.

5.7.6 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 drug refrigerator running at between 2 and 8 degrees Centigrade. **Foodstuffs and pathological specimens must never be stored in a drug refrigerator.**

Refrigerator temperature must be checked at least once daily and recorded 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°C Medicines Information (or the on-call pharmacist) must be contacted before using any medicine. They will advise on whether the medicine is safe to use.

5.7.7 Medicines Freezer

Medicines requiring storage below 0°C must be stored in an appropriate freezer.

5.7.8 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 medicines cupboard or to the Pharmacy Department.

5.7.9 Resuscitation Equipment

For Clinical emergencies, all wards and clinical departments must have access to a resuscitation trolley, in line with local cardiopulmonary resuscitation guidelines.

5.7.10 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.

5.7.11 Patients' bedside cabinet

Medicines listed in appendix 3 may be stored safely in the bedside cabinet for immediate use by the patient.

5.8 Siting of Storage Accommodation

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

5.8.1 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 drug refrigerators as this can affect temperature control.

5.8.1 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 drugs, or at an appropriate easily accessible height on the wall.

5.9 Access to Cupboards Containing Drugs

5.9.1 Cupboards Other Than CD Cupboards

In addition to Registered Nurses/Midwives, 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.

5.9.2 CD Cupboards

Pharmacists or Pharmacy Technicians should check stock of CDs with the authorisation of the Shift Co-ordinator and in the presence of a Registered Nurse/Midwife.

5.9.3 Cleaning Materials Cupboard

Since children and patients at risk of self-harm may be at particular risk of ingesting such materials, the Shift Co-ordinator must be satisfied with security arrangements for cleaning materials in addition to drugs.

5.10 Sample Medicines, Dressings or Equipment etc.

The Chief Pharmacist is responsible for ensuring the quality of supply of drugs that are administered to our patients; hence all supplies are required to be under the control of the Pharmacy Department. Therefore, samples must NOT be accepted by any staff on any ward or department. All pharmaceutical representatives must

be directed to the Pharmacy Department, and any samples must only be delivered to Pharmacy Department with prior agreement. Supply of individual samples may require approval of the Drug and Therapeutics Committee. Such sample delivery does not infer availability to Nursing, Medical or Pharmacy staff, and such availability must only be authorised through an agreed local procedure. Refer to the Policy for Pharmaceutical representatives ([link](#)) in appendix 2

Non-medicines may only be accepted with specific approval of the Supplies Department to ensure liability cover.

6 STOCK BALANCES LOSSES AND DISCREPANCIES

6.1 Stock Balances

6.1.1 Drugs Other Than Controlled Drugs

Ward or departmental stocks will be routinely monitored during the Pharmacy top-up service, and/or formally at least every 6 months by a member of the Pharmacy Department in conjunction with the Shift Co-ordinator/ Nurse-in-Charge.

6.1.2 Controlled Drugs

- 6.1.2.1 The stock balance of all CDs entered in the CD Register must be checked by two Registered Nurses/Midwives (ideally the Shift Co-ordinators for each shift) against the actual stock held **at least once during every 24-hour period. Any discrepancies must be dealt with immediately as described in section 6.2 below.**
- 6.1.2.2 The check must be undertaken at the ends of shifts, with the exception of the hospice and recorded in a CD Checking Register or CD Register, or a separate record book. The entry must be dated and signed by two Registered Nurses/Midwives. The levels in each record location must tally.
- 6.1.2.3 In areas where a 24-hour service does not operate, two Registered Nurses/Midwives must check stocks of CDs at the beginning and end of the working day. In the event of a ward/department closure greater than 24 hours, refer to Section 8.
- 6.1.2.4 Stock balances of individual preparations must be checked after every administration, and recorded in the CD Register. Liquids may be checked by visual inspection. Sealed packs must not be opened for counting purposes.
- 6.1.2.5 When recording in the CD register, if an error is made, it must NOT be crossed out or obliterated, instead the incorrect entry should be bracketed and asterisked and the word error recorded at the top or bottom of the page. The correct entry, as it should have appeared, should be made alongside. An example follows:

NAME, FORM OF PREPARATION AND STRENGTH Morphine Sulphate Concentrated solution 100mg/5ml

*Error

AMOUNTS ADMINISTERED						
Date	Time	Patient's Name	Amount Given	Given By (Signature)	Witnessed By (Signature)	STOCK BALANCE
2/4/8	14:15	John Smith	10ml	R Wann	SJ Farns	90ml
2/4/8	16:10	Jane Farriday	5ml	J Sykes	P Brody	85ml
2/4/8	18:30	Paul a Barnett	(5ml)* 10ml	J Skyes	P Brody	(80ml)* 75ml
2/4/8	18:45	John Smith	10ml	J Sykes	P Brody	(70ml)* 65ml

In the example above 5ml was entered incorrectly on the third line, but was not corrected until the next line. The incorrect entries are asterisked and bracketed and the correct entries written alongside.

- 6.1.2.6** It is the responsibility of the Nurse/Midwifery Manager to ensure that the above checks are carried out.
- 6.1.2.7** It is the responsibility of the Ward Pharmacist (or a nominated Pharmacist) to check CD stocks and registers every 3-6 months, including an accurate check of liquid volumes at this point.
- 6.1.2.8** The necessity for more frequent checks will be made at the discretion of Nurse/Midwifery Managers in liaison with the Chief Pharmacist.
- 6.1.2.9** Once full, CD Registers and Order Books must be retained on the ward/department to which they relate for a period of 2 years from the date of the last entry. They may be destroyed as confidential waste after this period.

6.2 Losses and Discrepancies of Medicines

6.2.1 Medicines Other Than Controlled Drugs

- 6.2.1.1** 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 drugs that should be transferred between wards together with the patient i.e. patients' own drugs and those drugs specifically labelled for individual patients. These will be generally stored in the patients' own drugs locker.

- 6.2.1.2** 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. If clear stock balance discrepancies are proven, the medicine(s) under investigation must be made subject to equivalent CD restrictions, with the maintenance of a register for all administered doses.
- 6.2.1.3** 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.
- 6.2.1.4** Where there is suspicion of drug misappropriation or abuse, investigations will be instigated under the direct supervision of the Nurse/Midwifery Manager and a Pharmacy Manager (see Section 6.2.2.4). The appropriate consultant(s) should be informed in the event of Medical staff involvement.
- 6.2.1.5** Where the loss is explainable, or there is no suspicion of misappropriation or abuse, the Shift Co-ordinator should report their findings to the Ward/Department Leader in writing.

6.2.2 Controlled Drugs

- 6.2.2.1 The controlled drugs accountable officer must be informed of any concern or suspicion around controlled drugs.**
- 6.2.2.2** The Shift Co-ordinator or Nurse-in-Charge must investigate all discrepancies between the stock balance and the CD Register.
- 6.2.2.3** Any discrepancy that is not satisfactorily resolved, following investigations made by the Shift Co-ordinator and the ward Pharmacist **MUST** be reported to the appropriate Nurse/Midwifery Manager and a Pharmacy Manager, and an incident form completed.
- 6.2.2.4** Out-of-hours the Duty Nurse Manager must be informed. The on-call pharmacist does not need to be called for minor losses of CDs. The appropriate Nurse/Midwifery Manager and Pharmacy Manager must be informed at the earliest reasonable opportunity in working hours. A pharmacy manager should be alerted if there is significant loss that may require the involvement of the police.
- 6.2.2.5** The Nurse/Midwifery Manager and Pharmacy Manager will determine the appropriate course of action (which could include the immediate implementation of systems to rigorously control the movement of stock). At this stage, the Director of Nursing Services, the Chief Pharmacist or Clinical Director must be informed.
- 6.2.2.6** Where there is any concern regarding the security of Controlled Drugs the Chief Pharmacist as the Trust Accountable Officer for Controlled Drugs must be informed.

- 6.2.2.7** If any other outside agency is involved (e.g. the police), then the Trust Chief Executive and appropriate Divisional General Manager must be notified.

7 RETURN OF MEDICINES NO LONGER REQUIRED

7.1 Medicines Other Than Controlled Drugs

Any such medicines should be returned to Pharmacy for destruction or recycling. They should be kept in their original container and placed in the ward Pharmacy box, until returned to the Pharmacy Department. The ward Pharmacy box should be closed and locked at all times if it contains any drugs.

Ward stock items should not be returned without consultation with the Ward Pharmacist or Pharmacy Technician.

7.2 Controlled Drugs (stock and patients' own)

Unwanted CDs must only be returned from a ward/department by a Pharmacist or Medicines Management Technician, or destroyed at ward/department level by a Pharmacist or Medicines Management Technician. They must NOT be returned in ward Pharmacy boxes or Pharmacy delivery packs. Any expired/unwanted CDs, or suspected illegal substances returned to Pharmacy by a Pharmacist MUST be processed as soon as feasible by that Pharmacist/ Medicines Management Technician, for return or destruction as appropriate.

7.2.1 Destruction on Ward/Department

Both stock and patient's own CDs can be destroyed at ward level by Pharmacists and Medicines Management Technicians trained to destroy CDs. The destruction must be witnessed and countersigned by a Registered Nurse/Midwife. A separate Pharmacy procedure outlines the process that must be followed.

7.2.2 Returning Controlled Drugs to Pharmacy

7.2.2.1 CDs must be removed from the ward by a Pharmacist or Medicines Management Technician in liaison with a Registered Nurse/Midwife, who must countersign the amended CD Register entry made by the Pharmacist or Technician.

7.2.2.2 A 'Record of a Controlled Drug Returned to Pharmacy' slip must be completed by the Pharmacist/Technician and the Registered Nurse/Midwife, stating the quantity returned and by whom, to accompany the drugs back to the Pharmacy. If this slip is not available, a CD requisition book order sheet can be utilised for this purpose, by replacing 'Ordered by' with 'Returned by' (for the Nurse's signature), and 'Supplied by' with 'Received by' (for the Pharmacist/Technician's signature).

7.2.2.3 The returned CDs must be transported back to Pharmacy by the Pharmacist/Technician, in a closed Pharmacy box or bag.

7.2.2.4 The returning Pharmacist/Technician must immediately make appropriate CD register and Pharmacy computer system entries (to ensure a complete audit trail), and return the item(s) to the CD cupboard.

7.2.3 Expired Controlled Drugs (Stock, Patients' Own and Pharmacy)

Destruction at ward level is achieved by denaturing to make irretrievable by use of controlled drugs destruction kits. Some medicines e.g. modified release tablets may need to be pulverised before adding to the kit by use of a blender.

7.2.3.1 Expired Stock Controlled Drugs

A Pharmacist or MMT in liaison with a Registered Nurse/Midwife can destroy such CDs on the ward/department. An entry must be made in the CD register that the CD was 'destroyed on ward by Pharmacist/MMT'. The CD Register entry must be filled out and signed for by the Pharmacist/MMT and countersigned by the Registered Nurse/Midwife.

7.2.3.2 Where it is not feasible to destroy CDs at ward level these may be returned to Pharmacy for destruction using a 'Record of Controlled Drugs Returned to Pharmacy form'.

7.2.4 Patients' Own prescribed Controlled Drugs

7.2.4.1 Patients' own CDs can be destroyed on the ward/department by a Pharmacist/MMT in liaison with a Registered Nurse/Midwife, who must countersign the 'destroyed on ward by Pharmacist/MMT' CD Register entry made, and signed for, by the Pharmacist/MMT.

7.2.4.2 Once CDs have been added to a controlled drugs destruction kits, they can be treated as Clinical waste and destroyed, as per standard practice.

7.2.5 Patients in Possession of Illicit Controlled Drugs

Patients may be, or be suspected to be, in possession of non-prescribed illicit controlled drugs such as those from schedule 1 (e.g. cannabis, LSD) or others such as heroin, barbiturates. A Home Office license is required to hold schedule 1 drugs with the exception that a Pharmacist may hold these drugs **only** for the purpose of subsequent destruction or handing to a police officer. If possession of illicit CDs is known or suspected the following action should be taken:

7.2.5.1 Inform the Nurse/Midwifery manager.

7.2.5.2 Inform the patient that possession of the drug is illegal and request that if they hand over the item for destruction by the Pharmacist their confidentiality will be maintained [but see 7.2.5.5 for large quantities]. If they refuse to hand over the substance refer to 7.2.5.4. Store the suspected substance in the CD cupboard observing the same procedure as for patients' own CDs. An appropriate entry should be made in the Patient's own CD register; if the identity of the substance is unknown a descriptive reference should be used e.g. 'white crystalline powder', 'herbal material'.

7.2.5.2.1 The substance should not be held on the ward for longer than 48 hours: Pharmacy should be contacted to collect for destruction or destroy on the ward.

- 7.2.5.3** If the patient refuses to hand over the substance they should be informed that they are committing a criminal offence and that the police will be called. If they continue to refuse to hand over the substance then call the police immediately. Staff should **never** use force to remove substances from patients, however, for the purposes of safe custody, illicit or suspected illicit substances should be removed from patients that are unconscious or otherwise unable to hand over an item.
- 7.2.5.4** Patient confidentiality will be maintained unless it is considered that the quantity is so large that it is unlikely that the substance is intended solely for the patients' personal use. In such cases the situation should be discussed with a senior Pharmacist with the possibility for calling in the Police to the Trust.
- 7.2.5.5** An incident report form should be completed making note of all staff involved in the consultation e.g. Pharmacist and police officer names.
- 7.2.5.6** Under no circumstances should illicit CDs be handed back to a patient, as this would constitute the illegal supply of a CD by that member of staff. The penalties for such offences are often high and can involve custodial sentences.
- 7.2.5.7** Small quantities of suspected illicit CDs must be transferred to Pharmacy. A Pharmacist/MMT will destroy 'illicit' CDs, including those in schedule 1; in accordance with the standard destruction of patients' own CDs.
- 7.2.5.8** If further advice is needed call a Pharmacy Manager or the Chief Pharmacist. Out of hours contact the on-call Pharmacist.

7.2.6 Destruction of Patients' Unwanted own CDs in Pharmacy

The return of patients' own CDs to Pharmacy for destruction should be discouraged. The Pharmacist returning such CDs is responsible for their immediate destruction.

- 7.2.6.1** The destruction of patients' own CDs must be recorded in the appropriate section of the Pharmacy CD Destruction Register.
- 7.2.6.2** Their destruction must be witnessed and signed for (the witness can be another Pharmacist or Medicines Management Technician).
- 7.2.6.3** Patients' own CDs should be kept on the ward only whilst the patient is within the hospital. Any unwanted CDs must be processed for destruction within 48 hours of the patient leaving.

7.2.7 Pharmacy Controlled Drugs

- 7.2.7.1** Expired or otherwise unusable Pharmacy CD stocks must be booked out of the Pharmacy computer system, the Pharmacy CD Register, and transferred into the appropriate section of the Pharmacy CD Destruction Register.
- 7.2.7.2** Such items must then be destroyed as per procedure.

7.3 Managing Deceased patients' Medicines

- 7.3.1 Patients' own medicines of inpatients that have died must be managed sensitively and appropriately.
- 7.3.2 Under no circumstances must Controlled Drugs be returned to family or carers as this would constitute an illegal supply.
- 7.3.3 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.
- 7.3.4 Medicines must **never** be sent to the Trust mortuary.

7.4 Donation of medicines to other countries.

- 7.4.1 Medicines returned from patients cannot be sent to other countries for their use.
- 7.4.2 In addition the World Health Organisation states:

"After arrival in the recipient country all donated medicines should have a remaining shelf-life of at least one year. Large quantities of donated medicines become a logistical challenge, even with a long shelf-life. Therefore, based on the national consumption and available quantities in stock or in the supply chain pipeline, all donated quantities should match the needs to be consumed before they are expired."

8 WARD AND DEPARTMENTAL CLOSURES

8.1 Intermittent Ward Closures (10 Days or Less)

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, and are not referred to in 8.3 below and includes Bank Holidays and weekends.

8.1.1 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. 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.

8.1.2 Controlled Drugs

CDs should not be left on a ward/department during its closure (although the CD Registers may be). They can either be transferred to the Pharmacy Department for safe storage, or to a designated receiving ward if required for use.

8.1.2.1 Removing Controlled Drugs from a Ward/Department to Pharmacy

- CDs should be checked into a Pharmacy delivery pack by either two Registered Nurses/Midwives, or a Registered Nurse/Midwife and a Pharmacist.
- The Pharmacy delivery pack must be sealed with a uniquely numbered tamper-evident tag.
- Entries must be made in the CD Checking Register by both members of staff, stating the contents of the Pharmacy pack and that the CDs have been removed due to ward/department closure.
- The sealed bag must then be delivered to Pharmacy by one of the signatory Registered Nurse/Midwives, where it is stored in the CD cupboard.
- On reopening the ward/department, the CDs will be returned from the Pharmacy Department and rechecked in to the Checking CD Register by either two Registered Nurses/Midwives, or a Registered Nurse/Midwife and a Pharmacist.

8.1.2.2 Removing Controlled Drugs From a Ward/Department to a Designated Receiving Ward

- The CDs AND the Registers must be transferred together to the designated receiving ward, by the Shift Co-ordinator
- CDs not required for use should be placed in an envelope, sealed and signed for across the seal by the Shift Co-ordinator. They must then be placed in the CD cupboard on the designated receiving ward.
- Appropriate entries must be made in the CD register and CD Checking register and signed by two Registered Nurses/Midwives, as per standard procedure.

8.2 Long Term Ward/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 (Sherwood Forest Hospitals only). Local arrangements exist for other areas.

Stocks of CDs must be returned by a Pharmacist/Pharmacy Technician as specified in Section 7.2.

8.3 Temporary Ward or Department Closures

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.

8.3.1 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.

8.3.2 Where departments or wards shut temporarily e.g. overnight, general medicine keys (see 8.3.2.1 for CD keys) must be stored in a secure place which should be staffed 24 hours a day. This can be either the security office or an agreed documented adjacent ward or department.

8.3.2.1 If CD keys are to be stored on other wards or departments, the keys must be stored in the CD cupboard. The keys must be signed in and out of the CD cupboard by an authorised member of staff (see authorised keyholders above) and witnessed by a second healthcare professional. There should be a book designated for this specific purpose on the ward receiving the keys.

9 PATIENTS' OWN MEDICINES

The Trust, in agreement with the local PCTs, 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.

9.1 Procedure on Admission

- 9.1.1** The admitting Registered Nurse/Midwife must ascertain whether the patient has brought any medicines into the Trust and inform the admitting Doctor.
- 9.1.2** 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.
- 9.1.3** As with any medicines, patients' own medicines must be stored securely during their stay. It is the responsibility of the Nurse-in-Charge 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.
- 9.1.4** Medicines brought into hospital by patients should be reviewed by the admitting Doctor in conjunction with any written communication from the GP or other referring practitioner. The process for medicines reconciliation is outlined in chapter 21.
- 9.1.4.1** It is the duty of the admitting Doctor to decide whether or not to continue the prescription of the existing medication as appropriate.
- 9.1.4.2** 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. Reason(s) for discontinuation should be stated.
- 9.1.5** Medicines brought into the hospital may, with the patients' permission, continue to be used provided:
- they have been prescribed on the patients' prescription chart
 - they are deemed suitable for use as specified by the **Checklist for the use of Patients' Own Drugs (PODs)** – see appendix 1.
 - it is not a schedule 2 or 3 controlled drug – see appendix 5.
 - the patients' own medicines are not in a compliance aid as this does not allow adequate identification of the medicine by Nursing staff to allow administration. The compliance aid should be stored on the ward and future use and supply issues discussed with the ward Pharmacist.
- 9.1.6** It is important to empty the Patients' Own Drugs (POD) locker as soon as a patient is discharged/transferred in avoid potential medication errors.

- 9.1.7** As with other medicines, Patients' Own must be stored within a secure cupboard when not in direct control of a practitioner.
- 9.1.8** Patients own medication must not be used for other patients under any circumstances.

9.2 Discharge Procedure

- 9.2.1** The discharge prescription and inpatient chart 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 (OWN)
 - a pre-labelled supply from the Trust is available at ward level (ON WARD)
 - or a new supply is made for that TTO (DISPENSARY).
- 9.2.1.1** Most TTOs are processed electronically, but for remaining areas that use paper prescriptions these will be signed in green by a Pharmacist or Accredited Checking Technician; this signature indicates that the prescription is complete and that the medicines may be supplied to the patient.
- 9.2.2** At discharge the Nurse **MUST** check all medicines, including patients' own, against the discharge prescription prior to issuing to the patient to take home.

9.3 Transfer of Patients' Own Medicines between Locations

- 9.3.1** 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. Failure to comply with this will require completion of incident form as described in section 6.2 – Losses and Discrepancies of Medicines.
- 9.3.2** 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.

9.4 Disposal of Unwanted Patients' Own Medicines

- 9.4.1** Patients' own medicines that are no longer needed or are unsuitable for use should ideally be destroyed by returning them to Pharmacy for incineration. This may only take place provided the patient or representative agrees to disposal.
- 9.4.2** Should the patient or patient's representative insist that the drugs be returned, they should be advised if the medicines are not safe for use or no longer required. A decision to not return the drugs 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.

10 PRESCRIBING

10.1 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.

10.2 Prescriptions

Treatment may only be administered on the authorisation of a Doctor, independent or supplementary prescriber. (Staff that are authorised within individual PGDs may **themselves** administer the medicine(s) within that PGD and Midwives may administer certain medicines on their exemption list). This is enacted in several ways:

10.2.1 A prescription written by the Practitioner on the official Trust 'Medicine Prescription and Administration Record' sheets is the normal authorisation (see Section 10.2). This applies to all areas of the Trust where nurses are administering to patients including 'Day Case' and 'ward attendees'. Where Day Case patients stay for longer than 48 hours they must have an inpatient 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 Trust Drugs and Therapeutics Committee.

10.2.2 Under exceptional circumstances, a Registered Nurse/Midwife or a Pharmacist may accept a verbal message from a Practitioner (see Section 11.10).

10.3 Prescribing Procedures

10.3.1 General Instructions - it is the responsibility of the Prescriber to:

10.3.1.1 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 where available NHS 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.

10.3.1.2 Where the dose of the drug is prescribed in accordance with BODY SURFACE AREA (BSA) or actual patient 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.

10.3.1.3 List the medicine(s) and known EFFECTS of any known drug allergies or hypersensitivities on 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.

10.3.1.4 Complete the Medication Changes on Admission section of the Medicine Prescription and Administration Chart, sign and date.

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

10.3.2 Prescribing Medicines

Prescriptions MUST be written LEGIBLY in INDELIBLE black or blue ink.

Pharmacists may add prescriptions under the Trust's Enabling Policy and these medicines are written in green. The Prescriber MUST ALWAYS complete:

10.3.2.1 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. *MST* or *MXL*).
- The FORM of the medicine (if not a tablet or capsule).

10.3.2.2 The DOSE

10.3.2.2.1 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 drug formulary and intranet.

10.3.2.2.2 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).

10.3.2.3 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, NASAL	-	into the eye(s), ear(s), nostril(s) <i>etc.</i> (specify which as necessary)

The prescribing of multiple routes of administration for a drug should be discouraged, and if used usually only relates to 'as required' drugs.

10.3.2.4 The TIMES of administration. The Prescriber must tick or ring the specified column beside those times at which the medicine is to be given. If these 'standard' times are inappropriate, the Prescriber must write the time required in one of the blank boxes provided, place a tick next to it and inform Nursing/Midwifery staff.

A continuous infusion should have a circle around all administration times.

10.3.2.5 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.

10.3.2.6 The STOP/REVIEW DATE box on the chart should be completed when appropriate for defined courses of therapy.

10.3.2.7 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.

10.3.3 The Administration Record

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

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

10.3.3.2 To terminate treatment – see section 10.3.1. Other lines drawn across the administration record may cause confusion.

10.3.3.3 To sign for an administered dose

10.3.4 Intravenous Medication

10.3.4.1 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.

10.3.4.2 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.

10.3.4.3 Medicines to be given by IV bolus injection must be written in the appropriate section of the main prescription sheet.

10.3.4.4 It is the responsibility of the person administering IV medicines to ensure that there are no incompatibilities between the IV medicines.

10.3.5 'Once-only' Prescriptions

The TIME of administration must be specified.

10.3.6 'As required' Prescriptions

10.3.6.1 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.

10.3.6.2 The MINIMUM INTERVAL between doses, and the MAXIMUM number of doses to be given in a specified period of time must be stated.

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

10.3.7 'Variable dose' Prescriptions

All such doses must be prescribed individually.

10.3.8 Use of Specialised Prescribing Charts, e.g. Insulin, Anticoagulation, Acute Pain etc. The Prescriber must:

10.3.8.1 Enter the name of the medicine in the 'regular' section of the prescription chart.

10.3.8.2 Write, "see.....chart", or "as per.....chart" in the 'regular' section of the prescription chart.

10.3.8.3 Write the full prescription on the specialised chart.

10.3.9 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).

10.3.10 Combination (sequential) Packs

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

10.3.11 Unclear, Ambiguous, Illegible or Incomplete Prescriptions

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

10.3.11.2 Pharmacists may make minor clarifying amendments to the prescription chart, but must consult the Prescriber if the original intention is unclear. Any Pharmacist annotation must be written clearly in green ink, signed, dated.

10.3.11.3 Only staff who are independent prescribers may amend prescriptions.

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

10.3.12 Supplementary Prescription Charts

The Trust has a number of additional charts for the prescribing of certain medications, particularly those with variable doses.

In order to prevent missed doses, it is important that these charts are appropriately cross referenced with the main Medication Prescription and Administration Record.

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

10.3.12.1.1 Refer to the additional chart on the front of the main 'Medicine Prescription and Administration Record' as shown in figure 1.

Figure 1: 'Other medicines charts / sections in use (TICK)'

pharmacy review check by: _____ Date: _____	
Other medicine charts/sections in use (TICK)	
Insulin <input checked="" type="checkbox"/>	Ophthalmology <input type="checkbox"/>
TPN/Nutrition <input type="checkbox"/>	Intrathecal <input type="checkbox"/>
SC Syringe Driver <input type="checkbox"/>	Chemotherapy <input type="checkbox"/>
IV Heparin <input type="checkbox"/>	Critical Care Infusion <input type="checkbox"/>
Anticoagulation <input type="checkbox"/>	
Additional 'Prescriptions for Infusions'	<input type="checkbox"/>
PCA/Epidural/Regional anaesthesia	<input type="checkbox"/>
Midwives Exemption Record	<input type="checkbox"/>
Others (specify) _____	<input type="checkbox"/>
TTO prescribed by: _____ Date & time: _____	

10.3.12.1.2 Prescribe the medication on the regular section of the 'Medicine Prescription and Administration Record' as shown in figure 2. 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 3.

Figure 2: Regular Prescription Administration Record example.

2 Medicine		24-hour review completed on: Date: _____	3-day review completed on: Date: _____
INSULIN		06	
Dose	Route	08	
APC	SIC	12	
Additional Instructions / Information	Stop/Review Date	14	
Signature	Print Name	17	
Pharmacist check	Source of Supply	22	
		If for infusion state: Fluid	Volume (ml)
		NEW <input type="checkbox"/> Counsellor <input type="checkbox"/> DfA Amended <input type="checkbox"/> DfA Unchanged <input checked="" type="checkbox"/> Supply at home <input type="checkbox"/>	

10.3.12.1.3 The signature for administration should appear on the specialist / additional prescription chart as shown in figure 3.

Figure 3: Signature record of the administered dose.

FOR REGULAR SUBCUTANEOUS									
Name of Insulin	Time	Dose in Units	Date	Date	Date	Date	Date	Date	Date
		START DATE	1st Dose DATE	2nd Dose DATE	3rd Dose DATE	4th Dose DATE	5th Dose DATE	6th Dose DATE	7th Dose DATE
HUMULIN I	8:00	16	15/3	16/3	17/3	18/3	19/3	20/3	21/3
Pharm	17:00	16	15/3	16/3	17/3	18/3	19/3	20/3	21/3
Signature									
Name of Insulin		Dose in Units	Date	Date	Date	Date	Date	Date	Date

10.3.13 Patient Group Directions (PGDs)

A PGD is a written direction relating to the supply and/or administration of medicines to a specified patient group, without the need for an individual prescription written by a Doctor. PGDs should only be used once the Healthcare Professional has been deemed as competent. Their name must be identified within the appropriate PGD. The administration of medicines via a PGD may not be delegated. Students cannot supply or administer under a PGD but would be expected to understand the principles and be involved in the process.

10.3.13.1 Specific PGDs are available in limited Clinical areas, to enable the facilitation of specified treatments to particular patient groups. PGDs are compiled and authorised by the Trust Drugs and Therapeutics Committee, with the signed agreement of the DTC Chairman, a Divisional Matron or equivalent professional lead and Pharmacy Manager.

10.3.13.2 Administration of medicines to inpatients under a PGD should be documented on the appropriate section on the front of the Medicine Prescription and Administration Chart.

10.3.13.3 PGDs specify:

- who can supply/administer the medicines
- what training/competency is required
- medicine dosage, route, indication, contraindication and patient instructions
- documentation
- treatment duration
- patient inclusion and exclusion criteria
- supporting information.

10.3.13.4 Such PGDs must be kept under regular review.

10.3.13.5 An updated list of appropriate trained staff should be kept within the Clinical area designated by the PGD and a duplicate copy in pharmacy.

10.3.14 Trust Global Directions (TGDs)

Sherwood Forest Hospitals has agreed a number of directions that permit the administration or supply of medicines to patients by groups of staff that are not covered under PGD legislation. Only staff that have been trained and approved to use these TGDs may operate within these directions.

10.4 Cancellations and Alterations to Prescriptions

10.4.1 To cancel a prescription

10.4.1.1 A bold 'X' must be drawn across the whole of the prescription section for the medicine in question.

10.4.1.2 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.

10.4.1.3 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'.

10.4.1.4 All cancellations MUST be signed and dated by the Prescriber making the cancellation.

10.4.1.5 A drug 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.

10.4.1 To amend a prescription

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.

10.5 Procedure when a Prescription Chart is Full or Unusable

Generally, no more than one prescription chart should be in use for each patient, UNLESS there are too many concurrently prescribed drugs to fit one chart.

10.5.1 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.

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

10.5.2.1 Annotate the charts as, e.g. "1 of 2", "2 of 2" charts etc.

10.5.2.2 Securely attach ALL active prescription sheets together (e.g. with a 'treasury tag').

10.5.2.3 Return to the use of a single prescription sheet as soon as possible.

10.5.2.4 Prescribers must not alter the established sequence of dates on the administration record in order to prolong the life of a prescription sheet.

10.6 Transferred Patients

The prescription sheet must accompany the patient and his/her notes during transfer.

- 10.6.1** On arrival at a new ward within the same hospital, or at a new location within the Trust, the SAME prescription sheet should be used with the ward, hospital and consultant details amended accordingly.
- 10.6.2** Any unusual, non-stock or patients' own or drugs specifically labelled for that patient MUST also be transferred with the patient to the new location.
- 10.6.3** For transfers external to the Trust, a letter giving details of current medicines and their start dates must accompany the patient. If it is likely that the patient will need treatment en route, then the prescription sheet and an adequate supply of medicines must accompany them. The original prescription sheet ceases to be valid on arrival at the receiving ward, and must be returned to the Trust for filing in the patients' notes.

10.7 Medicines to Take Out/Home (TTOs)

- 10.7.1** A prescription must be written for ALL medicines (including all dressings) to be dispensed for use after discharge or transfer outside the hospital, 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.
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.
In the case of Midwives dispensing medicines that are not prescribed but on the exemption list for Midwives please refer to section 20.
- 10.7.2** 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.
- 10.7.3** 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 overnight and require an inpatient prescription 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.
- 10.7.4** Prescription writing standards apply as in 10.2.2; it is the responsibility of the Prescriber to ensure that the patients' name, address, date of birth and ward are on the prescription, and that they are accurate.
- 10.7.5** Normally, medication for a maximum of **28 days treatment** will be supplied. Shorter courses (e.g. for antibiotics) MUST have the duration specified. Treatments to be continued beyond 28 days should be recorded on the discharge prescription. Such drugs will then be labelled appropriately.

- 10.7.6** It is important that the patient understands his/her discharge treatment, particularly where changes have been made. It is essential, therefore, that the details on the patient copy of the TTO form are legible – this can be increased by writing the TTO with a ballpoint pen on a hard surface.
- 10.7.7** Prescribers should seek Pharmacist assistance if necessary, to ensure that the advice given to patients about their discharge medication is clear and appropriate.

10.8 Outpatients

- 10.8.1** Prescriptions must be written on the appropriate outpatient and Emergency Department (ED) prescription forms.
- 10.8.2** Normally a maximum of **28 days' treatment** is supplied.
- 10.8.3** Any changes to a patient's prescription should be conveyed promptly to the GP.

10.10 Requirements for Prescribing of specific medicines

10.10.1 Oral methotrexate

- 10.10.1.1** 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.
- 10.10.1.2** The use of 'as directed' on prescriptions for methotrexate is not accepted.
- 10.10.1.3** The quantity **and** frequency of tablets must be regularly discussed with the patient.
- 10.10.1.4** 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 diarrhoea.
- 10.10.1.5** 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.
- 10.10.1.6** 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 (specified within the Medicines Policy) and monitoring.
- 10.10.1.7** 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).

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

10.10.1.9 When methotrexate is prescribed for an inpatient the prescriber must record the prescribing, monitoring and administration requirements within the patient's clinical notes.

10.10.1.10 The prescriber must ensure that methotrexate is prescribed **weekly** and that the other six days are scored out on the prescription chart to prevent inadvertent administration. In rare instances the weekly dose may be split into two separate doses during the stated day of the week.

10.10.1.11 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".

10.10.2 Prescribing Opioid Medicines

In response to an NPSA alert there are specific processes that must be undertaken to help reduce patient risk at the prescribing stage:

10.10.2.1 If the prescriber is not familiar with the opioid to be prescribed they must familiarise themselves with the therapeutic characteristics of the opioid to be prescribed or seek appropriate advice. The prescriber should be familiar with the usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose and common side-effects.

10.10.2.2 If the patient is already taking the opioid the prescriber must check the previous dose and formulation before prescribing.

10.10.2.3 If the patient is not already taking the opioid an appropriate recognised starting dose must be prescribed.

10.10.2.4 Where the opioid dose is to be increased the prescriber must ensure that the dose increase calculated is safe for the patient.

10.10.2.5 Refer to appendix 7 for a pictorial flowchart of the prescribing process.

10.10.3 Intravenous amphotericin

Following an alert issued by the NPSA highlighting deaths following errors with intravenous amphotericin products, the Medicines Policy specifies the following requirements:

10.10.3.1 All prescriptions for IV amphotericin **must** be approved by a consultant microbiologist.

10.10.3.2 All prescriptions for amphotericin **must** be written by **brand** name.

10.10.3.3 All supplies for amphotericin will be made directly from Pharmacy on a named patient basis: no stock will be kept within clinical areas.

10.10.4 Medicines that must be withheld until review on admission

10.10.4.1 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

10.11 Prescribing CDs for Outpatients, Emergency Department and TTOs

The law relating to such prescribing is explicit and strict adherence is mandatory. It is an offence for Pharmacists to supply CDs against incomplete prescriptions for CDs. Such prescriptions will be returned to the Prescriber for completion/correction as necessary, PRIOR TO DISPENSING.

Outpatient, ED and TTO prescriptions for Controlled Drugs MUST be written in indelible ink or printed electronically, and state:

10.11.1 The NAME and ADDRESS of the patient. (Where an addressograph label is used on a hand-written prescription e.g. outpatient prescriptions the prescriber must provide a signature that overlaps the prescription and addressograph label. This is to ensure that the label is not able to be fraudulently substituted for that of a different patient).

10.11.2 The FORM and, where appropriate, the STRENGTH of the preparation (e.g. pethidine 50mg tablets).

10.11.2.1 Where there is more than one strength available the strength MUST be specified unless that is the only strength that can be given (e.g. MST 50mg bd is not legally acceptable – 30mg and 10mg tablets must be specified separately).

10.11.3 The DOSE to be given.

10.11.4 The TOTAL QUANTITY, or the NUMBER OF DOSE UNITS to be dispensed, written in BOTH WORDS AND FIGURES (e.g. 'Rx MST tablets 30mg BD, dispense 14 (fourteen) x 30mg tablets').

10.11.5 The hand-written or printed prescription must be signed and dated.

Further details of the requirements may be found in the British National Formulary (BNF) and on the Trust intranet.

- 10.11.6** Any prescription for oral morphine must be written using the appropriate BRAND NAME, to ensure consistency of modified and 'normal' release dosage forms for the patient.

10.12 Medical Students/Clinical Observers

- 10.12.1** By law, Medical students are not permitted to prescribe.
- 10.12.2** Where a FINAL year Medical student acts as a student assistant, he/she may contact a fully registered supervising Doctor to appraise him/her of the state of the patient. The supervising Doctor may arrange a prescription by verbal message to the Nursing/Midwifery staff as described in Section 11.7. This only applies to patients already on the ward who have been previously assessed by a qualified Doctor.
- 10.12.3** The Consultant-in-Charge is responsible for the actions of Medical students acting as student assistants.

10.13 Non-Medical and Non Dental Prescribing

Medicines may be prescribed by other healthcare professionals following certificated training and registration.

- 10.13.1** Healthcare professionals who have successfully completed the non-medical independent prescribing course and are included on their registration body's list of authorised prescribers may prescribe a range of medicines they have agreed within the Trust's intention to prescribe documentation.
- 10.13.2** All prescribers must be aware of, and work in accordance with the SFHT Medicines Policy.

10.14 Prescribing of sip feeds

- 10.14.1** 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.

10.15 Prescribing of Oxygen

- 10.15.1** Oxygen therapy must be prescribed in the appropriate section on the patient's inpatient prescription chart. Trust staff should refer to the Trust Policy for the prescribing of oxygen (Hyperlink will be inserted when available).

10.16 Prescribing of wound care products

- 10.16.1** Wound care products should be written on the appropriate section of the inpatient prescription chart by prescribers or Tissue viability **nurses**.

10.17 Prescribing of Insulin

- 10.17.1** 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.
- 10.17.2** Doses should be indicated "see insulin chart", or "as per insulin chart".
- 10.17.3** 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.

10.18 Reducing harm from omitted and delayed 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 (see Appendix 9).

- 10.18.1** Prescribers should be aware of the 'critical' medicines/conditions list (Appendix 9) to ensure that all such medicines are appropriately prescribed to minimise the risk of delay/omission, particularly on admission.
- 10.18.2** Reasons for intentional dose/medicine omission/delay MUST be clearly documented in the medical notes (and in-patient prescription chart as necessary) and communicated to nursing/midwifery staff.
- 10.18.3** Prescribers should liaise closely with nursing/midwifery staff to clarify optimum administration times and to communicate prescribing of critical medicine 'stat' doses.
- 10.18.4** 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.
- 10.18.5** Significant delay/omission of 'critical' medicine administration must be recorded as an untoward incident on Datix.

11 ADMINISTRATION OF MEDICINES

11.1 Responsibility

- 11.1.1** The Ward/Department Leader is responsible for ensuring that the ward/department staff fulfil the **standard for medicines administration in their Clinical area, and that all prescribed medicines are administered as prescribed.**
- 11.1.2** The Registered Nurse/Midwife/ACP administering the medication should understand the prescription, and should have knowledge of the common indications, side effects and dosages of the medicine prescribed.
- 11.1.3** To facilitate the **safe** and **timely** administration of medicines, the Trust requires the use of 'red aprons' (do not disturb) during the medicines administration process. (Intensive care, the Emergency Department and other non-ward areas such as Theatres administer medicines on an ad-hoc basis and are not required to wear red aprons, but should apply the same principles).
- Staff wearing these aprons should **not** be disturbed by other staff.
 - However, if an interruption to the medication round is unavoidable the nurse should complete the administration for the current patient and then secure any medicines appropriately.
- 11.1.4** Student Nurses, Student Midwives and Trainee Nursing Associates must never administer or supply medicinal products without direct supervision.
- 11.1.5** The Registered Nurse/Midwife/ACP administering the medication will be accountable for their practice in accordance with the standards set out in the local Medicines Policy.
- 11.1.6** If at any time a Registered Nurse/Midwife/ACP feels that they would like a second opinion prior to the administration of a medicine, then this must be undertaken.
- 11.1.7** 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.
- 11.1.8** Within this Trust qualified, registered Nursing Associates **can**:
- Order and receive medicines, with the exception of Controlled Drugs;
 - Be second checker for patients' TTOs;
 - Undertake second checking practice for schedule 2 controlled drugs, providing that they are not being administered intravenously;
 - 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

Qualified, registered Nursing Associates **Cannot**:

- Administer via intravenous route;

- Administer as required (PRN) medicines administration;
- 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 or receiving, of any schedule 2 or 3 controlled drugs;
- Administer methotrexate;
- Administer or check any medicine via a verbal order.

11.2 Authorisation

A registered Midwife may administer a non-prescription medicine within the course of their professional practice without the need for a prescription. They may also administer prescription only medicines included on the Midwives exemption list on the [NMC website](#).

Other prescription only medicines will require an authorised prescription or PGD.

11.3 Administering medicines to patients

11.3.1 Medicines should be administered to patients only in accordance with a **prescription** written by a registered prescriber. The Trust permits medicines to be administered by:

- by a Doctor;
- by a Registered Nurse/Midwife;
- by a pre-registration student Nurse/Midwife who is NOT RGN as part of their training, but **ONLY** under the direct supervision of a Registered Nurse/Midwife/ACP who must accept full responsibility for the administration and documentation of the medicine prescribed;
- other healthcare professionals such as ODPs that have been assessed to be competent to administer medicines.
- HCAs in Ophthalmology Outpatients administering a limited range of prescribed eye drops within an agreed protocol.

11.3.1.1 The Trust does not permit the delegation of medicines administration to unqualified staff, however it is acceptable for unqualified staff and carers to **assist** in the administration of medicines such as ensuring patients receive nebulisers or assisting with the ingestion of a medicine. A registrant 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.

11.3.1.2 Carers approved at level 3 of the Trust's Self-Administration Scheme may also administer medicines to their dependent.

11.3.2 As indicated in section 15, specifically authorised patients may administer their own medication whilst in hospital, or be assisted by a carer if appropriate. As indicated in section 12, parents of children may participate in medicine administration under the supervision of a Registered Nurse/Midwife.

- 11.3.3** The administration of intravenous radio-diagnostic agents is the subject of local departmental arrangements and regulations concerning radiological protection. The Registered Nurse must have specific enabling certification and will have completed a Radiation Protection Certification Course.
- 11.3.4** The Trust uses UCL Hospitals Injectable Drug Administration Guide ('the UCL guide') for detailed guidance on the preparation, reconstitution and specific guidance on the administration of intravenous injections and infusions. UCL guides are available on every ward/unit.
- 11.3.5** Registered Nurses/Midwives must have completed IV training in accordance with the specific 'role development' before administering injections.
- 11.3.6** Compliance aids (e.g. *Mediwallets*) are intended for use by patients once discharged or for self-administration while in hospital. These should not 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. The dispensing Pharmacy should be asked to re-dispense the container/compliance aid to take into account the prescription changes.

11.4 Checking Medicines

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

- 11.4.1** Preceptorship nurses who have not completed their two supervised medicines assessments and their medicines and oxygen questions within the preceptorship pack.
- 11.4.2** In children under the age of 16 years, TWO qualified staff must always undertake the procedure (e.g. ODP, Registered Nurse/Midwives, Doctor).
- 11.4.3** 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 supervised medicines assessment and the pre-workbook for IV administration, attended the study day and passed the IV calculation test.
 - Note that within the Radiology department (under specific PGDs) the second check of the intravenous medicine may be undertaken by an Imaging Assistant trained to undertake this task.
 - 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.

- 11.4.4** Intramuscular injections – two registered practitioners
- 11.4.5** Intrathecal injections, spinal, epidural – two registered practitioners
- 11.4.6** Syringe drivers and all infusions, including subcutaneous infusions – two registered practitioners
- 11.4.7** Subcutaneous injections of insulin – all insulin injections require two registered practitioners
- 11.4.8** The two nurse check should include **all** stages up until the bolus injection or infusion has started to be administered. There are specific exceptions to the checking process for IM injections:
 - Midwives administering injectable medicines on the Midwives' exemption list (see section 20). 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 the Contraception and Sexual Health clinic administering IM and SC contraception.
 - Registered Nurses working in Occupational Health administering single dose IM or SC vaccinations.
- 11.4.9** 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.
- 11.4.10** ALL oral cytotoxic medicines must be checked by TWO registered practitioners, one of whom must be the administering Doctor or Registered Nurse/Midwife. Pharmacy staff will assist in identifying oral cytotoxic medicines on prescription charts. Refer to [section 15](#) for use of cytotoxic medicines.
- 11.4.11** There are specific requirements for the administration of:
 - intravenous potassium that has been added to an infusion bag – see [Policy for Use and Administration of Parenteral Potassium](#)
 - intrathecal cytotoxic drugs - see [Intrathecal Cytotoxic Chemotherapy Policy](#)

11.5 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.

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.

11.5 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.

11.5.2 Single Use Containers

- 11.5.2.1.** Single use containers of injectable products are for use in ONE patient only on a SINGLE occasion.
- 11.5.2.2.** Single use products must NOT be retained for use at a later time. The formulation does not contain a preservative. Any volume remaining must be discarded after a single use.
- 11.5.2.3.** The above 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.
- 11.5.2.4.** Devices which facilitate multiple access into bags of bottles of infusions such as multidose adaptors or needles with three way taps must not be used.
- 11.5.2.5.** Where an exception to this policy is deemed necessary then a local procedure must be authorised by the Medicines Optimisation Committee or Chief Pharmacist.

11.5.3. Multidose Containers

- 11.5.3.1.** 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.
- 11.5.3.2.** Multidose containers of injectable products may be used to prepare more than one dose but are for use in a SINGLE patient only.

11.5.3.3. 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)

11.5.3.4. Once opened multidose vials should be stored at room temperature and not in a fridge. Low temperatures prevent the preservative working effectively. Where possible products in use should be stored in the medicines' drawer within the bedside cabinet.

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

11.5.3.6. Where an exception to this policy is deemed necessary then a local procedure must be authorised by the Medicines Optimisation Committee or Chief Pharmacist.

11.6 Administering Medicines

Prior to the administration of a medicine, the person administering **MUST**:

- 11.6.1 READ** the prescription carefully. The medicine must NOT be given unless the prescription, dose and route of administration are clear, legible and clearly understood.
- 11.6.2 CHECK** that the prescribed dose has not already been given and that it is clinically appropriate to administer to this patient.
- 11.6.3 CHECK** the allergy status, if not documented, confirm and record the status on the prescription chart, either by direct confirmation with the patient or from the medical records. If unable to obtain then do not administer and consult with responsible prescriber unless in an emergency situation.
- 11.6.4 SELECT** the medicine required, paying particular attention to the strength and form e.g. a modified-release (MR) preparation must not be given if this is not specified and similarly a normal release preparation must not be given if an MR preparation is prescribed. Read any enclosed information leaflet or packaging for instructions on administration, dilution etc. If specified on the packaging, check the expiry date of the medicine. If an expiry is not printed, for example on a Patient's own drugs locker named-patient bottled tablets, the medicine must have been dispensed within the previous 6 months. Where medication has been prescribed within a range of dosages it is acceptable for registrants to titrate dosages according to patient response and symptom control and to administer medication within the prescribed range.
- 11.6.5 ALWAYS CHECK** that medicines are suitable for use, have been stored correctly and show no evidence of damage. **BEFORE** use:

- Check that packaging and seals have not been damaged and show no sign of tampering. If in doubt, do NOT use and return to pharmacy immediately
- Check that the product label is clear and contents show no sign of decomposition (e.g. colour change, precipitate in injections)
- Check that flexible plastic containers (e.g. infusion bags and plastic ampoules) are not leaking by squeezing them. If leaking, they **MUST NOT** be used and must be returned to pharmacy immediately.

11.6.6 PREPARE the drug/fluid and check with the prescription:

- the name of the patient
- the name and form of the medicine
- the route of administration
- the calculation (if made) - 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 medicines formulary and intranet. Infusion rate calculations should be checked as part of second nurse check.
- the measured dose
- the date and time of dosage
- the time of the last dose

11.6.7 When measuring and/or administering oral doses less than 10ml in volume, an appropriate sized graduated **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](#)).

11.6.8 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.

11.6.9 Crushing or cutting tablets

- Before tablets are crushed it must be confirmed that it is safe and appropriate to do so. Refer to 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.

- 11.6.10** The patient's identity bracelet should contain the Patient's First name and Surname, the patient's date of birth and the NHS number (or other unique identifier number if not available).
- 11.6.11** **CHECK** that the name, date of birth and NHS number (or equivalent identifier) on the patient's identity bracelet matches that on the prescription (a printed Addressograph label should be on **every** prescription). Medicines must **not** be administered unless the administering professional is certain of the patients' identity with respect to the prescribed medication.
- 11.6.12** After witnessing that the drug has been taken or has been administered the administering professional must initial or sign in the appropriate column of the prescribing document. All records must be clear, accurate and made at the time of administration.
- 11.6.13** If a medicine is not administered for any reason, including refusal, it should be entered on the prescription document using the codes listed on the Medicine Prescription and Administration Chart. In addition, it may be necessary to inform the Prescriber of this non-administration. Where a medicine on the critical medicines list is not administered an appropriate doctor must be informed immediately.
- 11.6.14** Manufacturer's containers for **oral medicines** whose contents are designed to be used for more than one patient are labelled in such a way to indicate that they are intended for multiple use. All other medicines must **NOT** be shared between patients. The Trust does not allow injections to be shared between patients as detailed in section 11.5.
- 11.6.15** 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 (9-5:30pm 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 Pharmacist.

11.7 Administration of Controlled Drugs

(See also safe administration of opioid medicines)

- 11.7.1** The administration of all schedule 2 CDs by any route must be witnessed. Administration must take place against a legally valid prescription or Midwives exemption and the CD must be administered by a competent, registered nurse, midwife or doctor. Each administration must be witnessed and recorded within the CD register. The witness may be a registered nurse, midwife, doctor, pharmacist or ODP. Both practitioners must be present during the whole procedure: they should both witness the preparation, administration to the patient and destruction of

any surplus. This includes the administration of controlled drugs by Midwives in hospital using the Midwives' exemption list.

11.7.2 The ward controlled drug register must be completed when a CD is removed from the CD cupboard. In an emergency it may be completed immediately after administration to the patient. The following details should be recorded on the page which corresponds to the drug, form and strength administered:

- Date and time when dose administered
- Patient name
- Quantity/dose administered*
- Name /signature of registered nurse/midwife who administered the dose
- Name/signature of witness (registered healthcare professional – see above)
- Remaining balance in stock (this must be verified against the actual contents in the CD cupboard)

*If part of a vial is administered to the patient, the registrant should record in the CD register the amount given and the amount wasted. E.g. if the patient is prescribed 2.5mg diamorphine and only a 5mg preparation is available, the record should show, '*2.5mg given and 2.5mg wasted*'.

11.7.3 Individual doses of CDs which have been prepared but not administered should be destroyed by the same two registrants that signed the register, and the reason for non-administration documented in the register.

In addition:

- Any tablets or liquids prepared for administration and refused should not be returned to their original container, but destroyed (see section on disposal of CDs on ward);
- Unbroken ampoules must be checked back into their original container by a registered nurse, and witnessed by a second registered nurse, carefully ensuring that the batch numbers on the ampoules correspond with those on the container.

11.7.4 In the event of a technical failure in on-going administration e.g. Fentanyl® patch becoming detached or syringe driver blocking, it is acceptable for the medicine to be re-administered against the existing prescription but the timing of subsequent prescriptions may need to be amended. The reason for the re-administration must be clearly documented in the CD register and the patient's clinical record.

11.7.5 Controlled drugs must not be borrowed. However, if a dose of a CD is required out of normal pharmacy hours and a neighbouring ward has a supply of that CD, then that dose may be given to a patient on one ward from stock on another ward. The necessary records must be made in the CD register of the ward making the supply, to the patient on the other ward (the patient's prescription must be verified by the nurse on the supplying ward). This can be repeated for each dose required until the pharmacy department reopens, and stocks can then be ordered.

11.7.6 Note that CD stocks cannot be transferred from one ward to another. Each time a dose is needed it must be obtained from the supplying ward, and the patient and prescription details recorded in the CD register on the supplying ward.

11.8 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 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. If appropriate 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. For patients receiving OPAT (Outpatient Parenteral Antimicrobial Therapy) at home see section 11.4.3 for single nurse administration and ‘checking’ by patients.

11.9 Administration of specific medicines

11.9.1 Oral methotrexate

- 11.9.1.1** The administration of oral methotrexate must be checked and witnessed by a second qualified healthcare professional (nurse, doctor, pharmacist, pharmacy technician). Both professionals should sign the administration record.
- 11.9.1.2** As with other medicines it is important that the patient’s wristband is checked against the medicine chart and the labels on the methotrexate container. Check the patient’s name, the medicine, the strength of tablet, the dose and the timing.
- 11.9.1.3** 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.
- 11.9.1.4** Ask the patient to confirm that the methotrexate is required. This includes whether any new medicines have been started since the last dose of methotrexate was administered.
- 11.9.1.5** 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.

11.9.2 Administering opioid medicines

In response to an NPSA alert there are specific processes that must be undertaken to help reduce patient risk at the administration stage:

- 11.9.2.1** The member of staff administering the opioid should ensure that they are familiar with the therapeutic characteristics of the opioid to be administered

i.e. usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose and common side-effects.

- 11.9.2.2** If the opioid medicine is prescribed at the usual starting dose the medicine may be administered if safe to do so.
- 11.9.2.3** If the opioid is not prescribed at the usual starting dose, but the medicine is already being taken by the patient then the current medicine, dose and formulation should be checked. Only then should the opioid be administered if it is safe to do so.
- 11.9.2.4** If the patient is prescribed an opioid at a dose that is not the usual starting dose and the patient is not already taking the medicine the prescriber must be contacted.
- 11.9.2.5** A flowchart of the above is given in Appendix 7.

11.9.3 Administering insulins

In response to a NPSA alert, there are specific processes that must be undertaken to help reduce patient risk at the administration stage:

- 11.9.3.1** 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.
- 11.9.3.2** Insulin doses prescribed in terms of 'U' or 'IU' must always be clarified prior to administration and clearly written in terms of dose 'units'.
- 11.9.3.3** 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.
- 11.9.3.4** Withdrawing insulin from pen devices or cartridges is dangerous and should not happen: pen devices or cartridges should be used as per manufacturers' instruction using the appropriate needle.

11.10 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:

- 11.10.1** The medicine must be prepared in the presence of the Doctor unless already prepared within the Pharmacy department.
- 11.10.2** 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.
- 11.10.3** The Doctor and Registered Nurse/Midwife/ACP must follow the procedure for checking and administering medicines as described in 11.5 above.

11.11 Verbal Orders

- 11.11.1 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.
- 11.11.2 The Prescriber's name, the date, time, drug, dose and route of administration must be recorded.
- 11.11.3 The verbal message should be repeated to a second Registered Nurse/Midwife/ACP that will act as witness. Both Nurses should sign the prescription.
- 11.11.4 The Doctor must counter-sign 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;
- 11.11.5 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.
- 11.11.6 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.
- 11.11.7 The following types of medicines are permitted to be prescribed via a verbal order:
- Intravenous or subcutaneous fluids
 - Analgesics (except CDs)
 - Anti-emetics
 - Anti-diarrhoea drugs
 - Laxatives (oral and PR)
 - Antacids
 - Cough mixtures
 - Drugs for excessive respiratory secretions
 - Anxiolytics (Nottinghamshire Healthcare NHS Trust only)
 - Antipsychotics (Nottinghamshire Healthcare NHS Trust only)
 - Antimuscarinics (Nottinghamshire Healthcare NHS Trust only)
 - Hypnotics (Nottinghamshire Healthcare NHS Trust only)
 - Midazolam and lorazepam for palliative care patients at John Eastwood Hospice
- 11.11.8 **No cytotoxic medicines or schedule 2 CDs can be prescribed via verbal order.**
- 11.11.9 In addition to the above the policy appreciates the specific needs of patients admitted to John Eastwood Hospice and permits the taking of verbal orders for

patients' own prescribed medicines (except schedule 2 CDs and cytotoxics medicines) within the current version of the Palliative Care Formulary.

11.12 Administration of parenteral medicines in life-saving emergencies

11.12.1 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

11.13 Preparation and administration of medicines during procedures outside Theatres

- 11.13.1** For all planned procedures performed in non-theatre areas the medication must be written on a prescription to allow safe prescribing, checking and administration.
- 11.13.2** Prescriptions may specify a dose range e.g. midazolam may be prescribed over a range for administration and top-up during an endoscopy procedure.
- 11.13.3** A specific pre-printed emergency prescription chart must be used in paediatric areas

11.14 Supply of Medicines to the Patient on discharge from hospital

Generally discharge medicines will be supplied directly to the patient or their accompanying relative or carer. (See below for 'supply of medicines after the patient has been discharged').

At the point of discharge the Registered Nurse/Midwife/ACP must check the patient's identity as in 11.6.6 and for each medicine, including their own medication that may have been brought in with the patient:

- 11.14.1** The medicine name agrees with the medicine written on the discharge prescription

- 11.14.2** The medicine strength agrees with the discharge prescription
- 11.14.3** The form and type agrees with the discharge prescription e.g. capsule, tablet and MR or normal release
- 11.14.4** The correct patient name appears on each container.
- 11.14.5** The instructions printed on the container agree with the instructions on the discharge prescription.

11.15 Supply of medicines after the patient has been discharged

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. However for controlled drugs the following 2 nurse/midwife procedure should be followed:

- 11.15.1** The controlled drug must be booked into the Patients' own controlled drug record book.
- 11.15.2** The CD must be stored in the CD cupboard.
- 11.15.3** Ideally the person that will collect the TTO and CD should be pre-agreed before discharge.
- 11.15.4** On supply of the TTO containing the CD to the representative their identity must be confirmed and they must sign the record book.

11.16 Reducing harm from omitted and delayed 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 (see Appendix 9).

- 11.16.1** Nursing/midwifery staff should be aware of the 'critical' medicines/conditions list (Appendix 9) and ensure administration of these medicines is as close as possible to the prescribed time.
- 11.16.2** Prescribers should liaise closely with nursing/midwifery staff to clarify optimum administration times and to communicate prescribing of critical medicine 'stat' doses.
- 11.16.3** In the event of medicine unavailability, pharmacy (or the on-call pharmacist) must be contacted without delay and a supply obtained.
- 11.16.4** The prescriber or other appropriate medical staff must be informed of any significant 'critical' medicine dose delay or omission, to enable prompt review of the

patients care. The outcome of the discussion should be documented in the nursing notes. Such a delay/omission must be recorded as an untoward incident on Datix.

- 11.16.5** The appropriate non-administration code must be annotated using **RED INK** on the in-patient prescription chart in the event of any medicine dose omission. The section on the chart describing the action taken must also be completed.
- 11.16.6** Significant delay or omission of 'critical' medicines may require the urgent prescribing and administration of a 'stat' dose for the patient.
- 11.16.7** Gaps in the administration record could indicate dose omission, or administration and documentation error. Such ambiguity must be minimised in order to reduce the potential risk to patients of 'critical' medicine dose duplication.

11.17 Covert administration of Medicines

The covert administration of medicines is now covered under a separate Trust Policy

11.18 Preparation and Administration of Covid-19 Vaccines

- 11.18.1** Administration of any Covid-19 vaccine should be in accordance with the most up-to-date [national guidance](#).
- 11.18.2** Non-registered (Band 4) vaccinators must operate strictly under a National Protocol or PSD specific to the vaccine in question and in accordance with the training and competency requirements as defined in the [National Protocols](#) and [local competency frameworks](#).

Persons must only work under National Protocols or PSDs where they are competent to do so. The [Named Supervisor](#) for each vaccination centre and the Roving Service will identify and authorise Trainer/Assessors, who will be an appropriately trained, experienced and knowledgeable registered practitioner in immunisation.

Non-professionally qualified persons operating under National Protocols or PSDs must be adequately supervised by experienced registered healthcare professionals.

National Protocols or PSD do not remove inherent professional obligations or accountability. All persons operating under National Protocols must work within their terms of employment at all times

Once appropriately trained and assessed as competent, Non-professionally qualified staff are permitted to undertake:

- Stage 2 (Vaccine Preparation) – **excluding** reconstitution or dilution of vaccines
- Stage 3 (Vaccine Administration) and

- Stage 4 (Record Keeping) of national protocols.

Non-professionally qualified persons **must never** deliver Covid-19 vaccines under PGD.

Non-professionally qualified staff undertaking vaccine preparation i.e. drawing up doses for injection, must have a second-check of the vaccine volume from a suitably trained registered healthcare professional or other competent non-professional qualified member of staff.

Non-professionally qualified staff must be supervised by a named designated registered nurse, eg protocol / POD clinical supervisor/ registered nurse assessor, working on the clinical floor. They must be able to regularly observe clinical practice and intervene should they have any concerns regarding the vaccine being prepared or administered. The number of non-professionally qualified staff e.g. Band 4 they oversee undertaking both stage 2 and stage 3 in the same pod/location on the clinical floor should normally not exceed a maximum of 6.

12 PRESCRIBING AND ADMINISTRATION OF DRUGS 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.

12.1 General Considerations

- 12.1.1 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.
- 12.1.2 A high proportion of medicines used in children are not licensed specifically for children *i.e.* they are used “off-label”. Chapter 14 provides further information on the use of unlicensed and “off-label” medicines.
- 12.1.3 It is essential that all staff involved in the prescription and administration of drugs to children familiarise themselves with the various problems and potential hazards of this situation.
- 12.1.4 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 drug dosages.

IF IN DOUBT ALWAYS ASK FOR ADVICE

12.2 Specific measures relating to children

The following measures are an important addition to earlier sections.

- 12.2.1 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 drugs and 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.
- 12.2.2 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.
- 12.2.3 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. 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.

- 12.2.4** 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.**
- 12.2.5** 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.
- 12.2.6** 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.
- 12.2.7** When measuring and/or administering oral doses less than 10ml in volume, an appropriate sized graduated **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.
- 12.2.8** **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 drugs in suitable dosage forms and concentrations for administration to children.
- 12.2.9** Children and infants should wear identity bracelets if medicine is required. Oral preparations should be sugar free wherever possible.

13 PRESCRIBING, DISPENSING AND ADMINISTRATION OF UNUSUAL TRIAL MEDICINES

13.1 Prescribing and Administration of Clinical Trial Material

- 13.1.1** The European Guidelines on Good Clinical Practice must be adhered to in all circumstances related to prescription for Clinical trial material.
- 13.1.2** Doctors wishing to prescribe drugs for an in-house trial must ensure that, where appropriate, the relevant licensing authorities (Medicines Control Agency) have been informed. This must include availability of a Clinical Trials Certificate or Clinical Trials Exemption Certificate. They are also required to see relevant indemnity cover in respect of claims related to medicine-induced injury. If in doubt, the Prescriber should consult the North Nottinghamshire Ethics Committee guidelines.
- 13.1.3** Prior to prescribing Clinical trial material each investigator must discuss with The Medicines Information Centre the exact procedure and necessary information for prescribing the trial material. In general the prescription should include:
- 13.1.3.1** the official trial name;
 - 13.1.3.2** the official trial number;
 - 13.1.3.3** the patients' name, address and individual patient number;
 - 13.1.3.4** the quantity of trial material required or the periods for which material is required (these should correspond to the medication bottles and treatment scheme);
 - 13.1.3.5** the daily dose of medication where there is possibility of altering the prescribed dose during the course of the trial.
- NB** In many cases pharmaceutical companies will provide pre-formatted prescriptions or prescription labels to further distinguish trial material or different trial periods.
- 13.1.4** For in-patient prescription charts, the above information should be included and clearly highlighted.
- 13.1.5** It is the investigator's responsibility to ensure that ward staff are well informed and given reasonable notice of pending Clinical trials.
- 13.1.6** Ward staff must be aware that particular patients are receiving trial medication and all relevant information related to administration and adverse drug reactions should be available on each ward. Ward staff should be aware of the confidentiality of such information.
- 13.1.7** Ward staff must be aware of the appropriate steps to be taken for proper documentation of drug administration and patient parameters when using trial material.

13.2 Patient Safeguards with regard to Clinical Trials

- 13.2.1** Investigators are responsible for informing patients with regard to trial medication and the potential for any harmful effects.
- 13.2.2** Patients must have a reasonable understanding of the proposed treatment and where possible be given written information and instructions. All patients must give their written informed consent prior to entry in the Clinical trial.

NB Diary cards are appropriate as an 'aide memoire' but are usually insufficient as the sole source of drug information.

13.3 Dispensing Clinical Trials Material

- 13.3.1** All medication intended for Clinical trial use should be stored in the Pharmacy Department. It is inappropriate for separate stocks to be kept on wards or in clinics unless by prior agreement with the Pharmacy Manager.
- 13.3.2** The Pharmacy Department will have a clear dispensing procedure for each Clinical trial and should ensure correct labelling of trial material.
- 13.3.3** Clinical trial labels will include clear dosage instructions, patients' name, patients' number and the relevant treatment periods.
- 13.3.4** The Pharmacy Department must hold information relevant to Clinical trials, which includes a protocol, randomisation codes and an investigator's brochure.

13.4 Prescribing, Dispensing and Administration of Named Patient Medication Supplied by a Pharmaceutical Company

- 13.4.1** Prescribers must complete all relevant documentation and undertakings with respect to named patient drugs obtained from a pharmaceutical company prior to prescribing and prior to the drug being released by the Pharmacy Department.
- 13.4.2** Dosage recommendations produced by the pharmaceutical company should be strictly adhered to.
- 13.4.3** The Pharmacy Department must keep an accurate record of each named patient drug dispensed and ensure that sufficient medication is available for each patient on subsequent return visits, unless further supplies are to be handled by Community Pharmacists by arrangement.

14 UNLICENSED MEDICINES AND MEDICINES USED OUTSIDE THEIR PRODUCT LICENCE

Please refer to the [Policy for the procurement and use of medicines without marketing authorisation and medicines used outside their marketing authorisation](#).

15 PRESCRIBING, DISPENSING AND ADMINISTRATION OF CYTOTOXIC CHEMOTHERAPY

15.1 Introduction

Particular care is needed when a patient is treated with potent chemotherapeutic agents. Detailed advice is available from the Specialist Oncology and Haematology Nurses and the Sterile Product Unit, Pharmacy Department, but the guidelines in this document are paramount.

It is important that all chemotherapy administration is undertaken in a designated Clinical area where chemotherapy administration takes place on a regular basis and that staff are familiar with the processes involved, to maintain expertise. Written protocols for cytotoxic drug administration are essential and must be available in the designated Clinical areas.

15.2 Records

Records for the prescription, preparation (reconstitution) and administration of cytotoxic chemotherapy must be organised so that the overall plan of treatment is clear. A cytotoxic chemotherapy prescription and administration record is available and must be used where appropriate. All documentation must be maintained as per section 10.2.

15.2.1 Prescribing

15.2.2 The decision to commence or continue a specific course of chemotherapy must be taken at Consultant level – this decision should be made in conjunction with the patient's consultant and their oncologist/haematologist. All prescribing must be undertaken on an authorised prescription form. This applies to all chemotherapy agents including oral medicines.

15.2.3 All prescriptions for cancer chemotherapy must be signed by a member of the Medical staff at or above Registrar level. A second person must check the prescription and sign it. The second person must be either:

- a Doctor at or above Registrar level
- an appropriately trained Pharmacist
- a Clinical Nurse Specialist for Haematology or Oncology

15.2.4 The prescription must be verified on arrival in the Pharmacy Department against a consultant-approved protocol. Protocols must be in a readily retrievable form and available to the Pharmacist responsible for the reconstitution of cytotoxic drugs.

15.2.5 All prescriptions must have undergone the above approval process before the dispensing (reconstitution) begins.

15.2.6 Prescriptions for methotrexate for termination of ectopic pregnancy may be written by F2 doctors and above once the decision to treat has been made by the patient's consultant.

15.3 Dispensing

- 15.3.1** All parenteral cytotoxic chemotherapy (including intravesicular) is prepared in the Pharmacy Department in a suitable dedicated area under appropriate supervision.
- 15.3.2** All dispensing of oral chemotherapy should take place within fume cupboard
- 15.3.3** To enable the most economical use of expensive medicines, adequate advance warning of the requirement for cytotoxic therapy should be given to the Pharmacy Department, even where this is provisional and the final decision to prepare and administer the medicine depends, for example, on the patients' blood count.
- 15.3.4** Prior to dispensing the cytotoxic chemotherapy the relevant patient details must be confirmed to ensure the safety of the patient. Such details may include height, weight, full blood count, and renal function. It is considered desirable to record such details on the cytotoxic chemotherapy prescription sheet where appropriate.
- 15.3.5** The Pharmacist must not release the medication for administration unless the approved cytotoxic drug prescription has been received or the prescription has been seen by another Pharmacist and the appropriate documentation completed.

15.4 Storage

Some medicines deteriorate rapidly after reconstitution. On receipt, the expiry date and storage conditions must be checked. The drug must not be administered outside of these conditions without further reference to a Pharmacist. All cytotoxic drugs should be stored in a suitable locked cupboard or refrigerator until they are required for use. Intrathecal medication must be stored in a designated intrathecal cytotoxic chemotherapy refrigerator.

15.5 Administration

- 15.5.1** On no account must a cytotoxic drug be administered, unless:
- an prescription has been written by the Doctor;
 - the drugs have been checked against both the prescription and the protocol;
 - the administration is to be undertaken by a suitably qualified Registered Nurse or Doctor;
 - the patient has been reviewed by Medical staff on the day of chemotherapy administration.
- 15.5.2** Cytotoxic chemotherapy should be administered within normal working hours unless there are exceptional circumstances.
- The prescription **MUST** always be present **BEFORE** ANY cytotoxic drug is administered
- 15.5.3** All staff administering cytotoxic chemotherapy must be fully aware of the principles of cytotoxic drug effects and toxicity and be familiar with the correct route of administration and procedures for use.
- 15.5.4** There is a separate Trust policy for the administration of intrathecal cytotoxic chemotherapy that reflects national guidance. Copies of these policies are available on the Trust Intranet, Haematology Ward and in the Welcome Treatment Centre.

Only staff who are trained and whose names appear on the Policy Register may be involved in this procedure.

- 15.5.5** Parenteral cytotoxic chemotherapy should only be administered to patients within designated areas; administration outside of these areas is undesirable.
- 15.5.6** Registered Nurses and Doctors who have completed special training under the relevant professional guidelines may administer intravenous cytotoxic chemotherapy.
- 15.5.7** Written procedures and suitable kits are available in the designated Clinical areas to manage extravasation and spillage. All personnel involved in the administration of cytotoxic chemotherapy must be familiar with these procedures.
- 15.5.8** If there is any doubt about any aspect of cytotoxic drug administration seek advice either from the Pharmacy Department, Nurse Specialist, or Consultant staff.

15.6 Disposal

The policy for the safe disposal of cytotoxic waste must be followed at all times.

16 SELF-ADMINISTRATION 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 Policy governs the self-administration of medicines. An approved Policy is in place for John Eastwood Hospice to allow patients attending the Hospice on a daily basis to self-administer.

17 MEDICINES IN OPERATING THEATRES, CLINIC AREAS, OTHER SPECIALIST TREATMENT AREAS AND X-RAY DEPARTMENTS

The Trust general policy applies to all these areas with some special arrangements as follows:

17.1 Medicines used in Operating Theatres

The responsibility for establishing and maintaining a system for the security of medicines shall be that of the Chief Pharmacist in consultation with the Head of Nursing for Theatres and day Case Surgery and the Service director for Anaesthetics.

17.1.1 Supply

As in section 2.

17.1.2 Ordering, Custody and Availability of Medicines

The Registered Nurse/Midwife or Operating Department Practitioner (ODP) acting as Theatre Co-ordinator is responsible for the ordering, custody and availability of drugs, including the ordering of CDs. The stock levels and ordering of other medicines and preparations will be provided through agreements with the Chief Pharmacist AND which have been authorised by the Theatre Co-ordinator.

17.1.3 Storage of Medicines

Within each theatre, the keys to medicine cupboards (including CD cupboards and refrigerators) may be held by a Registered Nurse/Midwife or delegated to an Authorised ODP. When the theatre is not in use, or between operating sessions, all drugs must be returned to lockable medicine cupboards.

17.1.4 Borrowing of Medicines

As in section 2.

17.1.5 Controlled Drugs in Theatres

17.1.5.1 The Registered Nurse/Midwife or ODP in charge of a theatre is legally responsible for:

- ordering, receiving, checking, recording and storing stock.
- recording the amount issued to Medical staff AND signing the CD register
- returning unused ampoules to stock
- amending balances accordingly.
- Ensuring correct procedures for checking controlled drugs are adhered to at all times by all personnel
- Checking and auditing control of controlled drugs.

The above may be delegated to an appropriately trained nurse/Midwife or ODP, however the legal responsibility still remains with the Nurse/Midwife or ODP in charge.

17.1.5.2 In addition Nursing staff/ODPs are responsible for:

- Ordering, receiving, checking, recording and storing stock of controlled drugs.
- Providing the controlled drug to the anaesthetist and immediately amending the stock balance.
- Ensuring only single ampoules of a controlled drug are supplied, that they are intended for immediate use AND for one patient.

- Immediately recording the controlled drug given to the anaesthetist in the controlled drug register by additionally completing the date, time, and patients name.
- Signing the controlled drug register to confirm the information entered is correct and the drug has been issued.
- Where practical, acting as a second person checker to the anaesthetist to verify the drug to be administered, the dose and the expiry date, in accordance with the Double Checking Process recommended by the Royal College of Anaesthetists and National Patient Safety Agency NPSA (see Appendix 9).
- Ensure all documentation is completed for current patient prior to receiving next patient into the anaesthetic room.
- Witness safe disposal of any unused controlled drug in accordance with the 'Procedure for Handling of Controlled Drugs in the operating department and theatres'.
- Returning any unused ampoules to stock and witnessing this with the anaesthetist.

17.1.5.3 Anaesthetists are responsible for:

- Clearly stipulating which controlled drug is required, and the dose (multiple ampoules may not be requested and will not be supplied unless for immediate use).
- Checking the drug to be administered, the dose and expiry date of the ampoule with a second checker in accordance with the double checking process recommended by the Royal college of Anaesthetists/NPSA (Appendix 8).
- Ensuring the safe custody of the controlled drug if administration is delayed or the drug is to be titrated
- Recording clearly and contemporaneously the amount of drug administered in the patient's anaesthetic record.
- Returning any unopened ampoules to a Registered Nurse/ODP/Midwife and witnessing the return of the drug into the controlled drug cupboard.
- Signing the controlled drug register to confirm the return of the controlled drug and correcting the stock level with the Registered Nurse/ODP/Midwife.
- The safe disposal of any unused controlled drug that remain within an open ampoule or syringe in accordance with the 'Procedure for Handling of Controlled Drugs in the operating department and theatres' and recording the amount used and wasted in the controlled drug register, witnessed by a Registered Nurse/ODP/Midwife.
- Label syringes in accordance with departmental practice.

17.1.5.4 The Pharmacist or designated MMT is responsible for:

- supply of CDs to each ordering location.
- regular audit of local policies.
- checking CD stocks and registers at least once every 3 months.

17.1.5.5 Theatre Support Workers may:

Administer eye drops under the direct supervision of an anaesthetist (the eye drop having been selected and checked by a registered nurse/ODP)
Draw up local anaesthetics for the surgeon to administer (the local anaesthetic having been selected and checked by a registered nurse/ODP)

17.1.6 Controlled Drug Keys

17.1.6.1 The keys to the CD cupboard must remain in the theatre when it is in use. The Senior Registered Nurse/Midwife in charge of each theatre has overall responsibility for the keys and drug stocks. The Senior Registered Nurse/Midwife within each theatre will normally hold the keys. If he/she wishes to leave the theatre or if it is difficult to handle the keys (e.g. when scrubbed), then they should be given temporarily to a deputy, either another Registered Nurse/Midwife, an Anaesthetist or an Authorised ODP. When in possession of the keys, the deputy becomes **temporary custodian** of the CD keys and is **responsible for recording any CDs issued**. The CD keys must be returned to the senior Registered Nurse/Midwife in charge of each theatre who has overall responsibility for the keys and drug stocks.

17.1.6.2 The disposal and accountability of unused CDs within the operating theatre environment is the responsibility of the Anaesthetist (or Surgeon if no Anaesthetist). A second person must be present to witness the disposal of unused CDs, e.g. Registered Nurse/Midwife or an Authorised ODP. Records must be made in the CD register.

17.1.7 Controlled Drugs Register

17.1.7.1 ALL receipts must be recorded in the CD register by two Registered Nurses/Midwives/ODPs.

17.1.7.2 The stock balance of CDs in each anaesthetic room must be checked after every operating session by two qualified persons ODP, Nurse/Midwife, Anaesthetist. The check must be documented in the checking register.

17.1.7.3 Entries within the controlled drug register must be clear and legible. Each ampoule used must be recorded as a single entry and the specific dose administered documented in the 'amount given' column for example 10mg morphine sulphate in 1ml; 7mg administered, 3mg wasted.

17.1.8 Records

A record must be made in the patient's notes, prescription chart or anaesthetic record for EVERY drug administered in theatre.

17.1.9 Responsibility for Prescribing and Administration

17.1.9.1 The Anaesthetist is responsible for the prescribing and administration of ALL drugs (anaesthetic agents or otherwise) given orally, parenterally or by inhalation on induction of anaesthesia and during an operative procedure.

Such drugs must be prepared by the Anaesthetist themselves, or within their sight and under their direct supervision by a Registered Nurse/Midwife or an Authorised ODP. This MUST be in response to a written prescription, standing order or verbal instruction. If an Anaesthetist gives a drug at a Surgeon's request BOTH share responsibility.

17.1.9.2 The Surgeon is responsible for the administration of drugs during an operative procedure given by themselves or at their request. They may delegate this responsibility to a Registered Nurse/Midwife by means of a written prescription. The system of verbal orders may be used where appropriate but written confirmation must be given as detailed in Section 11.7.

17.1.9.3 The application of topical agents is ultimately the responsibility of the Surgeon. They may authorise a Registered Nurse/Midwife, or an Authorised ODP to make a topical preparation by written instruction in the form of either an individual prescription or of a written Patient Group Direction previously agreed by the DTC. The making of any such preparation will be as per 13.5.4.

17.1.9.4 Injectable medicines must not be decanted into open systems e.g. gallipots.

17.1.10 Preparation of Medicines by ODPs

17.1.10.1 Preparation of Medicines

An Authorised ODP may only prepare drugs for administration under the direct instruction and supervision of the Anaesthetist or Surgeon.

17.1.10.2 Preparation of Medicines requiring Dilution and Infusion

The dilution of drugs by an Authorised ODP must be made under the direct supervision of a Registered Nurse/Midwife, or an Anaesthetist. The bottles/syringes must be labelled (using the correct available labels), dated and specify the drug name, diluent and strength, and be signed by the two persons concerned. All preparation and dilution must be made at the time they are required and not in advance of the procedure.

17.2 Medicines in X-ray

17.2.1 Administration of medicines by radiographers under Patient Group Directions must be checked by a second healthcare professional, however if a second healthcare professional is not available a trained radiology assistant may perform the second check. In the case of a radiology assistant performing a second check they are confirming the identity and expiry date of the medicine and take no responsibility for the dose and appropriateness of the medicine for the patient.

18 MEDICINE DEFECT REPORTING PROCEDURE

18.1 Suspected Medicine defects

All suspected medicine defects should be reported to the Quality Control Section Leader in the Pharmacy Department (extension 3168 or via the Ward Pharmacist). He/she will take charge of the investigation and reporting of the incident by following an agreed protocol. If a medicine defect is suspected outside the normal Pharmacy opening hours the On-call Pharmacist should be contacted. If in doubt, report the suspected defect. The following action should be taken in all cases:

- 18.1.1** If a patient is involved in the use of the suspect material, its use must be immediately discontinued.
- 18.1.2** The Consultants 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.
- 18.1.3** 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.
- 18.1.4** The defective drugs 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.

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.

Adverse Drug Reactions

Doctors and Pharmacists should either report or prompt the submission of a report on any suspected adverse drug reaction. Registered Nurses/Midwives must report any suspected adverse drug reactions to a Doctor or Pharmacist. Staff in doubt as to the reporting procedures should contact the Medicines Information Centre (extension 3163) for advice.

The guidance set out below concurs with the most recent advice of the Committee on the Safety of Medicines.

18.1.5 What To Report

18.1.5.1 New 'Black Triangle' Drugs (marked with ▼ in the BNF)

Report all suspected reactions, however minor, which could conceivably be attributed to the drug. Report even if the reaction is well recognised or if unsure of the causal relationship.

18.1.5.2 Serious Reactions to Established Drugs

All serious reactions should be reported. Serious reactions include those that are fatal, life-threatening, disabling, incapacitating or which result in or prolong hospitalisation and/or are medically significant. Other reactions that are considered serious include congenital abnormalities.

18.1.5.3 Vaccines

Report all reactions to vaccines.

18.1.6 How to Report

Yellow cards for reporting are available:

- in the back of the BNF,
- from Clinical Pharmacists,
- from the Medicines Information Centre.

18.1.7 Completing the form

Please give details wherever possible of brand name and batch number. This is particularly important for:

- slow or delayed release formulations,
- vaccines,
- biotechnology products, e.g. human growth hormone.

18.1.8 Where to Report

Completed forms should be routed to the Committee on Safety of Medicines via the Medicines Information Centre. This allows local records to be kept as well as feedback to the reporter. Confidentiality will of course be maintained.

19 OUTPATIENT AREAS

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

19.1 Key holding practices

- At bases where a number of designated practitioners may require access to the medicine cupboards at different times, a secure system must be agreed. This is a key coded key cupboard, within in secured clean utility room. in the event of controlled drugs within the KTC, refer to section 3 of the policy.
- The controlled drugs keys are kept under control of the nurse in charge during daytime working hours. No controlled drugs are routinely to be stocked in Outpatients and will be ordered on the day in the rare occasions that they are needed. Controlled drugs are not to be stored in Outpatients overnight.

19.2 Control of paper Prescriptions

- The trust will maintain clear records on FP10 prescription stationery stock received and distributed, both when prescriptions are received in to 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 is 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](#).

19.3 Administration of specific eye drops

- HCAs in Ophthalmology Outpatients administering a limited range of prescribed eye drops within an agreed protocol

19.4 Resuscitation

- It is the responsibility of staff in department 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.

20 ERRORS IN THE PRESCRIBING, DISPENSING AND ADMINISTRATION OF MEDICINES

Additional information relating to reporting incidents is available in the [Trust's Incident reporting Policy and Procedures](#).

20.1 Basic Principles

In all circumstances where a medication error has occurred i.e. has been received by a patient, this immediately becomes a **Clinical Incident** and an **Incident Form** must be completed.

The Medicines Safety Group will review all medication errors and near misses on a regular basis and make appropriate recommendations regarding policies, procedures, educational requirements and other strategies to minimise risk.

20.2 Prescribing Errors

Errors related to legibility including failure to use capital letters, legibility of signature, etc., should be pointed out to the Prescriber and corrections made. Repetitive errors of this kind noted by Pharmacy staff or Nursing/Midwifery staff should be reported to the Consultant with the knowledge of the Prescriber.

Where dosage or route of administration is incorrect and this has resulted in the incorrect administration of a drug this must be reported to the Consultant with the knowledge of the Prescriber. Because an actual error has occurred an Incident Form must be completed which will result in an appropriate investigation.

20.3 Dispensing Errors

As soon as it is realised that there has been a dispensing error:

20.3.1 Urgent steps should be taken to recover the wrongly dispensed medicine

20.3.2 A Dispensing Incident Form must be completed without delay and given to a Pharmacy Manager. (The incident must also be reporting on a Datix DIF1 form.) This Form includes supporting statements, full investigation by the Ward Pharmacist, proposed improvements in practice and outcome.

20.3.3 The incident should be reported to the Consultant team who prescribed the drug if the patient has received any of the incorrect medicine.

20.3.4 Where a patient has received an incorrectly dispensed medicine they or their carer's should be informed in line with the Trust's [Policy for Duty of Candour \(Being Open\)](#).

20.3.5 A Pharmacy Manager will maintain a log of these incidents and ensure that appropriate action has been taken, including informing the Trust's Drugs and Therapeutics Committee, that will monitor all errors of dispensing, prescribing and administration of medicines.

20.4 Administration Errors

Drug administration errors include an omission of prescribed medication. As soon as it is realised that there has been an error of drug administration the following action should be taken:

- 20.4.1** The Consultant's team should be contacted and, when necessary, remedial action taken to ensure the safety of the patient.
- 20.4.2** The incident should immediately be reported to the Line Manager of the person who had incorrectly administered the medication.
- 20.4.3** The incident should also be reported to the patient. The Consultant in charge who should be responsible for deciding the appropriate course of action regarding communication about the incident with the patient and/or relatives.
- 20.4.4** An online **Incident Form** must be completed. Supporting statements will be required from all staff concerned.
- 20.4.5** A Pharmacy Manager will be informed, who may delegate any action to the Ward Pharmacist. Out of hours the On-call Pharmacist should be contacted.
- 20.4.6** If a Nurse/Midwife in training is involved in a medicine error, the Ward Leader or designated deputy must inform the student's tutor who should inform the Principal of the College. The error will be investigated by the designated Nurse/Midwifery Manager and a member of the relevant University Department appointed by the Principal.

20.5 Investigation of Errors

Where the drug administration error is the first occurrence by the Practitioner, the Line Manager will take action in accordance with the incident reporting procedure. Where the drug administration error is a repeat occurrence or breaches the NMC Codes of Professional Conduct, the Line Manager will take appropriate action.

- All errors will be investigated by the Line Manager who will report to the appropriate Manager.
- The Senior Manager will report the drug administration error to the Strategic Health Authority by the approved mechanism and to the agreed timescales stated within the procedure.
- The results of all medicine administration error investigations must be presented to the next Medicines Optimisation Committee to facilitate effective risk management practices.

21 MIDWIVES

21.1 Midwifery practice and medicines

- 21.1.1 When a Midwife practises within the Trust; she/he must comply with sections in the Medicines Policy relevant to Midwives practising in the Trust.
- 21.1.2 Midwives may in the course of their professional practice supply and administer substance 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. Midwives practising within the Trust may only supply and administer medicines on the Trust's agreed list given in appendix 10.
- 21.1.3 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).
- 21.1.4 The midwives exemption list is available in the NMC publication 'Practising as a Midwife in the UK' available on the [NMC website](#) and a hard copy is displayed in the Maternity Unit. (Hard copies must be reviewed annually by the midwife in charge of the unit to ensure these lists are up to date and in line with the NMC website.)
- 21.1.5 Midwives can dispense pre-packed medicines from the maternity ward, providing they are medicines that are entitled to supply. A record of this should be made on the electronic maternity care pathway.
- 21.1.6 Midwives will make records of medicines administered under exemption on the drug chart when in hospital using the approved sticker for Midwives exemption records.
- 21.1.7 In the home Midwives should make a record of the administration within the maternity records.
- 21.1.8 Student Midwives can administer medicines on the midwives exemption list, except controlled drugs, under the direct supervision of a midwife.
- 21.1.9 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 'sign off mentor'.
- 21.1.10 Midwives must ensure their practice is evidence based and be familiar with current BNF guidance for any medicine they are supplying or administering.

- 21.1.11** 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.

21.2 Medicines that may be carried by Community Midwives

The Midwifery management team, the Supervisor of Midwives 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.

22 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 a doctor deems them to be clinically inappropriate.

22.1 Responsibilities for Medicines Reconciliation

- 22.1.1** 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 on-going 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.
- 22.1.2** 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.
- 22.1.3** It is the responsibility of the patient's nurse to ensure that complete and accurate information regarding the patient's usual medicines is collected and documented, whenever the admitting doctor delegates this task to him/her. Any omissions should be communicated to the admitting doctor, and pharmacist or MMT.
- 22.1.4** It is the responsibility of the pharmacist or MMT to ensure that the hospital prescription is checked against the primary care record 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.

22.2 Reconciling Medicines

- 22.2.1** 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 allow medication review and ensure the patient is receiving optimum treatment for their condition(s)
 - To ensure concordance/compliance and educate the patient regarding their medication
- 22.2.2** This process of medicines reconciliation should take place within 24 hours of admission wherever possible.

- 22.2.3** All patients should have their allergy status documented on the front of their drug chart and in the medical record. If the patient has no drug allergies then the box labelled 'No Known Drug Allergy' should be ticked on the front of the drug chart. For all known allergies, the drug and reaction should be recorded. All allergy information should be signed and dated and endorsed with the source of the information.
- 22.2.4** If the patient has a history of any serious ADRs it is helpful to document these also even though they are not true allergies. The chart should be endorsed 'Adverse Drug Reaction' followed by the drug or group of drugs and then the reaction. The information should be signed and dated and the source of the information recorded.
- 22.2.5** 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 possible, one of these sources should be the patient or their carer as information regarding how the patient actually takes their medication is essential. Exceptions may include patients who are confused, sedated or unconscious.
- 22.2.6** Possible information sources are listed in the table below with advantages and disadvantages of each.

Patient/carers recall and verification	Patient/carers recall may be incomplete and inaccurate. However it is useful to verify with the patient/carers whether medication is taken in accordance with the GP instructions or not. If the patient is not able to communicate details of their medication due to confusion etc. every effort should be made to confirm details with the usual carer, spouse or relative. If the patient is hard of hearing or does not speak English an interpreter should be used wherever possible.
Patients' own medicines	The patient may not bring all medicines into hospital. It is important to check whether they have left anything at home. Check that each medicine is for the correct patient. Check the date of dispensing – if it is more than 3 months ago this may indicate poor compliance or hoarding of medicines. Check whether the patient takes the medicine as specified on the label.
Repeat prescription list from GP	Ensure the list is current and for the correct patient. Check when each prescription was last issued. If issued more than 3 months ago check whether the patient is still taking it. Remember that recent acute prescriptions will not

	be included on this list.
Nursing home records/administration sheets e.g. MARS	Ensure the record is for the correct patient. Check the administration dates to make sure the prescription is current. These records are usually fairly accurate.
Patient dosing booklets e.g. warfarin, methotrexate, lithium	Usually accurate but will only provide information on one medicine. Check the date the record was last updated.
Medical Notes e.g. recent TTO, recent medication charts etc.	The more recent the information is, the more likely it is to still be correct. Medication charts and TTOs will only be accurate if medicine reconciliation was completed on previous admissions.
GP referral letter	Often such information is incomplete unless an electronic print out is provided from the GP record.
Verbal confirmation with GP surgery	Such information is best obtained from the surgery prescription clerk. Confirm that you have the correct patient using address and date of birth. Check when each item was last prescribed and whether there are any recent acute prescriptions. If the drug name is in doubt ask for it to be spelt out.
Community pharmacy	Many community pharmacies have electronic patient records especially if they provide a mediwallet for the patient. If the patient has brought some medicines into hospital the phone number should be on the dispensing label.
Specialist community support workers e.g. CPN	Can provide information on specialist medicines that the patient may be taking.

22.2.7 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 medication 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

- 22.2.8** As a minimum the drug 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.
- 22.2.9** A complete list of the patient's current medication should be recorded in the medical record as part of the admission clerking. 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.
- 22.2.10** If the medication information is incomplete for whatever reason this must be clearly documented in the drug history section of the clerking notes so that the pharmacist or MMT can follow this up e.g. GP needs contacting after the weekend to confirm current medication, or relative to bring in patient's own medicines which will then need checking.
- 22.2.11** Any subsequent additions or changes to the medication history must be clearly documented in the drug history section with the date, source of information and the signature of the individual making the amendments.
- 22.2.12** If any medication is altered on admission this must be clearly documented in the medical notes with the reason for such changes, to ensure that this information is communicated to the GP when the patient is discharged from hospital. It should also be documented on the front of the drug chart in the box 'Medication Changes on Admission'.
- 22.2.13** If the medication chart is rewritten during the hospital admission all endorsements should be transcribed onto the new chart. This should include details of compliance aids used, medication stopped etc.
- 22.2.14** The pharmacist or MMT should check the hospital prescription against the primary care record ideally within 24 hours of admission. Any discrepancies should be clearly documented in the medication history section of the clerking notes in black pen with a date and signature. The source of such information should also be documented. Where appropriate an entry should be made in the medical notes under the daily record requesting a review by the medical team and listing any discrepancies requiring action. Any major errors or omissions should be discussed directly with the doctor looking after the patient. The pharmacist or MMT should record on the drug chart that they have confirmed the medication history. This should be documented on the front of the drug chart in the box 'Medicines Management Information' with a signature, date and where the information was obtained.

- 22.2.15** 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.
- 22.2.16** Medicines reconciliation compliance should be audited on an annual basis in accordance with NICE/NPSA recommendations.

APPENDICES

Appendix 1 – Checklist for Use of 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 **drug name**, the **drug strength** (if applicable), plus the **name and address of the Pharmacy** dispensing the drug;
- Where possible cross check the drug 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 drug 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 6 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 6 months – check with the patient;
- The 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);

Product Integrity

- The medicines in the container correspond to the labelling e.g. liquid, tablet or capsule;
- 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 2 – Meeting and Dealing with Supplier Representatives (Pharmaceutical and Wound Management Products)

Purpose of this Policy:	To ensure pharmaceutical and wound management representatives abide by Trust policy and a process exists for accepting drug or wound product samples that ensures safe patient treatment.
Scope of this Policy:	Primarily medical, pharmacy and nursing staff, but any other Trust staff that may meet with business representatives covered by this policy.
Related policies/documents:	Nil
Responsibilities:	D&T Chairman, Chief Pharmacist, and Divisional Directors of Nursing Services.

1. Introduction

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

This policy document 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 promoting wound management products.

The ABPI Code was written further to consultation by the ABPI with the British Medical Association (BMA) and the Department of Health.

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).

2. Appointments

2.1. Pharmaceutical representatives must firstly contact the hospital pharmacy department, to inform the Formulary Pharmacist of what product(s) is/are being promoted and to whom.

2.1.1. This will include the completion of a registration form and will simplify any subsequent appointments with pharmacy staff.

2.1.2. All pharmaceutical representatives will be given a copy of this policy Document by pharmacy.

2.2. 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.

2.2.1 Supplier representatives must not make unplanned 'drop-in' visits to said staff, wards or departments for the purpose of distributing promotional material, or informally interviewing staff.

2.3 Supplier representatives must always respect hospital staff time. If, for any reason, the representative cannot meet an appointment, the longest possible notice must be given.

2.4 Supplier representatives must not use the telephone/internet/fax to promote products to hospital staff, unless explicit prior arrangements have been made with the individuals concerned.

2.5 Supplier representatives must ensure that the frequency, timing and duration of calls to hospital staff, together with the manner in which they are made, do not cause an inconvenience.

3. Drug Formulary

3.1 Only those drugs that are listed in the Trust Drug Formulary are routinely available for prescribing.

3.2 Requests for products not included in the Trust Formulary (including new chemical entities) can only be made by Consultant Physicians, by direct written application to the Trust Formulary Monitoring Group. Such application does not infer automatic inclusion in the Formulary.

3.3 Such restriction will also apply to wound management products pending the availability of a Trust Wound Management Formulary.

4. Samples

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

4.2 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 Formulary Monitoring Group. Any subsequent use will be strictly controlled and monitored by pharmacy, and does not infer automatic inclusion in the Formulary.

4.3 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. Gifts or Inducements

- 5.1 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 (i.e. costing the donor company no more than £5 per item excluding VAT), and relevant to the practice of that profession.
- 5.2 Amongst other articles, items such as pens, note pads, diaries and other miscellaneous stationery have been held to be acceptable gifts.
- 5.3 Distribution of such articles must be within the appointment restrictions as indicated in Section 2 of this document.

6. Hospitality

- 6.2 Hospitality offered to hospital staff for the purpose of product sales promotion must be secondary to the main purpose of the meeting.
- 6.3 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.
- 6.4 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.
- 6.5 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.
- 6.6 Hospital staff conduct with commercial/business sources should be in accordance with Health Service Guidelines, and in accordance with the Trust Standing Orders and Standing Financial Instructions.

7. General Notes

- 7.1 Supplier representatives must avoid the use of unfair or misleading comparisons, or comparisons implying a therapeutic advantage that is not in fact justified.
- 7.2 Claims made for products by representatives must be limited to the indications permitted by the Product Licence.
- 7.3 Information regarding relevant research into unlicensed indications may be supplied, but representatives must state clearly that the Product Licence does not cover such indications.
- 7.4 Supplier representatives must not use any inducement or subterfuge to gain an interview with hospital staff. No payment of a fee should be made for the granting of an interview.
- 7.5 Supplier representatives must not enlist the support of Consultant Medical Practitioners to 'test' new products by asking them to sign use/supply agreements.

- 7.6 When a representative initiates discussion about a product, he/she should place provide the member of hospital staff with a reference copy of the Summary of Product Characteristics (or equivalent) in respect of that product.

Appendix 3 – Medicines that need to be readily 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 – National Patient Safety Agency Alerts

The following is a list of alerts relevant to medicine usages. A complete list is available on the NPSA web site (www.npsa.nhs.uk/health/alerts)

Safer ambulatory syringe drivers	16 December 2010
Preventing fatalities from medication loading doses	25 November 2010
Prevention of over infusion of intravenous fluid* and medicines in neonates	26 August 2010
Reducing treatment dose errors with low molecular weight heparins	30 July 2010
Safer administration of insulin	16 June 2010
Reducing harm from omitted and delayed medicines in hospital	24 February 2010
Safer use of intravenous gentamicin for neonates	09 February 2010
Vaccine cold storage	21 January 2010
Safer lithium therapy	01 December 2009
Reducing risk of overdose with midazolam injection in adults	9 December 2009
Avoiding wrong side burr holes / craniotomy	12 November 2008
Risks of omitting Hib when administering Infanrix-IPV+Hib	21 October 2008
Risks to haemodialysis patients from water supply (hydrogen peroxide)	30 September 2008
Using Vinca Alkaloid Minibags (adult/adolescent units)	11 August 2008
Problems with infusions and sampling from arterial lines	28 July 2008
Reducing Dosing Errors with Opioid Medicines	4 July 2008
Risks of chest drain insertion	19 May 2008
Risks with Intravenous Heparin Flush Solutions	24 April 2008
Risks of incorrect dosing of oral anti-cancer medicines	22 January 2008
Fire Hazard with Paraffin Based Skin Products on Dressings and Clothing	26 November 2007
Emergency support in surgical units: Dealing with haemorrhage	10 Sep 2007
Rapid Response Report 2: Risk of confusion between non-lipid and lipid formulations of injectable amphotericin	3 Sep 2007
Rapid Response Report: Risk of confusion between cytarabine and liposomal cytarabine (Depocyte®)	18 June 2007
Actions that can make anticoagulants safer	28 th March 2007
Promoting safer measurement and administration of liquid medicines via oral and other enteral routes.	28 th March 2007
Promoting safer use of injectable medicines	28 th March 2007
Reducing the risk of hyponatraemia when administering intravenous infusions to children	28 th March 2007
Safer practice with epidural injections and infusions	28 th March 2007
Improving compliance with oral methotrexate guidelines	1 st June 2006
National Patient Safety Agency alerts NHS to risks with high dose morphine and diamorphine injections	25 th May 2006
Being open when patients are harmed	15 th Sept 2005
Vaccine incident – review of a clinical incident in a PCT	15 th April 2005
Ensuring safer practice with Repevax and Revaxis injections	29 th April 2005
Update on producing patient information on methotrexate usage	30 th Nov 2004
Methotrexate	29 th July 2004
Improving infusion device safety	20 th May 2004
Update on the implementation of recommended safety controls for potassium chloride in the NHS	6 Nov 2003
Potassium chloride concentrate solutions	23 rd July 2002
Administering vincristine	1 st April 2001

Appendix 5 – Commonly used Schedule 2 and 3 Controlled Drugs

A table of commonly used CDs is now maintained separately on the intranet and can be accessed by clicking [here](#).

APPENDIX 6: AUTHORISATION FOR THE ORDERING OF CONTROLLED DRUGS FORM

AUTHORISATION FOR THE ORDERING OF CONTROLLED DRUGS

Ward/Department _____

NAME of staff member authorised to order CDs	SIGNATURE of staff member authorised to order CDs	NAME of Authoriser	SIGNATURE of Authoriser	DESIGNATION of Authoriser

Appendix 7 – Procedure for the preparation and administration of intravenous bolus drugs and infusions

Purpose of this Procedure:	To ensure correct and safe preparation and administration of intravenous drugs and fluids
Scope of this Procedure:	Nurses, doctors and other staff preparing and administering these injections
Related procedures/documents:	Medicines Policy

Administration

Consent to treatment and patient education is paramount to ensure the patients psychological and physical wellbeing. In situations where the patient is confused or unconscious and it is in the patient's best interests, the individual practitioner must act in such a manner as to promote and safeguard the interests and wellbeing of the patient.

A registered nurse/midwife operating department practitioner (ODP) or doctor must never administer a medicine without an authorised prescription or a signed standing order (or in the case of community midwife, a supply order).

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 drugs or fluids via the intravenous route.

There are three broad classes of intravenous drug preparations;

- a) Those presented in a form ready for administration
- b) Those which require reconstitution before administration
- c) Those which require further dilution before administration

Before administration of a IVI drug or fluid;

1. Administration of intravenous therapy is a two-nurse / midwife, pharmacist, ODP or doctor procedure from start to finish.
2. The administering nurses / midwife or ODP must have attended the Trust's Intravenous Fluid Study Day (or have received an accredited prior experiential learning (A.P.E.L) competency form) and completed their competency assessment.
3. Always read the prescription carefully, if there is any ambiguity or lack of clarity in the

prescription, including the signature of the prescriber then the drug must not be given. The prescriber should be contacted to rewrite the prescription. The registered nurse / midwife or ODP needs to ensure there is a minimal delay in this instance and the administration of urgent IVIs is not affected.

4. Check that the prescribed dose has not already been given and that it is appropriate to administer this to the patient under the circumstances.
5. Check the allergy status, if not documented, confirm and record the status on the prescription chart, either by direct confirmation with the patient or from the medical records. If unable to obtain then do not administer and consult with responsible prescriber unless in an emergency situation.
6. Wash your hands and follow the Aseptic Non-touch technique.
7. Select the medicine required paying attention to the strength and expiry date. The drug name and strength on the label must be checked against the prescription, and the enclosed packaging information must be read in order to select an appropriate diluent and quantity of diluent.

Prepare the drug / fluid and check

1. the name of the patient
2. the name and form of the drug or fluid
3. the route for administration
4. the calculation, if any
5. the measured dose / drip rate
6. the date and time of the dosage
7. the time of the last dose

When giving intravenous drugs or fluids the administering person should be aware of;

1. the appropriate equipment required and how to use it
2. the therapeutic class of drug or fluid they are giving
3. why the patient is receiving this drug or fluid
4. whether the dose is appropriate for the patient and their condition
5. how should it be reconstituted if required
6. how it should be administered
7. is it for slow IV injection (bolus) or infusion

8. the infusion rate of the infusion required
9. over what period of time the bolus or infusion should be given
10. whether it should be given peripherally or centrally
11. what side effects should be anticipated
12. the appropriate action to take if side effects occurred in your patient

Administering an IV Therapy

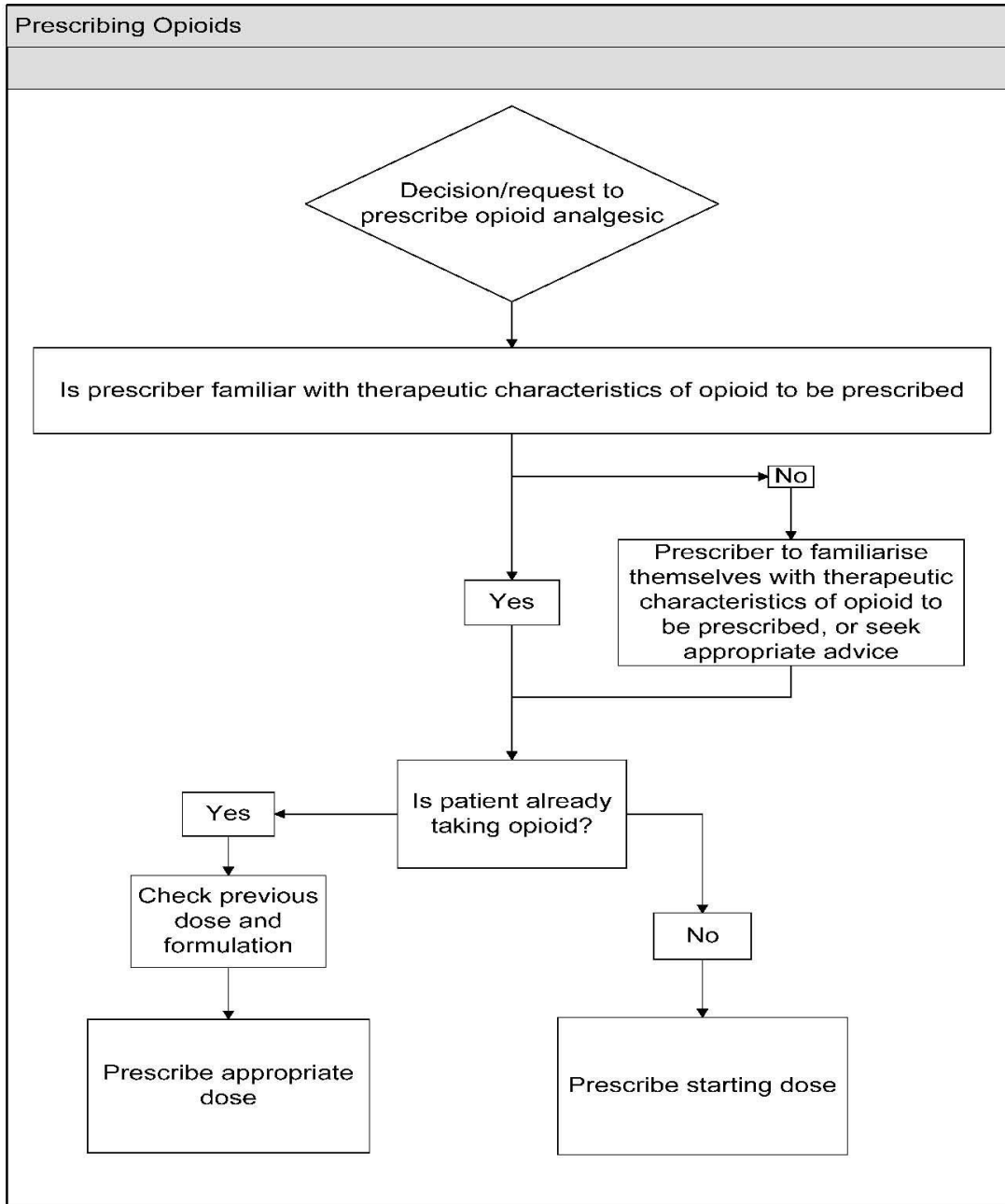
This is a two nurse / midwife, ODP or doctor procedure from start to finish. All checks listed in section 11.6.4 apply

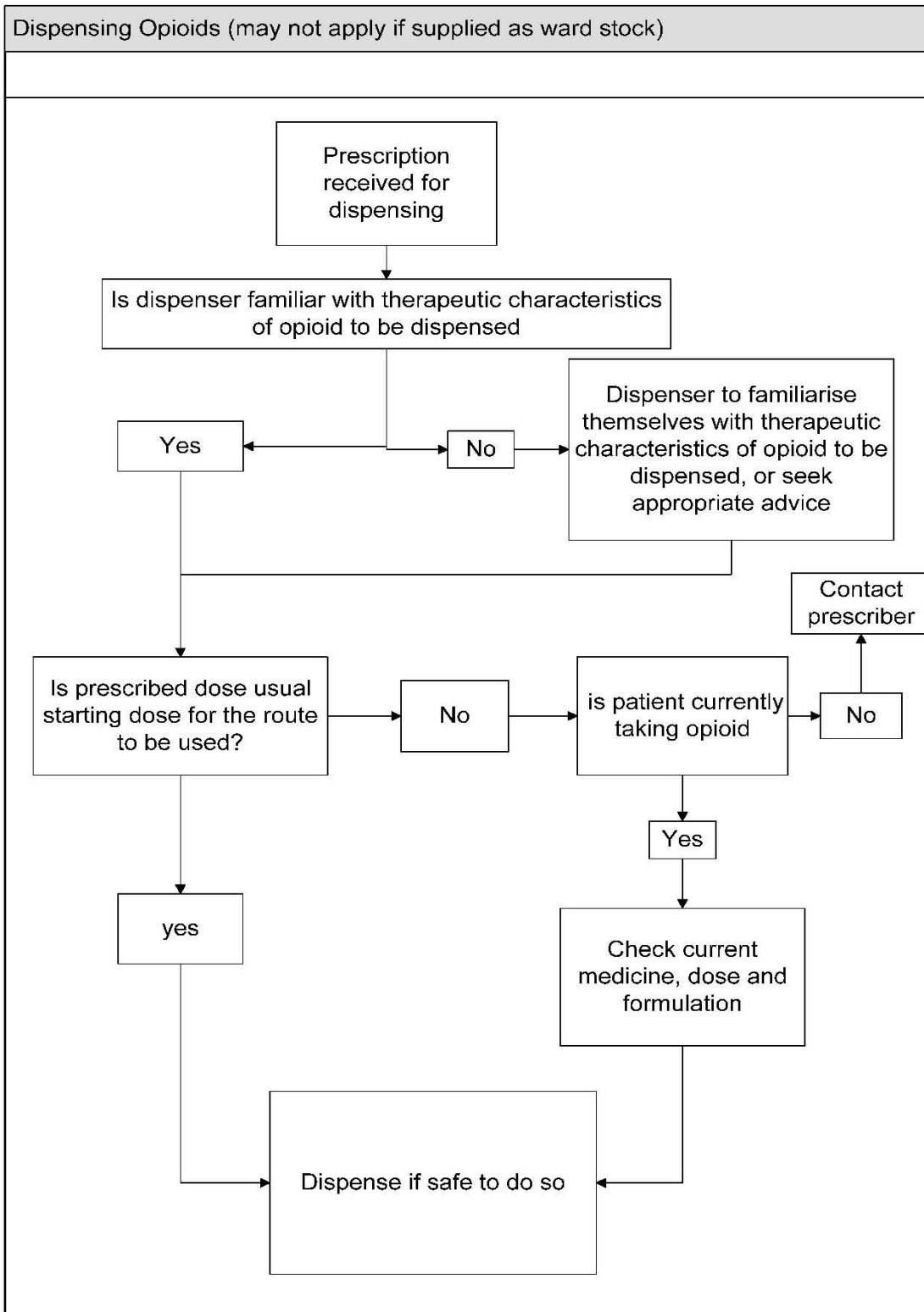
1. Check the prescription/fluid chart
2. Get the prescribed medication from the drug cupboard and any diluent(s) that may be required including a 10ml 0.9% sodium chloride flush (5mls pre and post bolus flush required for each bolus)
3. Check it against the medication chart with another registered nurse / midwife, ODP or doctor
4. Check the expiry dates of all ingredients and check that infusion bags are particle free.
5. Write out an additive label if required.
6. Wash hands and put on a pair of gloves if required e.g. for patients who are immunosuppressed
7. 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.
8. 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 diluents is used (see package insert guide). If the drug is being added to an infusion bag only use a green or filter needle and invert the bag several times to ensure adequate mixing.
9. Check the final injection/infusion for particles.
10. Make sure an additive label is completed and signed and then stuck to the infusion bag/syringe taking care not to obscure and details on the syringe or infusion bag
11. Both nurses / midwife, ODP or doctor should take the fluid/injection/infusion to the patient in a suitable receiver.
12. Check the patient's identity following the Trust's positive identification policy and the patient's allergy status.

13. Inform the patient of the procedure and the drug you are administering
14. Check the cannula site for signs of inflammation
15. Clean the needle free device (bionector) hub attached to the cannula hub with a Chlorotrip swab and leave to air dry for 30 seconds
16. 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
17. Administer the drug 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.
18. Repeat the 0.9% sodium chloride flush
19. Dispose of equipment safely according to Trust Policy
20. Sign and date the drug administration record and ensure the second nurse ,midwife, ODP or doctor signs the appropriate documentation
21. If more than one drug is being given then flush the cannula via the needle free device(bionector) hub with 10-5ml of 0.9% sodium chloride between each drug to avoid drug 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 drug. 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 drug should be disposed of and the procedure must be followed as above.
22. There are a limited number of drugs 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.

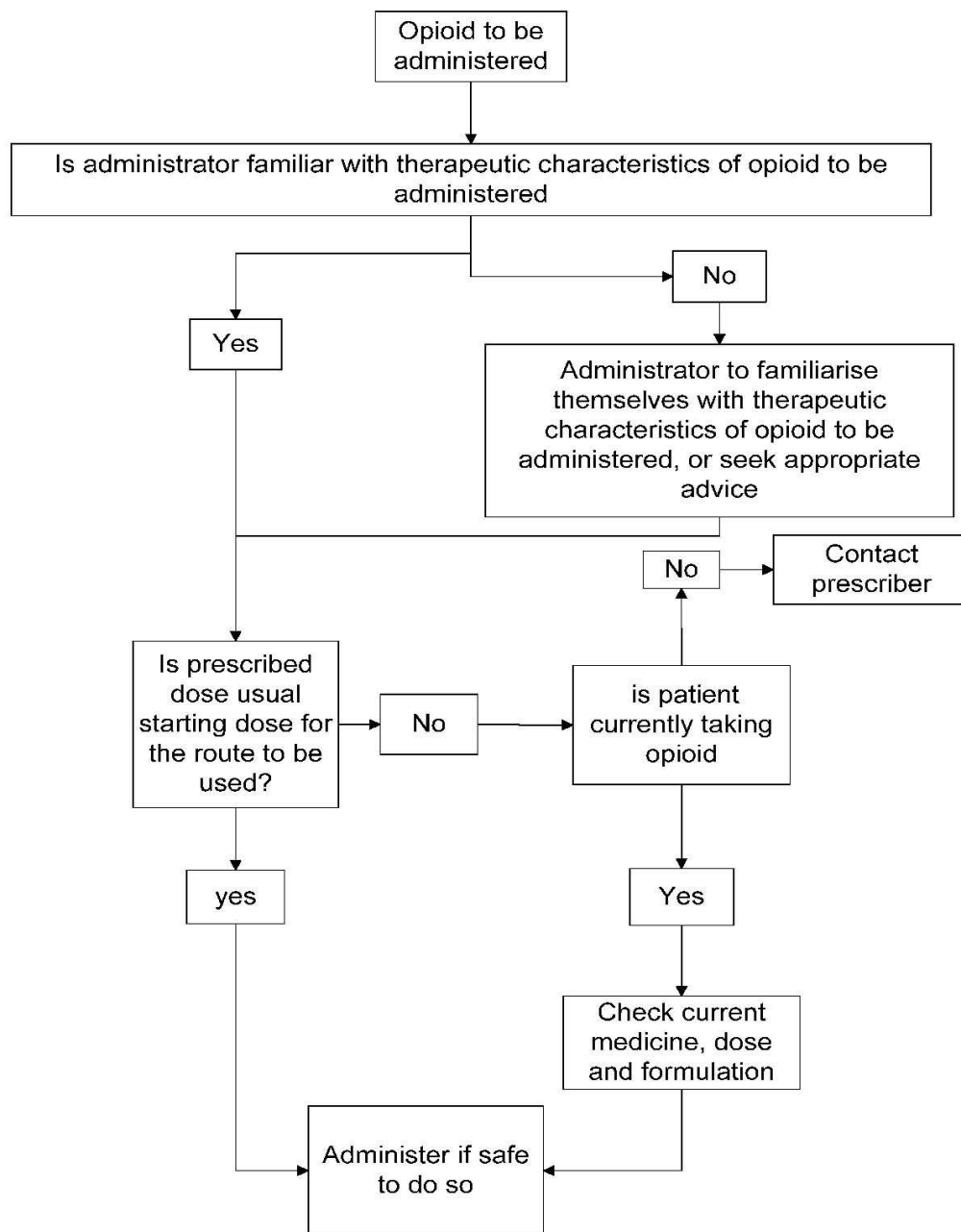
Written by: Alan Higginson Date: June 2012		Authorised by: Medicines Optimisation Committee Date: 22/06/12	
Document Reference: AHPOLMM		Status: Live	
Document effective from:	Date: 14 th February 08	Review Date: June 2014	
Supersedes doc. Ref:		Reason for change:	
No. of copies:	Location of copies:		

Appendix 8 – Safe prescribing, dispensing and administering opioid medicines

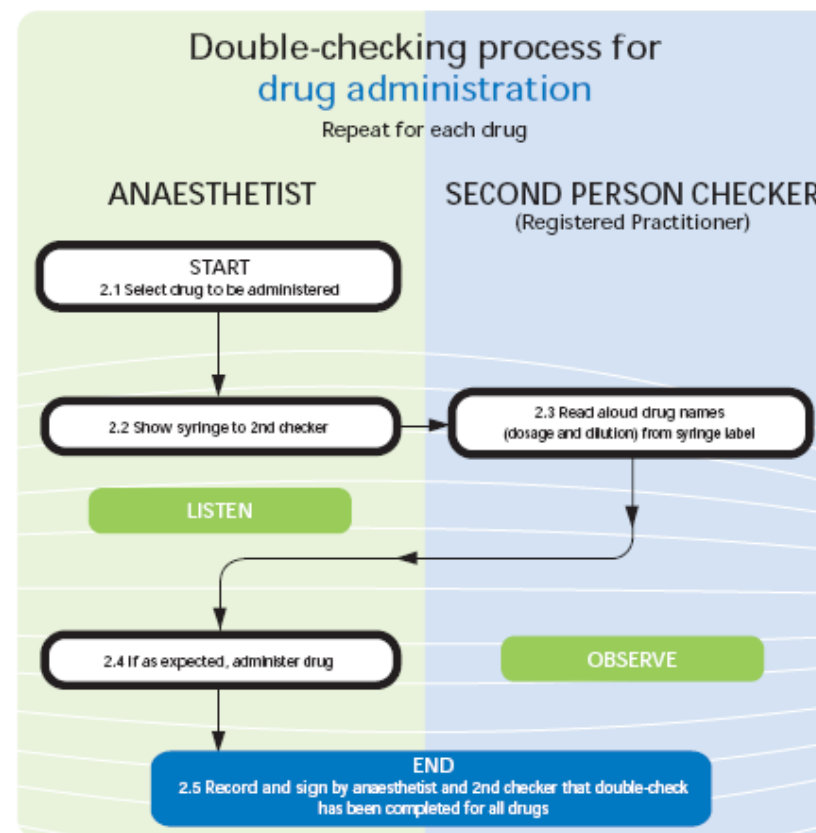
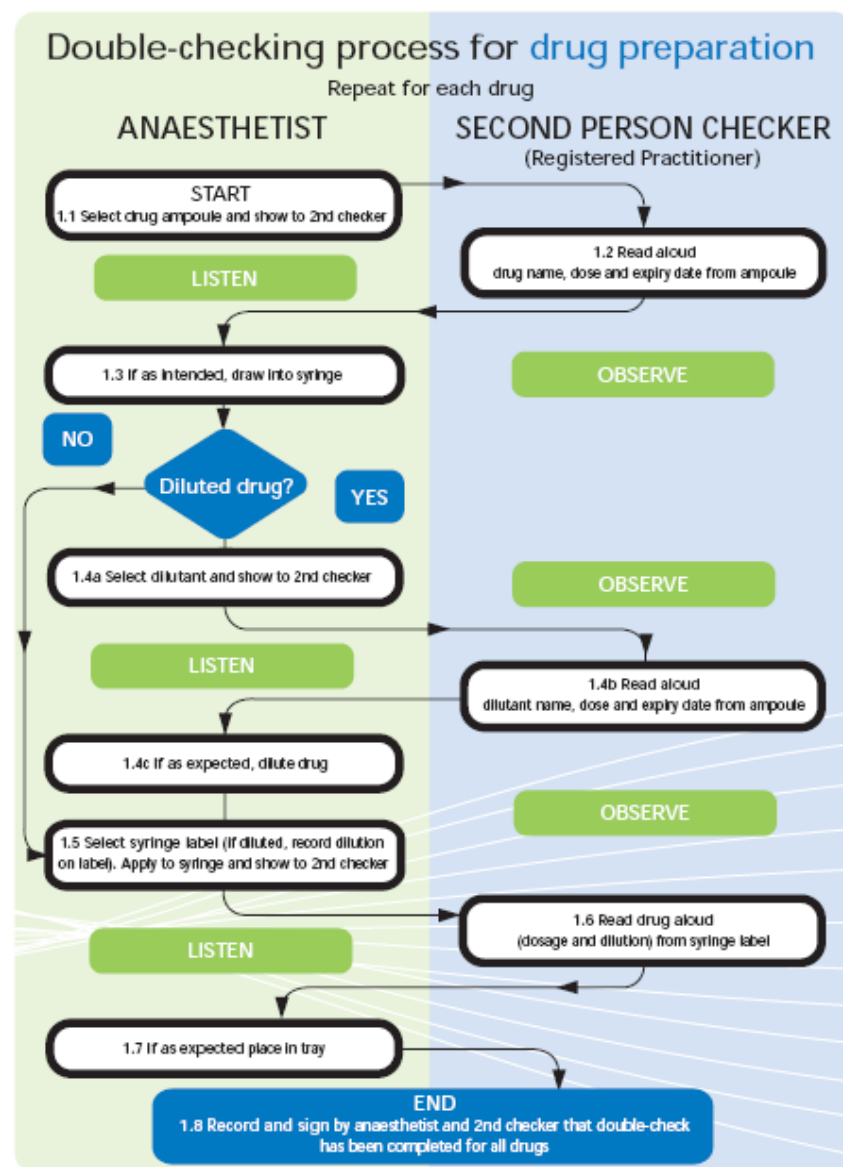




Administering Opioids



Appendix 9 Double-checking process for medicines preparation by anaesthetists



Appendix 10 Delayed or omitted medicines – NPSA critical list

Due to the risk of harm, the prescription, dispensing and administration of the following critical medicines must never be unintentionally omitted or delayed.

UNINTENTIONAL OMISSION OR DELAY OF THESE MEDICINES CONSTITUTES AN ADVERSE INCIDENT REPORTABLE ON DATIX.

DEFINITIONS	
Delay	<ul style="list-style-type: none"> Administration of a medicine 2 or more hours after the specified dose time.
Omission	<ul style="list-style-type: none"> Failure to prescribe a critical medicine in a timely manner. Failure to administer a dose before the next dose is due or, in the case of 'stat' doses, failure to administer within 2 hours of the specified dose time.
Medicine Name or Class	Rationale
Systemic antimicrobials (including antibiotic, antifungal, antiviral, antiretroviral & antimalarial medicines)	Potential worsening of systemic infection/emergence of resistance.
Gentamicin in neonates (within 1 hour of due dose time)	NPSA alert relating to gentamicin in neonates.
Oral hypoglycaemic medicines	Loss of glycaemic control.
Insulin	Loss of glycaemic control.
Glucose or Glucagon	Failure to treat symptomatic hypoglycaemia.
Glucose (in normoglycaemic patients on IV insulin)	Risk of hypoglycaemia.
Opioids (prescribed <u>regularly</u> for severe chronic pain)	Loss of pain control.
Analgesics (for acute post-operative pain)	Risk of exposure to avoidable pain.
Naloxone	Failure to treat opioid toxicity.
Immunosuppressants (in transplants) and corticosteroids .	Potential transplant rejection/treatment failure.
Chemotherapy (including cytotoxics and adjunctive treatments)	Potential cancer treatment failure.
Anticoagulants (therapeutic & thromboprophylaxis)	Potential life-threatening thrombus progression/embolic episode.
Parenteral electrolyte replacement (for urgent deficiencies)	Potential deterioration of clinical condition.
Calcium resonium or glucose/insulin (for treating hyperkalaemia)	Risk of severe hyperkalaemia.
Parenteral bisphosphonate (for symptomatic hypercalcaemia)	Potential worsening of symptoms.
Prophylaxis to reduce other drug toxicity (e.g. acetylcysteine and contrast media)	Potential ADRs from known toxic medicines
Anticonvulsants	Loss of seizure control.
Anti-Parkinsonian agents	Loss of symptom control; "Get It On Time" campaign.
Nebulised bronchodilators (for severe breathing difficulties).	
Resuscitation drugs and reversing agents	Failure to treat medical emergency.
Antiplatelets and thrombolytics (for acute cardiovascular events).	Potential poor outcomes post-MI; re-stenosis risks in PCI.
Beta blockers (perioperatively)	Risk of tachyarrhythmias.
Benzodiazepines & parenteral vitamins (for acute alcohol withdrawal symptoms)	
Oxygen	Potential harm from hypoxia.
Rapid tranquillisation medicines	Delay in symptom control

Appendix 11 – 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
- Co-codamol 8/500
- Docusate capsules
- Ferrous fumarate
- Ferrous sulfate
- Ibuprofen
- Ispaghula (Fybogel®)
- Lactulose
- Peppermint oil capsules
- Paracetamol tablets
- Peptac® liquid

Nicotine replacement therapies may be supplied and recorded within the maternity Orion pathway. These are GSL products and are not required to be labelled with patient-specific directions.

Appendix 12 – 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 is 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).

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